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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: MCH3

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00121

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245442**
2.STATE VENDOR OR MEDICAID NO.
(L2) **046545300**

3. NAME AND ADDRESS OF FACILITY
(L3) **SPRING VALLEY CARE CENTER**
(L4) **800 MEMORIAL DRIVE**
(L5) **SPRING VALLEY, MN** (L6) **55975**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **09/26/2015** (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 **50** (L18)

13.Total Certified Beds **50** (L17)

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	50			
(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 10/13/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 10/15/2015 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
03/01/1987
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
10/07/2015
(L33)

DETERMINATION APPROVAL

Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 245442

October 15, 2015

Ms. Penny Solberg, Administrator
Spring Valley Care Center
800 Memorial Drive
Spring Valley, Minnesota 55975

Dear Ms. Solberg:

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 22, 2015 the above facility is certified for:

50 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 50 skilled nursing facility beds.

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

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

Please contact me if you have any questions.

Sincerely,

Kamala Fiske-Downing

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

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered
October 13, 2015

Ms. Penny Solberg, Administrator
Spring Valley Care Center
800 Memorial Drive
Spring Valley, Minnesota 55975

RE: Project Number S5442026

Dear Ms. Solberg:

On August 27, 2015, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on August 13, 2015. 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, 2015, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on October 9, 2015 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 13, 2015. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of September 22, 2015. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on August 13, 2015, effective September 22, 2015 and therefore remedies outlined in our letter to you dated August 27, 2015, will not be imposed.

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

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

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

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245442	A. Building B. Wing	9/26/2015

Name of Facility	Street Address, City, State, Zip Code
SPRING VALLEY CARE CENTER	800 MEMORIAL DRIVE SPRING VALLEY, MN 55975

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

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix F0156 Reg. # 483.10(b)(5) - (10), 483.10(t LSC	09/22/2015	ID Prefix F0309 Reg. # 483.25 LSC	09/22/2015	ID Prefix F0334 Reg. # 483.25(n) LSC	09/22/2015
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By State Agency	Reviewed By GPN/kfd	Date: 10/13/2015	Signature of Surveyor: 10160	Date: 09/26/2015
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:
Followup to Survey Completed on: 8/13/2015		Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? YES NO		

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction A. Building B. Wing	(Y3) Date of Revisit
245442	01 - MAIN BUILDING 01	10/9/2015

Name of Facility	Street Address, City, State, Zip Code
SPRING VALLEY CARE CENTER	800 MEMORIAL DRIVE SPRING VALLEY, MN 55975

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

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix Reg. # NFPA 101 LSC K0050	09/21/2015	ID Prefix Reg. # NFPA 101 LSC K0062	09/21/2015	ID Prefix Reg. # NFPA 101 LSC K0144	09/21/2015
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	GS/kfd	10/13/2015	19251	10/09/2015
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on: 8/13/2015

Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? **YES** **NO**

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction A. Building B. Wing	(Y3) Date of Revisit
245442	02 - SPRING VALLEY CARE CENTER	10/9/2015

Name of Facility	Street Address, City, State, Zip Code
SPRING VALLEY CARE CENTER	800 MEMORIAL DRIVE SPRING VALLEY, MN 55975

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

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix Reg. # NFPA 101 LSC K0050	09/21/2015	ID Prefix Reg. # NFPA 101 LSC K0062	09/21/2015	ID Prefix Reg. # NFPA 101 LSC K0144	09/21/2015
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

	Reviewed By	Date:	Signature of Surveyor:	Date:
Reviewed By State Agency	GS/kfd	10/13/2015	19251	10/09/2015
Reviewed By CMS RO				

Followup to Survey Completed on: 8/13/2015

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: MCH3

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY Facility ID: 00121

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245442**
2.STATE VENDOR OR MEDICAID NO.
(L2) **046545300**

3. NAME AND ADDRESS OF FACILITY
(L3) **SPRING VALLEY CARE CENTER**
(L4) **800 MEMORIAL DRIVE**
(L5) **SPRING VALLEY, MN** (L6) **55975**

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 **08/13/2015** (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 **50** (L18)

13.Total Certified Beds **50** (L17)

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	50			
(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 :
Marietta Lee, HFE NE II 09/08/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 10/02/2015 (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
03/01/1987
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered
August 27, 2015

Ms. Penny Solberg, Administrator
Spring Valley Care Center
800 Memorial Drive
Spring Valley, Minnesota 55975

RE: Project Number S5442026

Dear Ms. Solberg:

On August 13, 2015, 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
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 22, 2015, 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 22, 2015 the following remedy will be imposed:

- Per instance civil money penalties. (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 13, 2015 (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 13, 2016 (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. Gary Schroeder
Health Care Fire Inspections
State Fire Marshal Division
pat.sheehan@state.mn.us
Telephone: (651) 201-7205
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
	245442	A. BUILDING _____ B. WING _____	08/13/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING VALLEY CARE CENTER	800 MEMORIAL DRIVE SPRING VALLEY, MN 55975

(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 156 SS=D	483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing. The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers	F 156		9/22/15

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

Electronically Signed | 09/02/2015

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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	245442	A. BUILDING _____ B. WING _____	08/13/2015

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F 156	Continued From page 1	F 156		

and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section.

The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate.

The facility must furnish a written description of legal rights which includes:
A description of the manner of protecting personal funds, under paragraph (c) of this section;

A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels.

A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification

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F 156	Continued From page 2 agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements. The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care. The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to provide the appropriate liability and appeals notice for 1 of 6 residents (R3) reviewed for liability notices and beneficiary appeals rights review. Findings Include: R3 was admitted to the facility on 1/27/15 according to the admission face sheet and also received Medicare Part A benefits. R3 was given the generic Notice of Medicare Non-Coverage on 4/17/15 informing R3 his Medicare Part A services would end on 4/20/15. R3 used 79 days of Medicare Part A services out of a maximum of 100 days and remained in the facility past 4/20/15. The facility did not provide R3 and/or his legal representative with a Skilled Nursing Facility	F 156	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? R3 was given the generic Notice of Medicare Non-Coverage form on 4/17/15 and Medicare part A services ended on 4/20/15 and resident remained in the facility with 79 days remaining. Facility will administer both the generic Notice of Medicare Non-Coverage form AND the SNFABN (CMS 10055) form upon discharge from Medicare A services with days remaining and when the resident is remaining in the facility. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? Other	

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F 156	Continued From page 3 Advanced Beneficiary Notice (SNFABN)/Centers for Medicare and Medicaid Services (CMS)-10055 to inform him of potential liability for non-covered services and of his right to appeal to Medicare. On 8/13/15 at 12:57 p.m. the director of nursing (DON) verified that residents who are ending Medicare Part A services only received the generic notice. DON said, "Yes, at this time that is what they receive." also, "We do not have that form for any resident that remained in the facility. We only gave the generic form." Policy was requested but none provided by facility.	F 156	residents who are admitted or re-admitted to the facility and have Medicare A benefits, and are subsequently discharged from Medicare A services prior to using their full 100 days benefit AND the resident remains in the facility are at risk for the same deficient practice. If the above situation occurs for future residents, both the Generic Notice of Medicare Non-Coverage form AND the SNFABN form will be completed at least 2 days prior to the end of their Medicare A coverage. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? Registered Nurses who complete the Non-Coverage forms were provided with education on 8/25/15 on the appropriate liability notices to be administered orally and written when a resident is discharging from Medicare A benefit coverage with days of benefit left and are remaining in the facility. Registered Nurses were given a word document copy of the SNFABN CMS 10055 form for use in conjunction with the generic Notice of Medicare Non-Coverage form. How the facility plans to monitor its performance to make sure that solutions are sustained? 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. Director of Nursing Services or designee will complete audits	

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F 156	Continued From page 4	F 156	on all residents who will be discharging from Medicare A who remain in the facility to ensure that the appropriate liability notices are given. This will be discussed in the daily IDT meetings. Audits will be completed on all residents who meet the criteria for requiring the SNFABN CMS 10055 form AND the generic Notice of Medicare Non-Coverage form through November of 2015. After formal audits are completed, random audits will be completed to ensure continued compliance. Plan of correction and results of audits will be discussed with Quality Assurance Committee. Person Responsible for plan of Correction: Director of Nursing Services or designee	
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 and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to coordinate services to ensure a dialysis site dressing was managed to reduce the risk of access site infection and clotting for 1 of 1 resident (R25) reviewed for dialysis.	F 309	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? R25¿s care plan was reviewed on 8/27/15 & 8/28/15 and updated to include specific instructions for	9/22/15

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F 309	Continued From page 5 Findings include: R25 was observed in his room after returning from dialysis on 8/11/15, at 1:46 p.m. A gauze-dressing adhered with two pieces of tape covered the dialysis access site on his right upper arm. A noticeable amount of blood was noted on the dressing. The resident explained he was dialyzed three times each week on Tuesdays, Thursdays, and Saturdays. He stated the dressing was changed at the dialysis facility and he usually removed the dressing when he returned to the facility. R25 said, "I leave it on for about twelve hours so I know the bleeding has stopped. If I forget, the nurses will take it off the next day." The following day on 8/12/15 at 9:17 a.m. R25 was observed in his bed. When asked if the dressing to his dialysis access site was still in place, R25 stated he had removed it himself earlier this morning. A discarded gauze dressing was observed in the garbage receptacle next to his night stand. R25 confirmed it was the dressing he removed from his arm. At 9:32 a.m. a registered nurse (RN)-B verified R25 is dialyzed at Mayo Clinic Dialysis Services (MCDS), Northeast Clinic, three times each week on Tuesday, Thursday and Saturday and that R25 did remove the dressing to his right arm earlier that morning. RN-B stated, "There have never been directions to manage the dialysis dressing in the two years I have been here. It is not in his care plan either." At 9:36 a.m., the nurse manager, (RN)-A stated staff monitors R25's fistula every shift, however,	F 309	care of R25¿s dialysis site dressing as instructed on R25¿s dialysis standing orders from individual dialysis center. Orders were also entered into the eTAR giving explicit instructions for management and monitoring of resident¿s dialysis access site and dressing. These orders include: To ensure the gauze dressing is removed 4 hours after R25¿s return from dialysis leaving the adhesive bandage (Band-Aid) intact; to ensure the adhesive bandage (Band-Aid) is removed the morning after dialysis; monitor the fistula and access site for: Bleeding, Redness, Swelling, Bruising, Absence of Thrill/Bruit every shift. If bleeding occurs, apply pressure to the site. If bleeding time is greater than 2 minutes, call 911. Take temperature (if greater than 100.5 contact dialysis center per dialysis contract found in chart) and make a progress note if any of the previous noted and to call dialysis center at appropriate # or send to ER. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? Other residents who have a potential to be affected by the same deficient practice will be identified if they are to start on dialysis while in the facility or are admitted to facility and are receiving dialysis. The appropriate orders will be entered into the eMAR/eTAR as prescribed by the individual¿s dialysis unit and will also be entered into the residents care plan. No other residents at risk to be affected currently reside in the facility.	

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F 309	Continued From page 6 there is no direction for staff to monitor the dressing. A telephone interview with R25's primary dialysis nurse on 8/12/15, at 10:36 a.m. revealed the dialysis facility expected the facility to manage the dressing to R25's dialysis access site. The dialysis nurse explained the dressing should be removed after four hours if there is no bleeding. The band aid should remain intact until the following day. She further explained that when a resident is admitted to dialysis through MCDS, the long-term care staff is given instructions and an educational booklet regarding the monitoring and care for residents who receive hemodialysis. She concluded she expected the facility to manage the dressing to assess for clotting and infection, "This is their life-line." R25's medication administrations records (MAR), the treatment administration record (TAR), current physician orders and his current care plan lacked direction to manage the dressing at the hemodialysis access site to minimize the potential for clotting and infection. The Memorandum of Understanding Mayo Clinic Dialysis Services (MCDS) Patients Who are Residents in Long-Term Care Facilities/Nursing Homes, signed 8/12/14, included that patients can experience infections; If there is any unusual redness, swelling, temperature greater than 100.5 degrees Fahrenheit contact MCDS; Remove adhesive Band-Aids from dialysis access arm the following day and assess any excessive bleeding from the sites; If patient experiences excessive bleeding the nurse should apply direct pressure to the site; Nursing Home staff should call 911 if bleeding time is more than 1-2 minutes or the	F 309	What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? Explicit orders for management/monitoring of the dialysis site and any dialysis site dressings will be entered into each individual¿s medical record, who receives dialysis, to prompt staff to check and document that the site is being managed and monitored per individual dialysis guidelines. Any orders for monitoring will also be referenced in the individuals care plan. How the facility plans to monitor its performance to make sure that solutions are sustained? 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. Random audits of R25¿s dialysis access site will be completed by Director of Nursing Services or designee weekly for 4 weeks (Starting the week of 8/31/15 and ending the week of 9/21/15). Audits will be conducted randomly on Tuesday or Thursday, several hours after residents return from dialysis to ensure gauze dressing was removed from access site, and on Wednesday or Friday morning to ensure adhesive bandage was removed. R25¿s medical record will also be reviewed to ensure staff is documenting in medical record that site and dressing is being monitored as ordered. After weekly audits are completed, random audits will be completed for 2 months (October 2015	

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F 309	Continued From page 7 nurse is unable to control bleeding. Although R25's care plan dated 5/26/15 identifies R25 as to having a fistula located in right upper arm, it does not direct staff to manage the site for clotting, bleeding and infection or care of the dressing. During an interview on 8/12/15, at 3:40 p.m. the director of nursing (DON) stated The Memorandum of Understanding Mayo Clinic Dialysis Services (MCDS) Patients Who are Residents in Long-Term Care Facilities/Nursing Homes were considered orders. DON said, "It is what we (facility staff) go by and staff is not doing this. It is not on his (R25's) MARS or TARS. I would expect staff nurses to follow these guidelines and document on the dressing site management." The facility's Checklist for Dialysis Residents directs staff to monitor the graft site and to include it on the MAR, obtain standing orders from dialysis unit and develop emergency procedures individualized to the specific resident. A policy regarding the management of hemodialysis access site and monitoring was requested but not provided.	F 309	and November 2015) to ensure correction is achieved and sustained. Plan of correction and results of audits will be discussed with Quality Assurance Committee. Who is responsible for this plan of correction? The Director of Nursing or designee will be responsible for compliance. Date of Correction: 9/22/15	
F 334 SS=D	483.25(n) INFLUENZA AND PNEUMOCOCCAL IMMUNIZATIONS The facility must develop policies and procedures that ensure that -- (i) Before offering the influenza immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the	F 334		9/22/15

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F 334	Continued From page 8 immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. The facility must develop policies and procedures that ensure that -- (i) Before offering the pneumococcal immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicated, at a minimum, the following:	F 334		

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F 334	Continued From page 9 (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. (v) As an alternative, based on an assessment and practitioner recommendation, a second pneumococcal immunization may be given after 5 years following the first pneumococcal immunization, unless medically contraindicated or the resident or the resident's legal representative refuses the second immunization. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to follow their Immunization Policy in regards to the Influenza Immunization by ensuring each influenza immunization was offered and/or received during the 2014/2015 influenza season for 2 of 5 residents (R47, R26) reviewed. Findings include: R47 was admitted to the facility on 11/14/14 according to the face sheet. After review of R47's records, there was no indication R47 had been offered and/or received an influenza vaccination during the 2014/15 influenza season. R26 was admitted to the facility on 6/27/14 per face sheet and had been discharged on 9/13/14;	F 334	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Facility obtained immunization records from R26 and R47¿s outside clinic records and have entered all current vaccinations into the Immunization tab on EMR. R26 and R47 will be offered Influenza immunization for the 2015-2016 flu season starting October 1st, 2015 and the administration or refusal will be documented in the EMR. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? All residents who resident in the facility and are eligible will be offered the Influenza	

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F 334	Continued From page 10 and then readmitted on 10/26/14. After review of R26's records there was no indication R26 was offered and/or received an influenza vaccination during the 2014/15 influenza season. When interviewed on 11/12/15, at 11:07 a.m. Director of Nursing (DON) verified that R47 and R26 had not received the influenza vaccination in the facility. She verified with R47's medical record at Olmsted Medical Center Clinic that the last time she received the influenza vaccination was 11/17/2000. The DON did verify there was no documentation which indicated R47 had declined to receive the influenza vaccination. R26 no other information was provided by facility. The DON stated that it is part of the facility's practice to obtain these records and keep it in the facility's medical record. The DON did affirm that the facility did not follow their policies and procedures for the influenza vaccination. The DON stated that it would be her expectation that either the infection coordinator or the admitting nurse follow up on having resident ' s either offered or received the influenza vaccination. Review of the facility policy titled, Influenza Vaccination dated December, 2010 stated that all residents and employees who have direct contact with residents will be offered the influenza vaccine annually to encourage and promote the benefits associated with vaccinations against influenza. Between October 1st and March 31st each year, the influenza vaccine shall be offered to residents and employees who have direct contact with residents. Employees hired or residents admitted between October 1st and March 31st shall be offered the vaccine within five working days of the employee's job assignment or the resident's admission to the facility. For	F 334	vaccination for the 2015-2016 flu season starting October 1st, 2015. If a resident is ineligible or refuses, documentation will be done in the EMR to indicate reason vaccination was not given. All residents who are newly admitted or re-admitted to facility during the 2015-2016 flu season (October 1st 2015-March 31st, 2016) will be offered the Influenza immunization upon admission. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? Starting October 1st, 2015 through March 31st, 2016, all current and newly admitted or re-admitted residents will be offered the Influenza Vaccination if records do not indicate they have received the vaccination for the 2015-2016 flu season. It will be documented in the EMR if the resident consents and receives the Influenza Vaccination within the facility, has received the Influenza Vaccination during the 2015-2016 flu season outside of the facility, or if they are ineligible or refuse the Influenza Vaccination during this time. All licensed staff will be educated on proper procedure of administering and documenting Influenza Vaccinations. How the facility plans to monitor its performance to make sure that solutions are sustained? 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. Facility has	

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F 334	Continued From page 11 those who receive the vaccine, the date of vaccination, lot number, expiration date, person administering, and the site of vaccination will be documented in the resident's medical record. A resident's refusal of the vaccine shall be documented in the resident's medical record. The Infection Control Coordinator will maintain surveillance data on influenza vaccine coverage and reported rates of influenza among residents and staff. Documentation of previous vaccination should be provided to the facility.	F 334	scheduled an Influenza Vaccination clinic to be done on October 1st, 2015 for all current residents. A comprehensive audit will be completed by Infection Control Coordinator/Director of Nursing Services or designee to ensure all administration of Influenza Vaccination was documented appropriately in EMR within 3 working days. If a current resident does not receive the Influenza Vaccination on October 1st, 2015, and they have not directly refused or are ineligible, they will be re-offered the vaccination within 7 working days. At that time, if any current eligible residents have not received the Influenza Vaccination, facility will document reasons vaccination was not given. New admissions or re-admissions on or after October 1st, 2015 will be audited by Infection Control Coordinator/Director of Nursing Services, or designee to ensure Influenza Vaccination was offered and documented appropriately. Who is responsible for this plan of correction? The Director of Nursing or designee will be responsible for compliance. Date of Correction: 9/22/15	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245442	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**08/13/2015**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING VALLEY CARE CENTER	**800 MEMORIAL DRIVE** **SPRING VALLEY, MN 55975**

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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 THAT 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 on August 13, 2015. At the time of this survey Spring Valley Care Center 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	K 000	EPOC	

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

Electronically Signed | 09/02/2015

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
	245442	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**08/13/2015**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING VALLEY CARE CENTER	**800 MEMORIAL DRIVE** **SPRING VALLEY, MN 55975**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	Continued From page 1 St Paul, MN 55101-5145, or By email to: Marian.Whitney@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. The Spring Valley Care Center is a 1-story building with a partial basement. The building was constructed in 1975 and was determined to be of Type II(111) construction. In 2014 the facility added a new Wing to the Northside of the building. The building is surveyed as 2 building for different years of construction. The building is fully fire sprinkler protected. The facility has a fire alarm system with full corridor smoke detection and spaces open to the corridor, that is monitored for automatic fire department notification. The facility has a licensed capacity of 50 beds and had a census of 41 at the time of the survey. The requirement at 42 CFR Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 050	NFPA 101 LIFE SAFETY CODE STANDARD	K 050		9/21/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245442	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**08/13/2015**

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SPRING VALLEY CARE CENTER	**800 MEMORIAL DRIVE** **SPRING VALLEY, MN 55975**

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K 050 SS=F	Continued From page 2 Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2 This STANDARD is not met as evidenced by: Based on review of records and interview, it was determined that the facility failed to conduct the required number of fire drills for each shift in the last 12-month period and vary the times in accordance with NFPA 101 LSC (00) Section 19.7.1.2. This deficient practice could affect how staff react in the event of a fire. Improper reaction by staff would affect the safety of all 41 residents. Findings include: On facility tour between 12:30 PM and 3:30 PM on 8/13/2015, a review of the available fire drill reports in 2014 and 2015 revealed that the facility had conducted Day-Shift fire drills between the hours of 9:30 AM, 11:00 AM, 11:30 AM, 9:15 AM, 12:00 PM and a Night-Shift fire drill between 5:45 AM, 5:45 AM, 5:45 AM, 12:30 AM not varying the times in accordance with Section 19.7.1.2. This deficient practice was confirmed by the Maintenance Director.	K 050	Fire Drills will be conducted in varying times according to the Life Safety Code for each shift. Person Responsible: Jim Parsons, Facilities Director	
K 062	NFPA 101 LIFE SAFETY CODE STANDARD	K 062		9/21/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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K 062 SS=F	Continued From page 3 Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by: Based on record review and interview, the facility has failed to inspect and maintain the sprinkler system in accordance with NFPA 13 (99) and NFPA 25 (98). This deficient practice could affect all the residents. Findings include: On facility tour between the hours of 12:30 PM and 3:30 PM on 8/13/2015, observation revealed that: 1. In the Office next to the Dietary Manager Office there are 3 sprinkler heads that are within 6ft. of each other and, 2. The facility could not provide documentation of the last three quarterly sprinkler flow test. This deficient practice was confirmed by the Maintenance Director.	K 062	Sprinkler flow testing will be done in accordance with the Life Safety Code with supporting documentation. Sprinkler heads in room next to dietary office have been updated to be the appropriate distance apart. Person Responsible: Jim Parsons, Facilities Director	
K 144 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1.	K 144		9/21/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245442	A. BUILDING **02 - SPRING VALLEY CARE CENTER** B. WING _____	**08/13/2015**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING VALLEY CARE CENTER	**800 MEMORIAL DRIVE SPRING VALLEY, MN 55975**

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	245442	A. BUILDING **02 - SPRING VALLEY CARE CENTER** B. WING _____	**08/13/2015**

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SPRING VALLEY CARE CENTER	**800 MEMORIAL DRIVE SPRING VALLEY, MN 55975**

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MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically submitted
August 27, 2015

Ms. Penny Solberg, Administrator
Spring Valley Care Center
800 Memorial Drive
Spring Valley, Minnesota 55975

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5442026

Dear Ms. Solberg:

The above facility was surveyed on August 10, 2015 through August 13, 2015 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health, Health Regulation Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

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

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm . The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute after the statement, "This Rule

is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

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

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

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact:

Gary Nederhoff, Unit Supervisor
Minnesota Department of Health
18 Wood Lake Drive Southeast
Rochester, Minnesota 55904
gary.nederhoff@state.mn.us
Telephone: (507) 206-2731 Fax: (507) 206-2711

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

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

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing, Program Specialist
Licensing and Certification Program
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
	00121	A. BUILDING: _____ B. WING _____	08/13/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING VALLEY CARE CENTER	800 MEMORIAL DRIVE SPRING VALLEY, MN 55975

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm The State licensing orders are delineated on the attached Minnesota	2 000		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING VALLEY CARE CENTER	800 MEMORIAL DRIVE SPRING VALLEY, MN 55975

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	Continued From page 1 Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. On August 10, 11, 12, and 13, 2015, surveyors of this Department's staff, visited the above provider and the following correction orders are issued. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed. Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.	2 000		

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	00121	A. BUILDING: _____ B. WING _____	08/13/2015

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2 000	Continued From page 2 THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to coordinate services to ensure a dialysis site dressing was managed to reduce the risk of access site infection and clotting for 1 of 1 resident (R25) reviewed for dialysis. Findings include: R25 was observed in his room after returning from dialysis on 8/11/15, at 1:46 p.m. A gauze-dressing adhered with two pieces of tape covered the dialysis access site on his right upper arm. A noticeable amount of blood was noted on	2 830	corrected	9/21/15

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2 830	Continued From page 3 the dressing. The resident explained he was dialyzed three times each week on Tuesdays, Thursdays, and Saturdays. He stated the dressing was changed at the dialysis facility and he usually removed the dressing when he returned to the facility. R25 said, "I leave it on for about twelve hours so I know the bleeding has stopped. If I forget, the nurses will take it off the next day." The following day on 8/12/15 at 9:17 a.m. R25 was observed in his bed. When asked if the dressing to his dialysis access site was still in place, R25 stated he had removed it himself earlier this morning. A discarded gauze dressing was observed in the garbage receptacle next to his night stand. R25 confirmed it was the dressing he removed from his arm. At 9:32 a.m. a registered nurse (RN)-B verified R25 is dialyzed at Mayo Clinic Dialysis Services (MCDS), Northeast Clinic, three times each week on Tuesday, Thursday and Saturday and that R25 did remove the dressing to his right arm earlier that morning. RN-B stated, "There have never been directions to manage the dialysis dressing in the two years I have been here. It is not in his care plan either." At 9:36 a.m., the nurse manager, (RN)-A stated staff monitors R25's fistula every shift, however, there is no direction for staff to monitor the dressing. A telephone interview with R25's primary dialysis nurse on 8/12/15, at 10:36 a.m. revealed the dialysis facility expected the facility to manage the dressing to R25's dialysis access site. The dialysis nurse explained the dressing should be removed after four hours if there is no bleeding.	2 830		

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2 830	Continued From page 4 The band aid should remain intact until the following day. She further explained that when a resident is admitted to dialysis through MCDS, the long-term care staff is given instructions and an educational booklet regarding the monitoring and care for residents who receive hemodialysis. She concluded she expected the facility to manage the dressing to assess for clotting and infection, "This is their life-line." R25's medication administrations records (MAR), the treatment administration record (TAR), current physician orders and his current care plan lacked direction to manage the dressing at the hemodialysis access site to minimize the potential for clotting and infection. The Memorandum of Understanding Mayo Clinic Dialysis Services (MCDS) Patients Who are Residents in Long-Term Care Facilities/Nursing Homes, signed 8/12/14, included that patients can experience infections; If there is any unusual redness, swelling, temperature greater than 100.5 degrees Fahrenheit contact MCDS; Remove adhesive Band-Aids from dialysis access arm the following day and assess any excessive bleeding from the sites; If patient experiences excessive bleeding the nurse should apply direct pressure to the site; Nursing Home staff should call 911 if bleeding time is more than 1-2 minutes or the nurse is unable to control bleeding. Although R25's care plan dated 5/26/15 identifies R25 as to having a fistula located in right upper arm, it does not direct staff to manage the site for clotting, bleeding and infection or care of the dressing. During an interview on 8/12/15, at 3:40 p.m. the director of nursing (DON) stated The	2 830		

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2 830	Continued From page 5 Memorandum of Understanding Mayo Clinic Dialysis Services (MCDS) Patients Who are Residents in Long-Term Care Facilities/Nursing Homes were considered orders. DON said, "It is what we (facility staff) go by and staff is not doing this. It is not on his (R25's) MARS or TARS. I would expect staff nurses to follow these guidelines and document on the dressing site management." The facility's Checklist for Dialysis Residents directs staff to monitor the graft site and to include it on the MAR, obtain standing orders from dialysis unit and develop emergency procedures individualized to the specific resident. A policy regarding the management of hemodialysis access site and monitoring was requested but not provided. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee, could review and revise policies and procedures related to dialysis, monitoring and care, and could provide staff education related to the care of resident related to dialysis. The director of nursing or designee could develop an audit tool to ensure appropriate care is provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 830		
21426	MN St. Statute 144A.04 Subd. 3 Tuberculosis Prevention And Control (a) A nursing home provider must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines	21426		9/21/15

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21426	Continued From page 6 issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in CDC's Morbidity and Mortality Weekly Report (MMWR). This program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, residents, and volunteers. The Department of Health shall provide technical assistance regarding implementation of the guidelines. (b) Written compliance with this subdivision must be maintained by the nursing home. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure a two-step tuberculosis (TST) skin test was administered for 1 of 5 residents (R31); failed to ensure a timely TST was administered for 1 of 5 residents (R26); and failed to ensure TB education was provided to 3 of 5 residents (R31, R49, R26) prior to administration of a TST. failed to ensure 2 of 5 employees (E-D, & E-A) received two-step tuberculin (TB) skin test timely; failed to ensure 2 of 5 employees (E-A, E-D) had a completed TB symptoms screen; failed to ensure 2 of 5 employees (E-A, E-D) had a timely TB screen; This had the potential to affect all 41 residents in the facility, staff and visitors. Findings include: LACKED A TWO STEP TST & EDUCATION: R31 had been admitted to the facility on 7/8/15 as found on admission record. After review of the	21426	corrected	

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21426	Continued From page 7	21426		

immunization record, R31 had an initial TST on 7/8/15. There was no evidence in the electronic or hard copy record that a required second TST was done. Additionally, R31 had no documentation in her medical record that required education was provided prior to administration of TST.
LACKED TST ON ADMISSION & EDUCATION:
R49 had been admitted to the facility on 1/8/15 as evidenced by the facility admission form. After review of the Resident 2-Step Mantoux Verification form, baseline screening was done on 6/30/15, not upon admission. Additionally, R49 had no documentation in his medical record that required education was provided prior to administration of TST.
LACKED SECOND TST IN REQUIRED TIME FRAME & EDUCATION:
R26 had been admitted to the facility on 10/8/14 as shown on the resident's face sheet. Prior to this admission, the resident had previously been admitted on 6/27/14 and later discharged on 9/13/14 as evidenced by R26's Census List. After review of the resident's Immunization Report, R26 had an initial TST on 6/27/14. A second required TST was performed on 8/25/14, outside the required window of one to three weeks after the initial test was read. Additionally, R26 had no documentation in his record that required education was provided prior to administration of TST.
LACK OF TB SCREENING UPON HIRING:
E-D, a Licensed practical nurse had been hired on 8/4/15 according to the list provided by the facility. On asking the facility for E-D's baseline TB screening none had been provided by the facility.
LACK OF TB SCREENING AND INITIAL TST ON HIRE:
E-A, a housekeeper, had been hired on 6/20/15

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21426	Continued From page 8	21426		

according to the list provided by the facility. After review of the TB Symptoms Questionnaire, no baseline screening was done for signs and symptoms of TB until 8/11/15, the date a state surveyor asked for the information on the TB status of the staff. Likewise, no TST was administered to H-A until a state surveyor asked for verification on 8/11/15.
E-B, a housekeeper, had been hired on 6/2/15 according to the list provided by the facility. After review of the TB Symptoms Questionnaire, no baseline screening was done for signs and symptoms of TB until 8/11/15, the date a state surveyor asked for this information. Likewise, no TST was administered to E-B until a state surveyor asked for verification on 8/11/15.
LACK OF SCREENING & SECOND TST IN TIME FRAME:
E-E, a nursing assistant, had been hired on 5/28/15 according to the list provided by the facility. After review of the TB Symptom Questionnaire, baseline screening for signs and symptoms of TB had not been dated. The first TST was administered to E-E on 6/22/15. The second mandatory TST was administered on 7/27/15, outside the required window of 1 to 3 weeks of the first step TST.
When interviewed on 11/12/15, at 11:07 a.m. the Director of Nursing (DON) stated that it would be her expectation to have the second step of the two-step TST to be completed within two weeks of the first TST. The DON further stated that it would be her expectation that education would be provided to residents that receive the TST. The DON stated that in regards to the employee symptom screen, she had done the symptom screen for E-D; however, had failed to write it down. She stated that both E-A and E-B work in a different department and she had not been notified that these employees had started working

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21426	Continued From page 9 in the facility. The DON stated that it would be her expectation that new employee's would receive the TST upon hire and have it read negative prior to contact with resident's on the floor. In regards to E-E, the DON stated that it would be her expectation that the TST would be in accordance with the policies and procedures. She stated that the facility did not follow their policy for employee screening. Review of the facility policy titled, Tuberculosis, Employee Screening (Feb 2013), indicated that all employees shall be screened for tuberculosis infection and disease, using a two-step tuberculin skin test. Each newly paid and unpaid HCW working who shared air space with residents would be screened for TB infection and disease after an employment offer had been made but prior to the employee's duty assignment. All employees had to complete an assessment for current symptoms of active TB disease. SUGGESTED METHOD OF CORRECTION: The director of nursing could review tuberculosis policies and procedures to ensure compliance. The director of nursing could educate nursing staff to their policies and procedures for employee and resident tuberculosis skin tests and tuberculosis screens and provide all staff ongoing tuberculosis training. The director of nursing could monitor staff compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21426		
21800	MN St. Statute144.651 Subd. 4 Patients & Residents of HC Fac.Bill of Rights Subd. 4. Information about rights. Patients and residents shall, at admission, be told that there are legal rights for their protection during their	21800		9/21/15

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21800	Continued From page 10 stay at the facility or throughout their course of treatment and maintenance in the community and that these are described in an accompanying written statement of the applicable rights and responsibilities set forth in this section. In the case of patients admitted to residential programs as defined in section 253C.01, the written statement shall also describe the right of a person 16 years old or older to request release as provided in section 253B.04, subdivision 2, and shall list the names and telephone numbers of individuals and organizations that provide advocacy and legal services for patients in residential programs. Reasonable accommodations shall be made for those with communication impairments and those who speak a language other than English. Current facility policies, inspection findings of state and local health authorities, and further explanation of the written statement of rights shall be available to patients, residents, their guardians or their chosen representatives upon reasonable request to the administrator or other designated staff person, consistent with chapter 13, the Data Practices Act, and section 626.557, relating to vulnerable adults. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to provide the appropriate liability and appeals notice for 1 of 6 residents (R3) reviewed for liability notices and beneficiary appeals rights review. Findings Include: R3 was admitted to the facility on 1/27/15	21800	corrected	

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21800	Continued From page 11 according to the admission face sheet and also received Medicare Part A benefits. R3 was given the generic Notice of Medicare Non-Coverage on 4/17/15 informing R3 his Medicare Part A services would end on 4/20/15. R3 used 79 days of Medicare Part A services out of a maximum of 100 days and remained in the facility past 4/20/15. The facility did not provide R3 and/or his legal representative with a Skilled Nursing Facility Advanced Beneficiary Notice (SNFABN)/Centers for Medicare and Medicaid Services (CMS)-10055 to inform him of potential liability for non-covered services and of his right to appeal to Medicare. On 8/13/15 at 12:57 p.m. the director of nursing (DON) verified that residents who are ending Medicare Part A services only received the generic notice. DON said, "Yes, at this time that is what they receive." also, "We do not have that form for any resident that remained in the facility. We only gave the generic form." Policy was requested but none provided by facility. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could develop and implement policies and procedures to ensure that residents receive the required Medicare denial and appeal rights notices; educate all staff. Then develop monitoring systems to ensure ongoing compliance and report the findings to the Quality Assurance Committee. TIME PERIOD FOR CORRECTION: Twenty one (21) days.	21800		