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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: CS0E

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00286

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245566**

2.STATE VENDOR OR MEDICAID NO.
(L2) **844240100**

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **09/15/2014** (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 **45** (L18)

13.Total Certified Beds **45** (L17)

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

17. SURVEYOR SIGNATURE Date :
Jennifer Lageson, HFE NE II 09/16/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 09/17/2014 (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
07/01/1991
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
09/05/2014
(L33)

DETERMINATION APPROVAL

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 245566

September 16, 2014

Mr. Brian Reindl, Administrator
Valley View Healthcare & Rehab
510 East Cedar Street
Houston, Minnesota 55943

Dear Mr. Reindl:

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 August 26, 2014 the above facility is certified for or recommended for:

45 Skilled Nursing Facility/Nursing Facility Beds

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

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

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

Please contact me if you have any questions.

Sincerely,

Kamala Fiske-Downing

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

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

September 16, 2014

Mr. Brian Reindl, Administrator
Valley View Healthcare & Rehab
510 East Cedar Street
Houston, Minnesota 55943

RE: Project Number S5566025

Dear Mr. Reindl:

On July 25, 2014, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on July 17, 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 September 15, 2014, the Minnesota Department of Health completed a Post Certification Revisit (PCR) and on August 27, 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 July 17, 2014. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of August 26, 2014. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on July 17, 2014, effective August 26, 2014 and therefore remedies outlined in our letter to you dated July 25, 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.

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

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

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
245566	A. Building B. Wing	9/15/2014

Name of Facility	Street Address, City, State, Zip Code
VALLEY VIEW HEALTHCARE & REHAB	510 EAST CEDAR STREET HOUSTON, MN 55943

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 **F0272** Reg. # **483.20(b)(1)** LSC	Correction Completed **08/26/2014**	ID Prefix **F0280** Reg. # **483.20(d)(3), 483.10(k)(2)** LSC	Correction Completed **08/26/2014**	ID Prefix **F0312** Reg. # **483.25(a)(3)** LSC	Correction Completed **08/26/2014**
ID Prefix **F0329** Reg. # **483.25(l)** LSC	Correction Completed **08/26/2014**	ID Prefix **F0371** Reg. # **483.35(i)** LSC	Correction Completed **08/26/2014**	ID Prefix **F0431** Reg. # **483.60(b), (d), (e)** LSC	Correction Completed **08/26/2014**
ID Prefix **F0441** Reg. # **483.65** LSC	Correction Completed **08/26/2014**	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	GN/KFD	09/17/2014	10155	09/15/2014
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?
7/17/2014	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
245566	A. Building B. Wing **01 - VALLEY VIEW NURSING HOME**	8/27/2014

Name of Facility	Street Address, City, State, Zip Code
VALLEY VIEW HEALTHCARE & REHAB	510 EAST CEDAR STREET HOUSTON, MN 55943

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	Correction Completed **08/26/2014**	ID Prefix	Correction Completed **08/26/2014**	ID Prefix	Correction Completed **08/26/2014**
Reg. # **NFPA 101**		Reg. # **NFPA 101**		Reg. # **NFPA 101**	
LSC K0038		LSC K0050		LSC K0062	
ID Prefix	Correction Completed **08/26/2014**	ID Prefix	Correction Completed **08/26/2014**	ID Prefix	Correction Completed
Reg. # **NFPA 101**		Reg. # **NFPA 101**		Reg. #	
LSC K0064		LSC K0069		LSC	
ID Prefix	Correction Completed	ID Prefix	Correction Completed	ID Prefix	Correction Completed
Reg. #		Reg. #		Reg. #	
LSC		LSC		LSC	
ID Prefix	Correction Completed	ID Prefix	Correction Completed	ID Prefix	Correction Completed
Reg. #		Reg. #		Reg. #	
LSC		LSC		LSC	
ID Prefix	Correction Completed	ID Prefix	Correction Completed	ID Prefix	Correction Completed
Reg. #		Reg. #		Reg. #	
LSC		LSC		LSC	

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	PS/KFD	09/16/2014	25822	08/27/2014
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?
7/16/2014	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
245566	A. Building B. Wing **02 - 2011 ADDITION**	8/27/2014

Name of Facility	Street Address, City, State, Zip Code
VALLEY VIEW HEALTHCARE & REHAB	510 EAST CEDAR STREET HOUSTON, MN 55943

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	**08/26/2014**	ID Prefix Reg. # **NFPA 101** LSC K0062	**08/26/2014**	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** PS/KFD	**Date:** 09/16/2014	**Signature of Surveyor:** 25822	**Date:** 08/27/2014
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on: 7/16/2014

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: CS0E

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00286

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245566**

2.STATE VENDOR OR MEDICAID NO.
(L2) **844240100**

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

4. TYPE OF ACTION: **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 **07/17/2014** (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 **45** (L18)

13.Total Certified Beds **45** (L17)

10.THE FACILITY IS CERTIFIED AS:

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

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
	45			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Josephine Hassinger, HFE NE II 08/06/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 09/04/2014 (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
07/01/1991
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30)

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

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

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7013 2250 0001 6356 5477

July 25, 2014

Mr.. Brian Reindl, Administrator
Valley View Healthcare & Rehab
510 East Cedar Street
Houston, Minnesota 55943

RE: Project Number S5566025

Dear Mr.. Reindl:

On July 17, 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;

Remedies - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS) if substantial compliance is not attained at the time of a revisit;

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

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

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

DEPARTMENT CONTACT

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

Gary Nederhoff
Minnesota Department of Health
18 Wood Lake Drive Southeast
Rochester, Minnesota 55904
Telephone: (507) 206-2731 Fax: (507) 206-2711

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by August 26, 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 August 26, 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 October 17, 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 January 17, 2015 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

In accordance with 42 CFR 488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to:

Nursing Home Informal Dispute Process
Minnesota Department of Health
Division of Compliance Monitoring
P.O. Box 64900
St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting a PoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_idr.cfm

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm

Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

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

Mr. Patrick Sheehan, Supervisor
Health Care Fire Inspections
State Fire Marshal Division
444 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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245566	A. BUILDING _____ B. WING _____ AUG 6 2014 MN Dept of Health Rochester	07/17/2014

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. Upon receipt of an acceptable POC an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000	This Plan of Correction constitutes my written allegation of compliance for the deficiencies cited. However, Submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by State and Federal Law.	
F 272 SS=D	483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit;	F 272	**F 272 483.20(b)(1) – Comprehensive Assessments** Valley View Healthcare & Rehab conducts initial and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. Valley View ensures a comprehensive assessment of a resident's needs using the RAI as specified by the State. The assessment must include at least the following: identification and demographic information; customary routine; cognitive patterns; communication; vision; mood and behavior patterns; psychosocial well-being; physical functioning and 8-6-14 GPN	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — Brian Reindl — TITLE Admin/CEO — 7-31-14 (X6) DATE

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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F 272	Continued From page 1 Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to identify broken, carious teeth on the annual MDS (Minimum Data Set) for 1 of 1 resident (R31) reviewed for dental services. Findings include: R31 had been admitted on 5/4/12. R31's admission record dated 7/17/14, identified diagnoses of but not limited to dementia and congestive heart failure. R31's annual Minimum Data Set (MDS) dated 4/9/14, had identified none of the above were present under oral/dental status. Broken and carious teeth had not been identified. During observation on 7/15/14, at 3:55 p.m., surveyor viewed R31's teeth and noted R31 had one broken tooth on upper right side and other teeth were carious. During observation on 7/16/14, at 2:45 p.m.,	F 272	structural problems; continence; disease diagnosis and health conditions; dental and nutritional status; skin conditions; activity pursuit; medications; special treatments and procedures; discharge potential; documentation of summary information regarding the additional assessments performed through the resident assessment protocols; and documentation of participation in assessment. The comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, any other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the legal resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.	

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F 272	Continued From page 2 registered nurse (RN)-B verified R31 had a broken tooth on right upper side. R31's dental progress note dated 6/20/13, identified R31 had caries and tooth fractures. R31's facility oral cavity assessment dated 4/7/14, identified under condition of teeth and gums: daily cleaning of teeth/dentures or daily mouth care by resident or staff, plaque build-up, receding, but had not identified broken and carious teeth. During interview on 7/17/14, at 11:04 a.m., director of nursing had stated she would expect broken and carious teeth to be carried forward to annual assessment dated 4/9/14, from dental progress note dated 6/20/13. Document review of the facility MDS policy undated, read, "Valley View Nursing Home will conduct comprehensive, accurate, standardized and reproducible assessments (MDS) of each resident's functional capacity, following HCFA Protocol as outlined in MDS manual: B. Assessment Review: The facility will examine each resident no less than once every 3 months and revise the resident's assessment to assure continued accuracy of the assessment."	F 272	On July 17, 2014, Registered Nurses that complete comprehensive assessments and MDS Coordinator were informed of observation assessment findings, MDS coding, and dental findings. Re-education was provided to check dental progress notes when completing oral observation assessments and coding MDS's. Resident was seen by dentist on July 22, 2014. "When discussing any type of restoration patient is expressly against them. I do not think it would be a good idea to try to force patient against her will to do so. I see the patient in no immediate distress and recommend another exam in one year." All residents have the potential to be affected by this practice. Director of Nursing and MDS Coordinator will monitor for compliance.	08/26/2014
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed	F 280	**F280 483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE REVISE CP** Valley View Healthcare & Rehab assures that a comprehensive plan of care must be reviewed and revised by	

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F 280	Continued From page 3 within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to revise the care plan for fall intervention of 15 minute checks for 1 of 3 residents (R44) reviewed for accidents. Findings include: R44 had been admitted on 4/25/11. R44's admission record dated 7/17/14, identified diagnoses of but not limited to dementia and hypertension. R44's quarterly Minimum Data Set (MDS) dated 6/3/14, had identified R44's brief interview of mental status (BIMS) had been 6 out of 15 and indicated severe cognitive impairment and R44 had falls, two with no injury. During continuous observation on 7/17/14, at 7:23 a.m., R44 had laid in bed sleeping, call light in reach and bed in low position. At 7:38 a.m., R44 remained the same, no staff had entered room. At 7:54 a.m., R44 remained the same, no staff had entered room. At 8:10 a.m., R44	F 280	an interdisciplinary team that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, with the participation of the resident, the resident's legal guardian or chosen representative at least quarterly and within seven days of the revision of the comprehensive resident assessment. Reeducation provided to registered nurses on July 17, 2014 on thoroughness, follow through of documentation and communication to staff on recommendations with assessments. Resident #44's care plan was updated with Registered Nurse's recommendations from June 14, 2014 to start resident on 15 minute checks upon notification of findings by surveyor on July 17, 2014. Resident's name was added to the list of resident on 15 minute checks and was passed on to nursing staff via verbal and written report. Social worker receives daily 15 minute check sheets to ensure checks are being completed. On July	

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F 280	Continued From page 4 remained the same, no staff had entered room. At 8:29 a.m., R44 remained the same, no staff had entered room. At 8:43 a.m., registered nurse (RN)-C entered R44's room and repositioned R44 from back and laid R44 on left side with pillow behind back. No staff had entered R44's room every 15 minutes to check on R44. Document review of R44's safety risk data collection dated 6/14/14, identified analysis or summary of safety risks: at risk for falls, five falls over past year without serious injury, alarms in place, every two hour checks for toileting needs and fifteen minute checks for safety. Document review of R44' s care plan dated 6/10/14, identified at risk for falls related to anemia, diabetes, osteoporosis, history of falls with interventions of check resident nightly about 11:45 p.m. to 12:15 a.m., bed kept in lowest position, call light within reach and staff to remind to use, encourage resident to lay down mid morning, fall precautions in place sensor alarm on bed and chair to alert staff if resident tries to get up, family declines floor mat and bed alarm, vitamin D as directed, when doing cares show and remind how to use call light and boost up on pillow when in bed. R44's care plan dated 6/10/14, lacked to include intervention of 15 minute checks. During interview on 7/17/14, at 8:50 a.m., RN-C had stated, "Yes" when asked by surveyor if 15 minute checks for safety was a fall intervention implemented on 6/14/14 from the safety risk data collection analysis. RN-C reviewed R44's care plan dated 6/10/14 and R44's resident status sheets (RN-C at time stated sheets nursing assistants follow for resident care, part of R44's	F 280	29, 2014, Resident #44's 15 minute checks were reviewed. No further falls or attempts to get up on her own. Resident is checked on routinely during the night around the time of previous falls. 15 minute checks were discontinued. Random audits will be done to ensure care plans have been updated by charge nurse, Social Worker, Director of Nursing, or MDS Coordinator. All residents have the potential to be affected by this practice. Director of Nursing and Social worker will monitor for compliance.	08/26/2014

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F 280	Continued From page 5 care plan, one sheet is in resident chart and one sheet is in resident room inside closet door) lacked to include intervention of 15 minute safety checks. RN-C proceeded to say they had not written on R44's care plan 15 minute checks and also write on R44's resident status sheets 15 minute checks with date of 7/16/14 on one of the sheets. RN-C had stated we also have a 15 minute check list of residents and added R44 to the list and then RN-C had verbalized to staff over the walkie-talkies (used by staff to communicate) R44 is on 15 minute checks. During interview on 7/17/2014, at 11:10 a.m., director of nursing had stated she would expect 15 minute checks implemented on 6/14/14 to be carried over to the care plan, passed on to staff and include resident on check board list of residents on 15 minute checks.	F 280		
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure clean nails for 1 of 3 residents (R31) reviewed for activities of daily living. Findings include:	F 312	**F312 483.25(a)(3) ADL Care Provided for Dependent Residents** Valley View Healthcare & Rehab ensures that if a resident is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. The nursing assistants were instructed on job requirement and expectations that they be aware of and follow the residents' plan of care for nail care. Memo was posted to remind all licensed staff and nursing aides	

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F 312	Continued From page 6 Admission record dated 7/17/14, identified diagnoses of but not limited to dementia and congestive heart failure. R31's annual Minimum Data Set (MDS) dated 4/9/14, had identified R31's brief interview of mental status (BIMS) had been 10 out of 15 and indicated moderate cognitive impairment and R31 required extensive assist of one for personal hygiene. During observation on 7/16/14, at 10:40 a.m., R31 had been in the dining room sitting in a wheelchair at a dining room table eating breakfast independently. R31's fingernails on both hands were noted to have debris underneath nails and R31 had been picking up a piece of bacon with these fingers and eating the bacon. During observation on 7/16/14, at 2:31 p.m., nursing assistant (NA)-C verified R31 had debris underneath fingernails on both hands. NA-C had stated R31 is not diabetic so it would be the nursing assistant's responsibility to clean and trim nails for R31. NA-C had sated R31 can be very difficult at times and refuse cares. Surveyor asked NA-C if there was anywhere refusal of nail care would be documented by nursing assistants and NA-C had replied in the computer. NA-C showed computer charting for R31 to surveyor and verified there had been no place in the computer for nursing assistants to document refusal of nail care. During observation on 7/16/14, at 2:45 p.m., registered nurse (RN)-B verified R31 had debris underneath fingernails on both hands. RN-B had stated nursing assistants were responsible to clean and trim nails for residents on bath day unless the resident is a diabetic than the nurse would be responsible.	F 312	regarding importance of nail care on July 21, 2014. Nursing staff were instructed to document refusal of cares in resident's point of care. Oncoming staff should then attempt nail care on resident during day time hours. Nursing in-service scheduled for August 13, 2014. Weekly audits will be conducted for four weeks on random resident's to ensure that nail care is being performed per resident's plan of care. If problems are noted additional audits and staff training will be completed. All residents have the potential to be affected by this practice. Director of nursing/designee will monitor for compliance.	08/26/2014

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F 312	Continued From page 7 Document review of R31's resident status sheet undated identified grooming: nails offer assist. Document review of the facility bath schedule sheets identified R31 bath days were Thursday p.m. and Saturday. During interview on 7/17/14, at 11:04 a.m., director of nursing had stated the resident status sheet is part of R31's care plan and was what the nursing assistants follow for resident care. Director of nursing had sated she would expect nursing assistant giving bath provide nail care at the time of bath if resident was cooperative. At 12:25 p.m., director of nursing had stated she would expect if resident refused bath to attempt to clean and trim nails between baths. Document review of the facility NAILS, CARE OF (FINGER AND TOE) undated, read, "PURPOSE 1. To provide cleanliness. 2. To prevent spread of infection. 3. For comfort. 4. To prevent skin problems."	F 312		
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	F 329	**F329 483.25(l) Drug Regimen is Free from Unnecessary Drugs** Valley View Healthcare & Rehab assures that each resident's drug regime is free from unnecessary medication. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without	

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F 329	Continued From page 8 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 drugs. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to monitor individualized, targeted behaviors for the use of three antidepressants and an antipsychotic medication for 1 of 5 residents (R19) reviewed for unnecessary medications. Findings include: R19 was admitted to the facility on 10/13/14 as noted on the signed physician orders dated 4/2/14 and indicated that R19 had orders for the following medications: Buspar 10 mg (an antidepressant) two times a day, Trazodone 50 mg (an antidepressant) at bedtime, Zyprexa 2.5 mg (an antipsychotic) once a day, and Celexa 20 mg (an antidepressant) once a day. A physician visit note dated on 6/4/14 indicated that R19's diagnosis included but was not limited to: delusional disorder, anxiety disorder, somatization disorder (Somatization disorder is a psychiatric condition marked by multiple medically unexplained physical, or somatic, symptoms), and insomnia. The quarter Minimum Data Set	F 329	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 behavior interventions, unless clinically contraindicated, in an effort to discontinue these drugs. The resident's drug regime is reviewed by the licensed staff, physician, and consultant pharmacist to assure that medications are not used in excessive doses, for excessive duration, without adequate monitoring, without adequate indications, or in the presence of adverse consequences. Pharmacist consultant reviews medication regime on all residents monthly. The preliminary survey findings were provided to pharmacist	

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F 329	Continued From page 9 (MDS) dated 6/30/14 indicated R19 had a diagnosis of dementia and a Brief Interview for Mental Status (BIMS) of 12, which indicated moderately impaired cognition. R19's care plan dated 7/8/14 indicated that resident had a problem entitled anxiety disorder, diagnosis of somatization. History of numerous health and other concerns, including visits to emergency room when at home, prior to starting on Zyprexa. Diagnosis of delusional disorder; psychosis with paranoia and obsession about possible cancer. Approaches include to administer Zyprexa and observe for medication effectiveness. R19's care plan dated 7/8/14 had a problem entitled diagnosis of anxiety disorder and somatization, History of daily anxious concerns about doing the right thing, and making sure she will be okay. Past history of daily health concerns. States does get/feels restless 2-6 days/14. Approaches include to administer Buspar, Trazodone and Celexa. Observe for effectiveness and potential side effects. The facility pharmacy and therapeutics committee, antipsychotic medication use assessment summary dated 6/29/14 indicated that R19's targeted symptoms or behaviors included anxiety, dementia, delusions, paranoia, obsession about health, and psychosis. Onset of the behaviors was 3/7/10. The antipsychotic medication use assessment summary dated 6/29/14 indicated that R19's started on Zyprexa 2.5 mg every day on 10/3/13. It noted that the reason for the use of the antipsychotic was behavioral and psychological symptoms of dementia. Other condition other than dementia: paranoia, anxiety, somatization, delusional. Targeted behaviors were listed as: anxiety, dementia, delusions, paranoia, obsession about health, psychosis.	F 329	consultant and primary medical doctor on July 17, 2014. Memo was posted on July 21, 2014 directing all staff to document on resident #19's mood each shift as her antipsychotic medications was prescribed for resident's anxiety. Valley View has requested Point of Care provider to check if their system is able to highlight the Mood questions on all residents routinely to alert staff to document on resident's mood each shift. Point of care also individually lists every individual's care plan which includes resident's target behaviors and interventions. Resident #19 does receive an antipsychotic for her anxiety disorder and somatization. All residents that exhibit behaviors are routinely monitored monthly by licensed staff with weekly charting documentation rotation. The social worker will review residents' mood and behaviors quarterly with their MDS schedule. The Interdisciplinary team will continue to complete antipsychotic medication use assessment summaries quarterly with findings and recommendations sent to resident's PMD on resident #19 and all other	

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F 329	Continued From page 10 Review of the nursing assistant documentation in the point of care history (an electronic charting application) from 1/16/14 - 7/16/14 indicated that the behaviors being monitored were not specific to the identified targeted behaviors for the use of three antidepressants and an antipsychotic medication use. The clinical record lacked evidence of target behavior monitoring for the efficacy of Zyprexa. Review of the nursing progress notes dated 4/17/14 - 7/17/14 lacked evidence of target behavior monitoring for the efficacy of Zyprexa. Review of the nursing assistant sheet for R19 indicated no behaviors that were being monitored. R19 indicated during an interview on 7/16/14 at 11:09 a.m. that she enjoyed going to activities and stated that she feels a little nervous. R19 stated that watching television helps. On 7/16/14 1:15 p.m. the social worker (SW)-A stated that there was no specific form that was used for tracking the targeted behaviors. SW-A indicated that she monitors R19's targeted behaviors by 1:1 observation, the point of care documentation, nurse's notes, and that the staff will tell her if R19 is having any issues. On 7/16/14 at 11:25 a.m. registered nurse (RN)-A indicated that the nurses are trying to do charting on R19. RN-A stated R19 has improved immensely. The nursing assistants chart to the point of care. The nursing assistants are to report any untoward behavior to the nurse. On 7/16/14 at 11:42 a.m. nursing assistant (NA)-A stated that she was a new nursing assistant and NA-A had never seen the resident experience any behaviors. NA-A stated that she did not know what the behaviors R19 had. On 7/16/14 at 11:42 a.m. nursing assistant (NA)-B stated that she didn't really know what	F 329	residents on an antipsychotic medication. All resident's drug regime is audited monthly by consulting pharmacist with recommendations as indicated, and by attending physician/nurse practitioner every 60 days. All residents on antipsychotics have the potential to be affected by this practice. In-servicing will be provided on August 13, 2014, educating nursing staff that residents' current care plans can be viewed under resident profile in Point of Care which lists target behaviors and interventions. Staff compliance with above process will be monitored by nursing coordinator, the DON/designee, Social Worker, and Consultant Pharmacist.	08/26/2014

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	245566	A. BUILDING _____ B. WING _____	07/17/2014

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F 329	Continued From page 11 behaviors R19 would have. NA-B did not recall what behaviors the resident had had before. NA-B stated that the nursing assistants have a list of behaviors, not specific to the resident, which they check on the point of care if the resident exhibited them and then they would tell the nurse. The director of nurses (DON) in an interview on 7/1614 at 11:35 a.m. indicated that the nursing assistants chart behaviors in point click care. All behaviors are listed and if they see any of those behaviors they would click on it. A message was left for the consultant pharmacist (RPh)-A on 7/17/14 at 10:46 a.m. There was no return call from RPh-A. An undated policy titled Daily Behavior Observation Tool indicates the purpose of the policy: Resident's identified with targeted behaviors will be monitored on a daily basis. An ongoing log will be retained identifying target behaviors, interventions, outcomes of intervention, and frequency of behaviors exhibited.	F 329		
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by:	F 371	**F371 483.35(i) Storage, Preparation, Distribution, and Serving Food Under Sanitary Conditions** Valley View Healthcare & Rehab Follows proper sanitation and food handling practices to prevent the outbreak of foodborne illness. Safe food handling for the prevention of foodborne illnesses begins when food is received from the vendor and continues throughout the facility's food	

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F 371	Continued From page 12 Based on observation, interview and document review, the facility failed to maintain sanitary conditions when serving food. This had the potential to affect 41 of 41 residents who received food prepared from the kitchen. Findings include: During meal service observation in the kitchen on 7/16/14, at 12:09 p.m., cook-A was observed to take buns out of a plastic bag with the same soiled pair of gloves they wore when handling the door to the refrigerator to get a container of pureed pea salad. During an interview on 7/16/14, at 12:44 p.m., cook-A stated staff were always supposed to wash their hands and change their gloves when they touch something in the kitchen. Cook-A verified she did not wash her hands or change her gloves after she open the refrigerator door and returned to the serving line and pulled buns out of a plastic bag for the pulled chicken sandwiches. During interview on 7/16/14, at 12:52 p.m., certified dietary manager (CDM) stated she would expect staff to wash their hands and change gloves any time a contaminated surface was touched. Review of facility Guideline: Use of Plastic Gloves dated 2009 read, "Procedure: 1. If used, single use gloves shall be used for only one task (such as working with ready to eat food or with raw animal food), used for no other purpose, and discarded when damaged or soiled, or when interruptions occur in the operation ... 4. Remember gloves are just like hands. They get soiled. Anytime a contaminated surface is touched, the gloves must be changed."	F 371	handling processes. In-service on hand washing and glove use was completed on June 26, 2014. Memo placed in dietary communication book on proper procedure. Copy of policy was provided to each dietary staff member. Audits will be conducted 5x per week for, hand washing and glove use for compliance for 4 weeks and conducted 3 times of week for the next 30 days. All residents have the potential to be affected by this practice. Results will be brought to the Quarterly Quality Assurance Meeting for compliance or until substantial compliance is achieved.	08/26/2014

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F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview and	F 431	**F431 483.60(b), (d), (e) Drug Records, Labeling/Storage of Drugs and Biologicals** Valley View Healthcare & Rehab ensures that accurate labeling of medications to facilitate consideration of precautions and safe administration. Drugs and biologicals used in Valley View are labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. Upon notifications of findings of label not matching physician's order on individual medication sheets a "Direction changed refer to med sheet" label was placed to medication label. Pharmacy was notified of discrepancy of medication label. Licensed staff was reeducated on checking of medication labels on notification of discrepancy of labels. Medication Pass Procedure was updated on July 21, 2014. All licensed staff and TMAs have been provided a copy of the updated policy. First memo was given to licensed staff and TMAs on July 21, 2014 regarding change in label stickers if the	

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F 431	Continued From page 14 documentation review the facility failed to ensure accurate medication labels for 2 of 21 medication labels reviewed for 2 of 8 residents (R25 and R37) observed during medication pass. Findings include: An observation on 7/15/14, at 5:00 p.m. of R25's scheduled acetaminophen (pain reliever) 1000 milligram (mg) given orally medication label directed staff to dispense R25's acetaminophen four times a day. R25's physician orders dated 6/19/14, directed staff to dispense acetaminophen 1000 mg three times a day. Although the pharmacy label was incorrect R25 received the correct dosage. An interview on 7/15/14, at 5:05 p.m. with licensed practical nurse (LPN)-B verified R25's acetaminophen medication label was incorrect from pharmacy. LPN-B stated the nurse working when the pharmacy delivers the medication is to check the medication when it comes in. An observation on 7/16/14, at 12:20 p.m. of R37's scheduled Refresh Plus (eye lubricant) 0.5% eye drop to administer two drops in affected eye(s) four times a day. R37's physician orders dated 6/5/14, directed staff to dispense Refresh Plus 0.5% two drops in both eyes four times a day. Although the pharmacy label was incorrect R37 received the correct dosage. An interview on 7/16/14, at 12:21 p.m. with registered nurse (RN)-B verified R37's pharmacy label was incorrect. RN-B indicated the pharmacy delivers the medication and the nurse is to check the medication administration record (MAR) and the medication label to confirm the	F 431	medication label and medication sheet do not match. A random audit of Medication Carts will be completed weekly x 4 weeks to ensure that the label/order/MAR all matches. If problems are noted additional audits and staff training will be completed. In-servicing will be provided on August 13, 2014. Pharmacy LPN consultant will perform random medication pass audits quarterly. All residents have the potential to be affected by this practice. Monitored by: Pharmacist consultant, Director of Nursing or designee	08/26/2014

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F 431	Continued From page 15 correct medication was delivered. An interview on 7/17/14, at 7:10 a.m. with the director of nursing (DON) revealed staff is to check medication delivered from pharmacy with the print out of medication and compare them. Staff is then to put the medication in the medication cart. The DON stated if the medication labels are incorrect a sticker that directs staff to refer to the MAR, check orders, or dose change. The DON verified the nurses are to put the stickers on the pharmacy labels if incorrect. The facility policy Delivery and Receipt of Routine Deliveries revision date 1/1/13, related to receiving pharmacy products, indicated the upon delivery the facility nurse note the time of arrival, and take responsibility for the receipt, proper storage and distribution of the delivered medications.	F 431		
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	F 441	**F441 483.65 Infection Control Program, Prevent Spread, Linens** Valley View Healthcare & Rehab has established and maintains 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. On July 21, 2014, the Director Nursing updated monthly staff log of infection to include the total number of infections for the month. The number	

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F 441	Continued From page 16 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 interview and document review the facility failed to track and analyze employee infections. This had the potential to affect all residents, staff and visitors. Findings include: Document review of the facility staff infections sheets dated monthly form 9/2013 through 6/2014, identified infections "GI [gastro-intestinal], RESP [respiratory], SKIN, UTI [urinary tract infection], STREP [streptococcus-an infection], EYE, OTHER MEDICAL, NON MEDICAL" with number of staff called in written in	F 441	of infections resolved for the month. Also, in addition, any specific infection problems or trends were identified during the month and action taken if indicated. Director of Nursing will include staffs infections during quarterly quality assurance meetings including: number of infections, type of infection, any correlation to resident infections, and actions taken if indicated. All residents have the potential to be affected by this practice. The Medical Director and Administrator will monitor for compliance.	08/26/2014

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F 441	Continued From page 17 column by infection. Document review of the facility "MONTHLY INFECTION RATES: 2013-14" , identified analysis of resident infections. The analysis lacked documentation of employee infections and analysis. During interview on 7/16/14, at 11:11 a.m., director of nursing verified only information tracked for employee infections was the name of the employee who called in, date the employee called in, reason why employee called in and wing worked on identified from the schedule. Director of nursing had stated we have not been tracking the resolve date of employee infections and had stated we are not doing a summary of analysis for employee infections and only doing analysis for residents. Document review of the facility policy VALLEY VIEW HEALTHCARE AND REHAB INFECTION CONTROL INFECTION CONTROL COMMITTEE dated 3/09, read, "POLICY: A multi-disciplinary Infection Control Committee is responsible for monitoring the infection control program of Valley View Healthcare & Rehab to institute appropriate control measures when there is reasonable consideration of danger to any resident or personnel." Document review of the facility policy VALLEY VIEW HEALTHCARE AND REHAB INFECTION CONTROL INFECTION CONTROL PROGRAM OUTLINE dated 3/09, read, "POLICY: Valley View Healthcare & Rehab has an active, facility-wide infection control program with effective measures to identify, control, and prevent infections acquired or brought into the Home."	F 441		

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	245566	A. BUILDING **01 - VALLEY VIEW NURSING HOME** B. WING _____	**07/16/2014**

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K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS 2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THE SUBSTANTIAL COMPLIANCE WITH THE REGULATION HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety - State Fire Marshal Division. At the time of this survey, Valley View Nursing Home was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: Health Care Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St Paul, MN 55101-5145, or	K 000	POC ok PB 8-5-14 RECEIVED AUG - 4 2014 MN DEPT. OF PUBLIC SAFETY STATE FIRE MARSHAL DIVISION	

DC: 8-26-14
EXIT: 7-17-14

Brian Reindl — Admin/CEO — 7-31-14

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

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 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. This facility will be surveyed as two separate buildings. Valley View Nursing Home is a 1-story building with no basement. The building was constructed at 3 different times. The original building was constructed in 1967 and was determined to be of Type II(111) construction. In 1973, addition was constructed to the West Wing that was determined to be of Type II(111) construction. In 1989, another addition was added to the South Wing and was determined to be Type II (111). Because the original building and the 2 additions are of the same type of construction and meet the construction type allowed for existing buildings, the facility was surveyed as one building. The building became fully sprinklered. The facility has a fire alarm system with full corridor smoke detection, spaces open to the corridors that is monitored for automatic fire department notification. The facility has a capacity of 45 beds and had a	K 000		

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K 000	Continued From page 2 census of 41 at the time of the survey. The requirement at 42 CFR Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 038 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1 This STANDARD is not met as evidenced by: Based on observation, the facility failed to provide means of egress in accordance with the following requirements of 2000 NFPA 101, Section 19.2., 7.1.6.2 and 7.2.1.4.5. The deficient practice could affect all 41 residents. Findings include: On facility tour between 9:00 AM and 12 noon on 07/16/2014, observation revealed, that the activity south and west wing hallway exit discharge has a change in elevation of more than 1/2 inch from door thresh hold to concrete sidewalk. This deficient practice was confirmed by the Facility Maintenance Director (DJ) at the time of discovery.	K 038	**K 038:** The elevation change was due to earth settling. The two affected concrete slabs on the west entrance will be removed and re-poured so they will have no space. On the activity room south exit, that slab will be re-poured also to ensure that there is no change in elevation greater than ½ inch. Both slabs are scheduled to be completed 7/30/2014 by Randy Steinfeldt and RG Steinfeldt Construction paying special attention to assure that there is not a change in elevation greater than ½ inch. Maintenance supervisor will monitor for compliance.	08/26/2014
K 050 SS=F	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	K 050	**K050:** There was one fire drill missed in 4th quarter on evening shift. Valley View made new sheet to chart and ensure that fire drills are conducted on	

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K 050	Continued From page 3 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 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: Based on documentation review and staff interview, the facility failed to assure fire drills were conducted once per shift per quarter for all staff under varying times and conditions as required by 2000 NFPA 101, Section 19.7.1.2. This deficient practice could affect all 41 residents. Findings include: On facility tour between 9:00 AM and 12 noon on 07/16/2014, the review of the fire drills reports for July 2013 to June 2014 and the 2013 - 4th quarter - Evening shift drill was missed. This deficient practice was confirmed by the Facility Maintenance Director (DJ) at the time of discovery.	K 050	every shift, every quarter. Maintenance personal was re-trained on 7/17/2014 and made aware of the importance of having these regularly scheduled drills. Maintenance supervisor and Administrator will monitor for compliance.	08/26/2014
K 062 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5	K 062	**K62:** It was Valley View's expectation with Summit Fire Protection that they would come and monitor their equipment with-in the requirements of Life Safety Code. Summit was called to	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245566	A. BUILDING **01 - VALLEY VIEW NURSING HOME** B. WING _____	**07/16/2014**

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K 062	Continued From page 4 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain the fire sprinkler system in accordance with the requirements of 2000 NFPA 101, Sections 19.3.4.1 and 9.6, as well as 1998 NFPA 25, sections 2-1 and 2-3.3. This deficient practice could affect all 41 residents. Findings include: On facility tour between 9:00 AM and 12 noon on 07/16/2014, a review of the annual fire sprinkler inspection records revealed the following: 1. more than 12 months passed between the inspection conducted on 05/22/2013 and the inspection conducted on 06/19/2014. 2. No documentation for quarterly flow alarm tests in past 12 months These deficient practices were confirmed by the Director of Maintenance (DJ) at the time of discovery.	K 062	do the sprinkler system inspection. Inspection was completed on 6/19/2014 but was not completed in the 12 month allotted time frame. Maintenance supervisor called and notified Summit of the issue that this caused. Valley View is now on Summit's regular schedule to ensure that we stay in compliance in the future. Maintenance supervisor will been trained on how to do and document quarterly flow test. Summit has been called and will complete the flow test and train maintenance supervisor on 8/7/2014. Maintenance supervisor will be responsible for conducting the charts from 8/7/2014 on. Maintenance supervisor will monitor for compliance.	08/26/2014
K 064 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Portable fire extinguishers are provided in all health care occupancies in accordance with 9.7.4.1. 19.3.5.6, NFPA 10	K 064	**K64:** The fire extinguisher has been inspected but didn't have the correct tag because A1 forgot to put the new tag on it. Monthly inspections were documented to make sure that extinguisher was in working condition.	

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K 064	Continued From page 5 This STANDARD is not met as evidenced by: Based on observation and staff interview, it was determined that the facility failed to maintain portable fire extinguisher in accordance with NFPA 101-2000 edition, Section 9.7.4.1 and NFPA 10. This deficient practice could affect 10 out of 41 residents. Findings include: On facility tour between 9:00 AM and 12 noon on 07/16/2014, observation reveal that the fire extinguisher located in the medical record office has not been annual inspected since October 2012. according to the tag on the fire extinguisher. This deficient practice was confirmed by the Director of Maintenance (DJ) at the time of discovery.	K 064	Maintenance supervisor was re-trained on 7/17/2014 in importance of having correct tags on the extinguisher. The fire extinguisher was taken by A1 to ensure that it's still in proper working condition, and returned with the correct tag attached. Maintenance supervisor will monitor for continued compliance.	08/26/2014
K 069 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Cooking facilities are protected in accordance with 9.2.3. 19.3.2.6, NFPA 96 This STANDARD is not met as evidenced by: Based on documentation review and staff interview, the facility's kitchen cooking hood fire extinguishing system was not arranged in accordance with 2000 NFPA 101 - Sections 19.3.5 and 9.7 and 1998 NFPA 96 section 9-1.2.2. The deficient practice could affect 5 out of 41 residents. Findings include:	K 069	**K69:** A1 was contacted and completed the work for moving the piping and nozzles so they covered the stove/grill appropriately. Horse shoe tire placement devices will be installed to ensure that equipment is moved back to the appropriate position in the future. They have been ordered and will be installed when they arrive. Kitchen staff and maintenance received training on placement of stove/grill on 7/21/2014 to ensure that it gets put	

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K 069	Continued From page 6 On facility tour between 9:00 AM and 12 noon on 07/16/2014, review of the last two semi-annual inspection reports indicated that the kitchen stove was not placed in proper position. While on tour observation of the kitchen hood fire protection system, revealed that the kitchen stove was not in proper position. The kitchen hood fire protection system spray nozzles are now out of alignment and stove is not properly protected. This deficient practice was confirmed by Director of Facility Maintenance (DJ) at the time of discovery. *TEAM COMPOSITION* Gary Schroeder, Life Safety Code Spc.	K 069	back in correct position after cleaning. The shoe tire devices will ensure that equipment continues to be repositioned appropriately for long term compliance. Maintenance supervisor will monitor for continued compliance.	08/26/2014

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

FS566023

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OMB NO. 0938-0391

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	245566	A. BUILDING **02 - 2011 ADDITION** B. WING _____	**07/16/2014**

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K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS 2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THE SUBSTANTIAL COMPLIANCE WITH THE REGULATION HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety - State Fire Marshal Division. At the time of this survey, Valley View Nursing Home 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 18 New Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: Health Care Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St Paul, MN 55101-5145, or	K 000	POC ok JB 8-5-14	

Brian Reindl — Admin/CEO — 7-31-14

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

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 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. This facility will be surveyed as two separate buildings. Valley View Nursing Home, 2011 addition is a 1-story building with no basement. The 2011 addition was determined to be of Type II (111) construction. The building is fully sprinklered. The facility has a fire alarm system with full corridor smoke detection, spaces open to the corridors and resident rooms that is monitored for automatic fire department notification. The facility has a capacity of 45 beds and had a census of 41 at the time of the survey. The requirement at 42 CFR Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 050 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift.	K 050	**K050:** There was one fire drill missed in 4th quarter on evening shift. Valley View made new sheet to chart and	

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K 050	Continued From page 2 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 conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 18.7.1.2 This STANDARD is not met as evidenced by: Based on documentation review and staff interview, the facility failed to assure fire drills were conducted once per shift per quarter for all staff under varying times and conditions as required by 2000 NFPA 101, Section 18.7.1.2. This deficient practice could affect all 41 residents. Findings include: On facility tour between 9:00 AM and 12 noon on 07/16/2014, the review of the fire drills reports for July 2013 to June 2014 and the 2013 - 4th quarter - Evening shift drill was missed. This deficient practice was confirmed by the Facility Maintenance Director (DJ) at the time of discovery.	K 050	ensure that fire drills are conducted on every shift, every quarter. Maintenance personal was re-trained on 7/17/2014 and made aware of the importance of having these regularly scheduled drills. Maintenance supervisor and Administrator will monitor for compliance.	08/26/2014
K 062 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 18.7.6, 4.6.12, NFPA 13, NFPA 25,	K 062	**K62:** It was Valley View's expectation with Summit Fire Protection that they would come and monitor their equipment with-in the requirements of Life Safety Code. Summit was called to	

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K 062	Continued From page 3 9.7.5 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain the fire sprinkler system in accordance with the requirements of 2000 NFPA 101, Sections 18.3.4.1 and 9.6, as well as 1998 NFPA 25, sections 2-1 and 2-3.3. This deficient practice could affect all 41 residents. Findings include: On facility tour between 9:00 AM and 12 noon on 07/16/2014, a review of the annual fire sprinkler inspection records revealed the following: 1. more than 12 months passed between the inspection conducted on 05/22/2013 and the inspection conducted on 06/19/2014. 2. No documentation for quarterly flow alarm tests in past 12 months These deficient practices were confirmed by the Director of Maintenance (DJ) at the time of discovery. *TEAM COMPOSITION* Gary Schroeder, Life Safety Code Spc.	K 062	do the sprinkler system inspection. Inspection was completed on 6/19/2014 but was not completed in the 12 month allotted time frame. Maintenance supervisor called and notified Summit of the issue that this caused. Valley View is now on Summit's regular schedule to ensure that we stay in compliance in the future. Maintenance supervisor will been trained on how to do and document quarterly flow test. Summit has been called and will complete the flow test and train maintenance supervisor on 8/7/2014. Maintenance supervisor will be responsible for conducting the charts from 8/7/2014 on. Maintenance supervisor will monitor for compliance.	08/26/2014