DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL
PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: E6WU Facility ID: 00286

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MEDICARE/MEDICAID PROVID NO.(L1) 245566	DER	3. NAME AND AI (L3) VALLEY V			REHAB	4. TYPE OF ACT	<u>-</u> ` ′	
2. STATE VENDOR OR MEDICAID	NO	(L4) 510 EAST C	CEDAR STRE	ET		1. Initial 3. Termination	2. Recertification 4. CHOW	
(L2) 844240100	NO.	(L5) HOUSTON,	, MN		(L6) 55943	5. Validation 7. On-Site Visit	6. Complaint 9. Other	
5. EFFECTIVE DATE CHANGE OF	OWNERSHIP	7. PROVIDER/SU	JPPLIER CATE	GORY	<u>02</u> (L7)			
(L9)		01 Hospital	05 HHA	09 ESRD	13 PTIP 22 CLIA	8. Full Survey A	fter Complaint	
6.IATEIOFISURVEY 9/26/2016	(L34)	02 SNF/NF/Dual	06 PRTF	10 NF	14 CORF			
8. ACCREIITATIONISTATUS:	(L10)	03 SNF/NF/Distinct	07 X-Ray	11 ICF/IID	15 ASC	FISCAL YEAR EN	DING DATE: (L35)	
0 Unaccredited 1 TJC 2 AOA 3 Other		04 SNF	08 OPT/SP	12 RHC	16 HOSPICE	09/30		
11LTC PERIOD OF CERTIFICATION	N	10.THE FACILITY	Y IS CERTIFIED	AS:				
From (a):		x A. In Complia	ance With		And/Or Approved Waivers Of	The Following Require	ements:	
To (b):		Program R	equirements		2. Technical Personnel	6. Scope of	f Services Limit	
		Complianc	e Based On:		3. 24 Hour RN	7. Medical	Director	
12.Total Facility Beds	45 (L18)	1. A	acceptable POC		4. 7-Day RN (Rural SN	NF) 8. Patient R	Loom Size	
•	45 (L18) 45 (L17)	B.IIINotIinICom	nlionaalwithIDra	orom	5. Life Safety Code	9. Beds/Ro	om	
13.Total Certified Beds	43 (E17)	1	and/or Applied	_	* Code: A *	(L12)		
14. LTC CERTIFIED BED BREAKDO	OWN	1	Tr		15. FACILITY MEETS			
18 SNF 18/19 SNF	19 SNF	ICF	IID		1861 (e) (1) or 1861 (j) (1):	(L15)		
45	17 5111	101	1112		1001 (c) (1) 01 1001 (j) (1).	()		
(L37) (L38)	(L39)	(L42)	(L43)					
(E37) (E36)	(1.57)	(L42)	(1.43)					
16. STATE SURVEY AGENCY REM	ARKS (IF APPLICA	ABLE SHOW LTC CA	ANCELLATION	DATE):				
17. SURVEYOR SIGNATURE		Date :			18. STATE SURVEY AGENCY	Y APPROVAL	Date:	
Gary Nederhoff, Unit	Supervisor	1	10/7/2016	(L19)	Kamala Fiske-Downing	, Enforcement Sp	ecialist 10/7/2016 (L20)	
PA	RT II - TO BE	COMPLETED	BY HCFA R	EGIONAL	OFFICE OR SINGLE S	STATE AGENCY	()	
19. DETERMINATION OF ELIGIBII	JTY		MPLIANCE WIT	'H CIVIL	Statement of Financial Solvency (HCFA-2572) Ownership/Control Interest Disclosure Stmt (HCFA-1513)			
1. Facility is Eligible to I	Participate	RIGHTS ACT:			3. Both of the Above :			
2. Facility is not Eligible								
	(L21)							
22. ORIGINAL DATE	23. LTC AGREE	MENT 2	4. LTC AGREE	MENT	26. TERMINATION ACTION	:	(L30)	
OF PARTICIPATION	BEGINNING	G DATE	ENDING DA	ATE	VOLUNTARY 00	<u>INVOI</u>	UNTARY	
07/01/1991					01-Merger, Closure	05-Fail	to Meet Health/Safety	
(L24)	(L41)		(L25)		02-Dissatisfaction W/ Reimburs	sement 06-Fail	to Meet Agreement	
25. LTC EXTENSION DATE:	27. ALTERNATI	VE SANCTIONS			03-Risk of Involuntary Termination	on <u>OTHE</u> I	3	
	A. Suspension	n of Admissions:			04-Other Reason for Withdrawal	07-Prov	vider Status Change	
(1.27)			(L44)			00-Act	ive	
(L27)	B. Rescind S	uspension Date:						
			(L45)					
28. TERMINATION DATE:	29). INTERMEDIARY	/CARRIER NO.		30. REMARKS			
		03001						
	(L28)			(L31)				
31. RO RECEIPT OF CMS-1539	32	2. DETERMINATION	N OF APPROVA	L DATE				
	(L32)			(L33)	DETERMINATION APP	ROVAL		



PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

CMS Certification Number (CCN): 245566

October 7, 2016

Mr. Charles Ness, Administrator Valley View Healthcare & Rehab 510 East Cedar Street Houston, MN 55943

Dear Mr. Ness:

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 September 1, 2016 the above facility is certified 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

Minnesota Department of Health Licensing and Certification Program

Kumalu Fiske Downing

Health Regulation Division

Telephone: (651) 201-4112 Fax: (651) 215-9697 Email: Kamala.Fiske-Downing@state.mn.us



PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered October 7, 2016

Mr. Charles Ness, Administrator Valley View Healthcare & Rehab 510 East Cedar Street Houston, MN 55943

RE: Project Number S5566027

Dear Mr. Ness:

On August 22, 2016, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on August 11, 2016. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required.

On September 26, 2016, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on October 4, 2016 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on August 11, 2016. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of September 1, 2016. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on August 11, 2016, effective September 1, 2016 and therefore remedies outlined in our letter to you dated August 22, 2016, will not be imposed.

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

Feel free to contact me if you have guestions.

Sincerely,

Kamala Fiske-Downing

Minnesota Department of Health Licensing and Certification Program

Kumalu Fiske Downing

Program Assurance Unit

Valley View Healthcare & Rehab October 7, 2016 Page 2

Health Regulation Division

Telephone: (651) 201-4112 Fax: (651) 215-9697 Email: Kamala.Fiske-Downing@state.mn.us

POST-CERTIFICATION REVISIT REPORT

	MULTIPLE CONSTRUCTION			DATE OF REV	ISIT
IDENTIFICATION NUMBER	A. Building				
245566 _{Y1}	B. Wing	,	Y2	9/26/2016	Y3
NAME OF FACILITY		STREET ADDRESS, CITY, STATE, ZIP CODE			
VALLEY VIEW HEALTHCARE	& REHAB	510 EAST CEDAR STREET			
		HOUSTON, MN 55943			
	<u> </u>	_			

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0241 Reg. # 483.15(a)	Correction	ID Prefix F024 Reg. # 483.1	6 Correction 5(e)(1) Completed	ID Prefix F0	Correction 3.25 Completed
LSC	09/01/2016	LSC	09/01/2016	LSC	09/01/2016
ID Prefix F0431	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # 483.60(b), LSC	(d), (e) Completed 09/01/2016	Reg. # LSC	Completed	Reg. # LSC	Completed
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. # LSC	Completed
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. # LSC	Completed
ID Prefix Reg. #	Correction	ID Prefix	Correction	ID Prefix	Correction
LSC		LSC		LSC	
REVIEWED BY	REVIEWED BY (INITIALS) GPN/kfd REVIEWED BY	DATE 10/7/2016 DATE	SIGNATURE OF SURVEYOR 10160 TITLE		9/26/2016 DATE
CMS RO (INITIALS) FOLLOWUP TO SURVEY COMPLETED ON 8/11/2016			PR ANY UNCORRECTED DEFICIEN CTED DEFICIENCIES (CMS-2567)		

Form CMS - 2567B (09/92) EF (11/06)

Page 1 of 1

EVENT ID:

E6WU12

POST-CERTIFICATION REVISIT REPORT

	MULTIPLE CONSTRUCTION A. Building 01 - VALLEY VIEW NURSING HOME B. Wing			DATE OF RE	VISIT
				10/4/2016	Y3
NAME OF FACILITY VALLEY VIEW HEALTHCARE		STREET ADDRESS, CITY, STATE, ZIP CODE 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).

ITE Y4		DATE Y5	ITEM Y4		DATE Y5	ITEM Y4			DATE Y5
ID Prefix		Correction	ID Prefix		Correction	ID Prefix			Correction
Reg. #	NFPA 101	Completed	Reg. #	A 101	Completed	Reg. #	NFPA 101		Completed
LSC	K0018	09/01/2016	LSC K002	25	09/01/2016	LSC	K0027		09/01/2016
ID Prefix		Correction	ID Prefix		Correction	ID Prefix			Correction
Reg. #	NFPA 101	Completed	Reg. #		Completed	Reg. #			Completed
LSC	K0046	09/01/2016	LSC			LSC			
ID Prefix		Correction	ID Prefix		Correction	ID Prefix			Correction
Reg. #		Completed	Reg. #		Completed	Reg. #			Completed
LSC			LSC			LSC			
ID Prefix		Correction	ID Prefix		Correction	ID Prefix			Correction
Reg. #		Completed	Reg. #		Completed	Reg. #			Completed
LSC			LSC			LSC			
ID Prefix		Correction	ID Prefix		Correction	ID Prefix			Correction
Reg. #		Completed	Reg. #		Completed	Reg.#			Completed
LSC			LSC			LSC			
REVIEWI STATE A		REVIEWED BY (INITIALS) TL/kfd	DATE 10/7/2016	SIGNATURE OF	SURVEYOR 37008			DATE 10	/4/2016
REVIEWI		REVIEWED BY (INITIALS)	DATE	TITLE				DATE	
FOLLOWUP TO SURVEY COMPLETED ON 8/10/2016			OR ANY UNCORREC			IE EA OU IEVO	YE:	s 🗆 NO	

POST-CERTIFICATION REVISIT REPORT

				_	
	MULTIPLE CONSTRUCTION			DATE OF REV	ISIT
IDENTIFICATION NUMBER	A. Building 02 - 2011 ADDITION			I	
245566 _{Y1}	B. Wing	`	Y2	10/4/2016	Y3
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).

ITE Y4		DATE Y5	ITEM Y4	DATE Y5			DATE Y5
ID Prefix		Correction	ID Prefix	Correc	ction ID Prefix		Correction
Reg. #	NFPA 101	Completed	Reg. #	Comp	leted Reg. #		Completed
LSC	K0056	09/01/2016	LSC		LSC		_
ID Prefix		Correction	ID Prefix	Correc	ction ID Prefix		Correction
Reg. #		Completed	Reg. #	Comp	leted Reg. #		Completed
LSC			LSC		LSC		_
ID Prefix		Correction	ID Prefix	Correc	ction ID Prefix		Correction
Reg. #		Completed	Reg. #	Comp	leted Reg. #		Completed
LSC			LSC		LSC		_
ID Prefix		Correction	ID Prefix	Correc	ction ID Prefix		Correction
Reg. #		Completed	Reg. #	Comp	leted Reg. #		Completed
LSC			LSC		LSC		
ID Prefix		Correction	ID Prefix	Correc	ction ID Prefix		Correction
Reg. #		Completed	Reg. #	Сотр	leted Reg. #		Completed
LSC			LSC		LSC		
REVIEWI STATE A		REVIEWED BY (INITIALS) TL/kdf	DATE 10/7/2016	SIGNATURE OF SURVE		DATE 7008	10/4/2016
REVIEWS CMS RO		REVIEWED BY (INITIALS)	DATE	TITLE		DATE	
FOLLOWUP TO SURVEY COMPLETED ON 8/10/2016			CHECK FOI UNCORREC	R ANY UNCORRECTED DE CTED DEFICIENCIES (CMS	EFICIENCIES. WAS S-2567) SENT TO T		/ES NO

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: E6WU Facility ID: 00286

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1. MEDICARE/MEDICAID PROVIDE NO.(L1) 245566	DER	3. NAME AND ADDRESS OF FACILITY (L3) VALLEY VIEW HEALTHCARE & REHAB			REHAB	4. TYPE OF ACTI		
2. STATE VENDOR OR MEDICAID	NO	(L4) 510 EAST C	EDAR STRE	ET		1. Initial 3. Termination	2. Recertification 4. CHOW	
(L2) 844240100	J NO.	(L5) HOUSTON,	MN		(L6) 55943	5. Validation 7. On-Site Visit	6. Complaint 9. Other	
5. EFFECTIVE DATE CHANGE OF	OWNERSHIP	7. PROVIDER/SU			<u>02</u> (L7)	8. Full Survey Afte		
(L9)		01 Hospital	05 HHA	09 ESRD	13 PTIP 22 CLIA		*	
	1/2016 (L34)	02 SNF/NF/Dual	06 PRTF	10 NF	14 CORF	FISCAL YEAR END	ING DATE: (L35)	
8. ACCREDITATION STATUS:	(L10)	03 SNF/NF/Distinct	07 X-Ray	11 ICF/IID			(200)	
0 Unaccredited 1 TJC 2 AOA 3 Other		04 SNF	08 OPT/SP	12 RHC	16 HOSPICE	09/30		
11LTC PERIOD OF CERTIFICATIO	N	10.THE FACILITY	IS CERTIFIED	AS:				
From (a):		A. In Complia	ance With		And/Or Approved Waivers Of	The Following Requiren	nents:	
To (b):		_	equirements		2. Technical Personnel	_ 6. Scope of S	Services Limit	
		Compliance	e Based On:		3. 24 Hour RN	7. Medical D	irector	
12 Total Facility Dada	45 (I 19)	1. A	cceptable POC		4. 7-Day RN (Rural SN	NF) 8. Patient Ro	om Size	
12. Total Facility Beds	45 (L18) 45 (L17)	V D N C	r :4 p		5. Life Safety Code	9. Beds/Roor	n	
13.Total Certified Beds	43 (L17)	X B. Not in Con Requirements	and/or Applied \	-	* Code: B *	(L12)		
14. LTC CERTIFIED BED BREAKDO	OWN				15. FACILITY MEETS			
18 SNF 18/19 SNF	19 SNF	ICF	IID		1861 (e) (1) or 1861 (j) (1):	(L15)		
45								
(L37) (L38)	(L39)	(L42)	(L43)					
16. STATE SURVEY AGENCY REM	TARKS (IF APPLICA	ARLE SHOW LTC CA	ANCELL ATION	DATE).				
10. SIME SORVET NGENCT KEN.	nucks (ii mi lier	IBLE SHOW ETC CI	incella in ion	DML).				
17. SURVEYOR SIGNATURE		Date :			18. STATE SURVEY AGENCY	APPROVAL	Date:	
Michelle Jaeckels, H	FE NE II	0	08/30/2016		Kamala Fiske-Downing,	Enforcement Sne	cialist 09/20/2016	
	DE II TO DE	COMPLETED I	DV HOEL DI	(L19)			(L20)	
-					OFFICE OR SINGLE S			
19. DETERMINATION OF ELIGIBI	LITY		IPLIANCE WITI HTS ACT:	H CIVIL	 Statement of Financial Solvency (HCFA-2572) Ownership/Control Interest Disclosure Stmt (HCFA-1513) 			
1. Facility is Eligible to	Participate	Rights/Act.			3. Both of the Above :			
2. Facility is not Eligible	e (L21)							
	(L21)							
22. ORIGINAL DATE	23. LTC AGREED	MENT 24	4. LTC AGREEN	MENT	26. TERMINATION ACTION		(L30)	
OF PARTICIPATION	BEGINNING	G DATE	ENDING DA	TE	VOLUNTARY 00			
07/01/1991					01-Merger, Closure		Meet Health/Safety	
(L24)	(L41)		(L25)		02-Dissatisfaction W/ Reimburs		Meet Agreement	
25. LTC EXTENSION DATE:	27. ALTERNATI	VE SANCTIONS			03-Risk of Involuntary Termination	OTHER		
	A. Suspension	n of Admissions:			04-Other Reason for Withdrawal	07-Provid	der Status Change	
(L27)			(L44)			00-Activ	e	
(L27)	B. Rescind St	uspension Date:						
			(L45)					
28. TERMINATION DATE:	29	O. INTERMEDIARY	CARRIER NO.		30. REMARKS			
		03001						
	(L28)			(L31)				
31. RO RECEIPT OF CMS-1539	32	2. DETERMINATION	I OF APPROVAI	L DATE				
	(L32)			(L33)	DETERMINATION APP	ROVAL		
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PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered August 22, 2016

Mr. Charles Ness, Administrator Valley View Healthcare & Rehab 510 East Cedar Street Houston, MN 55943

RE: Project Number S5566027

Dear Mr. Ness:

On August 11, 2016, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

This letter provides important information regarding your response to these deficiencies and addresses the following issues:

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

<u>Electronic 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;

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

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

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

DEPARTMENT CONTACT

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

Gary Nederhoff, Unit Supervisor Minnesota Department of Health 18 Wood Lake Drive Southeast Rochester, Minnesota 55904

Email: gary.nederhoff@state.mn.us

Telephone: (507) 206-2731 Fax: (507) 206-2711

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by September 20, 2016, the Department of Health will impose the following remedy:

• State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by September 20, 2016 the following remedy will be imposed:

• Per instance civil money penalty. (42 CFR 488.430 through 488.444)

ELECTRONIC PLAN OF CORRECTION (ePoC)

An ePoC for the deficiencies must be submitted within **ten calendar days** of your receipt of this letter. Your ePoC must:

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;
- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;
- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;
- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;
- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,
- Submit electronically to acknowledge your receipt of the electronic 2567, your review and your ePoC submission.

If an acceptable ePoC is not received within 10 calendar days from the receipt of this letter, we will recommend to the CMS Region V Office that one or more of the following remedies be imposed:

- Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));
- Per day civil money penalty (42 CFR 488.430 through 488.444).

Failure to submit an acceptable ePoC could also result in the termination of your facility's Medicare and/or Medicaid agreement.

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the respective deficiencies (if any) is

acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. A Post Certification Revisit (PCR) will occur after the date you identified that compliance was achieved in your plan of correction.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

Original deficiencies not corrected

If your facility has not achieved substantial compliance, we will impose the remedies described above. If the level of noncompliance worsened to a point where a higher category of remedy may be imposed, we will recommend to the CMS Region V Office that those other remedies be imposed.

Original deficiencies not corrected and new deficiencies found during the revisit

If new deficiencies are identified at the time of the revisit, those deficiencies may be disputed through the informal dispute resolution process. However, the remedies specified in this letter will be imposed for original deficiencies not corrected. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed.

Original deficiencies corrected but new deficiencies found during the revisit

If new deficiencies are found at the revisit, the remedies specified in this letter will be imposed. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed. You will be provided the required notice before the imposition of a new remedy or informed if another date will be set for the imposition of these remedies.

FAILURE TO ACHIEVE SUBSTANTIAL COMPLIANCE BY THE THIRD OR SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

If substantial compliance with the regulations is not verified by November 11, 2016 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on

the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by February 11, 2017 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

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

Mr. Tom Linhoff, Fire Safety Supervisor Health Care Fire Inspections Minnesota Department of Public Safety State Fire Marshal Division 445 Minnesota Street, Suite 145

St. Paul, Minnesota 55101-5145

Email: tom.linhoff@state.mn.us Telephone: (651) 430-3012

Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing, Program Specialist

Kumala Fiske Downing

Licensing and Certification Program Health Regulation Division

Minnesota Department of Health

Kamala.Fiske-Downing@state.mn.us

Telephone: (651) 201-4112

Fax: (651) 215-9697

PRINTED: 08/29/2016 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		245566	B. WING		08/11/2016	
	PROVIDER OR SUPPLIER	& REHAB		STREET ADDRESS, CITY, STATE, ZIP CODE 510 EAST CEDAR STREET HOUSTON, MN 55943		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLÉTION	
F 000	as your allegation of Department's acception enrolled in ePOC, year the bottom of the	of correction (POC) will serve of compliance upon the otance. Because you are your signature is not required of first page of the CMS-2567 ic submission of the POC will	F 00	0		
F 241 SS=E	Upon receipt of an on-site revisit of you validate that substate regulations has been your verification. 483.15(a) DIGNITY INDIVIDUALITY The facility must promanner and in an elenhances each resisted to some content of the promanner and in an elenhances each resisted to some content of the promanner and in an elenhances each resisted to some content of the promanner and in an elenhances each resisted to some content of the promanner and in an elenhances each resisted to some content of the promanner and in an elenhances each resisted to some content of the promanner and in an elenhances.	acceptable electronic POC, an ur facility may be conducted to intial compliance with the en attained in accordance with AND RESPECT OF	F 24	1	9/1/16	
	This REQUIREMENT by: Based on observation review the facility farmanner that promoresidents (R5, R7, I who were observed Findings include: R5's annual Minimulassessment dated Brief Interview for N 5, indicating severe	Is or her individuality. NT is not met as evidenced sion, interview and document alled to provide services in a sted dignity for 4 of 27 R15 and R16) in the sample I during the meal times. Im Data Set (MDS) 6/27/16 identified R5 with a Mental Status (BIMS) score of a cognitive impairment and suiring supervision of one staff		F241 - 483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY (LO TERM CARE FACILITIES) The facility must promote care for residents in a manner and in an environment that maintains or enha each resident's dignity and respect recognition of his or her individuality R5, R7, R15, & R16 were referred to for w/c positioning and safety.	nces in full /.	
ABORATORY	/ DIRECTOR'S OR PROVID	ER/SUPPLIER REPRESENTATIVE'S SIGN	JATURE	TITLE	(X6) DATE	

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

Electronically Signed

08/25/2016

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

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			SURVEY PLETED
		245566	B. WING		08/1	11/2016
	PROVIDER OR SUPPLIER VIEW HEALTHCARE	& REHAB		STREET ADDRESS, CITY, STATE, ZIP CODE 510 EAST CEDAR STREET HOUSTON, MN 55943		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 241	on 8/8/16, at 5:05 p at the dining room to table height was at the level of the table eat her meal by reathe table to scoop for bring the food back table to eat. R5 was maintaining food or to drop food on her the clothing protect food. During observation at 11:21 a.m. R5 was her wheelchair sitting the table edge just to have difficulty reating utensils and edge of the table. On 8/10/16, at 8:04 meal, the director of interviewed in the dimediant the dining room table the table was not condependence with dignity needs were the table not only in also interfered with other residents at the table was at its lower table in the table was at its lower table was at its l	of the evening meal service c.m. R5 was observed seated table in a position where her we the edge of the table. The a level where R5's chin was at e edge. R5 was observed to thing up and over the edge of the social position and to to the level of the edge of the social position at the edge of the social position at the edge of the edge of the social position at the edge of the edge of the social position at the edge of the edge	F 2	OT was informed of preliminary fi on August 11, 2016. An OT order positioning and mobility was obtathe mentioned residents and forw Occupational therapy. Final surve findings were provided to therapy department on August 23, 2016 the arrival. On August 10, 2016, tables were rearranged in the dining room to put the facilities lowest adjustable tabe house to promote independence dining and to accommodate their individual needs. In addition, two (2) lower adjustable were ordered on August 23, 2016 new tables will be implemented un arrival to facility. Other residents have the potential affected by this practice. Nursing attempt interventions for proper positioning in w/c, if unsuccessful to OT services. All staff in-servicing will be provided August 25, 2016. All residents have the potential to affected by this practice. Monitored by: Director of Nursing Occupational Therapist, or design	for w/c ned for arded to y pon provide les in with esidents' le tables . The con I to be staff will will refer ed on be	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	IPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED		
		245566	B. WING _		08	/11/2016	
	PROVIDER OR SUPPLIER VIEW HEALTHCARE	& REHAB		STREET ADDRESS, CITY, STATE, ZIP CO 510 EAST CEDAR STREET HOUSTON, MN 55943			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 241	identified R7 with a Status (BIMS) scor cognitive impairme requiring limited as set up. R7 was observed to 8/8/16, at 5:05 p.m the dining room take chin at level of the observed in a seatcher eyes were just R7 was observed to but had difficulties above the edge of her silverware. R7 by reaching up and scoop food off of her food back to the leve at. R7 was noted food on the silverw food on her clothing fingers and eat. On 8/9/16, at 9:27 in the dining room in her wheelchair. Feat independently and over the table nursing assistant (I assisted her with en NA-J at the time of R7 was able to fee assistance and end	assessment dated 6/19/16 Brief Interview for Mental e of 7, indicating moderate nt and identified R7 as sistance of one staff with meal during the evening meal on R7 was observed seated at ble in her wheelchair with her edge of table. R7 was ed position at the table where above the edge of the table. o attempt to eat independently due to the need to reach the table to place her food on was observed to eat her meal over the edge of the table to er plate and had to bring the vel of the edge of the table to to have difficulty maintaining are and was noted to drop g protector, pick it off with her a.m. R7 was observed seated at the dining room table seated R7 was observed to attempt to but had difficulty reaching up to reach her food. At 9:30 a.m. NA)-J sat beside R7 and ating. During interview with the observation, NA-J stated d herself but needed couragement at times.	F 24	41			
	was again observe	on 8/10/16, at 7:35 a.m. R7 d seated at the dining room at a level below the edge of					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		245566	B. WING		08	/11/2016		
	PROVIDER OR SUPPLIER VIEW HEALTHCARE	& REHAB		STREET ADDRESS, CITY, STATE, ZI 510 EAST CEDAR STREET HOUSTON, MN 55943				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		ION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE		
F 241	served a bowl of sli eating by herself wi reach up and over to contents of bowl we she could not see in higher than her line stick her fork in the looked at fork after gotten any banana observed to drop be protector then pick eat them. On 8/10/16, at 8:04 meal, the director of interviewed in the of meal. The DNS visit the dining room tab the table was not of independence with dignity needs were the table not only in also interfered with other residents at the table was at its lown needed to be change R15's quarterly (MI identified R15 with and identif	pright in w/c at table. R7 was ced up bananas which she is th difficulty due to having to table with her arms. The ere positioned in a manner that not the bowl as the bowl was of site. R7 was observed to bowl to get banana slices and removing it to see if she had on her fork. R7 was further anana slices on her clothing them up with her fingers and them up with her fingers and a lie and verified R7's position at onducive to enhancing eating and verified R7's not being met. R7's position at the potential to socialize with the table. The DNS stated the est level and stated the table ged to meet R7's needs.	F 2	241				

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED			
		245566	B. WING			08/	11/2016
	PROVIDER OR SUPPLIER VIEW HEALTHCARE	& REHAB		510	REET ADDRESS, CITY, STATE, ZIP CODE D EAST CEDAR STREET DUSTON, MN 55943		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 241	liquids using a stray R15's lap under the R15 drink while ber observed to assist I food onto a spoon a table height and bri mouth while R15 whowards her lap. Th NA-H or other staff while eating. On 8/9/16, at 11:30 seated at the dining the level of the edge down towards lap. If the table with R15 a interview with NA Gobservation the NA low residents were they had never add stated the nursing stresidents and knew on 8/9/16 R15 was her coffee cup off or reach it. R15 was oit." R15 was referrir On 8/10/16, at 12:1 assistant (PTA)-A was to enter the dining refied the position accommodate inde not appear very dig table either needed	was observed to give R15 her wand placing the cup near edge of the table and having at forward. NA-H was R15 with eating by scooping and lowering the spoon belowinging the food up to R15's as bent forward with her face ere was no observation of encouraging R15 to sit upright. a.m. R15 again was observed groom table with her head at end of the table and bent face NA's G and H were seated at and other residents. During and H at the time of the stated they had noticed how sitting at the tables but verified ressed it with nursing and staff sometimes helped feed to hoe they sat. At 11:40 a.m., observed to attempt to reach fithe table and struggled to verheard to say, "I can't see ing to her coffee cup. 6 p.m. the physical therapy was requested by the surveyor soom and observe positioning groom table. The PTA-A was not a position to pendence with eating and did nified. The PTA-A stated the to be lowered or R15 needed er wheelchair to support	F 2	41			

-	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,				E SURVEY PLETED
		245566	B. WING			08/	11/2016
	PROVIDER OR SUPPLIER			5	TREET ADDRESS, CITY, STATE, ZIP CODE 10 EAST CEDAR STREET HOUSTON, MN 55943	,	,
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 241	identified R16 with and identified R16 assistance of one During observation 8/9/16, at 9:27 a.m assisting R16 eat positioned at the twas bent forward with the top of her edge. NA-H was down under the tabring the straw up forward position. Nabout R16's ability stated she always H also identified R leaning forward ar positioning was not buring observation 11:22 a.m. R16 was dining room table forward with her h table with table at observed to feed I plate then lowering and bringing the foleaning forward, faheight at the time position if R16 was been at approximate During observation 8/10/16, a 8:00 a.m.	IDS) assessment dated 6/28/16 a severely impaired cognition as requiring extensive staff with eating. In of the morning meal on an in. NA-H was observed to be there breakfast. R16 was able in a manner where she with her face towards her lap head parallel with the table abserved to take a cup of juice ble and near R16's lap then the R16's mouth while in the bent JA's-D and H were interviewed to independently eat and both needed assistance. NA-D and c16 frequently sat at the table and acknowledged her	F 2	241			
	positioned at the t	able in manner where her eyes the table edge. NA-G and H were					

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA

	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				COMPLETED	
		245566	B. WING _		08	/11/2016	
	PROVIDER OR SUPPLIER VIEW HEALTHCARE			STREET ADDRESS, CITY, STATE, ZIP COE 510 EAST CEDAR STREET HOUSTON, MN 55943			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 241	stated they were at table but verified the nursing staff. On 8/10/16, at 8:04 interviewed and verified and verified the staff should upright before place promote good eating. During interview with p.m. PTA-A verified optimal for eating. During observation 8/11/16, at 8:26 a.r. again at the dining leaning forward with the table edge. NA eat while leaning for upright to feed her. During interview with the table edge. NA eat while leaning forward with the table edge. NA eat while leaning fo	the positioning of R16 and ware R16 was sitting low at the ney had never addressed it with a.m. the DNS was rified she had observed R16's able after being brought up as urveyor and had initiated a tional therapy to evaluate her lining room table. The DNS tion was poor at the table and d attempt to position her ing food in her mouth to ng position and dignity. Atth PTA-A on 8/10/16, at 12:16 d R16's positioning was not in R16 was observed seated room table in her wheelchair the her forehead at the level of J was observed to assist R16 prward versus positioning her	F 24	11			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING		` ´,	DATE SURVEY COMPLETED		
		245566	B. WING		08/11/2016
	PROVIDER OR SUPPLIER VIEW HEALTHCARE	& REHAB	5	TREET ADDRESS, CITY, STATE, ZIP CODE 10 EAST CEDAR STREET 10USTON, MN 55943	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC 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 241	until yesterday whe the staff's attention	ide assessment and treatment n the concern was brought to	F 241		
F 246 SS=E	A resident has the services in the facil accommodations o preferences, excep	right to reside and receive	F 246		9/1/16
	by: Based on observareview the facility fareview the facility farewiew that promo accommodations or residents (R5, R7, who were observed Findings include: R5's annual Minimulassessment dated Brief Interview for M5, indicating severe identified R5 as receivith meal set up. During observation	f individual needs for 4 of 27 R15 and R16) in the sample I during the meal times.		F246 483.15(e) (1) REASONABLE ACCOMODATION OF NEEDS/PREFERENCES Valley View Healthcare & Rehab ensure that the resident has the right to reside and receive services in the facility with reasonable accommodations of individuneeds and preferences, except when the health or safety of the individual or other residents would be endangered. R5, R7, R15, & R16 were referred to Offor w/c positioning and safety. OT was informed of preliminary findings on August 11, 2016. An OT order for we positioning and mobility was obtained for	ial e r T

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL ⁻ A. BUILDI	LTIPLE CONSTRUCTION (X3) DATE SU DING COMPLET			
		245566	B. WING			08/-	11/2016
	PROVIDER OR SUPPLIER			51	TREET ADDRESS, CITY, STATE, ZIP CODE 10 EAST CEDAR STREET OUSTON, MN 55943		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 246	at the dining room eyes were just abortable height was at the level of the taber eat her meal by rethe table to scoop bring the food back table to eat. R5 was maintaining food of to drop food on he the clothing protect food. During observation at 11:21 a.m. R5 wher wheelchair sitt the table edge just to have difficulty reeating utensils and edge of the table. On 8/10/16, at 8:00 meal, the director interviewed in the meal. The DNS visithe dining room tall the table was not condependence with table was at its low needed to be charmally as a status (BIMS) scoognitive impairment requiring limited as set up.	table in a position where her ove the edge of the table. The talevel where R5's chin was at le edge. R5 was observed to aching up and over the edge of food off of her plate and had to k to the level of the edge of the as noted to have difficulty in the silverware and was noted in clothing protector, pick it off tor with her fingers and eat the in of the lunch meal on 8/9/16, was again observed seated in inguiping upright with the height of it below her chin. R5 was noted eaching her plate with her if had to reach up and over the industry and over the industry and the sualized R5's seating position at conducive to enhancing in eating. The DNS stated the west level and stated the table aged to meet R5's needs. Assessment dated 6/19/16 a Brief Interview for Mental are of 7, indicating moderate ent and identified R7 as assistance of one staff with meal during the evening meal on	F 2	46	the mentioned residents and forwa Occupational therapy. Final survey findings were provided to therapy department on August 23, 2016 uparrival. On August 10, 2016, tables were rearranged in the dining room to provide the facilities lowest adjustable table house to promote independence with dining and to accommodate the resindividual needs. In addition, two (2) lower adjustable were ordered on August 23, 2016. new tables will be implemented uparrival to facility. Other residents have the potential that affected by this practice. Nursing stattempt interventions for proper positioning in w/c, if unsuccessful with oot services. All staff in-servicing will be provided August 25, 2016. All residents have the potential to be affected by this practice. Monitored by: Director of Nursing, Occupational Therapist, or designed.	on ovide es in eth sidents' e tables The on co be etaff will will refer d on	

	ENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) AN OF CORRECTION (X3) A. BUILDING			(3) DATE SURVEY COMPLETED		
		245566	B. WING		80	/11/2016
	PROVIDER OR SUPPLIER VIEW HEALTHCARE			STREET ADDRESS, CITY, STATE, ZIP CC 510 EAST CEDAR STREET HOUSTON, MN 55943		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 246	8/8/16, at 5:05 p.m the dining room take chin at level of the observed in a seather eyes were just R7 was observed to but had difficulties above the edge of her silverware. R7 by reaching up and scoop food off of her food back to the leeat. R7 was noted food on the silverware food on the silverware food on her clothin fingers and eat. On 8/9/16, at 9:27 in the dining room in her wheelchair, eat independently and over the table nursing assistant (assisted her with end assisted her with end assistance and end During observation was again observed table with her chin table when sitting userved a bowl of sleating by herself we reach up and over contents of bowl we she could not see higher than her line	age 9 I. R7 was observed seated at ole in her wheelchair with her edge of table. R7 was ed position at the table where above the edge of the table. In o attempt to eat independently due to the need to reach the table to place her food on was observed to eat her meal dover the edge of the table to er plate and had to bring the vel of the edge of the table to to have difficulty maintaining are and was noted to drop grotector, pick it off with her a.m. R7 was observed seated at the dining room table seated R7 was observed to attempt to but had difficulty reaching up to reach her food. At 9:30 a.m. NA)-J sat beside R7 and ating. During interview with the observation, NA-J stated d herself but needed couragement at times. If on 8/10/16, at 7:35 a.m. R7 and seated at the dining room at a level below the edge of upright in w/c at table. R7 was iced up bananas which she is with difficulty due to having to table with her arms. The ere positioned in a manner that into the bowl as the bowl was se of site. R7 was observed to bowl to get banana slices and	F 24			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					
		245566	B. WING			08/	11/2016
	PROVIDER OR SUPPLIER VIEW HEALTHCARE	& REHAB		5	STREET ADDRESS, CITY, STATE, ZIP CODE S10 EAST CEDAR STREET HOUSTON, MN 55943	,	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 246	looked at fork after gotten any banana observed to drop be protector then pick eat them. On 8/10/16, at 8:04 meal, the director of interviewed in the dimeal. The DNS visit the dining room tabe the table was not condependence with table was at its lowenceded to be changed. R15's quarterly (MI identified R15 with and identified R15 with and identified R15 with and identified R15 and identifi	removing it to see if she had on her fork. R7 was further anana slices on her clothing them up with her fingers and a.m., during the breakfast f nursing services (DNS) was ining room while observing the ualized R7's seating position at le and verified R7's position at le and verified R7's position at londucive to enhancing eating. The DNS stated the lest level and stated the table ged to meet R7's needs. OS) assessment dated 6/2/16 moderately impaired cognition as requiring limited assistance	F 2	246			

_	TATEMENT OF DEFICIENCIES ND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED				
		245566	B. WING			08/	11/2016
	PROVIDER OR SUPPLIER			510	REET ADDRESS, CITY, STATE, ZIP CODE EAST CEDAR STREET OUSTON, MN 55943	,	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES :Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 246	seated at the dining the level of the edge down towards lap. the table with R15 interview with NA-observation the National low residents were they had never adstated the nursing residents and knew on 8/9/16 R15 was her coffee cup off reach it. R15 was it." R15 was referring the commodate independent of R15 at the dining of R16 assistant (PTA)-A to enter the dining of R15 at the dining of R15 at the dining of R15 at the dining of R16 assistance of one During observation R16's quarterly (Midentified R16 assistance of one During observation R/9/16, at 9:27 a.m assisting R16 eat positioned at the tawas bent forward with the top of her	a.m. R15 again was observed g room table with her head at ge of the table and bent face NA's G and H were seated at and other residents. During G and H at the time of the A's stated they had noticed how e sitting at the tables but verified dressed it with nursing and staff sometimes helped feed w hoe they sat. At 11:40 a.m., a observed to attempt to reach of the table and struggled to overheard to say, "I can't see ing to her coffee cup. 16 p.m. the physical therapy was requested by the surveyor room and observe positioning g room table. The PTA-A n was not a position to ependence with eating and did gnified. The PTA-A stated the d to be lowered or R15 needed her wheelchair to support DS) assessment dated 6/28/16 severely impaired cognition as requiring extensive	F 2	246			

-	OF DEFICIENCIES OF CORRECTION			TE SURVEY MPLETED		
		245566	B. WING		08	/11/2016
	PROVIDER OR SUPPLIER VIEW HEALTHCARE	& REHAB		STREET ADDRESS, CITY, STATE, ZIP CO 510 EAST CEDAR STREET HOUSTON, MN 55943		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 246	bring the straw up of forward position. No about R16's ability stated she always of H also identified Raleaning forward and positioning was not During observation 11:22 a.m. R16 was dining room table in forward with her hetable with table at juring observed to feed Raplate then lowering and bringing the following forward, fact height at the time of position if R16 was been at approximate. During observation 8/10/16, a 8:00 a.m. at the table in the copositioned at the table.	ole and near R16's lap then it R16's mouth while in the bent A's-D and H were interviewed to independently eat and both needed assistance. NA-D and I6 frequently sat at the table d acknowledged her it good. of the noon meal on 8/9/16, at is again observed seated at the inher wheelchair leaning and towards her lap. at same just below chin level. NA-F was in 16 by scooping food off of her the spoon below table height od up to R16's mouth while to towards lap. The table of the observation was in a sitting upright it would have tely her chin level. of the breakfast meal on in NA's-G and H were seated lining room with R16. R16 was ible in manner where her eyes	F 2-	46		
	interviewed about t stated they were averable but verified the nursing staff. On 8/10/16, at 8:04 interviewed and verified the	e table edge. NA-G and H were he positioning of R16 and ware R16 was sitting low at the ey had never addressed it with a.m. the DNS was ritled she had observed R16's				
	a concern by the su referral for occupat positioning at the d	able after being brought up as urveyor and had initiated a ional therapy to evaluate her ining room table. The DNS ion was poor at the table and				

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E SURVEY PLETED		
		245566	B. WING			08/	11/2016
	PROVIDER OR SUPPLIER	& REHAB		51	REET ADDRESS, CITY, STATE, ZIP CODE 0 EAST CEDAR STREET DUSTON, MN 55943		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 246	verified staff should upright before placi promote good eating. During interview with p.m. PTA-A verified optimal for eating. During observation 8/11/16, at 8:26 a.m again at the dining leaning forward with the table edge. NA-eat while leaning fouright to feed her. During interview with (OT)-A on 8/11/201 R16's positioning with should have been swhen eating. OT-A should be seated upaximize independent practices. OT-A stafacility for a couple concerns with position table height but had from facility to proviuntil yesterday whe the staff's attention	attempt to position her ng food in her mouth to g position. th PTA-A on 8/10/16, at 12:16 R16's positioning was not of the breakfast meal on a R16 was observed seated room table in her wheelchair a her forehead at the level of J was observed to assist R16 rward versus positioning her th the occupational therapist 6, at 8:35 a.m. OT-A verified as poor and stated R16 reated back in her wheelchair stated residents in general oright prior to them eating to ence and safe eating the deated back in her wheelchair stated she been going to the weeks and had noted the ioning in wheelchairs and if not received any referrals de assessment and treatment in the concern was brought to by the surveyor. CARE/SERVICES FOR	F 2				9/1/16
	provide the necessary or maintain the high mental, and psycho	receive and the facility must ary care and services to attain nest practicable physical, social well-being, in e comprehensive assessment					

AND BLAN OF CORRECTION IN IDENTIFICATION NUMBER:		` '	TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		245566	B. WING _		08/	11/2016
	PROVIDER OR SUPPLIER VIEW HEALTHCARE	& REHAB		STREET ADDRESS, CITY, STATE, ZIP CO 510 EAST CEDAR STREET HOUSTON, MN 55943		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF ((EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 309	and plan of care. This REQUIREMENT by: Based on observative review, the facility for care and services to for 2 of 2 residents	ge 14 NT is not met as evidenced ion, interview and document ailed to provide the necessary or maintain good positioning (R39 and R16) who lacked while seated in the wheelchair	F 3	F309 483.25 PROVIDE CARE/SERVICES FOR HIGH BEING Valley View Healthcare & Re that each resident receives a the necessary care and servi or maintain the highest pract	hab ensures and provides ices to attain	
	R39's quarterly Min assessment dated requiring extensive daily assistance (Al identified R39 with identified her with b functional limitation R39's During the in 8/8/16 at 4:00 p.m. a high back wheelc main nurses station significantly to her rwheelchair and not pressed against he armrest. During the observed to enter the residents out and don 8/8/16, at 5:20 pin the dining room pR39 was again obsover the right side of	imum Data Set (MDS) 7/11/16 identified R39 as assistance with all activities of DL's). The MDS further unstable balance and ilateral upper and lower in range of motion (ROM) itial tour of the facility on R39 was observed seated in hair in the dayroom behind the in R39 was noted to be leaning ight over the armrest of her ed to have her body weight ir right arm against the observation staff were the dayroom to take other id not reposition R39. in R39 was observed seated orior to the meal being served. erved leaning significantly of her wheelchair with her right at the wheelchair armrest.		physical, mental, and psycho well-being, in accordance wit comprehensive assessment care. R39 & R16 were referred to 0 positioning and safety. OT was informed of prelimina on August 11, 2016. An OT o positioning and mobility was the mentioned residents and Occupational therapy. Final s findings were provided to the department on August 23, 20 arrival. On August 10, 2016, tables v rearranged in the dining room the facilities lowest adjustable house to promote independed dining and to accommodate individual needs. In addition, two (2) lower adjustable to promote independed individual needs.	and plan of OT for w/c ary findings order for w/c obtained for forwarded to survey orapy of upon were on to provide e tables in once with the residents'	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	TIPLE CONSTRUCTION NG		E SURVEY IPLETED
		245566	B. WING _		08/	11/2016
	PROVIDER OR SUPPLIER VIEW HEALTHCARE			STREET ADDRESS, CITY, STATE, ZIP 510 EAST CEDAR STREET HOUSTON, MN 55943	.	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 309	There were no sup wheelchair to prev the observation did observed walking food orders from attempt to have st. On 8/9/2016, at 9: seated in the dining wheelchair with he seated in the dayr in her chair toward forward with no evin her wheelchair. On 8/11/16, at 8:13 services (DNS) was positioning while swheelchair. The D not support her postated she felt R33 and have her need therapy. On 8/11/16 at 8:13 the dining room ar table with nursing her. R39 was obseface towards her laupright seated posobserve her leaning. On 8/11/2016, at 8 the occupation the room, OT-A verifier.	ports observed in the ent R39 from leaning. During etary assistant (DA)-A was past R39 multiple times taking other residents and did not aff reposition R39. 27 a.m. R39 was observed g room leaning forward in her er face towards her lap. 0 a.m. R39 was again observed com with her head bent forward is her lap. R39 was bent idence of upper torso supports 3 a.m. the director of nursing as asked to view R39's eated in the dayroom in her NS stated R39's wheelchair did sitioning needs. The DNS of should be referred to therapy is addressed by occupation a.m. R39 was wheeled into the day was place at a dining room assistant (NA)-H seated beside erved leaning forward with her ap and was not assisted to an sition even when NA-H could	F 30	were ordered on August 23 new tables will be impleme arrival to facility. Other resident have the po affected by this practice. N attempt interventions for pr positioning in w/c, if unsuce to OT services. All staff in-servicing will be August 25, 2016 to all staff Occupational therapist on a positioning. All residents have the pote affected by this practice. Monitored by: Director of N Occupational Therapist, or	ented upon betential to be lursing staff will roper cessful will refer provided on f on w/c by wheelchair ential to be	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		DNSTRUCTION		E SURVEY PLETED
		245566	B. WING			08/	11/2016
	PROVIDER OR SUPPLIER VIEW HEALTHCARE	& REHAB		510 E	ET ADDRESS, CITY, STATE, ZIP CODE AST CEDAR STREET STON, MN 55943	,	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 309	reposition R39 whe facility should have improve positioning R16's quarterly Min assessment dated requiring extensive daily assistance (Al identified R39 with During observation 9:27 a.m. NA-H wabeside R16 at the opositioned at the tawas bent forward with the top of her redge. NA-H was obreposition R16 to alleaning forward ever R39. NA-D and H wpositioning and bot lean forward in her R16's positioning with her her National Positioning with her her On 8/10/16, at 8:04 interviewed and verpositioning at the taa concern by the sureferral for occupat positioning. The DN poor and verified sther upright.	n observed leaning and the a OT referral submitted to l. imum Data Set (MDS) 6/28/16 identified R16 as assistance with all activities of DL's). The MDS further unstable balance. of the dining room 8/9/16, at s observed to be seated lining room table. R16 was ble in a manner where she with her face towards her lap nead parallel with the table observed not to attempt to an upright position and left her en when seated right beside were interviewed about R16's in stated she frequently would wheelchair and acknowledged was not good. of the noon meal on 8/9/16, at a again observed seated at the inher wheelchair leaning ad towards her lap.	F3	09			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	NG		TE SURVEY MPLETED
		245566	B. WING		08	/11/2016
			STREET ADDRESS, CITY, STATE, ZIP COI 510 EAST CEDAR STREET HOUSTON, MN 55943	CITY, STATE, ZIP CODE STREET		
PRÉFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	ID PREFI) TAG	PROVIDER'S PLAN OF CORR ((EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 309	(PTA)-A on 8/10/16 R16's positioning with should be evaluated. During observation 8/11/16, at 8:26 a.r. again at the dining leaning forward with the table edge. On 8/11/16, at 8:11 seated in the day reforward in her chain R39's wheelchair with the bolsters did from leaning forward. On 8/11/16, at 8:13 services (DNS) was positioning while sew wheelchair. The DI not support her positioning while sew wheelchair. The DI not support her positioning looked be evaluated. On 8/11/16, at 8:35 OT-A while seated room. OT-A verified her wheelchair and positioned back an OT-A stated she has for a couple weeks with position in wheelchair in wheelchair in wheelchair and positioned back an OT-A stated she has for a couple weeks with position in wheelchair in w	s, at 12:16 p.m. PTA-A verified was not optimal and stated R16 of for upper body support. If of the breakfast meal on m. R16 was observed seated room table in her wheelchair the her forehead at the level of a.m. R39 was observed oom in her wheelchair leaning r. R39's face was towards her. was noted to have side bolsters if not support R39's upper torso rd. If a.m. the director of nursing s asked to view R16's eated in the dayroom in her NS stated R39's wheelchair did sitioning needs. The DNS is positioning needed to be	F3	09		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ,		E CONSTRUCTION		E SURVEY IPLETED
		245566	B. WING			08/	11/2016
	PROVIDER OR SUPPLIER VIEW HEALTHCARE	& REHAB		5	TREET ADDRESS, CITY, STATE, ZIP CODE 10 EAST CEDAR STREET IOUSTON, MN 55943		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 431 SS=D	The facility must en a licensed pharmac of records of receip controlled drugs in accurate reconciliat records are in order controlled drugs is reconciled. Drugs and biological abeled in accordant professional princip appropriate access instructions, and the applicable. In accordance with facility must store a locked compartmer controls, and perminave access to the The facility must prepermanently affixed controlled drugs list Comprehensive Dru Control Act of 1976 abuse, except when package drug distri	nploy or obtain the services of sist who establishes a system at and disposition of all sufficient detail to enable an sion; and determines that drug and that an account of all maintained and periodically als used in the facility must be accewith currently accepted ales, and include the ory and cautionary are expiration date when state and Federal laws, the all drugs and biologicals in ants under proper temperature at only authorized personnel to keys. Sovide separately locked, a compartments for storage of and other drugs subject to an the facility uses single unit bution systems in which the animal and a missing dose can	F4	131			9/1/16
	by:	NT is not met as evidenced ion, interview, and document			F431 ¿483.60(b)(2)(3), (d), (e)		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION		E SURVEY PLETED
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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			STREET ADDRESS, CITY, STATE, ZI 510 EAST CEDAR STREET HOUSTON, MN 55943	<u> </u>		
PRÉFIX	(EACH DEFICIENCY	/ MUST BE PRECEDED BY FULL	ID PREFIX TAG		ION SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 431	review, the facility f were stored in the of for 1 of 2 medication cart) observed belon R42. Findings include: On 8/8/16 at 5:47 p cart was observed. medication cart were cups. Licensed prathe medication cup and R42. LPN-A state [medications] right believe it is in our proom number and tresident they belon. R21's pre-set up m calcium, diltiazem (medicaiton), simvan Nieferex (iron supp.) R42's pre-set up m (controlled anti-anx (seizure medication, and mimedication.) On 8/8/16 at 7:37 p stated, "They [staff medications] should medications." Facility policy, Prep Guidelines, Medica 2006, reads; "B. Acc.)	ailed to ensure medications original pharmacy packaging in carts (East hall medication origing to resident (R21) and in the top drawer of the re two pre-set up medication in ctical nurse (LPN)-A identified is were medications for R21 ated, "They want them away so I always pre-set up. I olicy. I just label them with the he name and last initial [of g too]."	F 4	Controlled Substances as Labeling/Storage of Drug Valley View Healthcare & the storage of all drugs a locked compartments untemperature controls, and authorized personnel to his the keys. Medication Pass Procedure on August 24, 2016. All I TMAs have been provide updated policy. A random audit of Medical completed to ensure that pre-set up medications. Mandatory nursing medical in-service will be provided 2016 & August 30, 2016. Pass procedure and review policy, Preparation and Guidelines, Medication And Pharmacy LPN consultar random medication pass Monitored by: Pharmacis Director of Nursing or design and the storage of the substances of the substances are also because	Rehab ensures nd biologicals in der proper der permit only nave access to the access t	

	FOF DEFICIENCIES DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION NG	(X3) DA	ATE SURVEY OMPLETED
		245566	B. WING		0	8/11/2016
	PROVIDER OR SUPPLIER VIEW HEALTHCARE	& REHAB		STREET ADDRESS, CITY, STATE, ZIP OF STATE ADDRESS, CITY, S		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE
F 431	Continued From pa Medications are no		F 4	31		

PRINTED: 08/31/2016 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING 01 - VALLEY VIEW NURSING HOME 245566 B. WING 08/10/2016 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER **510 EAST CEDAR STREET VALLEY VIEW HEALTHCARE & REHAB** HOUSTON, MN 55943 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION DATE (X4) ID ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) K 000 INITIAL COMMENTS K 000 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 dated August 10, 2016, 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 LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

Electronically Signed

08/26/2016

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

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,		CONSTRUCTION 1 - VALLEY VIEW NURSING HOME		E SURVEY IPLETED	
		245566	B, WING			08/	10/2016	
	PROVIDER OR SUPPLIER	& REHAB		510	REET ADDRESS, CITY, STATE, ZIP CODE DEAST CEDAR STREET DUSTON, MN 55943	,	10/2010	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETIO DATE	
K 000	DEFICIENCY MUS FOLLOWING INFO 1. A description of to correct the deficiency of the correct the actual, or provide a solution of the correct the actual, or provide a solution of the correct the actual of the correct t	RRECTION FOR EACH ST INCLUDE ALL OF THE DRMATION: what has been, or will be, done lency. oposed, completion date. r title of the person rection and monitoring to lence of the deficiency. surveyed as two separate liew Nursing Home is a 1-story sement. The building was ferent times. The original ructed in 1967 and was for Type II (111) construction. In constructed to the West Wing and to be of Type II (111) and to be of Type II (111) and to be of Type II (111) and the same type of leet the construction type is buildings, the facility was		000				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			1 ' '	IPLE CONSTRUCTION NG 01 - VALLEY VIEW NURSING HOME	(X3) DATE SURVEY COMPLETED		
		245566	B. WING_		08/1	0/2016	
	PROVIDER OR SUPPLIER	& REHAB		STREET ADDRESS, CITY, STATE, ZIP CODE 510 EAST CEDAR STREET HOUSTON, MN 55943		00/10/2010	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE- (EACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
K 000	census of 37 at the	apacity of 41 beds and had a time of the survey. 42 CFR Subpart 483.70(a) is	K 00	00			
K 018 SS=D	Doors protecting or required enclosure hazardous areas si as those constructed core wood, or capa 20 minutes. Cleara and floor covering in fully sprinklered required to resist the no impediment to to open devices that repushed or pulled an provided with a medoor closed. Dutch permitted. Door framade of steel or ot with 8.2.3.2.1. Rolle CMS regulations in 19.3.6.3 This STANDARD in Doors protecting or required enclosure hazardous areas si as those constructions core wood, or capa 20 minutes. Cleara and floor covering	pridor openings in other than so of vertical openings, exits, or hall be substantial doors, such ed of 13/4 inch solid-bonded able of resisting fire for at least not exceeding 1 inch. Doors smoke compartments are only ne passage of smoke. There is the closing of the doors. Hold release when the door is re permitted. Doors shall be ans suitable for keeping the doors meeting 19.3.6.3.6 are mees shall be labeled and ther materials in compliance er latches are prohibited by all health care facilities. Is not met as evidenced by: corridor openings in other than so of vertical openings, exits, or hall be substantial doors, such ed of 13/4 inch solid-bonded able of resisting fire for at least noce between bottom of door is not exceeding 1 inch. Doors smoke compartments are only	K 0	K018 NFPA 101 Life Safety Constructed of 13/4 inch solid-	ode ings in s of vertical areas shall those	9/1/16	
	no impediment to t open devices that i pushed or pulled a	ne passage of smoke. There is the closing of the doors. Hold release when the door is re permitted. Doors shall be ans suitable for keeping the		core wood, or capable of resist at least 20 minutes. Clearance bottom of door and floor cover exceeding 1 inch. Doors in full sprinklered smoke compartme	between ing is not y		

CLIVILI	13 FOR MEDICARE	& MEDICAID SERVICES				IVID INO.	0930-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ' '		CONSTRUCTION 1 - VALLEY VIEW NURSING HOME		E SURVEY PLETED
		245566	B. WING			08/	10/2016
	PROVIDER OR SUPPLIER VIEW HEALTHCARE	& REHAB		STREET ADDRESS, CITY, STATE, ZIP CODE 510 EAST CEDAR STREET HOUSTON, MN 55943		3.	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
K 018	door closed. Dutch permitted. Door fra made of steel or ot with 8.2.3.2.1. Rolle CMS regulations in 19.3.6.3 On facility tour betwon 8/10/2016, base revealed Findings in 1. Resident room # This deficient pract the 19 residents win 2. Fire doors in bot latch when tested, affect the safety of wings. This deficient pract Facility Maintenand discovery.	doors meeting 19.3.6.3.6 are mes shall be labeled and her materials in compliance er latches are prohibited by all health care facilities. I ween 09:30 AM and 12:30 PM ed on observation and interview include: I g did not latch when tested. The safety of thin the smoke compartment. In West and East wings did not this deficient practice could the 37 residents within these ince was confirmed by the see Director (DJ) at the time of	KO		required to resist the passage of some There is no impediment to the closs the doors. Hold open devices that when the door is pushed or pulled permitted. Doors shall be provided means suitable for keeping the docklosed. Dutch doors meeting 19.3, are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.2.3. Roller latches are prohibited by CN regulations in all health care faciliti 19.3.6.3 On August 16, 2016 the Maintenar Director removed the obstruction of door to room 19. All Fire doors we adjusted for spring tension and lubrication. Monthly checks will be performed to insure proper function fire doors. Monitored by: Facility Maintenance Director	sing of release are with a or 6.3.6 e 2.1. MS es. es. ere	0/4/40
K 025 SS=D	Smoke barriers shalleast a one half hor constructed in according barriers shall be per atrium wall. Windowsteel frames. 8.3, 19.3.7.3, 19.3. This STANDARD is STANDARD is STANDARD is smoke barriers shall be per atrium wall.	all be constructed to provide at ur fire resistance rating and ordance with 8.3. Smoke exmitted to terminate at an ws shall be protected by r by wired glass panels and 7.5 is not met as evidenced by: lall be constructed to provide at ur fire resistance rating and ordance with 8.3. Smoke exmitted to terminate at an ws shall be protected by	K)25	K025 NFPA 101 Life Safety Code Standards Smoke barriers shall be constructed provide at least a one half hour fire	ed to	9/1/16

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - VALLEY VIEW NURSING HOME			(X3) DATE SURVEY COMPLETED	
		245566	B. WING			08/	10/2016
	PROVIDER OR SUPPLIER	& REHAB	STREET ADDRESS, CITY, STATE, ZIP CODE 510 EAST CEDAR STREET HOUSTON, MN 55943		EAST CEDAR STREET		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
K 025	fire-rated glazing or steel frames. 8.3, 19.3.7.3, 19.3. On facility tour betwon 8/10/2016, base revealed findings in A large 1' x 3' pene ceiling in the smoke This deficient pract all the residents with This deficient pract Facility Maintenance discovery. NFPA 101 LIFE SA Door openings in second to the bottom of Horizontal sliding deficient protective plates the from the bottom of Horizontal sliding deficient protective plates the from the bottom of Horizontal sliding deficient protective plates the second ance with 19 not required to swirl latching is not required to swirl l	r by wired glass panels and 7.5 Veen 09:30 AM and 12:30 PM d on observation and interview Include: Itration was found above the e barrier wall. Itice could affect the safety of hin the smoke compartment. Itice was confirmed by the e Director (DJ) at the time of FETY CODE STANDARD Important the safety of the safety of the time of The property of the safety of the safety of the time of The property of the safety of the s			resistance rating and constructed accordance with 8.3. Smoke barribe permitted to terminate at an at wall. Windows shall be protected fire-rated glazing or by wired glas and steel frames. 8.3, 19.3.7.3, 19.3.7.5 A licensed contractor has been on to repair existing breech in the sm barrier wall. Work will be comple to 09/01/2016. Monitored by: Facility Maintenan Director K027 NFPA 101 Life Safety Code Standard (LSC 2000 Health Exist Door openings in smoke barriers least a 20-minute fire protection rare at least 10-inch thick solid bo	ers shall rium by s panels ontracted noke ted prior ce eting) have at rating or	9/1/16

CENTER	RS FOR MEDICARI	& MEDICAID SERVICES				IVID INU.	0938-039
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		E CONSTRUCTION D1 - Valley view nursing home	(X3) DATE SURVEY COMPLETED	
		245566	B, WING		φ	08/1	0/2016
	PROVIDER OR SUPPLIER	& REHAB					
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETIO DATE
K 027	on August 10,2016 interview revealed 1.The smoke barritested. This deficient practine 37 residents w This deficient practine 37 residents w	ween 09:30 AM and 12:30 PM , based on observation and	КО	27	7.2.1.14. Doors are self-closing or automatic closing in accordance w 19.2.2.2.6. Swinging doors are not required to swing with egress and latching is not required. 19.3.7.5, 19.3.7.7. On August 16, 2016 the Maintenar Director removed the obstruction of door to room 19. All Fire doors we adjusted for spring tension and lubrication. Monthly checks will be performed to insure proper function fire doors.	vith t positive 19.3.7.6, nce on the ere en of all	
K 046 SS=F	Emergency lighting is provided automat 18.2.9.1, 19.2.9.1. This STANDARD Emergency lighting is provided automat 18.2.9.1, 19.2.9.1. On facility tour beton 8/10/2016, bas revealed the finding 1. There are no recemergency lights to	ween 09:30 AM and 12:30 PM ed on observation and interview gs include: cords of battery-operated ested /inspected monthly. tice could affect the safety of all)46	Monitored by: Facility Maintenance Director K046 NFPA Life Safety Code Star (LSC 2000 Existing) Emergency lighting of at least 1 1/2 duration is provided automatically accordance with 7.9. 18.2.9.1, 19.2.9.1. An inspection form was created to emergency lighting monthly and y Findings of inspections will be documented and maintained by the Maintenance Director.	ndard /2 hour in o monitor early.	9/1/16
		tice was confirmed by the ce Director (DJ) at the time of			Monitored by: Facility Maintenanc Director	е	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION ING 01 - VALLEY VIEW NURSING HOME	(X3) DATI COM	E SURVEY PLETED
		245566	B. WING		08/	10/2016
	PROVIDER OR SUPPLIER	& REHAB		STREET ADDRESS, CITY, STATE, ZIP CODE 510 EAST CEDAR STREET HOUSTON, MN 55943		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFII TAG		.D BE	(X5) COMPLETION DATE
K 046	Continued From pa	nge 6	KO	046		
					Si .	

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PRINTED: 08/31/2016 FORM APPROVED OMB NO. 0938-0391

(X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING 02 - 2011 ADDITION B. WING 245566 08/10/2016 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER **510 EAST CEDAR STREET VALLEY VIEW HEALTHCARE & REHAB** HOUSTON, MN 55943 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (EACH CORRECTIVE ACTION SHOULD BE PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) K 000 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 dated August 10, 2016, 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

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

TITLE

Facility ID: 00286

(X6) DATE

Electronically Signed

08/26/2016

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

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUI	TIPI	LE CONSTRUCTION	(X3) DATE	SURVEY	
	OF CORRECTION	IDENTIFICATION NUMBER:			02 - 2011 ADDITION	08/10/2016		
		245566	B. WING					
	PROVIDER OR SUPPLIER VIEW HEALTHCARE	& REHAB		5	STREET ADDRESS, CITY, STATE, ZIP CODE 510 EAST CEDAR STREET HOUSTON, MN 55943			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE	
K 000	DEFICIENCY MUSE FOLLOWING INFO. 1. A description of to correct the defic. 2. The actual, or proceed of the correct the defic. 3. The name and/oresponsible for corprevent a reoccurrent a reoccurrent of the facility will be buildings. Valley V building with no be constructed at 3 disconstructed at 3 disconstruction. In 19 added to the South be Type II (111). Be the 2 additions are construction and mallowed for existing surveyed as one building became has a fire alarm system of the suilding became has a fire alarm system.	RRECTION FOR EACH ST INCLUDE ALL OF THE DRMATION: what has been, or will be, done iency. roposed, completion date. or title of the person rection and monitoring to ence of the deficiency. surveyed as two separate iew Nursing Home is a 1-story sement. The building was fferent times. The original ructed in 1967 and was f Type II(111) construction. In constructed to the West Wing ed to be of Type II(111) 89, another addition was a Wing and was determined to because the original building and of the same type of neet the construction type is buildings, the facility was	K	0000				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - 2011 ADDITION B. WING		- Community	(X3) DATE SURVEY COMPLETED 08/10/2016		
		245566						
NAME OF PROVIDER OR SUPPLIER VALLEY VIEW HEALTHCARE & REHAB				STREET ADDRESS, CITY, STATE, ZIP CODE 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)		PREFIX (EACH CORRECTIVE ACTION		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	SHOULD BE COMPLETION		
K 000 K 056 SS=D	The facility has a c census of 37 at the The requirement at NOT MET as evide	Continued From page 2 The facility has a capacity of 41 beds and had a census of 37 at the time of the survey. The requirement at 42 CFR Subpart 483.70(a) is NOT MET as evidenced by: NFPA 101 LIFE SAFETY CODE STANDARD		056		9/1/16		
99=D			K 056		K056 NFPA 101 Life Safety Code Standard (LSC 2000 Health New) There is an automatic sprinkler system installed in accordance with NFPA13, Standard for the Installation of Sprinkler Systems, with approved components, device and equipment, to provide complete coverage of all portions of the facility. Systems are equipped with waterflow and tamper switches, which a connected to the fire alarm system. In Type I and II construction, alternative protection measures shall be permitted be substituted for sprinkler protection in specific areas where State or local regulations prohibit sprinklers. 18.3.5, 18.3.5.1.	re		

		- A MILDIONID OLIVIOLO				. 0000 000
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A, BUILDING 02 - 2011 ADDITION		(X3) DATE SURVEY COMPLETED	
		245566	B. WING		08/	10/2016
NAME OF PROVIDER OR SUPPLIER VALLEY VIEW HEALTHCARE & REHAB				STREET ADDRESS, CITY, STATE, ZIP CO 510 EAST CEDAR STREET HOUSTON, MN 55943	5/10/2010	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI) TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETIC DATE
K 056	Continued From page 3 the residents within the dining area. This deficient practice was confirmed by the Facility Maintenance Director (DJ) at the time of discovery.			sprinkler head in laundry roc inspections will be performe sprinkler heads will be clear conjunction with dryer maint cleaning.	d and fire ned in enance and	
				Monitored by: Facility Mainte Director	enance	