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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: E6WU

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00286

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

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

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9)

6.IATEIOFISURVEY **9/26/2016** (L34)

8. ACCREIITATIONISTATUS: __ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

01 Hospital	05 HHA	09 ESRD	13 PTIP	22 CLIA
02 SNF/NF/Dual	06 PRTF	10 NF	14 CORF	
03 SNF/NF/Distinct	07 X-Ray	11 ICF/IID	15 ASC	
04 SNF	08 OPT/SP	12 RHC	16 HOSPICE	

FISCAL YEAR ENDING DATE: (L35) **09/30**

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

12.Total Facility Beds **45** (L18)

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

10.THE FACILITY IS CERTIFIED AS:

X A. In Compliance With Program Requirements

Compliance Based On:
___1. Acceptable POC

B.IIINotIinICmplianceIwithIProgram Requirements and/or Applied Waivers:

And/Or Approved Waivers Of The Following Requirements:
___ 2. Technical Personnel
___ 3. 24 Hour RN
___ 4. 7-Day RN (Rural SNF)
___ 5. Life Safety Code
__ 6. Scope of Services Limit
__ 7. Medical Director
__ 8. Patient Room Size
__ 9. Beds/Room

* Code: **A*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

17. SURVEYOR SIGNATURE Date :
Gary Nederhoff, Unit Supervisor 10/7/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 10/7/2016 (L20)

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY
____ 1. Facility is Eligible to Participate
____ 2. Facility is not Eligible (L21)

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

21. 1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :
_____

22. ORIGINAL DATE OF PARTICIPATION **07/01/1991** (L24)

23. LTC AGREEMENT BEGINNING DATE (L41)

24. LTC AGREEMENT ENDING DATE (L25)

25. LTC EXTENSION DATE: (L27)

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

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

28. TERMINATION DATE: (L28)

29. INTERMEDIARY/CARRIER NO. **03001** (L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE (L33)

DETERMINATION APPROVAL

MDH
Minnesota Department of Health

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

Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

MDH
Minnesota Department of Health

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 questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit

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

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
245566 Y1	A. Building 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

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	Correction	ID Prefix F0246	Correction	ID Prefix F0309	Correction
Reg. # 483.15(a)	Completed	Reg. # 483.15(e)(1)	Completed	Reg. # 483.25	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), (d), (e)	Completed	Reg. #	Completed	Reg. #	Completed
LSC	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	

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
	GPN/kfd	10/7/2016	10160	9/26/2016
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON
8/11/2016

☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
245566 Y1	A. Building 01 - VALLEY VIEW NURSING HOME 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).

ITEM 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. #	NFPA 101	Completed	Reg. #	NFPA 101	Completed
LSC	K0018	09/01/2016	LSC	K0025	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		

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS) TL/kfd	DATE 10/7/2016	SIGNATURE OF SURVEYOR 37008	DATE 10/4/2016
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON 8/10/2016

☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
245566	A. Building 02 - 2011 ADDITION B. Wing	10/4/2016

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).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix Reg. # NFPA 101 LSC K0056	Correction Completed 09/01/2016	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
	TL/kdf	10/7/2016	37008	10/4/2016
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON	
8/10/2016	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: E6WU

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00286

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

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

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9)

6. DATE OF SURVEY **08/11/2016** (L34)

8. ACCREDITATION STATUS: __ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

01 Hospital	05 HHA	09 ESRD	13 PTIP	22 CLIA
02 SNF/NF/Dual	06 PRTF	10 NF	14 CORF	
03 SNF/NF/Distinct	07 X-Ray	11 ICF/IID	15 ASC	
04 SNF	08 OPT/SP	12 RHC	16 HOSPICE	

FISCAL YEAR ENDING DATE: (L35) **09/30**

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

12.Total Facility Beds **45** (L18)

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

10.THE FACILITY IS CERTIFIED AS:

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

X B. Not in Compliance with Program Requirements and/or Applied Waivers:

And/Or Approved Waivers Of The Following Requirements:
___ 2. Technical Personnel
___ 3. 24 Hour RN
___ 4. 7-Day RN (Rural SNF)
___ 5. Life Safety Code
__ 6. Scope of Services Limit
__ 7. Medical Director
__ 8. Patient Room Size
__ 9. Beds/Room

* Code: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

17. SURVEYOR SIGNATURE Date :
Michelle Jaeckels, HFE NE II 08/30/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 09/20/2016 (L20)

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY
____ 1. Facility is Eligible to Participate
____ 2. Facility is not Eligible
(L21)

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

21. 1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :
_____

22. ORIGINAL DATE OF PARTICIPATION **07/01/1991** (L24)

23. LTC AGREEMENT BEGINNING DATE (L41)

24. LTC AGREEMENT ENDING DATE (L25)

25. LTC EXTENSION DATE: (L27)

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

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

28. TERMINATION DATE: (L28)

29. INTERMEDIARY/CARRIER NO. **03001** (L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE (L33)

DETERMINATION APPROVAL

MDH
Minnesota Department of Health

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:

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

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

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

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

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

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

DEPARTMENT CONTACT

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

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

Email: gary.nederhoff@state.mn.us
Telephone: (507) 206-2731 Fax: (507) 206-2711

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245566	A. BUILDING _____ B. WING _____	08/11/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 241 SS=E	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to provide services in a manner that promoted dignity for 4 of 27 residents (R5, R7, R15 and R16) in the sample who were observed during the meal times. Findings include: R5's annual Minimum Data Set (MDS) assessment dated 6/27/16 identified R5 with a Brief Interview for Mental Status (BIMS) score of 5, indicating severe cognitive impairment and identified R5 as requiring supervision of one staff	F 241	F241 - 483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY (LONG TERM CARE FACILITIES) The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. R5, R7, R15, & R16 were referred to OT for w/c positioning and safety.	9/1/16

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

Electronically Signed | 08/25/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 241	Continued From page 1 with meal set up. During observation of the evening meal service on 8/8/16, at 5:05 p.m. R5 was observed seated at the dining room table in a position where her eyes were just above the edge of the table. The table height was at a level where R5's chin was at the level of the table edge. R5 was observed to eat her meal by reaching up and over the edge of the table to scoop food off of her plate and had to bring the food back to the level of the edge of the table to eat. R5 was noted to have difficulty maintaining food on the silverware and was noted to drop food on her clothing protector, pick it off the clothing protector with her fingers and eat the food. During observation of the lunch meal on 8/9/16, at 11:21 a.m. R5 was again observed seated in her wheelchair sitting upright with the height of the table edge just below her chin. R5 was noted to have difficulty reaching her plate with her eating utensils and had to reach up and over the edge of the table. On 8/10/16, at 8:04 a.m., during the breakfast meal, the director of nursing services (DNS) was interviewed in the dining room while observing the meal. The DNS visualized R5's seating position at the dining room table and verified R5's position at the table was not conducive to enhancing independence with eating and verified R5's dignity needs were not being met. R5's position at the table not only impeded her ability to eat but also interfered with her potential to socialize with other residents at the table. The DNS stated the table was at its lowest level and stated the table needed to be changed to meet R5's needs.	F 241	OT was informed of preliminary findings on August 11, 2016. An OT order for w/c positioning and mobility was obtained for the mentioned residents and forwarded to Occupational therapy. Final survey findings were provided to therapy department on August 23, 2016 upon arrival. On August 10, 2016, tables were rearranged in the dining room to provide the facilities lowest adjustable tables in house to promote independence with dining and to accommodate the residents' individual needs. In addition, two (2) lower adjustable tables were ordered on August 23, 2016. The new tables will be implemented upon arrival to facility. Other residents have the potential to be affected by this practice. Nursing staff will attempt interventions for proper positioning in w/c, if unsuccessful will refer to OT services. All staff in-servicing will be provided on August 25, 2016. All residents have the potential to be affected by this practice. Monitored by: Director of Nursing, Occupational Therapist, or designee	

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F 241	Continued From page 2	F 241		

R7's annual MDS assessment dated 6/19/16 identified R7 with a Brief Interview for Mental Status (BIMS) score of 7, indicating moderate cognitive impairment and identified R7 as requiring limited assistance of one staff with meal set up.

R7 was observed during the evening meal on 8/8/16, at 5:05 p.m. R7 was observed seated at the dining room table in her wheelchair with her chin at level of the edge of table. R7 was observed in a seated position at the table where her eyes were just above the edge of the table. R7 was observed to attempt to eat independently but had difficulties due to the need to reach above the edge of the table to place her food on her silverware. R7 was observed to eat her meal by reaching up and over the edge of the table to scoop food off of her plate and had to bring the food back to the level of the edge of the table to eat. R7 was noted to have difficulty maintaining food on the silverware and was noted to drop food on her clothing protector, pick it off with her fingers and eat.

On 8/9/16, at 9:27 a.m. R7 was observed seated in the dining room at the dining room table seated in her wheelchair. R7 was observed to attempt to eat independently but had difficulty reaching up and over the table to reach her food. At 9:30 a.m. nursing assistant (NA)-J sat beside R7 and assisted her with eating. During interview with NA-J at the time of the observation, NA-J stated R7 was able to feed herself but needed assistance and encouragement at times.

During observation on 8/10/16, at 7:35 a.m. R7 was again observed seated at the dining room table with her chin at a level below the edge of

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table when sitting upright in w/c at table. R7 was served a bowl of sliced up bananas which she is eating by herself with difficulty due to having to reach up and over table with her arms. The contents of bowl were positioned in a manner that she could not see into the bowl as the bowl was higher than her line of site. R7 was observed to stick her fork in the bowl to get banana slices and looked at fork after removing it to see if she had gotten any banana on her fork. R7 was further observed to drop banana slices on her clothing protector then pick them up with her fingers and eat them.

On 8/10/16, at 8:04 a.m., during the breakfast meal, the director of nursing services (DNS) was interviewed in the dining room while observing the meal. The DNS visualized R7's seating position at the dining room table and verified R7's position at the table was not conducive to enhancing independence with eating and verified R7's dignity needs were not being met. R7's position at the table not only impeded her ability to eat but also interfered with her potential to socialize with other residents at the table. The DNS stated the table was at its lowest level and stated the table needed to be changed to meet R7's needs.

R15's quarterly (MDS) assessment dated 6/2/16 identified R15 with moderately impaired cognition and identified R15 as requiring limited assistance of one staff with eating.

During observation of the morning meal on 8/9/16, at 9:27 a.m. NA-H was observed assisting R15 to eat breakfast. During the observation R15 was positioned in her wheelchair at the dining room table bent forward with her face towards her lap and her head below the edge of the dining

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F 241	Continued From page 4	F 241		

room table. NA-H was observed to give R15 her liquids using a straw and placing the cup near R15's lap under the edge of the table and having R15 drink while bent forward. NA-H was observed to assist R15 with eating by scooping food onto a spoon and lowering the spoon below table height and bringing the food up to R15's mouth while R15 was bent forward with her face towards her lap. There was no observation of NA-H or other staff encouraging R15 to sit upright while eating.

On 8/9/16, at 11:30 a.m. R15 again was observed seated at the dining room table with her head at the level of the edge of the table and bent face down towards lap. NA's G and H were seated at the table with R15 and other residents. During interview with NA G and H at the time of the observation the NA's stated they had noticed how low residents were sitting at the tables but verified they had never addressed it with nursing and stated the nursing staff sometimes helped feed residents and knew hoe they sat. At 11:40 a.m., on 8/9/16 R15 was observed to attempt to reach her coffee cup off of the table and struggled to reach it. R15 was overheard to say, "I can't see it." R15 was referring to her coffee cup.

On 8/10/16, at 12:16 p.m. the physical therapy assistant (PTA)-A was requested by the surveyor to enter the dining room and observe positioning of R15 at the dining room table. The PTA-A verified the position was not a position to accommodate independence with eating and did not appear very dignified. The PTA-A stated the table either needed to be lowered or R15 needed some supports in her wheelchair to support upright seating.

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R16's quarterly (MDS) assessment dated 6/28/16 identified R16 with severely impaired cognition and identified R16 as requiring extensive assistance of one staff with eating.

During observation of the morning meal on 8/9/16, at 9:27 a.m. NA-H was observed to be assisting R16 eat her breakfast. R16 was positioned at the table in a manner where she was bent forward with her face towards her lap with the top of her head parallel with the table edge. NA-H was observed to take a cup of juice down under the table and near R16's lap then bring the straw up t R16's mouth while in the bent forward position. NA's-D and H were interviewed about R16's ability to independently eat and both stated she always needed assistance. NA-D and H also identified R16 frequently sat at the table leaning forward and acknowledged her positioning was not good.

During observation of the noon meal on 8/9/16, at 11:22 a.m. R16 was again observed seated at the dining room table in her wheelchair leaning forward with her head towards her lap. at same table with table at just below chin level. NA-F was observed to feed R16 by scooping food off of her plate then lowering the spoon below table height and bringing the food up to R16's mouth while leaning forward, face towards lap. The table height at the time of the observation was in a position if R16 was sitting upright it would have been at approximately her chin level.

During observation of the breakfast meal on 8/10/16, a 8:00 a.m. NA's-G and H were seated at the table in the dining room with R16. R16 was positioned at the table in manner where her eyes were just above the table edge. NA-G and H were

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interviewed about the positioning of R16 and stated they were aware R16 was sitting low at the table but verified they had never addressed it with nursing staff.

On 8/10/16, at 8:04 a.m. the DNS was interviewed and verified she had observed R16's positioning at the table after being brought up as a concern by the surveyor and had initiated a referral for occupational therapy to evaluate her positioning at the dining room table. The DNS verified R16's position was poor at the table and verified staff should attempt to position her upright before placing food in her mouth to promote good eating position and dignity.

During interview with PTA-A on 8/10/16, at 12:16 p.m. PTA-A verified R16's positioning was not optimal for eating.

During observation of the breakfast meal on 8/11/16, at 8:26 a.m. R16 was observed seated again at the dining room table in her wheelchair leaning forward with her forehead at the level of the table edge. NA-J was observed to assist R16 eat while leaning forward versus positioning her upright to feed her.

During interview with the occupational therapist (OT)-A on 8/11/2016, at 8:35 a.m. OT-A verified R16's positioning was poor and stated R16 should have been seated back in her wheelchair when eating. OT-A stated residents in general should be seated upright prior to them eating to maximize independence and safe eating practices. OT-A stated she been going to the facility for a couple weeks and had noted the concerns with positioning in wheelchairs and table height but had not received any referrals

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F 241	Continued From page 7 from facility to provide assessment and treatment until yesterday when the concern was brought to the staff's attention by the surveyor. Policy was requested for dignity and none provided.	F 241		
F 246 SS=E	483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to provide services in a manner that promoted reasonable accommodations of individual needs for 4 of 27 residents (R5, R7, R15 and R16) in the sample who were observed during the meal times. Findings include: R5's annual Minimum Data Set (MDS) assessment dated 6/27/16 identified R5 with a Brief Interview for Mental Status (BIMS) score of 5, indicating severe cognitive impairment and identified R5 as requiring supervision of one staff with meal set up. During observation of the evening meal service on 8/8/16, at 5:05 p.m. R5 was observed seated	F 246	F246 483.15(e) (1) REASONABLE ACCOMODATION OF NEEDS/PREFERENCES Valley View Healthcare & Rehab ensures that the resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. R5, R7, R15, & R16 were referred to OT for w/c positioning and safety. OT was informed of preliminary findings on August 11, 2016. An OT order for w/c positioning and mobility was obtained for	9/1/16

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F 246	Continued From page 8 at the dining room table in a position where her eyes were just above the edge of the table. The table height was at a level where R5's chin was at the level of the table edge. R5 was observed to eat her meal by reaching up and over the edge of the table to scoop food off of her plate and had to bring the food back to the level of the edge of the table to eat. R5 was noted to have difficulty maintaining food on the silverware and was noted to drop food on her clothing protector, pick it off the clothing protector with her fingers and eat the food. During observation of the lunch meal on 8/9/16, at 11:21 a.m. R5 was again observed seated in her wheelchair sitting upright with the height of the table edge just below her chin. R5 was noted to have difficulty reaching her plate with her eating utensils and had to reach up and over the edge of the table. On 8/10/16, at 8:04 a.m., during the breakfast meal, the director of nursing services (DNS) was interviewed in the dining room while observing the meal. The DNS visualized R5's seating position at the dining room table and verified R5's position at the table was not conducive to enhancing independence with eating. The DNS stated the table was at its lowest level and stated the table needed to be changed to meet R5's needs. R7's annual MDS assessment dated 6/19/16 identified R7 with a Brief Interview for Mental Status (BIMS) score of 7, indicating moderate cognitive impairment and identified R7 as requiring limited assistance of one staff with meal set up. R7 was observed during the evening meal on	F 246	the mentioned residents and forwarded to Occupational therapy. Final survey findings were provided to therapy department on August 23, 2016 upon arrival. On August 10, 2016, tables were rearranged in the dining room to provide the facilities lowest adjustable tables in house to promote independence with dining and to accommodate the residents' individual needs. In addition, two (2) lower adjustable tables were ordered on August 23, 2016. The new tables will be implemented upon arrival to facility. Other residents have the potential to be affected by this practice. Nursing staff will attempt interventions for proper positioning in w/c, if unsuccessful will refer to OT services. All staff in-servicing will be provided on August 25, 2016. All residents have the potential to be affected by this practice. Monitored by: Director of Nursing, Occupational Therapist, or designee	

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8/8/16, at 5:05 p.m. R7 was observed seated at the dining room table in her wheelchair with her chin at level of the edge of table. R7 was observed in a seated position at the table where her eyes were just above the edge of the table. R7 was observed to attempt to eat independently but had difficulties due to the need to reach above the edge of the table to place her food on her silverware. R7 was observed to eat her meal by reaching up and over the edge of the table to scoop food off of her plate and had to bring the food back to the level of the edge of the table to eat. R7 was noted to have difficulty maintaining food on the silverware and was noted to drop food on her clothing protector, pick it off with her fingers and eat.

On 8/9/16, at 9:27 a.m. R7 was observed seated in the dining room at the dining room table seated in her wheelchair. R7 was observed to attempt to eat independently but had difficulty reaching up and over the table to reach her food. At 9:30 a.m. nursing assistant (NA)-J sat beside R7 and assisted her with eating. During interview with NA-J at the time of the observation, NA-J stated R7 was able to feed herself but needed assistance and encouragement at times.

During observation on 8/10/16, at 7:35 a.m. R7 was again observed seated at the dining room table with her chin at a level below the edge of table when sitting upright in w/c at table. R7 was served a bowl of sliced up bananas which she is eating by herself with difficulty due to having to reach up and over table with her arms. The contents of bowl were positioned in a manner that she could not see into the bowl as the bowl was higher than her line of site. R7 was observed to stick her fork in the bowl to get banana slices and

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looked at fork after removing it to see if she had gotten any banana on her fork. R7 was further observed to drop banana slices on her clothing protector then pick them up with her fingers and eat them.

On 8/10/16, at 8:04 a.m., during the breakfast meal, the director of nursing services (DNS) was interviewed in the dining room while observing the meal. The DNS visualized R7's seating position at the dining room table and verified R7's position at the table was not conducive to enhancing independence with eating. The DNS stated the table was at its lowest level and stated the table needed to be changed to meet R7's needs.

R15's quarterly (MDS) assessment dated 6/2/16 identified R15 with moderately impaired cognition and identified R15 as requiring limited assistance of one staff with eating.

During observation of the morning meal on 8/9/16, at 9:27 a.m. NA-H was observed assisting R15 to eat breakfast. During the observation R15 was positioned in her wheelchair at the dining room table bent forward with her face towards her lap and her head below the edge of the dining room table. NA-H was observed to give R15 her liquids using a straw and placing the cup near R15's lap under the edge of the table and having R15 drink while bent forward. NA-H was observed to assist R15 with eating by scooping food onto a spoon and lowering the spoon below table height and bringing the food up to R15's mouth while R15 was bent forward with her face towards her lap. There was no observation of NA-H or other staff encouraging R15 to sit upright while eating.

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On 8/9/16, at 11:30 a.m. R15 again was observed seated at the dining room table with her head at the level of the edge of the table and bent face down towards lap. NA's G and H were seated at the table with R15 and other residents. During interview with NA-G and H at the time of the observation the NA's stated they had noticed how low residents were sitting at the tables but verified they had never addressed it with nursing and stated the nursing staff sometimes helped feed residents and knew hoe they sat. At 11:40 a.m., on 8/9/16 R15 was observed to attempt to reach her coffee cup off of the table and struggled to reach it. R15 was overheard to say, "I can't see it." R15 was referring to her coffee cup.

On 8/10/16, at 12:16 p.m. the physical therapy assistant (PTA)-A was requested by the surveyor to enter the dining room and observe positioning of R15 at the dining room table. The PTA-A verified the position was not a position to accommodate independence with eating and did not appear very dignified. The PTA-A stated the table either needed to be lowered or R15 needed some supports in her wheelchair to support upright seating.

R16's quarterly (MDS) assessment dated 6/28/16 identified R16 with severely impaired cognition and identified R16 as requiring extensive assistance of one staff with eating.

During observation of the morning meal on 8/9/16, at 9:27 a.m. NA-H was observed to be assisting R16 eat her breakfast. R16 was positioned at the table in a manner where she was bent forward with her face towards her lap with the top of her head parallel with the table edge. NA-H was observed to take a cup of juice

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	245566	A. BUILDING _____ B. WING _____	08/11/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 246	Continued From page 12	F 246		

down under the table and near R16's lap then bring the straw up t R16's mouth while in the bent forward position. NA's-D and H were interviewed about R16's ability to independently eat and both stated she always needed assistance. NA-D and H also identified R16 frequently sat at the table leaning forward and acknowledged her positioning was not good.

During observation of the noon meal on 8/9/16, at 11:22 a.m. R16 was again observed seated at the dining room table in her wheelchair leaning forward with her head towards her lap. at same table with table at just below chin level. NA-F was observed to feed R16 by scooping food off of her plate then lowering the spoon below table height and bringing the food up to R16's mouth while leaning forward, face towards lap. The table height at the time of the observation was in a position if R16 was sitting upright it would have been at approximately her chin level.

During observation of the breakfast meal on 8/10/16, a 8:00 a.m. NA's-G and H were seated at the table in the dining room with R16. R16 was positioned at the table in manner where her eyes were just above the table edge. NA-G and H were interviewed about the positioning of R16 and stated they were aware R16 was sitting low at the table but verified they had never addressed it with nursing staff.

On 8/10/16, at 8:04 a.m. the DNS was interviewed and verified she had observed R16's positioning at the table after being brought up as a concern by the surveyor and had initiated a referral for occupational therapy to evaluate her positioning at the dining room table. The DNS verified R16's position was poor at the table and

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F 246	Continued From page 13 verified staff should attempt to position her upright before placing food in her mouth to promote good eating position. During interview with PTA-A on 8/10/16, at 12:16 p.m. PTA-A verified R16's positioning was not optimal for eating. During observation of the breakfast meal on 8/11/16, at 8:26 a.m. R16 was observed seated again at the dining room table in her wheelchair leaning forward with her forehead at the level of the table edge. NA-J was observed to assist R16 eat while leaning forward versus positioning her upright to feed her. During interview with the occupational therapist (OT)-A on 8/11/2016, at 8:35 a.m. OT-A verified R16's positioning was poor and stated R16 should have been seated back in her wheelchair when eating. OT-A stated residents in general should be seated upright prior to them eating to maximize independence and safe eating practices. OT-A stated she been going to the facility for a couple weeks and had noted the concerns with positioning in wheelchairs and table height but had not received any referrals from facility to provide assessment and treatment until yesterday when the concern was brought to the staff's attention by the surveyor.	F 246		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment	F 309		9/1/16

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F 309	Continued From page 14 and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide the necessary care and services to maintain good positioning for 2 of 2 residents (R39 and R16) who lacked optimal positioning while seated in the wheelchair (W/C). Findings include: R39's quarterly Minimum Data Set (MDS) assessment dated 7/11/16 identified R39 as requiring extensive assistance with all activities of daily assistance (ADL's). The MDS further identified R39 with unstable balance and identified her with bilateral upper and lower functional limitations in range of motion (ROM) R39's During the initial tour of the facility on 8/8/16 at 4:00 p.m. R39 was observed seated in a high back wheelchair in the dayroom behind the main nurses station. R39 was noted to be leaning significantly to her right over the armrest of her wheelchair and noted to have her body weight pressed against her right arm against the armrest. During the observation staff were observed to enter the dayroom to take other residents out and did not reposition R39. On 8/8/16, at 5:20 p.m. R39 was observed seated in the dining room prior to the meal being served. R39 was again observed leaning significantly over the right side of her wheelchair with her right arm pressed against the wheelchair armrest.	F 309	F309 483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Valley View Healthcare & Rehab ensures that each resident receives and provides the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. R39 & R16 were referred to OT for w/c positioning and safety. OT was informed of preliminary findings on August 11, 2016. An OT order for w/c positioning and mobility was obtained for the mentioned residents and forwarded to Occupational therapy. Final survey findings were provided to therapy department on August 23, 2016 upon arrival. On August 10, 2016, tables were rearranged in the dining room to provide the facilities lowest adjustable tables in house to promote independence with dining and to accommodate the residents' individual needs. In addition, two (2) lower adjustable tables	

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F 309	Continued From page 15 There were no supports observed in the wheelchair to prevent R39 from leaning. During the observation dietary assistant (DA)-A was observed walking past R39 multiple times taking food orders from other residents and did not attempt to have staff reposition R39. On 8/9/2016, at 9:27 a.m. R39 was observed seated in the dining room leaning forward in her wheelchair with her face towards her lap. On 8/11/16, at 8:10 a.m. R39 was again observed seated in the dayroom with her head bent forward in her chair towards her lap. R39 was bent forward with no evidence of upper torso supports in her wheelchair. On 8/11/16, at 8:13 a.m. the director of nursing services (DNS) was asked to view R39's positioning while seated in the dayroom in her wheelchair. The DNS stated R39's wheelchair did not support her positioning needs. The DNS stated she felt R39 should be referred to therapy and have her needs addressed by occupation therapy. On 8/11/16 at 8:19 a.m. R39 was wheeled into the dining room and was place at a dining room table with nursing assistant (NA)-H seated beside her. R39 was observed leaning forward with her face towards her lap and was not assisted to an upright seated position even when NA-H could observe her leaning forward. On 8/11/2016, at 8:37 a.m. during interview with the occupation therapist (OT)-A, in the dining room, OT-A verified the mal-positioning of R39. OT-A stated she felt staff should attempt to	F 309	were ordered on August 23, 2016. The new tables will be implemented upon arrival to facility. Other resident have the potential to be affected by this practice. Nursing staff will attempt interventions for proper positioning in w/c, if unsuccessful will refer to OT services. All staff in-servicing will be provided on August 25, 2016 to all staff on w/c by Occupational therapist on wheelchair positioning. All residents have the potential to be affected by this practice. Monitored by: Director of Nursing, Occupational Therapist, or designee	

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reposition R39 when observed leaning and the facility should have a OT referral submitted to improve positioning.

R16's quarterly Minimum Data Set (MDS) assessment dated 6/28/16 identified R16 as requiring extensive assistance with all activities of daily assistance (ADL's). The MDS further identified R39 with unstable balance.

During observation of the dining room 8/9/16, at 9:27 a.m. NA-H was observed to be seated beside R16 at the dining room table. R16 was positioned at the table in a manner where she was bent forward with her face towards her lap with the top of her head parallel with the table edge. NA-H was observed not to attempt to reposition R16 to an upright position and left her leaning forward even when seated right beside R39. NA-D and H were interviewed about R16's positioning and both stated she frequently would lean forward in her wheelchair and acknowledged R16's positioning was not good.

During observation of the noon meal on 8/9/16, at 11:22 a.m. R16 was again observed seated at the dining room table in her wheelchair leaning forward with her head towards her lap.

On 8/10/16, at 8:04 a.m. the DNS was interviewed and verified she had observed R16's positioning at the table after being brought up as a concern by the surveyor and had initiated a referral for occupational therapy to evaluate her positioning. The DNS verified R16's position was poor and verified staff should attempt to position her upright.

During interview with physical therapy aide

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(PTA)-A on 8/10/16, at 12:16 p.m. PTA-A verified R16's positioning was not optimal and stated R16 should be evaluated for upper body support.

During observation of the breakfast meal on 8/11/16, at 8:26 a.m. R16 was observed seated again at the dining room table in her wheelchair leaning forward with her forehead at the level of the table edge.

On 8/11/16, at 8:11 a.m. R39 was observed seated in the day room in her wheelchair leaning forward in her chair. R39's face was towards her. R39's wheelchair was noted to have side bolsters but the bolsters did not support R39's upper torso from leaning forward.

On 8/11/16, at 8:13 a.m. the director of nursing services (DNS) was asked to view R16's positioning while seated in the dayroom in her wheelchair. The DNS stated R39's wheelchair did not support her positioning needs. The DNS further stated R39's positioning needed to be evaluated due to her frequently leaning forward. The DNS also stated she will make a referral to OT for wheelchair positioning for R16 as the positioning looked uncomfortable and needed to be evaluated

On 8/11/16, at 8:35 a.m.,. R16 was observed by OT-A while seated in her wheelchair in the dining room. OT-A verified R16 was mal-positioned in her wheelchair and stated R16 should be positioned back and upright in the wheelchair. OT-A stated she had been coming to the facility for a couple weeks and has noted the concerns with position in wheelchairs but had not received any referrals from facility to provide assessment and treatment.

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F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document	F 431	F431 ¿483.60(b)(2)(3), (d), (e) □	9/1/16

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F 431	Continued From page 19 review, the facility failed to ensure medications were stored in the original pharmacy packaging for 1 of 2 medication carts (East hall medication cart) observed belonging to resident (R21) and R42. Findings include: On 8/8/16 at 5:47 p.m. the east hall medication cart was observed. In the top drawer of the medication cart were two pre-set up medication in cups. Licensed practical nurse (LPN)-A identified the medication cups were medications for R21 and R42. LPN-A stated, "They want them [medications] right away so I always pre-set up. I believe it is in our policy. I just label them with the room number and the name and last initial [of resident they belong too]." R21's pre-set up medication cup included; calcium, diltiazem (high blood pressure medicaiton), simvastatin (cholesterol medication), Nieferex (iron supplement), and a multi-vitamin. R42's pre-set up medication cup included; Ativan (controlled anti-anxiety medication), valproic acid (seizure medication), gabapentin (chronic pain medication, and mirtazapine (anti-depressant medication.) On 8/8/16 at 7:37 p.m. the director of nursing stated, "They [staff who are assigned to pass medications] should not be presetting up medications." Facility policy, Preparation and General Guidelines, Medication Administration dated 2006, reads; "B. Administration...4. Medications are administered at the time they are prepared.	F 431	Controlled Substances and Labeling/Storage of Drugs and Biologicals Valley View Healthcare & Rehab ensures the storage of all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. Medication Pass Procedure was updated on August 24, 2016. All licensed staff and TMAs have been provided a copy of the updated policy. A random audit of Medication Carts will be completed to ensure that the there are no pre-set up medications Mandatory nursing medication training in-service will be provided on August 25, 2016 & August 30, 2016 on Medication Pass procedure and reviewed the facility policy, Preparation and General Guidelines, Medication Administration. Pharmacy LPN consultant will perform random medication pass audits quarterly. Monitored by: Pharmacist consultant, Director of Nursing or designee	

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F 431	Continued From page 20 Medications are not pre-poured."	F 431		

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	245566	A. BUILDING **01 - VALLEY VIEW NURSING HOME** B. WING _____	**08/10/2016**

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K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS 2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE 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	K 000	EPOC	

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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K 000	Continued From page 1 By email to: Marian.Whitney@state.mn.us and Angela.Kappenman@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. This facility will be surveyed as two separate buildings. Valley View Nursing Home is a 1-story building with no basement. The building was constructed at 3 different times. The original building was constructed in 1967 and was determined to be of Type II(111) construction. In 1973, addition was constructed to the West Wing that was determined to be of Type II(111) construction. In 1989, another addition was added to the South Wing and was determined to be Type II (111). Because the original building and the 2 additions are of the same type of construction and meet the construction type allowed for existing buildings, the facility was surveyed as one building. The building became fully sprinklered. The facility has a fire alarm system with full corridor smoke detection, spaces open to the corridors that is monitored for automatic fire department notification.	K 000		

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K 000	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:	K 000		
K 018 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas shall be substantial doors, such as those constructed of 13/4 inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Clearance between bottom of door and floor covering is not exceeding 1 inch. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Doors shall be provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.2.3.2.1. Roller latches are prohibited by CMS regulations in all health care facilities. 19.3.6.3 This STANDARD is not met as evidenced by: Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas shall be substantial doors, such as those constructed of 13/4 inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Clearance between bottom of door and floor covering is not exceeding 1 inch. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Doors shall be provided with a means suitable for keeping the	K 018	K018 NFPA 101 Life Safety Code Standard (LSC Health Existing) Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas shall be substantial doors, such as those constructed of 13/4 inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Clearance between bottom of door and floor covering is not exceeding 1 inch. Doors in fully sprinklered smoke compartments are only	9/1/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245566	A. BUILDING **01 - VALLEY VIEW NURSING HOME** B. WING _____	**08/10/2016**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 018	Continued From page 3 door closed. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.2.3.2.1. Roller latches are prohibited by CMS regulations in all health care facilities. 19.3.6.3 On facility tour between 09:30 AM and 12:30 PM on 8/10/2016, based on observation and interview revealed Findings include: 1. Resident room #19 did not latch when tested. This deficient practice could affect the safety of the 19 residents within the smoke compartment. 2. Fire doors in both West and East wings did not latch when tested. This deficient practice could affect the safety of the 37 residents within these wings. This deficient practice was confirmed by the Facility Maintenance Director (DJ) at the time of discovery.	K 018	required to resist the passage of smoke. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Doors shall be provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.2.3.2.1. Roller latches are prohibited by CMS regulations in all health care facilities. 19.3.6.3 On August 16, 2016 the Maintenance Director removed the obstruction on the door to room 19. All Fire doors were adjusted for spring tension and lubrication. Monthly checks will be performed to insure proper function of all fire doors. Monitored by: Facility Maintenance Director	
K 025 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers shall be constructed to provide at least a one half hour fire resistance rating and constructed in accordance with 8.3. Smoke barriers shall be permitted to terminate at an atrium wall. Windows shall be protected by fire-rated glazing or by wired glass panels and steel frames. 8.3, 19.3.7.3, 19.3.7.5 This STANDARD is not met as evidenced by: Smoke barriers shall be constructed to provide at least a one half hour fire resistance rating and constructed in accordance with 8.3. Smoke barriers shall be permitted to terminate at an atrium wall. Windows shall be protected by	K 025	K025 NFPA 101 Life Safety Code Standards Smoke barriers shall be constructed to provide at least a one half hour fire	9/1/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245566	A. BUILDING **01 - VALLEY VIEW NURSING HOME** B. WING _____	**08/10/2016**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 025	Continued From page 4 fire-rated glazing or by wired glass panels and steel frames. 8.3, 19.3.7.3, 19.3.7.5 On facility tour between 09:30 AM and 12:30 PM on 8/10/2016, based on observation and interview revealed findings include: A large 1' x 3' penetration was found above the ceiling in the smoke barrier wall. This deficient practice could affect the safety of all the residents within the smoke compartment. This deficient practice was confirmed by the Facility Maintenance Director (DJ) at the time of discovery.	K 025	resistance rating and constructed in accordance with 8.3. Smoke barriers shall be permitted to terminate at an atrium wall. Windows shall be protected by fire-rated glazing or by wired glass panels and steel frames. 8.3, 19.3.7.3, 19.3.7.5 A licensed contractor has been contracted to repair existing breech in the smoke barrier wall. Work will be completed prior to 09/01/2016. Monitored by: Facility Maintenance Director	
K 027 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Door openings in smoke barriers have at least a 20-minute fire protection rating or are at least 1o-inch thick solid bonded wood core. Non-rated protective plates that do not exceed 48 inches from the bottom of the door are permitted. Horizontal sliding doors comply with 7.2.1.14. Doors are self-closing or automatic closing in accordance with 19.2.2.2.6. Swinging doors are not required to swing with egress and positive latching is not required. 19.3.7.5, 19.3.7.6, 19.3.7.7 This STANDARD is not met as evidenced by: Door openings in smoke barriers have at least a 20-minute fire protection rating or are at least 1o-inch thick solid bonded wood core. Non-rated protective plates that do not exceed 48 inches from the bottom of the door are permitted. Horizontal sliding doors comply with 7.2.1.14. Doors are self-closing or automatic closing in accordance with 19.2.2.2.6. Swinging doors are not required to swing with egress and positive latching is not required. 19.3.7.5, 19.3.7.6,	K 027	K027 NFPA 101 Life Safety Code Standard (LSC 2000 Health Existing) Door openings in smoke barriers have at least a 20-minute fire protection rating or are at least 1o-inch thick solid bonded wood core. Non-rated protective plates that do not exceed 48 inches from the bottom of the door are permitted. Horizontal sliding doors comply with	9/1/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245566	A. BUILDING **01 - VALLEY VIEW NURSING HOME** B. WING _____	**08/10/2016**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 027	Continued From page 5 19.3.7.7 On facility tour between 09:30 AM and 12:30 PM on August 10,2016, based on observation and interview revealed findings include: 1.The smoke barrier door did not latch when tested. This deficient practice could affect the safety of the 37 residents within the smoke compartment. This deficient practice was confirmed by the Facility Maintenance Director (DJ) at the time of discovery.	K 027	7.2.1.14. Doors are self-closing or automatic closing in accordance with 19.2.2.2.6. Swinging doors are not required to swing with egress and positive latching is not required. 19.3.7.5, 19.3.7.6, 19.3.7.7. On August 16, 2016 the Maintenance Director removed the obstruction on the door to room 19. All Fire doors were adjusted for spring tension and lubrication. Monthly checks will be performed to insure proper function of all fire doors. Monitored by: Facility Maintenance Director	
K 046 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Emergency lighting of at least 1 1/2 hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1. This STANDARD is not met as evidenced by: Emergency lighting of at least 1 1/2 hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1. On facility tour between 09:30 AM and 12:30 PM on 8/10/2016, based on observation and interview revealed the findings include: 1.There are no records of battery-operated emergency lights tested /inspected monthly. This deficient practice could affect the safety of all the residents in the facility. This deficient practice was confirmed by the Facility Maintenance Director (DJ) at the time of	K 046	K046 NFPA Life Safety Code Standard (LSC 2000 Existing) Emergency lighting of at least 1 1/2 hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1. An inspection form was created to monitor emergency lighting monthly and yearly. Findings of inspections will be documented and maintained by the Maintenance Director. Monitored by: Facility Maintenance Director	9/1/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245566	A. BUILDING **01 - VALLEY VIEW NURSING HOME** B. WING _____	**08/10/2016**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 046	Continued From page 6 discovery.	K 046		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245566	A. BUILDING **02 - 2011 ADDITION** B. WING _____	**08/10/2016**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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	K 000	EPOC	

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245566	A. BUILDING **02 - 2011 ADDITION** B. WING _____	**08/10/2016**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 000	Continued From page 1 By email to: Marian.Whitney@state.mn.us and Angela.Kappenman@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. This facility will be surveyed as two separate buildings. Valley View Nursing Home is a 1-story building with no basement. The building was constructed at 3 different times. The original building was constructed in 1967 and was determined to be of Type II(111) construction. In 1973, addition was constructed to the West Wing that was determined to be of Type II(111) construction. In 1989, another addition was added to the South Wing and was determined to be Type II (111). Because the original building and the 2 additions are of the same type of construction and meet the construction type allowed for existing buildings, the facility was surveyed as one building. The building became fully sprinklered. The facility has a fire alarm system with full corridor smoke detection, spaces open to the corridors that is monitored for automatic fire department notification.	K 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245566	A. BUILDING **02 - 2011 ADDITION** B. WING _____	**08/10/2016**

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

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K 000	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:	K 000		
K 056 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD 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 are connected to the fire alarm system. In Type I and II construction, alternative protection measures shall be permitted to be substituted for sprinkler protection in specific areas where State or local regulations prohibit sprinklers. 18.3.5, 18.3.5.1. This STANDARD is not met as evidenced by: 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 are connected to the fire alarm system. In Type I and II construction, alternative protection measures shall be permitted to be substituted for sprinkler protection in specific areas where State or local regulations prohibit sprinklers. 18.3.5, 18.3.5.1. On facility tour between 09:30 AM and 12:30 PM on 8/10/2016, based on observation and interview revealed the findings include: Lint was found around fire sprinkler heads in the Laundry room. This deficient practice could affect the safety of	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 are connected to the fire alarm system. In Type I and II construction, alternative protection measures shall be permitted to be substituted for sprinkler protection in specific areas where State or local regulations prohibit sprinklers. 18.3.5, 18.3.5.1. Lint was removed from and around	9/1/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245566	A. BUILDING **02 - 2011 ADDITION** B. WING _____	**08/10/2016**

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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.	K 056	sprinkler head in laundry room. Monthly inspections will be performed and fire sprinkler heads will be cleaned in conjunction with dryer maintenance and cleaning. Monitored by: Facility Maintenance Director	