DEPARTMENT OF HEALTH	AND HUMA	N SERVICES			CENTERS FOR MEI	DICARE & MEDICAID SERVICES
	MEDIC	ARE/MEDICAL	D CERTIFIC	CATION	AND TRANSMITTAL	ID: NI7Q
	PART I -	TO BE COMPI	LETED BY T	THE STA	TE SURVEY AGENCY	Facility ID: 00286
1. MEDICARE/MEDICAID PROVIDER (L1) 245566	NO.	3. NAME AND AL (L3) VALLEY VI			REHAB	4. TYPE OF ACTION: <u>7 (L8)</u> 1. Initial 2. Recertification
2.STATE VENDOR OR MEDICAID NO (L2) 844240100		(L4) <b>510 EAST C</b> (L5) <b>HOUSTON</b> ,		ET	(L6) <b>55943</b>	3. Termination4. CHOW5. Validation6. Complaint
5. EFFECTIVE DATE CHANGE OF OV (L9)	VNERSHIP	7. PROVIDER/SU 01 Hospital	JPPLIER CATEG 05 HHA	ORY 09 ESRD	<u>02</u> (L7) 13 PTIP 22 CLIA	7. On-Site Visit 9. Other 8. Full Survey After Complaint
6. DATE OF SURVEY 07/20/2 8. ACCREDITATION STATUS: 0 Unaccredited 1 TJC 2 AOA 3 Other	015 (L34) (L10)	02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	06 PRTF 07 X-Ray 08 OPT/SP	10 NF 11 ICF/III 12 RHC	14 CORF D 15 ASC 16 HOSPICE	FISCAL YEAR ENDING DATE: (L35) 09/30
11. LTC PERIOD OF CERTIFICATION		10.THE FACILITY	IS CERTIFIED	AS:		·
From (a):		X A. In Complia	nce With		And/Or Approved Waivers Of	The Following Requirements:
To (b):			equirements		2. Technical Personnel	6. Scope of Services Limit
12. Total Facility Beds	<b>45</b> (L18)	1	e Based On: cceptable POC		3. 24 Hour RN 4. 7-Day RN (Rural SN	<ul> <li>7. Medical Director</li> <li>JF) 8. Patient Room Size</li> </ul>
	45 (210)				5. Life Safety Code	9. Beds/Room
13.Total Certified Beds	<b>45</b> (L17)		npliance with Prog ents and/or Appli		* Code: <b>A</b> *	(L12)
14. LTC CERTIFIED BED BREAKDOW	N				15. FACILITY MEETS	
18 SNF 18/19 SNF 45	19 SNF	ICF	IID		1861 (e) (1) or 1861 (j) (1):	(L15)
(L37) (L38)	(L39)	(L42)	(L43)			
16. STATE SURVEY AGENCY REMAI	RKS (IF APPLICA	ABLE SHOW LTC CA	ANCELLATION 1	DATE):		
17. SURVEYOR SIGNATURE		Date :			18. STATE SURVEY AGENCY	YAPPROVAL Date:
Gary Nederhoff, Unit Super	visor	0	7/28/2015	(L19)	Kamala Fiske-Downing,	Enforcement Specialist 07/28/2015 (L20)
PAR	T II - TO BE	COMPLETED I	BY HCFA RE	GIONA	L OFFICE OR SINGLE S	TATE AGENCY
<ol> <li>DETERMINATION OF ELIGIBILIT</li> <li><u>X</u></li> <li>1. Facility is Eligible to Par</li> </ol>			IPLIANCE WITH HTS ACT:	I CIVIL		ncial Solvency (HCFA-2572) ol Interest Disclosure Stmt (HCFA-1513) e :
2. Facility is not Eligible	(L21)					
22. ORIGINAL DATE	23. LTC AGREE	MENT 24	4. LTC AGREEN	4ENT	26. TERMINATION ACTION:	(L30)
OF PARTICIPATION <b>07/01/1991</b>	BEGINNING	G DATE	ENDING DA	ГЕ	<u>VOLUNTARY</u> <u>00</u> 01-Merger, Closure	<u>INVOLUNTARY</u> 05-Fail to Meet Health/Safety
(L24)	(L41)		(L25)		02-Dissatisfaction W/ Reimburs	ement 06-Fail to Meet Agreement
25. LTC EXTENSION DATE:		VE SANCTIONS n of Admissions:			03-Risk of Involuntary Termination 04-Other Reason for Withdrawal	on <u>OTHER</u> 07-Provider Status Change
(L27)	B. Rescind S	uspension Date:	(L44)			00-Active
			(L45)			
28. TERMINATION DATE:	29	. INTERMEDIARY/	CARRIER NO.		30. REMARKS	
		03001				
	(L28)			(L31)		
31. RO RECEIPT OF CMS-1539	32	2. DETERMINATION	OF APPROVAL	DATE		
	(L32)	07/27/2015		(L33)	DETERMINATION APPI	ROVAL



Protecting, Maintaining and Improving the Health of Minnesotans CMS Certification Number (CCN): 245566

July 28, 2015

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

Dear Mr. Reindl:

The Minnesota Department of Health assists the Centers for Medicare and Medicaid Services (CMS) by surveying skilled nursing facilities and nursing facilities to determine whether they meet the requirements for participation. To participate as a skilled nursing facility in the Medicare program or as a nursing facility in the Medicaid program, a provider must be in substantial compliance with each of the requirements established by the Secretary of Health and Human Services found in 42 CFR part 483, Subpart B.

Based upon your facility being in substantial compliance, we are recommending to CMS that your facility be recertified for participation in the Medicare and Medicaid program.

Effective July 15, 2015 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.

Please contact me if you have any questions.

Sincerely,

Kumalu Fiske Downing

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

cc: Licensing and Certification File



# Protecting, Maintaining and Improving the Health of Minnesotans

July 28, 2015

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

RE: Project Number S5566026

Dear Mr. Reindl:

On June 25, 2015, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on June 5, 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 July 20, 2015, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on July 21, 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 June 5, 2015. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of July 15, 2015. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on June 5, 2015, effective July 15, 2015 and therefore remedies outlined in our letter to you dated June 25, 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.

Enclosed is a copy of the Post Certification Revisit Form, (CMS-2567B) from this visit.

Feel free to contact me if you have questions.

Sincerely,

Kumalu Fiske Downing

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

Enclosure cc: Licensing and Certification File

### **Post-Certification Revisit Report**

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D.C. 20503.

(Y1)	Provider / Supplier / CLIA / Identification Number 245566	(Y2) Multiple Construction A. Building B. Wing		(Y3) Date of Revisit 7/20/2015
Nam	e of Facility		Street Address, City, State, Zip Code	
VA	LLEY VIEW HEALTHCARE & REHAB	3	510 EAST CEDAR STREET HOUSTON, MN 55943	

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

(Y4) Item		(Y5)	Date	(Y4) Item		(Y5)	Date	(Y4)	Item		(Y5)	Date
ID Prefix Reg. # LSC	F0225 483.13(c)(1)		Correction Completed 07/15/2015 2) -	ID Prefix Reg. # LSC	F0226 483.13(c)		Correction Completed 07/15/2015		ID Prefix Reg. # LSC	F0246 483.15(e)(1)		Correction Completed 07/15/2015
ID Prefix Reg. # LSC	F0249 483.15(f)(2)		Correction Completed 07/15/2015	ID Prefix Reg. # LSC	F0280 483.20(d)(3), 483.		Correction Completed 07/15/2015 2)		ID Prefix Reg. # LSC	F0309 483.25		Correction Completed 07/15/2015
ID Prefix Reg. # LSC	F0323 483.25(h)		Correction Completed 07/15/2015	ID Prefix Reg. # LSC	F0329 483.25(I)		Correction Completed 07/15/2015		ID Prefix Reg. # LSC	F0333 483.25(m)(2)		Correction Completed 07/15/2015
ID Prefix Reg. # LSC	F0428 483.60(c)		Correction Completed 07/15/2015	ID Prefix Reg. # LSC	F0431 483.60(b), (d), (e)		Correction Completed 07/15/2015		ID Prefix Reg. # LSC	F0441 483.65		Correction Completed 07/15/2015
ID Prefix Reg. # LSC	F0465 483.70(h)		Correction Completed 07/15/2015	ID Prefix Reg. # LSC	F0514 483.75(I)(1)		Correction Completed 07/15/2015		ID Prefix Reg. # LSC			
Reviewed I State Agen Reviewed I CMS RO	су	Reviewed GPN/kfc Reviewed	1	Date: 07/28/201 Date:	5 Signature Signature		10	0160			Date: ( Date:	)7/20/2015_
Followup	to Survey Co 6/5/2	mpleted on 2015	:		Check for any Uncorrected					Summary of the Facility?	YES	NO

### **Post-Certification Revisit Report**

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D.C. 20503.

(Y1) Provider / Supplier / CLIA / Identification Number 245566	(Y2) Multiple Cons A. Building B. Wing	truction 01 - VAI	(Y3) Date of Revisit 7/21/2015	
Name of Facility			Street Address, City, State, Zip Code	
VALLEY VIEW HEALTHCARE & REHA	В		510 EAST CEDAR STREET HOUSTON, MN 55943	

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

(Y4) Item	(	Y5) Date	(Y4) Item	(Y5)	Date	(Y4) Item	(Y5)	Date
		Correction			Correction			Correction
ID Prefix		Completed 07/15/2015	ID Prefix		Completed 07/15/2015	ID Prefix		Completed 07/15/2015
	NFPA 101			NFPA 101			NFPA 101	
LSC	K0029		LSC	K0062	-	LSC	K0144	
		Correction			Correction			Correction
		Completed			Completed			Completed
ID Prefix			ID Prefix		-			
Reg. # LSC			Reg. #		-	Reg. #		
		Correction			Correction			Correction
ID Prefix		Completed	ID Profix		Completed	ID Profix		Completed
					-			
Reg. # LSC			Reg. # LSC		-	LSC		
		Correction			Correction			Correction
ID Prefix		Completed	ID Prefix		Completed	ID Prefix		Completed
Reg. #					-	Reg. #		
LSC			LSC		-	LSC		
		Correction			Correction			Correction
		Completed			Completed			Completed
					-			
Reg. #			Reg. #		-	Reg. #		
Reviewed I			Date:	Signature of Su	rveyor:		_	te:
State Agen			07/28/201			25822		07/21/2015
Reviewed I CMS RO	3y Review	ed By	Date:	Signature of Su	rveyor:		Da	ite:
Followup t	o Survey Completed	on:		Check for any Unco	rrected Defic	ciencies. Was a	Summary of	
	6/4/2015			Uncorrected Defi				ES NO

### **Post-Certification Revisit Report**

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D.C. 20503.

(Y1) Provider / Supplier / CLIA / Identification Number 245566	(Y2) Multiple Construction A. Building B. Wing 02 - 201	1 ADDITION	(Y3) Date of Revisit 7/21/2015
Name of Facility		Street Address, City, State, Zip Code	
VALLEY VIEW HEALTHCARE & REHA	В	510 EAST CEDAR STREET HOUSTON, MN 55943	

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

(Y4) Item		(Y5) Date	(Y4) Item		(Y5) Date	(Y4) Item	(Y5)	Date
ID Prefix		Correction Completed 07/15/2015	ID Prefix		Correction Completec 07/15/201	Ł	fix	Correction Completed
-	NFPA 101		0	NFPA 101		Reg.		
LSC	K0062		LSC	K0144		LS	SC	
		Correction			Correction			Correction
ID Prefix		Completed	ID Profix		Completed		fix	Completed
Reg. #			Reg. #			Dee	fix	
						LS	#	
		Correction			Correction			Correction
ID Profix		Completed	ID Profix		Completed		fix	Completed
							fix	
Reg. # LSC			Reg. # LSC			Reg. LS	# SC	
		Correction			Correction			Correction
ID Prefix		Completed	ID Prefix		Completed	ID Pre	fix	Completed
Reg. #								
LSC			LSC			LS	SC	
ID Prefix		Correction Completed	ID Prefix		Correction Completed	ł	fix	Correction Completed
Reg. #						Reg.	#	
LSC			LSC			LS	# SC	
Reviewed E	By Revie	wed By	Date:	Signature	e of Surveyor:		Da	te:
State Agen	cy PS/k	tfd	07/28/20	15	2	5822	07	//21/2015
Reviewed E CMS RO	3y <u> </u>	wed By	Date:	Signature	e of Surveyor:		Da	te:
Followup t	o Survey Complete 6/4/2015	d on:			y Uncorrected De ed Deficiencies (C		to the Feeling	ES NO

DEPARTMENT OF HEALTH AND	) HUMA	N SERVICES		CENTERS FOR MED	DICARE & MEDICAID SERVICES
	MEDICA	<b>RE/MEDICAID CER</b>	<b>TIFICATION</b> A	AND TRANSMITTAL	ID: NI7Q
]	PART I -	TO BE COMPLETED	) BY THE STAT	<b>FE SURVEY AGENCY</b>	Facility ID: 00286
1. MEDICARE/MEDICAID PROVIDER NO. (L1) <b>245566</b> 2.STATE VENDOR OR MEDICAID NO.		3. NAME AND ADDRESS (L3) VALLEY VIEW HE (L4) 510 EAST CEDAR	EALTHCARE & I		4. TYPE OF ACTION:       2 (L8)         1. Initial       2. Recertification         3. Termination       4. CHOW
(L2) <b>844240100</b>		(L5) HOUSTON, MN		(L6) <b>55943</b>	5. Validation6. Complaint7. On-Site Visit9. Other
5. EFFECTIVE DATE CHANGE OF OWNER (L9)	SHIP	7. PROVIDER/SUPPLIER01 Hospital05 HH		<u>02</u> (L7) 13 PTIP 22 CLIA	8. Full Survey After Complaint
6. DATE OF SURVEY     06/05/2015       8. ACCREDITATION STATUS:	(L34) (L10)	02 SNF/NF/Dual06 PR'03 SNF/NF/Distinct07 X-F04 SNF08 OP'	Ray 11 ICF/IID	14 CORF 15 ASC 16 HOSPICE	FISCAL YEAR ENDING DATE: (L35) 09/30
11LTC PERIOD OF CERTIFICATION		10.THE FACILITY IS CER	TIFIED AS:		
From (a): To (b):		A. In Compliance With Program Requireme Compliance Based (	ents	And/Or Approved Waivers Of ' 2. Technical Personnel 3. 24 Hour RN	The Following Requirements: 6. Scope of Services Limit 7. Medical Director
12.Total Facility Beds 45	(L18)	<u>1</u> . Acceptable	e POC	4. 7-Day RN (Rural SN	
13.Total Certified Beds 45	; (L17)	<b>X</b> B. Not in Compliance w Requirements and/	with Program for Applied Waivers:	5. Life Safety Code * Code: <b>B</b>	9. Beds/Room (L12)
14. LTC CERTIFIED BED BREAKDOWN				15. FACILITY MEETS	
18 SNF 18/19 SNF	19 SNF	ICF	IID	1861 (e) (1) or 1861 (j) (1):	(L15)
45 (L37) (L38)	(L39)	(L42)	(L43)		
16. STATE SURVEY AGENCY REMARKS (I	F APPLICA	BLE SHOW LTC CANCELL	ATION DATE):		
17. SURVEYOR SIGNATURE		Date :		18. STATE SURVEY AGENCY	APPROVAL Date:
Kathy Sass, HFE NE II		07/17/2	2015 <sub>(L19)</sub> k	Kamala Fiske-Downing, E	Enforcement Specialist 07/22/2015 (L20)
PART II -	TO BE	COMPLETED BY HC	FA REGIONAI	COFFICE OR SINGLE ST	<b>FATE AGENCY</b>
19. DETERMINATION OF ELIGIBILITY        1. Facility is Eligible to Participate        2. Facility is not Eligible	e (L21)	20. COMPLIANC RIGHTS ACT		<ol> <li>Statement of Finan</li> <li>Ownership/Contro</li> <li>Both of the Above</li> </ol>	l Interest Disclosure Stmt (HCFA-1513)
	(L21)				
22. ORIGINAL DATE 23. LT	C AGREEN	MENT 24. LTC A	GREEMENT	26. TERMINATION ACTION:	(L30)
OF PARTICIPATION B 07/01/1991	EGINNING	DATE ENDI	ING DATE	VOLUNTARY         00           01-Merger, Closure         0	
(L24) (I	LA1)	(L25)		02-Dissatisfaction W/ Reimburse	
25. LTC EXTENSION DATE: 27. A	LTERNATI	VE SANCTIONS		03-Risk of Involuntary Termination 04-Other Reason for Withdrawal	OTHER
A.	Suspensior	of Admissions:	4)	04-Other Reason for withdrawar	07-Provider Status Change 00-Active
(L27) B.	. Rescind Su	(L4- spension Date:	4)		00 10110
		(L4	-5)		
28. TERMINATION DATE:	29	. INTERMEDIARY/CARRIE	ER NO.	30. REMARKS	
		03001			
(L2:	8)		(L31)		
31. RO RECEIPT OF CMS-1539	32	. DETERMINATION OF APP	PROVAL DATE		
(L32	2)		(L33)	DETERMINATION APPR	ROVAL



Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7010 0780 0000 9011 4835 June 25, 2015

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

RE: Project Number S5566026

Dear Mr. Reindl:

On June 5, 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:

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

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

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

Potential Consequences - the consequences of not attaining substantial compliance 3 and 6

# months after the survey date; and

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

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

# DEPARTMENT CONTACT

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

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

# **OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES**

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by July 15, 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 July 15, 2015 the following remedy will be imposed:

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

# PLAN OF CORRECTION (PoC)

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

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;
- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;
- Address what measures will be put into place or systemic changes made to ensure that the

deficient practice will not recur;

- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;

- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,
- Include signature of provider and date.

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

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

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

# PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

# VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved PoC, unless it is determined that either correction actually occurred between the latest correction date on the PoC and the date of the first revisit, or correction Valley View Healthcare & Rehab June 25, 2015 Page 4 occurred sooner than the latest correction date on the PoC.

# Original deficiencies not corrected

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

# Original deficiencies not corrected and new deficiencies found during the revisit

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

# Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by September 5, 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 December 5, 2015 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

# INFORMAL DISPUTE RESOLUTION

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

Valley View Healthcare & Rehab June 25, 2015 Page 5

> 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 a PoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: <a href="http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc\_idr.cfm">http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc\_idr.cfm</a>

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

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

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

Mr. Patrick Sheehan, Supervisor Health Care Fire Inspections State Fire Marshal Division 444 Minnesota Street, Suite 145 St. Paul, Minnesota 55101-5145 Telephone: (651) 201-7205 Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

ato Johnston

Kate JohnsTon, Program Specialist Licensing and Certification Program Health Regulations Division Telephone: (651) 201-3992 Fax: (651) 215-9697 Enclosure (s) cc: Licensing and Certification File

		D HUMAN SERVICES			FORM APPROVED
CENTER	S FOR MEDICARE &	MEDICAID SERVICES		1111 1 0.04/2	OMB NO. 0938-0391
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE ( A. BUILDING	MN Dept of Health	(X3) DATE SURVEY COMPLETED
		245566	B. WING	Production of the g	06/05/2015
NAME OF P	ROVIDER OR SUPPLIER		1	REET ADDRESS, CITY, STATE, ZIP CODE	
VALLEY V	IEW HEALTHCARE & RE	ЕНАВ		0 EAST CEDAR STREET DUSTON, MN 55943	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	
F 000	as your allegation of Department's accepta enrolled in ePOC, you at the bottom of the fi form. Your electronic be used as verification	correction (POC) will serve compliance upon the ance. Because you are ur signature is not required rst page of the CMS-2567 submission of the POC will	F 000	This Plan of Correction constitut written allegation of compliance deficiencies cited. However, submis this Plan of Correction is not an adr that a deficiency exists or that or cited correctly. This Plan of Correc submitted to meet require established by State and Federal La	for the sion of nission ne was ction is ements
F 225 SS=E	on-site revisit of your validate that substant regulations has been your verification. 483.13(c)(1)(ii)-(iii), (d INVESTIGATE/REPO ALLEGATIONS/INDIA The facility must not been found guilty of a mistreating residents had a finding entered registry concerning a of residents or misap and report any knowl court of law against a indicate unfitness for other facility staff to ti or licensing authorities The facility must ensu- including injuries of u misappropriation of re- immediately to the ac- thorough established p State survey and cer	facility may be conducted to ial compliance with the attained in accordance with c)(2) - (4) ORT VIDUALS employ individuals who have abusing, neglecting, or by a court of law; or have into the State nurse aide buse, neglect, mistreatment propriation of their property; edge it has of actions by a in employee, which would service as a nurse aide or he State nurse aide registry es. ure that all alleged violations ht, neglect, or abuse, nknown source and esident property are reported deministrator of the facility and cordance with State law procedures (including to the tification agency).	F 225	management staffs that intervie hires new staff for their department been educated on performing re- checks on all individuals prior to hird Memo sent to all department he June 29, 2015 on importan completing reference checks on p new hires prior to their start date	ensures Is who busing, s by a entered registry eatment of their e it has inst an ifitness facility istry or Rehab w and ts have ference e. ads on cce of otential
LABORATORY		SUPPLIER REPRESENTATIVE'S SIGNATUR	:E	TITLE	7/. (X6) DATE
L	mene (1)	TAX/DON			16115

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.

FORM CMS-2567(02-99) Previous Versions Obsolete

PRINTED: 06/25/2015

PRINTED: 06/25/2015 FORM APPROVED OMB NO. 0938-0391

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

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING		(X3) DATE SURVEY COMPLETED	
		245566	B. WING		06/	05/2015
	ROVIDER OR SUPPLIER	REHAB	510	EET ADDRESS, CITY, STATE, ZIP CODE EAST CEDAR STREET USTON, MN 55943		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 225	Continued From pag		F 225	Vulnerable Adult Policy and I was reviewed and revised.		
	violations are thorou	ve evidence that all alleged ughly investigated, and must ntial abuse while the ogress.		The Business Office Manager w for compliance.	ill monitor	07/15/1
	The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.					
	by: Based on interview failed to adequately	IT is not met as evidenced and document review, facility screen 5 or 5 newly E2, E3, E4, E5) who have esidents.				. *
	Findings include: Review of personnel files for newly hired staff revealed the facility had not conducted reference checks to determine whether 5 of 5 new hires had any past history of criminal prosecutions. E1, a nursing assistant (NA), had a hire date of 4/29/15. No reference checks were conducted.	had not conducted reference whether 5 of 5 new hires				
		ant, had a hire date of ce checks were conducted.				
	E3, a NA, had a hire reference checks w	e date of 3/30/15. No ere conducted.				
	E4, a NA, had a hire	e date of 5/19/15 No				

		D HUMAN SERVICES MEDICAID SERVICES			JUL 10 2015	FORM	0: 06/25/2015 APPROVED 0. 0938-0391
STATEMENT O	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	TIPLE CONS	STRUCTION MN Debit of Heelth	(X3) DATE COMP	SURVEY LETED
		245566	B. WING			06/	05/2015
NAME OF PI	ROVIDER OR SUPPLIER			STREE	T ADDRESS, CITY, STATE, ZIP CODE		
VALLEY V	IEW HEALTHCARE & RE	EHAB			ST CEDAR STREET TON, MN 55943		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 225	Continued From page reference checks wer E5, a NA, had a hire o	e conducted.	F	225			
SS=E	reference checks wer During an interview o director of nursing (D does not do reference employees, further st everyone knows ever and who isn't." This w Human Resources D The facility Vulnerable revised 7/17/2012, in are screened through check. This includes use of external pool a be allowed direct resis been cleared through Division of the MDH [ Health]. The policy la attempting to obtain i and/or current employ 483.13(c) DEVELOP, ABUSE/NEGLECT, E The facility must deve policies and procedur mistreatment, neglec and misappropriation This REQUIREMENT by: Based on interview a facility failed to devel	re conducted. n 6/5/15, at 5:26 p.m. the ON) verified that the facility a checks on newly hired ating "this is a small town, yone. We know who is good vas also verified by the irector. e Adult Policy and Procedure dicated "all new employees the use of a background any nursing staff through the agencies. Employees will not dent contact until they have the Criminal Background Minnesota Department of acked direction to include nformation from previous yers. /IMPLMENT ETC POLICIES elop and implement written res that prohibit t, and abuse of residents of resident property. T is not met as evidenced and document review, the op policies for adequate		226	F226 483.1 (c) DEVELOP/IM ABUSE/NEGLECT, ETC PO Valley View Healthcare & developed and impleme policies and procedures mistreatment, neglect, ar resident and misappropriati property. Valley View Healthcare & F that it does not employ im have been found guilty neglecting, or mistreating r court of law; or have had a f into the State nurse concerning abuse, neglect,	DLICIES Rehab has inted written that prohibit d abuse of on of resident Rehab ensures dividuals who of abusing, esidents by a inding entered aide registry mistreatment	ret Dage - 3 of 53
FORM CMS-25	57(02-99) Previous Versions Ob	solete Event ID: NI7Q	. 11	Facility I	D: 00286	If continuation she	et Page 3 of 58

# DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 06/25/2015 FORM APPROVED

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED	
		245566	B. WING			06	/05/2015
	PROVIDER OR SUPPLIER	ЕНАВ		510	EET ADDRESS, CITY, STATE, ZIP CODE EAST CEDAR STREET JSTON, MN 55943		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	<	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETIC DATE
F 226	screening of 5 or 5 ne E3, E4, E5) whose po contact with residents Findings include: The facility's Vulneral Procedure revised 7// employees are screen background check." T staff through the use "Employees will not b contact until they hav Criminal Background [Minnesota Departme lacked direction to incl information from prev employers." New employee person E1, a nursing assistan 4/29/15. No reference E2, a dietary assistan 1/27/15. No reference E3, a NA, had a hire c reference checks were E4, a NA, had a hire c reference checks were E5, a NA, had a hire c reference checks were During an interview or director of nursing (DC not do reference check	ewly employed staff (E1, E2, positions included direct s.	F2	226	of residents or misappropriati property; and report any knowl of actions by a court of law employee, which would indicat for service as a nurse aide or of staff to the State nurse aide licensing authorities. Valley View Healthcare management staffs that inte hires new staff for their departr been educated on performing checks on all individuals prior to date. Memo sent to all department June 29, 2015 on impo completing reference checks of new hires prior to starting their The Vulnerable Adult Po Procedure was reviewed and re The Business Office Manager of for compliance.	edge it has against an e unfitness ther facility registry or & Rehab rview and nents have reference their start heads on rtance of on potential orientation. blicy and vised.	07/15/20

DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 06/25/2015 FORM APPROVED OMB NO. 0938-0391

STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	E CONSTRUCTION ILL 10 2015	ATE SURVEY DMPLETED
		245566	B. WING	ACH/Dapt of Lealth	06/05/2015
	ROVIDER OR SUPPLIER	HAB	5	BTREET ADDRESS, CITY, STATE, ZIP CODE 10 EAST CEDAR STREET HOUSTON, MN 55943	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 226 F 246 SS=D	<ul> <li>isn't." The Human Represent at the time of information.</li> <li>483.15(e)(1) REASOI OF NEEDS/PREFER</li> <li>A resident has the rigl services in the facility accommodations of in preferences, except withe individual or other endangered.</li> <li>This REQUIREMENT by:</li> <li>Based on observation review, the facility failwas within reach for 1 sample reviewed for a Findings include:</li> <li>R10 was observed in The resident's call light dresser, approximatel resident and out of his use his call light to su</li> <li>A registered nurse (Riverify R10 could not him to the second could be approximated for the second could be app</li></ul>	know who is good and who sources Director, also interview, confirmed this NABLE ACCOMMODATION ENCES Int to reside and receive with reasonable idividual needs and when the health or safety of residents would be is not met as evidenced in, interview, and document ed to ensure the call light of 4 residents (R10) in the faccidents. bed on 6/1/15, at 3:31 p.m. it was connected to the y 2.5 feet away from the is reach. R10 reported he did mmon assistance. N)-C was then asked to ave reached his call light for ed the call light and attached	F 226	<ul> <li>F246 483.15(e) (1) REASONABLE ACCOMODATION OF NEEDS/PREFERENCES</li> <li>Valley View Healthcare &amp; 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 othe residents would be endangered.</li> <li>Valley View Healthcare &amp; Rehat implemented call light placement audits of June 9, 2015 to ensure that call lights are within residents reach. Audits were implemented on June 9, 2015 with two daily checks for two weeks, then daily checks for a month, then weekly for a month, then quarterly. If a resident is found without a call light, call light is immediately repositioned and stat assigned to resident is re-educated. I problems are noted additional audits and staff training will be completed.</li> <li>Memo placed on July 6, 2015 re educating all staff on having call lights in place. In-servicing will be provided on July 13 2015.</li> <li>All residents have the potential to be affected by this practice.</li> <li>Monitored by: Director of Nursing or designee</li> </ul>	- - - - - - - - -
		m Data Set assessment was cognitively intact, and			07/15/15

FORM CMS-2567(02-99) Previous Versions Obsolete

Facility ID: 00286

If continuation sheet Page 5 of 58

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	S FOR MEDICARE &	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	IPLE CONSTRUCTION	(X3) DATE		
ND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN	IG	COMF	COMPLETED	
		245566	B. WING		06/	05/2015	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP	· · · · · · · · · · · · · · · · · · ·		
VALLEY V	VIEW HEALTHCARE & RE	НАВ		510 EAST CEDAR STREET HOUSTON, MN 55943			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETIO DATE	
F 246	required extensive as mobility, transfers, an	sistance of two staff for bed d toilet use. The care plan ed R10 used his call light to	F 2	46			
F 249	(NA)-A stated R10 us needs assistance. The director of nursin p.m. she expected ca all residents. 483.15(f)(2) QUALIFI	g stated on 6/5/15, at 1:38 Il lights to be within reach of CATIONS OF ACTIVITY	F 2	1 243 403.13 (1) (2) QC			
SS=C	The activities program qualified professional therapeutic recreation professional who is lic applicable, by the Sta eligible for certification specialist or as an act recognized accrediting 1, 1990; or has 2 year or recreational progra of which was full-time program in a health ca occupational therapist	specialist or an activities ensed or registered, if te in which practicing; and is as a therapeutic recreation ivities professional by a g body on or after October es of experience in a social m within the last 5 years, 1 in a patient activities are setting; or is a qualified to roccupational therapy poleted a training course		ACTIVITY PROFESSION Valley View Healthcarr that the activities progra qualified professional therapeutic recreation activities professional registered, if applicab which practicing; ar certification as a the specialist of as an act by a recognized accr after October 1, 1990 experience in a soc program within the last was full-time in a patien in a health care settir occupational therapis therapy assistant; or training course approve	e & Rehab ensures ram is directed by a who is qualified a specialist or an who is licensed or ole, by the state in nd is eligible for prapeutic recreation ctivities professional rediting body on or b; or has years of cial or recreational t 5 years, 1 of which nt activities program ng; or is a qualified ot or occupational has completed a ed by the State.		
	by: Based on interview a facility failed to provid	is not met as evidenced nd document review, the e a qualified activity director. to affect all 41 residents e facility.		contracted with our provider, Therapy N Occupational Therap consultant for the activ occupational therapist activity director until s	in-house therapy Network, with the pist to be our ity department. The t will oversee the		

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Facility ID: 00286

If continuation sheet Page 6 of 58

		ID HUMAN SERVICES MEDICAID SERVICES				FOR	M APPROVED 0. 0938-0391
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI				E SURVEY PLETED
		245566	B. WING_		WM Dopt of Depth	06/	05/2015
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	•	
VALLEY V	IEW HEALTHCARE & RE	HAB			10 EAST CEDAR STREET OUSTON, MN 55943		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE
F 249	Findings include:	e 6 eting Minutes dated 4/9/15, did hire [name] as the new	F	249	certified or until has obtained 1 yea time experience exclusively in activiti Monitored by: Nursing Home Administrator		07/15/15
	Director. She will offic social worker coming and will work in capac When interviewed on administrator explaine was directly involved i another facility, and if qualified. On 6/5/15, at 12:32 p. stated she was a soci had worked in an activ combined position. Sh had not worked in act The 3/15, Valley View Director position desc Qualification: The folk regulations covering t Activity Director: 1. A therapist or 2. A certifi assistant (COTA) or 3	ially start [date]. She was a from other nursing home city of activity director." 6/5/15, at 12:27 p.m. the ed that the activity director in activities in social work at anything, was over m. the activity director (AD) al worker and previously vity department that had a ne further stated that she ivities solely for a full year. Nursing Home, Activity ription indicated, "Job owing are federal and state he qualifications of the certified occupational ied occupational therapy					
F 280 SS=D	The resident has the r incompetent or otherw incapacitated under th	ING CARE-REVISE CP ight, unless adjudged vise found to be ne laws of the State, to o care and treatment or	F 2	280	F280 483.20 (d) (3), 483.10 (k) (2) R TO PARTICIPATE PLANNING CAR REVISE CP Valley View Healthcare & Rehab as that a comprehensive plan of care m reviewed and revised by interdisciplinary team that include attending physician, a registered with responsibility for the resident	E- ssures ust be an s the nurse	

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Facility ID: 00286

If continuation sheet Page 7 of 58

PRINTED: 06/25/2015

PRINTED: 06/25/2015 FORM APPROVED

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			ONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		245566	B. WING			06/05/2015		
	ROVIDER OR SUPPLIER				EET ADDRESS, CITY, STATE, ZIP CODE EAST CEDAR STREET	1 00	00/2010	
VALLEY V	IEW HEALTHCARE & R	ЕНАВ			USTON, MN 55943			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETI DATE	
F 280	80 Continued From page 7 A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.		F	280	other appropriate staff in discipl determined by the resident's nee- to the extent practicable, w participation of the resident, the re- legal guardian or chosen represen- least quarterly and within seven the revision of the comprehensive assessment. Reeducation will be provided to I staff on July 13, 2015 on thorou follow through of documentatic updating of care plans on findin assessments. The MDS sections Cognitive Patterns, (G) Functional and (H) Bowel and Bladder will be out for comparison to the care pla- care conferences. Referrals will b to OT/PT if significant decli	ds, and, ith the sident's tative at days of resident icensed ghness, in with gs from s for (C) Status, printed ins with e made nes in		
	This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to update the plan of care after a recognized decline in ambulation for 1 of 4 residents reviewed for accidents (R17).			functional abilities noted with comp Random audits will be done to care plans have been updated by nurse, Social Worker, Director of I or MDS Coordinator.	ensure charge			
	Findings include:				All residents have the potential affected by this practice.	to be		
	R17 was admitted to the facility 3/3/12, and had an annual review on 3/17/15, with diagnoses of short term memory loss, ischemic heart disease (decreased blood flow and oxygen to the heart muscle itself) with edema and diuretic medications (medication to promote urination), hypertension (high blood pressure), polymyalgia rheumatica (pain and stiffness in shoulders, neck, upper arms and hips) and osteoarthritis (degenerative arthritis).				MDS Coordinator or designee will for compliance.	monitor	07/15/15	
	A Fall Risk assessmer R17 had unsteady gai	) nt dated 3/15/15, identified t and balance problems, nt paint, arthritis, and a						

	PRINTED: 06/25/2015
	FORM APPROVED
81C	OND NO. 0000 0004

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) D	B NO. 0938-0391 DATE SURVEY COMPLETED
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:	
245566 B. WING	06/05/2015
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE	
VALLEY VIEW HEALTHCARE & REHAB 510 EAST CEDAR STREET HOUSTON, MN 55943	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE	COMPLETION
TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	DATE
F 280 Continued From page 8 F 280	
decline in decision making skills. R17 used a	
WW [wheeled walker] or W/C [wheelchair], and	
was a safety risk due to weakness and	
deconditioning. The facility lacked any changes in	
the care plan after this fall assessment.	
The annual Minimum Data Set (MDS) dated	
3/17/15, moderate cognitive impairment. R17 had	
no depression or behaviors. R17 was	
independent with bed mobility, required	
supervision or cueing and one person physical	
assist for transfers and toilet use, but was	
considered set up help only in ambulation in her	
room, even though she was assessed to require	
one person physical assist with transfers and	
toileting, which was a decline in functional abilities	
from the 12/17/15, quarterly MDS. R17 also had a	
decline in cognitive ability to moderately impaired from the 12/17/15, MDS.	
The Care Area Assessment (CAA) dated 3/17/15,	
indicated R17 had issues with delirium, cognitive	
loss, dementia, activities of daily living (ADL)	
-functional status, urinary incontinence, falls and	
nutritional status. According to the CAA summary,	
delirium and urinary incontinence were not	
addressed in the care plan.	
The Care Plan dated 3/24/15, identified	
independent with transfers, bed mobility and ambulation with walker, directed staff to notify MD	
of significant decline to physical and cognitive	
functioning and refer to therapies as indicated.	
R17 was at risk for falls related to degenerative	
joint disease, polymyalgia and history of falls and	
directed staff to notify MD of significant decline in	
physical or cognitive function, and refer to	
therapies as indicated. R17 preferred to sleep in	
her recliner. Pain in the right hip and right knee	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: NI7Q11

Facility ID: 00286

If continuation sheet Page 9 of 58

		ND HUMAN SERVICES		·		D: 06/25/20 MAPPROVE D. 0938-03
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	LE CONSTRUCTION	(X3) DATE COMF	SURVEY
		245566	B. WING		06/	05/2015
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD	E	
VALLEY V	IEW HEALTHCARE & RI	EHAB		510 EAST CEDAR STREET		
				HOUSTON, MN 55943		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETIO DATE
F 280	Continued From page	e 9	F 28	0		
F 309	from polymyalgia and therapies as indicated staff to encourage us and directed indepen mobility and ambulati The care plan was no functional abilities fro 12/17/15, to the annu to reflect the physical for transfers and toile On 6/5/15, at 12:38 p was still her own pers always able to alert u could and did transfer The facility failed to u refer R17 to PT/OT w and functional abilitie MDS assessment. In nursing progress note ambulation and indica should be done. 483.25 PROVIDE CA HIGHEST WELL BEII Each resident must re provide the necessary or maintain the higher mental, and psychoso	I directed to refer to d. The care plan directed e of walker with ambulation, dent with transfer, bed on with walker. to updated with the decline in m the quarterly MDS dated al assessment 3/17/15, and assist of one staff member ting. .m. the DON stated R17 son, alert, had poly myalagia, s if she needed assistance, r and toilet by self. pdate the plan of care or then a decline in cognitive s was noted the 3/17/15, addition on 4/29/15, a e indicated a decline in ated a referral to PT/OT .RE/SERVICES FOR NG eccive and the facility must y care and services to attain st practicable physical,	F 30		NG Rehab ensures es and provides ervices to attain est practicable psychosocial ychosocial well- e with the	
	by:	is not met as evidenced n, interview and document		care. Valley View ensures that obtains optimal improvem deteriorate within the limits right to refuse treatment,	ent or does not s of a resident's	

FORM CMS-2567(02-99) Previous Versions Obsolete

Facility ID: 00286

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PRINTED: 06/25/2015

PRINTED: 06/25/2015 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MUI A. BUILC		(X3) DATE SURVEY COMPLETED			
		245566	B. WING				6/05/2015
NAME OF PROVIDER OR S				5'	TREET ADDRESS, CITY, STATE, ZIP CODE 10 EAST CEDAR STREET IOUSTON, MN 55943	<u> </u>	0/00/2010
PREFIX (EAC	H DEFICIENCY MUS	NT OF DEFICIENCIES T BE PRECEDED BY FULL ENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETIO DATE
review, the wheelchair residents (i who had a left in the e support his Findings in R10 was ad admission of (CVA) with per the Adm On 6/1/15, the dining r wheelchair over the arr On 6/2/15, a leaning to le was leaned arm rest. He of the (indic left knee wa lean. His left as it rested of hung down. On 6/4/15 at was leaning and partially able to becom	positioning asse R10) who was re left hemiplegia a lectric wheelcha left arm and lef clude: dmitted to the fa diagnoses of cer left sided weakr hission Record. at 12:29 p.m. R <sup>2</sup> com, he was lea (w/c) and his lef n rest. at 8:40 a.m. R10 eft. The arm rest over so far, you a stated he leand ated left arm and is pointed out ar t arm hung down at 10:40 a.m. R1 is left leg was tu foot was rolled on the footrest, a t 11:00 R10 was in the wheelcha	cility on 11/16/11, with rebrovascular accident less and hypertension 10 was returning from aning left in his electric t arm was hanging 0 was sitting in the w/c was there, but he could not see the ed that way because d leg hemiplegia). The nd foot was tipped left n. 0 was returning from rned out to the left over onto the ankle and his right arm was asked if he knew he ir. R10 stated yes, upright, but was not by himself.	F	309	limits of recognized pathology normal aging process. OT was informed of preliminary on June 8, 2015. An OT order positioning and mobility was obta resident and provided to Occu therapy. Final survey finding provided to therapy department of 29, 2015 upon arrival in the mail. R10 was referred to OT for w/c pos and safety. Other resident have the potentia affected by this practice. Nursing a attempt interventions for positioning in w/c, if unsuccessful w to OT services. Monitored by: Director of N Occupational therapist, or designed	findings for w/c ined for pational s were in June sitioning l to be staff will proper vill refer	07/15/15

		ND HUMAN SERVICES					Form OMB NC	): 06/25/201 /I APPROVE ). 0938-039
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SUR COMPLETI	
		245566	B. WING				06/	05/2015
NAME OF PI	ROVIDER OR SUPPLIER	/		1	STREET ADDRESS, CITY, STATE, ZI	CODE		
VALLEY V	IEW HEALTHCARE & RI	EHAB			510 EAST CEDAR STREET HOUSTON, MN 55943			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG	IX	PROVIDER'S PLAN ( (EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	CTION SHOULD B O THE APPROPRI		(X5) COMPLETION DATE
F 309	Continued From page	e 11 tensive assistance for	F	309	9			
	activities of daily livin plan dated 3/24/15, ir falls, required an EZ	g. The corresponding care ndicated: R10 was at risk for stand for transfers or Hoyer for transfers with increased						
	weakness.							
	(OT). The documenta Treatment for outpatient The treatment noted wheelchair related to roommate's foot. Also	or Occupational Therapy				·		
	hallway, within 10-12 swaying right to left, a	inches from wall with some and he was able to manage ssessment for safe driving."						
	positioning was signe OT therapy order date maximum rehab pote last treatment day 3/2	, therapeutic activities, w/c d by physician 3/11/15. At ed 3/2/15, stated reached ntial, discontinue OT with 2/15. An OT assessment for						
	at lowest speed, dem "excuse me" and able drive) when scooter is	nstrated good speed control onstrated ability to verbalize e to use horn. "Safe (to s set at lowest speed." cked documentation of a						
	The quarterly Minimu 3/19/15, indicated R1 required extensive as	m Data Set (MDS) dated 0 was cognitively intact, sist of two with bed mobility, nd required the use of a						
	7(02-99) Previous Versions Obs	olete Event ID: NI7Q			acility ID: 00286	If continu	ation sheet	Page 12 of 5

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		ID HUMAN SERVICES					FORM	): 06/25/201 APPROVE
STATEMENT	S FOR MEDICARE & OF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		ECONSTRUCTION	015	(X3) DATE	0. 0938-039 SURVEY LETED
		245566	B. WING		MM Dopt of Moa	lih	06/	05/2015
NAME OF P	ROVIDER OR SUPPLIER			s	STREET ADDRESS, CITY, STATE, ZIP COD	Ε		
VALLEY V	IEW HEALTHCARE & RE	EHAB			10 EAST CEDAR STREET IOUSTON, MN 55943			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG	L IX	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD B		(X5) COMPLETION DATE
F 323	activities of daily living and locomotion due to was dependent upon A review of the PT file on 1/2 of a sheet of cc PT-OT on Monday 6/ an evaluation or may! We've noticed lately t wheelchair his left leg at times sometimes s his hip is popped out also makes it difficult stand even when usir can add a pad to left straight." On 6/3/15, at 2:00 p.r been assessed for pro- electronic w/c, only sa On 6/4/15, at 2:00 p.r been assessed for pro- electronic w/c, only sa On 6/4/15, at 2:00 p.r stated the note was g he changed it to OT fc PT-A stated "it (wheel up in the past before, many accessories for On 6/5/15, at 1:38 p.n (DON) stated that R10 his wheelchair to the I back to bed and get h facility lacked a wheel positioning for R10, er ordered. 483.25(h) FREE OF A	3/24/15, indicated deficits in g, transfers, bed mobility, o left sided weakness. R10 staff for all cares. e indicated: An undated note computer paper was given to 1/15, "I think room 13 needs be an adaptive pad of sorts. hat at times in his g starts to turn out to the side everely where it looks like of socket. At these times it to keep left leg within the EZ ng the leg belt. Not sure if we of w/c to help keep leg n. OT-A stated R10 had not oper positioning in the afe driving. n. physical therapist (PT)-A iven to them by a NA, and or the proper evaluation. Ichair positioning) has come unfortunately there were not electric wheelchairs." n. the director of nursing 0 was sometimes leaning in left. Staff would then lift him im up after a rest. The I chair assessment for ven though it had been ACCIDENT		309				
SS=D	HAZARDS/SUPERVI	SION/DEVICES						
FORM CMS-256	7(02-99) Previous Versions Obs	olete Event ID: NI7Q	11	Fa	cility ID: 00286	If continu	ation sheet	Page 13 of 5

Facility ID: 00286

PRINTED: 06/25/2015 FORM APPROVED OMB NO 0938-0391

		MEDICAID SERVICES					D. 0938-039
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					E SURVEY PLETED
		245566	B. WING			06/05/2015	
NAME OF F	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE	•	
VALLEY	/IEW HEALTHCARE & RI	ЕНАВ			0 EAST CEDAR STREET DUSTON, MN 55943		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	DBE	(X5) COMPLETIOI DATE
F 323	Continued From page	e 13	F	323	F323 483.25(h) FREE OF ACCIE HAZARDS/SUPERVISION/DEVI		
	as is possible; and ea adequate supervision prevent accidents. This REQUIREMENT by: Based on interview a facility failed to develou interventions to preve (R17, R40) who were Findings include: The admission record been admitted to the f R17 R17's Fall Risk asses described R17 as hav balance problems, urg arthritis, and a decline and the assessment in [wheeled walker] or W safety risk due to wea An annual Minimum E 3/17/15, indicated R17 short term memory los (decreased blood flow muscle itself), edema medications (medicati hypertension (high blo	as free of accident hazards ach resident receives and assistance devices to is not met as evidenced ind document review, the op and implement int falls for 2 of 4 residents reviewed for accidents. I sheet indicated R17 had facility 3/3/12. sment dated 3/15/15, ring an unsteady gait and ge incontinence, joint paint, a in decision making skills, indicated R17 utilized a WWV //C [wheelchair], and was a kness and deconditioning.			<ul> <li>Valley View Healthcare &amp; Rehat that the resident environment refree of accident hazards as is and each resident receives supervision and assistance deprevent accidents. All accider internal investigation reports widetails of a full investigation causal factors related to the inc will be documents as such on the All accident/incident reports are daily by Nursing and/or Social Set their applicability to the Vulnera Reporting guidelines.</li> <li>Facility policy to identify risks, interventions consistent with needs, and monitors the effectivinterventions.</li> <li>The preliminary survey finding provided to pharmacist consultant and Director on June 29, 2015 upon the mail.</li> <li>Valley View Healthcare &amp; Rehat the pamphlet "The False Assuration packet and is provided in the admission packet and is provided on 2015. Valley View Policy and Procedu fall Assessment was revised.</li> <li>In-servicing will be provided on 2015. Staff will be re-educing for survey finding du "event" "Understanding the Fall" forms consultant forms consistent with admission packet and is provided on 2015. Staff will be re-educing for survey finding for the fall" forms consultant and point the mail.</li> </ul>	e ensures mains as possible; adequate vvices to t/incident ill reflect including dent and re report. screened rvices for ble Adult develops residents' reness of gs were tant and 17, 2015. vvided to Medical arrival in arrival in trance of . The resident d to new s on July re: Post- July 13, pation of and the impletely.	

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CENTER	S FOR MEDICARE &	MEDICAID SERVICES				araanin tita aratteenar attee a s	OMB NC	0938-039
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILDI		CONSTRUCTION	JULIJ 201	(X3) DATE COMP	SURVEY LETED
		245566	B. WING			- Statistic	06/	05/2015
NAME OF P	ROVIDER OR SUPPLIER		warten a	STF	REET ADDRESS, CITY, ST	TATE, ZIP CODE	<u>.</u>	
VALLEY \	IEW HEALTHCARE & RI	ЕНАВ			EAST CEDAR STREET	ſ		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		(EACH CORRE CROSS-REFERE	B PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETIO DATE
F 323	(degenerative arthritis The annual MDS from moderately impaired indicated R17 could u communicated and co understood, had no d symptoms, was indep required supervision of physical assist for tra ambulation in her roo MDS dated 12/17/14, required set up help f the room, and toilet u 3/17/15, indicated R1 transfers and ambula MDS did not indicate any restorative nursin corresponding Care A dated 3/17/15, indicat delirium, cognitive los daily living (ADL) -fun incontinence, falls and did not indicate wheth initiated for an evalua need for increased as ambulation in the corr The Care Plan dated experienced pain in th polymyalgia, and indic to therapies "as indicated indicated staff were to doctor) of any signific cognitive functioning a as indicated. The care	s). In 3/17/15, indicated R17 had cognition. The MDS further understand what was build make herself epression or behavior bendent with bed mobility, or cueing and one person insfers, toilet use and m. A previous quarterly had indicated R17 had or transfers, ambulation in se. The annual MDS from 7 needed assist with tion in the corridor. The the resident had received ig or PT/OT. The area Assessment (CAA) red R17 had issues with s, dementia, activities of ctional status, urinary d nutritional status. The CAA her any referral had been tion by OT or PT of R17's issist with transfers and	F	323	the fall. Cur reviewed on a implementation appropriate wil fall. All falls are revi pharmacist con recommendatic Primary care pr weekly by the I involvement to of fall, current in implemented ai should be attern All residents ha affected by this	ons forwarded to resid rovider. Falls are revi DT team with therapy review fall, possible c interventions, interven and if any other interven apted. we the potential to be practice. Director of Nursing, se	vill be s with s if felt each lent's ewed ause tions intions	07/15/15

Facility ID: 00286

If continuation sheet Page 15 of 58

TATEMENT	S FOR MEDICARE & DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	OMB NO. 0938-03 (X3) DATE SURVEY COMPLETED 06/05/2015	
		245566	B. WING				
	ROVIDER OR SUPPLIER	2+0000		ST	REET ADDRESS, CITY, STATE, ZIP CODE	1 00	/05/2015
	NONDER OR GOIT LIER		510 EAST CEDAR STREET				
VALLEY V	IEW HEALTHCARE & R	EHAB			DUSTON, MN 55943		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETIC DATE
F 323	Continued From page	e 15	F3	323			
	disease, polymyalgia	and history of falls.					
		d for staff to notify the MD of					
		e in physical or cognitive					
		to therapy as indicated. A the care plan dated 4/29/15,					
		ition was changing, "history					
		ning room after lunch and					
	eating off of other res	sident's plates. Staff were to					
	-	om, clear plates, redirect					
		offee and snack." The care					
		he use of staff intervention of the staff intervention in her room as					
		current MDS dated 3/17/15.					
		er Report dated 2/11/15 ated R17 should be UP AD					
	Review of R17's Nurs	sing Notes identified a					
		had been identified for R17					
		5, at approximately 3:15 p.m.					
		equested physical therapy al therapy (OT) services to					
		ne in ambulation. Nursing					
		ell on 5/1/15, at 6:54 p.m.					
		he hospital emergency room					
		as subsequently diagnosed					
		Therapy notes for PT and OT none were provided during					
	the survey.	iene were previded during					
		ote dated 5/1/15, at 6:45					
	•	vas heard in her room yelling entered she was laying on					
	her back on the floor						
		covered that resident was					
		ight leg. When staff was					
	feeling her hip she (R	(17) did state that her right					

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	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TPLE CON	STRUCTION		TE SURVEY MPLETED
		245566	B. WING			06/05/2015	
	ROVIDER OR SUPPLIER	ЕНАВ		510 EA	T ADDRESS, CITY, STATE, ZIP CODE ST CEDAR STREET TON, MN 55943		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETIC DATE
F 323	Vital signs stable, sta [emergency room] for Care plan updated, fa notified." A report entitled, Und 5/1/15, indicated R17 "Unwitnessed. Actual w/c to floor. Takes set supper, has water at I recliner. R [right] hip/I p.m., no alarms." An additional report e dated 5/1/15, was rev documented by licens indicated the resident hospital on 5/1/15, an Changes to the care p the resident had susta and had pain, and tha intervention. Intervent with assistance of two chair/commode. Depe Bed/chair bound." On 5/2/15, a nursing p resident required skille should continue with p transfer bed to chair, o with assist. The note in restorative walking pro SBA [stand by assist] identified as, "ambulat with 2VWV."	ff did send her into ER *x-ray of right hip and leg. amily and doc (doctor) were erstanding the Fall dated 's incident had been time of fall was 6:25 p.m. If to bathroom, just had bedside. Trying to get into eg pain. Last meds at 2:00 ntitled, Safety Event -Falls iewed. The form, the d practical nurse (LPN)-A, had been sent to the d had returned on 5/2/15. Dan dated 5/1/15, indicated ained a fractured right hip t there had been no surgical ions included: "Bedrest, o staff and Hoyer lift to endent on staff for all needs. progress note indicated the ed nursing and bedrest, previous activity, and would chair/bed to commode only ncluded, "was on ogram average 23 feet with 2WW." The goal was te independently in room	F	323			
		t completed by the social cated R17 had experienced					

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING 245566 B. WING 06/05/2015 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER **510 EAST CEDAR STREET** VALLEY VIEW HEALTHCARE & REHAB HOUSTON, MN 55943 SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X5) (X4) ID COMPLETION (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) F 323 Continued From page 17 F 323 an unwitnessed fall in her room on 5/1/15. The report indicated that per the care plan R17 had been up independently with her walker at the time of the fall and was able to use her call light. Details of the report documented that R17 had been sent to the ER and had been diagnosed with a right hip fracture, that R17 had spent one night in the hospital and after it had been decided not to pursue surgical intervention, R17 had returned to the facility on 5/2/15, with orders for bed rest with assistance with transfers to chair or commode. The investigative report further indicated R17 continued to be alert, have a joking nature with staff, smiled easily and expressed interest in activities and eating. On 6/5/15, at 12:38 p.m. the director of nursing (DON) stated, "R17 was still her own person, she was alert, had polymyalgia, was always able to alert us if she needed assistance, and could and did transfer and toilet by herself. After the fall the family opted not to do surgery. We had a conference with the family because we had to do a lot of pain control, which was going to cause the demise of R17. It seemed like quite a surprise to the family that Hospice would be an option, and the family didn't want Hospice. We kept the family updated. R17 was not getting up and was eating very little, drinking very little, did not want to take medications. When her medical doctor (MD)-A saw her, he ordered a Hospice referral." In addition, the DON stated the usual process for falls was for the aide to report to the nurse who would assess the resident, document an event report, and complete a post fall assessment form. The DON stated, the interdisciplinary team (IDT) would review every fall to make recommendations and to determine whether therapy should be involved.

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Event ID: NI7Q11

Facility ID: 00286

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PRINTED: 06/25/2015

FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING 245566 B. WING 06/05/2015 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **510 EAST CEDAR STREET** VALLEY VIEW HEALTHCARE & REHAB HOUSTON, MN 55943 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION ID (X4) ID (X5) COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 323 Continued From page 18 F 323 R40 was admitted to the facility 8/15/12, with admission diagnoses including Alzheimer disease, anxiety state, dementia and weight loss due to Alzheimer disease. A guarterly MDS dated 4/1/15, indicated R40 had severe cognitive impairment, moderate depression, behaviors of wandering and refusal of care, and that R40 required extensive assistance of one staff for all activities of daily living. A Care Area Assessment (CAA) dated 1/6/15, indicated R40 had memory, mood and behaviors issues, was not aware of needs or safety, was at risk for falls and elopement. Dependent on staff to meet needs. The care plan dated 1/6/15, indicated R40 had been on 15 minute checks since 4/7/15, and other interventions included remindering R40 of the potential for injury if she hits others. The care plan further indicated R40 was a high fall risk related to impulsiveness, paranoia and delusions. Fall precautions in place were identified as a bed sensor pad, chair alarm and floor mat. In addition, the resident was identified as at risk for wandering and elopement related to poor memory and not being aware of safety issues. Interventions included 15 minute checks daily for location and activity, and a watchmate band on wrist and ankle which were to be checked for proper placement every shift, and proper function at least every 3 months. R40 experienced numerous falls in the facility between 10/11/14 and 6/2/15, even though there were bed and chair alarms in place, and even FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: NI7Q11 Facility ID: 00286 If continuation sheet Page 19 of 58

DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 06/25/2015

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

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED	
		245566	B. WING				6/05/2015
NAME OF P	ROVIDER OR SUPPLIER			STREE	ET ADDRESS, CITY, STATE, ZIP CODE		
VALLEY V	IEW HEALTHCARE & RI	ЕНАВ			AST CEDAR STREET STON, MN 55943		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE
F 323	10	e 19 ks had been initiated. In	F	323			
	comprehensively ass including medical cha	ion, the falls were not always prehensively assessed for causative factors ding medical changes, and new interventions not always considered. view of the falls for R40 included: 10/11/14, 12:00 a.m. Unwitnessed fall (staff responded to alarm). The report included,					
	A review of the falls f 1. 10/11/14, 12:0 had responded to ala						
	one with staff) for 3 h do 3 day sleep study.	injury, had been 1:1 (one to ours. Continue alarms, will " No sleep study results investigation for this fall.					
	(transitional care unit "INJURY: bruising, bi	ump back of head. 1:1					
	study results were re for this fall.	ss get up in chair." No sleep viewed for the investigation n. Unwitnessed fall in					
	resident room (staff r	esponded to alarm). No on added after this fall: "					
	clinic and PMD in hor	ergency room), memory use after adjustment in cerbation of increased					
	place and appropriate 4. 11/8/14, 12:29 p	m. Witnessed fall in hallway					
	"Combative and aggr while attacking staff h	Documentation indicated, essive, lowered to the floor hitting and kicking, no longer rered to floor. Sent to ER					
	(emergency room) fo 5. 11/30/14, 6:09 p.				· .		
	"has red mark (scrate	h) on both of her inner m (centimeters),  10 cm x					

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# DEPARTMENT OF HEALTH AND HUMAN SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION		X3) DATE SURVEY COMPLETED	
		245566	B. WING			6/05/2015	
NAME OF PROVIDER OR SUPPLIER VALLEY VIEW HEALTHCARE & REHAB			STREET ADDRESS, CITY, STATE, ZIP CO 510 EAST CEDAR STREET HOUSTON, MN 55943	ODE			
				PROVIDER'S PLAN OF (	CORRECTION	(X5)	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC	ION SHOULD BE HE APPROPRIATE		
F 323	<ol> <li>12/13/14, 10:20 responded to alarm). in Lounge. Continue</li> <li>1/7/15, at 1:45 p (respond to alarm)." wanted to go for a w to left side and hit bat to back of head. Abruin unmeasurable d/t (dw wound, did not want re-bleed. 1/8/15, c/o touch, weak and shat bathroom. Appears was assistance with eatir uncontrollably, state blankets on at this til 8. 1/14/15, 2:28 p. responded to alarm) attempting to stand, hit bed wall. "INJUF skin covering old he head from fall was o Temperature 100.1 Discussion in investiv would be next intervinappropriate; would restricted movement physician's orders. N checks, and ice to a minutes four times a to side of wall."</li> <li>1/18/15, 9:55 p. had responded to alarun out of her Broda chat battery and did not earlier. Injury 3 cen right buttock, no c/o</li> </ol>	p.m. Unwitnessed fall (staff Slid out of chair to the floor e current measures. o.m. Unwitnessed fall Fell from Broda chair, alk, alarm sounded. She fell ock of head. Injury: abrasion asion to back of head, ue to) blood sticking to to wash it and cause it to headache and tender to aking when taken to weaker and required ng. In bed and shaking s she is cold, several me. Continue Broda alarm." m. Witnessed fall (staff . Fall in Resident Room was fell back onto bed and head RY Scraped off small part of ad injury, previous lump on n 15 minute checks, BP (blood pressure) 96/50." igation included, "Restraints ention and this is I cause, anxiety, confusion, ts. No Changes. New Monitor for 72 hours, neuro ffected area of injury for 20 a day for 3 days. Added a pad m. Unwitnessed fall (staff arm). Fell while trying to get air, "alarm was on with new work. Alarm was working timeter reddened area on tenderness. Continue cked and are working." No 15	F 323	3			

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	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					TE SURVEY MPLETED
		245566	B. WING				6/05/2015
NAME OF P	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		
					EAST CEDAR STREET		
VALLEY V	IEW HEALTHCARE & R	EHAB			OUSTON, MN 55943		
(X4) ID PREFIX TAG	(EACH DEFICIENC	IATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETIC DATE
F 323	Continued From page	e 21	F	323			
		n. Unwitnessed fall in her					
		d to alarm). "No injury noted.					
		nute) checks and alarms.					
	Found on sensor ma						
		Care plan updated and family					
	notified."	and plan aparted and farming					
	11. 2/25/15. at 1:55	a.m. Unwitnessed fall (staff					
		irms). Nurse's note included,					
		ne bathroom in her room					
	and fell to the floor."						
	documentation indica	ited, "bed alarm going off,					
	found scooting towards bed, incontinent of urine.						
	No injury. Continue a	larms. No changes continue					
	with current measure						
	12. 3/1/15, at 5:00 a.	m. Unwitnessed fall (staff					
		. Fell in bedroom while					
		been toileted at 2:30 a.m.					
		atch, right side back of head					
		on- 3cm X 2cm x 1cm raised,					
		che after fall. Continue					
		in a different environment					
		rm due to plumbing project					
	with current measures	n. No changes continue					
		s m.  Witnessed fall (staff					
	•	. R40 fell in her room trying					
		to bed. A little bit of pain.					
		head. The back of the head					
	hit the floor pain score	e 1/10. Ice bag applied. No					
		val for self-release belt in					
		ve devices in place, alarm					
	did sound. On 15 min						
		ns changes. Resident was					
		creased restlessness,					
		fter visit with her daughter.					
		ferred to OT for evaluation					
	and treatment as indic	cated. Will follow their					
	recommendations. Wi	II continue with current					
	measures. No change	e to plan of care at this time.					

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STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	ECONSTRUCTION	JUE 1 2 205	(X3) DATE	E SURVEY PLETED
		245566	B. WING		- MAN Dept of Means	06/	/05/2015
	ROVIDER OR SUPPLIER	HAB	5	TREET ADDRESS, CITY, S 10 EAST CEDAR STREE IOUSTON, MN 55943			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION ECTIVE ACTION SHOULD BI ENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 323	No documentation in related to fall. 14. 4/12/15, at 12:54 dayroom (staff resport on her knees in front of Resident stated she heresident. 4/12/15, 1:04 (oxygen saturation) 90 added after this fall: the "Supportive devices in 15 minute checks, rour medications changes. environment room chas plumbing project in re- changes continue with 15. 4/12/15, 8:40 p.m (responding to alarm)) on the floor " I'm taking chair and I hit my hea Broda. Supportive devises sound. On 15 minute No medications changed different environment plumbing project in re- changes continue with 16. 5/25/15, 6:30 p.m (responded to alarm). room 16, stated " going later she said she fell seen. Supportive devises sound. On 15 minute No medications changed different environment due to plumbing project in re- cond the states and the fell seen. Supportive devises sound. On 15 minute No medications changed different environment due to plumbing project in re- cond the states and she fell seen. Supportive devises the states and the states and sound. On 15 minute of the states and th	15 minute check form p.m. Witnessed fall in ided to alarm). "Observed of another resident. ad stood up and fallen into 4 p.m. sitting 90/70 O2 sats 0%." New interventions his was left blank. In place, alarm did sound. On itinely toileted. No Resident was in a different ange short term due to sident's bathroom. No In current measures." I. Unwitnessed fall . Found in lounge face down hg a nap, I fell out of my d ". OT self-release in <i>vices</i> in place, alarm did checks, routinely toileted. ges. Resident was in a room change short term d/t sident 's bathroom. No in current measures. I. Unwitnessed fall Found crawling on floor in hg to bed ". A few minutes on her right butt. No injuries ces in place, alarm did checks, routinely toileted.	F 323				

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Facility ID: 00286

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		MEDICAID SERVICES				OMB NO. 0938-039		
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TPLE CONS			TE SURVEY MPLETED	
		245566	B. WING_			06/05/2		
NAME OF PI	ROVIDER OR SUPPLIER	d		STREET	ADDRESS, CITY, STATE, ZIP CODE		*	
	IEW HEALTHCARE & R	EHΔB		510 EAS	T CEDAR STREET			
				HOUST	ON, MN 55943			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	×	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 323	Continued From page	e 23	F3	323				
	17. 5/27/15, at 8:30							
		pelt; got up and laid down on				-		
		ot a fall. Resident laid herself						
		ot slide or fall out of her						
		essed fall. Nursing progress						
		nursing assistant (CNA)						
		, found resident sitting on						
		ng to lay down. Opened eleasing seat belt was						
		e that she is able to release						
		led to alarm. Resident						
	-	elt; got up and laid down on						
		ot a fall. Resident laid herself						
	down on the floor did	not slide out of her Broda						
	chair. No fall.							
	18. 5/28/15, at 8:00	p.m. Unwitnessed fall (staff						
		"Found on floor in lounge in						
		to get into a different chair.'						
		she stood and tried to get						
		ervention: offer to get ready						
	for bed by 8:00 p.m." 19. 6/2/15, at 4:40 a	m. Unwith append fall						
		. "Bed alarm sounding and						
	· · · /	resident room after alarm						
		s or less. Resident was in						
		on the floor by toilet. "						
-	-	ement when sitting." Event						
	was not yet closed.	-						
	The facility had a she	et of paper that was			·			
		/ 15 minutes through the						
	day.	. –						
		nute check forms indicated						
		equently filled out by the						
	same hand, with the severy 15 minutes.	same pen for 8-12 hours						
	On 6/5/15, at 1:15 p.r	n. the social worker (SW)						
	was interviewed and	stated the 15 minute check						

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Facility ID: 00286

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	S FOR MEDICARE &	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE (		OMB NO. 0938-03 (X3) DATE SURVEY
	FCORRECTION	IDENTIFICATION NUMBER:			COMPLETED
		245566	B. WING		06/05/2015
NAME OF P	ROVIDER OR SUPPLIER		ST	REET ADDRESS, CITY, STATE, ZIP CODE	
VALLEY	/IEW HEALTHCARE & R	EHAB		DEAST CEDAR STREET DUSTON, MN 55943	
(X4) ID	SUMMARY ST	TATEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF CORRECTION	(×5)
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	COMPLETIC
F 323	Continued From pag	e 24	F 323		
		er when complete. The SW			
		is aware of the research			
		ninute checks may actually			
		W had sent out notices to			
		r is going to try to eliminate			
		nily insists on the alarms. 15 minute check forms were			
	not always completed				
	The facility failed to t	horoughly investigate and			
		R40 and did not attempt new			
		ery fall. It was unclear			
	whether medical reas				
		en elevated temperatures			
	incident forms.	ures were recorded on the	-		
F 329		GIMEN IS FREE FROM	F 329		
SS=E				F329 483.25(I) DRUG REGIMEN IS F FROM UNNECESSARY DRUGS	REE
		regimen must be free from		Valley View Healthcare & Rehab ens	
		An unnecessary drug is any ccessive dose (including		that each resident's drug regimen is from unnecessary drugs. An unneces	
		for excessive duration; or		drug is any drug when used in exce	ssive
		nitoring; or without adequate		dose (including duplicate therapy); o excessive duration; or without adeo	
	indications for its use	; or in the presence of			quate
		es which indicate the dose		indications for its use; or in the pres	ence
		r discontinued; or any		of adverse consequences which inc the dose should be reduced	
	combinations of the r	easons above.		discontinued; or any combination o	
	Based on a compreh	ensive assessment of a		reasons above.	
		nust ensure that residents		Based on a comprehensive assessme	ent of
		ntipsychotic drugs are not		a resident, Valley View ensures	that
	-	less antipsychotic drug		residents who have not used antipsyc drugs are not given these drugs u	
		to treat a specific condition cumented in the clinical		antipsychotic drug therapy is necessa	ary to
		who use antipsychotic		treat a specific condition as diagn	
		I dose reductions, and		and documented in the clinical record residents who use antipsychotic of	
	behavioral intervention	ons, unless clinically		receive gradual dose reductions,	

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CENTER						OMB NO	D. 0938-039
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION		E SURVEY PLETED
		245566	B. WING			06	/05/2015
NAME OF P	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
VALLEY V	IEW HEALTHCARE & R	ЕНАВ			10 EAST CEDAR STREET OUSTON, MN 55943		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETIO DATE
F 329		e 25 n effort to discontinue these	F	329	behavioral interventions, unless contraindicated, in an effort to d these drugs.	clinically iscontinue	
	This REQUIREMENT by: Based on observation review, the facility fait (R14, R39, R40, R10) medication had adeq failed to ensure there indication for continue of 5 residents (R21). Findings include: R14 was observed on was observed dresses wheelchair at the dim feeding herself. The Care Area Assess for psychotropic med was at risk for side e R14's diagnoses include delusional disorder a The current Medicati (MAR) from 12/1/14 R14 received daily at antidepressants, Cel antipsychotic Zyprex Review of the Vitals 6/1/15, indicated orth	ed use of an antibiotic for 1 n 6/3/15, at 7:56 a.m. R14 ed, calmly sitting in ing room table independently ssment (CAA) dated 9/24/14 lication use indicated R14 ffects including risk for falls. uded dementia with ind anxiety on Administration Record through 6/4/15, indicated dministration of exa and Trazodone and			The resident's drug regime is re the licensed staff, physici consultant pharmacist to as medications are not used in doses, for excessive duration adequate monitoring, without indications, or in the presence of consequences. Pharmacist reviews medication regime on al monthly. The preliminary surve were provided to pharmacist and Medical Director on June Final survey findings were pr pharmacist consultant and Director on June 29, 2015 upor the mail. On June 6, 2015 audit per ensure that nursing orders wer on all residents for orthostation residents on antipsychotic med the electronic record. The pr consultant did make a recomme discontinuation of resident's C for prophylaxis/neurogenic LElbsernd, PA-C did discor prophylactic antibiotic on R21. All resident's drug regime is monthly by consulting pharm recommendations as indicated attending physician/nurse pr every 60 days. All residents on antipsychotics potential to be affected by thi Audit completed on all ress antipsychotics to ensure a nur was in the electronic record fo orthostatic blood pressure mon completed on June 8, 2015.	an, and sure that excessive a, without adequate of adverse consultant residents ey findings consultant 17, 2015. ovided to Medical a arrival in formed to e in place b BPs for ications in oharmacist notation for Dephalexin bladder. tinue the reviewed acist with l, and by practitioner have the s practice. idents on sing order or monthly	

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Event ID: NI7Q11

Facility ID: 00286

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	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					E SURVEY PLETED
		245566	B. WING			06	/05/2015
	(EACH DEFICIENC	EHAB ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	510 HO	EET ADDRESS, CITY, STATE, ZIP CODE EAST CEDAR STREET USTON, MN 55943 PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETIC DATE
F 329	6/1/15. The quarterly Minimu 3/11/15, indicated R1 impairment. R14's care plan dated on Zyprexa and to ob effects and medicatio medication review by to routinely check vita R14's current physicia through 6/4/15, indica (antipsychotic) 2.5 mi and directed staff to c pressure] once a day Monthly Medication R the consultant pharma- medications on 1/21// pharmacist on 2/20/13 5/15/15, but did not in monitoring which inclu- pressure for the antip During an interview of director of nursing (D0 blood pressure should was not. R39's was observed dressed (type of wheelchair) w room, calm, and indep	m Data Set (MDS) dated 4 had moderate cognitive d 3/17/15, indicated R14 was serve for potential side n effectiveness, monthly consulting pharmacist and al signs per facility policy. an report dated 5/4/15 tied orders for Zyprexa lligrams (mg) once a day heck orthostatic BP [blood on the 1st of the month. egimen Review revealed acist reviewed R14's 15 and another consultant 5, 3/16/15, 4/17/15, and idicate the lack of adequate uded orthostatic blood	F	329	In-servicing will be provided of 2015, educating licensed residents' on antipsychotic r must have orthostatic BPs monthly. Valley View Healthcare & Reh and Procedures for P Medication was updated obtaining Orthostatic BP's mon Staff compliance with above p be monitored by the DON/de Consultant Pharmacist.	staff that nedications obtained hab's Policy sychotropic to include thly.	07/15/1

TATEMENT	OF DEFICIENCIES F CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED		
		245566	B. WING				06/05/2015	
	ROVIDER OR SUPPLIER	REHAB			STREET ADDRESS, CITY, STATE, ZIP CODE 510 EAST CEDAR STREET HOUSTON, MN 55943	/, STATE, ZIP CODE EET		
(X4) ID PREFIX TAG	(EACH DEFICI	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETIC DATE	
F 329	medication use inc administration of a antipsychotic (Ser- effects including ri The Quarterly MD had severe cogniti R39's care plan da to observe for pote medication effectiv review by consultin check vital signs p R39's diagnoses in behavioral disturba combative behavior obtained from the 5/4/15 through 6/4. Report indicated o (antipsychotic) 50 i (decreased from th 5/20/15) and direct BP [blood pressure month. The current MAR ff indicated R39 rece 12/1/14 through 5/2 through 6/3/15. Review of the Vital 5/28/15, indicated o taken only one of fi Monthly Medicatior the consultant phan	d 12/11/14, for psychotropic dicated R39 required daily intidepressant (Paxil) and oquel), and was at risk for side sk for falls. S dated 3/10/15, indicated R39 ve impairment. Atted 3/17/15, indicated staff was ential side effects and reness, monthly medication ng pharmacist and to routinely er facility policy. Ancluded dementia with ances of agitation and ir, delusions and hallucinations Physician Order Report dated (15. R39's current Physician	F	329	9			

#### FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING 245566 B. WING 06/05/2015 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **510 EAST CEDAR STREET VALLEY VIEW HEALTHCARE & REHAB** HOUSTON, MN 55943 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID ID (X5) COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PRÉFIX REGULATORY OR LSC IDENTIFYING INFORMATION) DATE TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) F 329 Continued From page 28 F 329 pharmacist on 2/20/15, 3/16/15, 4/17/15, and 5/15/15, but did not indicate lack of adequate monitoring for the antipsychotic medication. During an interview on 6/4/15, at 9:35 a.m. the DON verified the orthostatic blood pressure should have been completed and were not, stating "I would have expected sitting and lying blood pressures for this resident who does not stand." The Valley View Nursing Home Policy and Procedures for Psychotropic Medication updated June 20, 2006 indicated the registered nurse will manage the psychotropic medication program and "will development, implement and maintain a Psychotropic Medication Flow Sheet to document mediation [medication] monitoring and dosing adjustment recommendations." The policy lacked direction for vital sign monitoring. R10 was admitted to the facility on 11/16/11, with admission diagnoses of cerebrovascular accident (CVA) with left sided weakness and hypertension, and bipolar disease. The quarterly Minimum Data Set (MDS) dated 3/19/15, indicated R10 was cognitively intact, FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: NI7Q11 Facility ID: 00286 If continuation sheet Page 29 of 58

DEPARTMENT OF HEALTH AND HUMAN SERVICES

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED OMB NO. 0938-0391 **CENTERS FOR MEDICARE & MEDICAID SERVICES** (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING B. WING 245566 06/05/2015 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER **510 EAST CEDAR STREET** VALLEY VIEW HEALTHCARE & REHAB HOUSTON, MN 55943 SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 329 Continued From page 29 F 329 required extensive assist of 2 with bed mobility, transfers, toilet use, and required the use of a stand assist lift. The care plan dated 3/24/15, indicated: R10 was at risk for falls, EZ stand for transfers, or Hoyer lift with assist of two for transfers with increased weakness. Deficits in transfers, bed mobility, and locomotion due to left sided weakness. The Physician Orders dated 5/5/15, included Depakote extended release for bipolar disorder, Zyprexa for bipolar disorder R10 's Orthostatic BP's were recorded for Sept 2014, October 2014, March 2015, April 2015, May 2015, The physician orders were followed 5 of 11 months. On 6/5/15, at 1:38 p.m. the DON stated that R10 should have had the ordered orthostatic blood pressure checks to ensure adequate side effect monitoring was being completed. R40 was admitted to the facility 8/15/12, with admission diagnoses of Alzheimer 's disease, anxiety state, dementia and weight loss. Physician review of medications was as follows: - 7/31/14, Lorazepam 0.5 mg at bed time and lorazepam 0.5 mg. - 10/30/14, Seroquel 25 mg in afternoon and 50 mg at HS discontinued 11/3/14. - 11/3/14, Seroquel Give 25 mg TID and 75 mg at HS discontinued 11/13/14. - 11/13/14, Seroquel Give 25 mg TID and 100 mg

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Event ID: NI7Q11

Facility ID: 00286

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DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 11 11 A. BUILDING B. WING 245566 06/05/2015 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **510 EAST CEDAR STREET** VALLEY VIEW HEALTHCARE & REHAB HOUSTON, MN 55943 SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 329 Continued From page 30 F 329 at HS. The annual CAA dated 1/6/15, indicated R40 had memory, mood and behaviors issues, was not aware of needs or safety, was at risk for falls and elopement. Dependent on staff to meet needs. The care plan, dated 1/6/15, indicated R40 had a history of tossing and turning every night and the goal was to sleep four consecutive hours every night. Observe for side effects and effectiveness. Zoloft was given for depression, and the staff was to monitor for assess/record effectiveness, and document targeted behaviors. Lorazepam was given for anxiety/agitation. Staff was to monitor for effectiveness and adverse consequences, monitor mood in response to lorazepam. The primary consultant was to review monthly and notify physician. The MDS dated 4/1/15, indicated severe cognitive impairment, moderate depression, behaviors of wandering and refusal of care. R40 required extensive assistance of one staff for all activities of daily living. On 6/5/15, at 1:39 p.m. the DON stated R40 was on Seroquel, and DON was aware the medical record lacked evidence of adequate side effect monitoring which would have included orthostatic blood pressures. R21's quarterly MDS dated 5/6/15, indicated moderate cognitive impairment. R21 also had diagnoses of neurogenic bladder, and diabetes mellitus The CAA summary report urinary incontinence FORM CMS-2567(02-99) Previous Versions Obsolete Facility ID: 00286 Event ID: NI7Q11 If continuation sheet Page 31 of 58

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

PRINTED: 06/25/2015 FORM APPROVED

CENTER	S FOR MEDICARE &	MEDICAID SERVICES		109-an-		OMB NO. 0938-039		
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTR			ATE SURVEY OMPLETED	
		245566	B. WING				06/05/2015	
NAME OF P	ROVIDER OR SUPPLIER			STREET AD	DDRESS, CITY, STATE, ZIP CODE		50/03/2013	
	IEW HEALTHCARE & RI	ΞHΔB		510 EAST	CEDAR STREET			
				HOUSTO	N, MN 55943			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 329	Continued From near	21	-					
1 329	Continued From page		F	329				
		er analysis of findings dated						
		at risk for skin irritation and						
		tinence of urine, will review						
	and continue with car	e pian."						
	The Bowel & bladder	screening (3-day void)						
	dated 2/4/15 through							
		nent of bowel and bladder,						
		ducts which staff change."						
	The	ducis which stall change.						
		ening (3-day void) dated						
	4/30/15 through 5/2/1							
		y incontinent of bladder and						
	bowel, wears brief, to							
	The Physician Orders	dated 5/5/15 through						
		x capsule 250 mg orally						
		8/1//14, diagnosis: infection,						
		Ciprofloxacin HCI 500 mg						
		or 10 days start date 5/27						
		Bladder scan as needed						
		9/13, for bladder discomfort						
	or distension with stra							
	retention of 200 cc or	-						
	Care plan dated 5/13/	15, indicated "history of						
		[UTIs], neurogenic bladder.						
		it signs of urinary tract						
		ches were to administer						
		n antibiotic) per physician						
	(MD) order as prophyl							
	evaluate, record, and							
	effectiveness/adverse							
		ize prn for discomfort or						
		onitor labs per MD order.						
		cute confusion, urgency,						
		asms, nocturia, burning,						
	pain, difficulty urinating							
		ting, chills, fever, foul odor,						
AM CMS-256	(02-99) Previous Versions Obsc		l	Eaglith: ID: 000	296	16	L	
00-2007	(ar and i revious versions Obsc	blete Event ID:NI7G		Facility ID: 002	200	If continuation she	Per Page 32 of !	

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Event ID:NI7Q11

Facility ID: 00286

If continuation sheet Page 32 of 58

		& MEDICAID SERVICES	0/02 1000	101 7			<u>O. 0938-03</u>
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					e survey IPleted
		245566	B. WING_			06	6/05/2015
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	•	
		DELLAD		5	10 EAST CEDAR STREET		
VALLEY	IEW HEALTHCARE &	КЕПАВ		н	IOUSTON, MN 55943		
(X4) ID		STATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG		NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	PREFIX	< 	(EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		COMPLETIO
F 329	Continued From pa	age 32	F 3	329			
	concentrated urine indicated.	, blood in urine) to MD as					
	On 6/4/15, at 1:49	p.m. registered nurse (RN)-A					
	was interviewed ab	out the Keflex order for					
		ked if R21 currently had a UTI,					
		blood sugars had been very the hospital, and now they					
	-	al. RN-A stated ciprofloxacin					
		5, for ten days for a urinary					
		eared up and blood sugars					
		e they should be. She stated					
	R21 was still getting	g Keflex.					
	On 6/5/15, at 1:06	p.m. DON stated MD-A					
		loes not have yeasty rash in					
		I stated prior to resident					
		ad a history of UTI and had					
		requently due to it. While R21 was tapered down, urinary					
		and she had not been					
	catheterized while t						
		piotic, it was started long ago					
	and she did not kno	w where the documentation					
	•	ave been prior to R21 coming					
		did trial off the antibiotic for					
		as restarted due to UTI and . DON further commented R21					
		c and could bottom down					
		Jgars were better controlled					
		e into the facility. They had to					
		hts and have not had to					
	-	since she had been there.					
	They could bladder						
		nad a recent UTI on 5/27/15, ated blood sugar and was put					
		r blood sugar was better and					
	the UTI was gone.	5					
	- At 1:17 p.m. DON	stated they had a new					

		MEDICAID SERVICES			
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED
		245566	B. WING		06/05/2015
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	DDE
VALLEY V	IEW HEALTHCARE & RI	ЕНАВ		510 EAST CEDAR STREET HOUSTON, MN 55943	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC'	ON SHOULD BE COMPLETE HE APPROPRIATE DATE
F 329			F 32	29	
F 333 SS=D	ReadyMeds last revis reduce the developm bacteria and maintair cephalexin and other cephalexin should be infections that are pro to be caused by bact 483.25(m)(2) RESIDI SIGNIFICANT MED I	n the effectiveness of antibacterial drugs, used only to treat or prevent oven or strongly suspected eria." ENTS FREE OF ERRORS	F 3:	<ul> <li>F333 483.25 (m) (2) RE</li> <li>OF SIGNIFICANT MED</li> <li>Valley View Healthcare</li> </ul>	ERRORS
	The facility must ensu any significant medic	ure that residents are free of ation errors.		that residents are free medication errors.	of any significant
	by: Based on observatio			On June 15, 2015, Do were obtained from th placed on medication not be crushed per pha Pharmacy services we will be adding "Do No acting or enteric-co medications that shoul when the new cycle fill due to be refilled.	ne pharmacy and cards that should armacy guidelines. re consulted and t Crush" on long- nated forms of d not be crushed
	on 6/5/15, at 8:49 a.n aide (TMA)-A crushe Metoprolol XL (a med and blood pressure).	r medication administration n. and the trained medication d the extended release tablet lication to reduce heart rate TMA-A then checked the vas 60 beats per minute, dications to R31.		Mandatory nursing m was provided by Health Nurse Consultant on Ju included a topic of medications. Pharmacy staff was pe med pass audits on ran and/or TMAs. Pharmac	n Direct Pharmacy ne 23, 2015 which of Non-crushable erforming quarterly dom licensed staff

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PRINTED: 06/25/2015 FORM APPROVED

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					E SURVEY PLETED
		245566	B. WING			06	/05/2015
	ROVIDER OR SUPPLIER	REHAB	•	510	REET ADDRESS, CITY, STATE, ZIP CODE D EAST CEDAR STREET DUSTON, MN 55943	•	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPR( DEFICIENCY)	ILD BE	(X5) COMPLETIC DATE
F 333	Metoprolol XL (extra crushed. TMA-A furt always crushed the l giving it to R31. R31 was admitted to admission diagnoses hypertension (high b peripheral vascular of through the legs) per The Minimum Data S indicated R31 had se with inattention and of had minimal depress required extensive a transfers, and toilet of A review of a Physici 5/21/15, indicated R3 and the medication M decreased, and to re- pulse next week on r A review of the medii through 5/20/15, indi Metoprolol XL dose v milligrams (mg) ever per day. A recheck w later. On 5/28/15, the reduced even further directions for use for Crush. On 6/5/15, at 1:30 p. the consultant pharm On 6/5/15, at 1:38 th	<ul> <li>-long acting) should not be her stated that she had Metoprolol XL dose when</li> <li>a the facility 4/26/11, with s of chronic kidney disease, lood pressure), and disease (poor blood flow r the Admission Record.</li> <li>Set (MDS) dated 5/19/15, evere cognitive impairment, disorganized thinking. R31 sion and no behaviors. R31 ssistance with bed mobility, use.</li> <li>ian 's Progress note dated 31's blood pressure was low Metoprolol XL would be eview the blood pressure and rounds.</li> <li>cation order dated 3/26/15 cated on 5/21/15, the was reduced from 100 y day to Metoprolol XL dose was to 25 mg every day. The Metoprolol XL stated Do Not</li> <li>m. a message was left for</li> </ul>	F	333	TMAs. Pharmacist nurse cons then perform a monthly med par 3 and then quarterly. In-servicing will be provided on 2015 All residents have the potenti affected by this practice. Monitored by: Pharmacist c Director of Nursing or designee	ss audit x July 13, al to be	07/15/1

		MEDICAID SERVICES	[		OMB NO. 0938	
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	, 
		245566	B. WING		06/05/201	5
NAME OF P	ROVIDER OR SUPPLIER	•	ST	REET ADDRESS, CITY, STATE, ZIP CODE		
VALLEY	/IEW HEALTHCARE & RI	ЕНАВ		0 EAST CEDAR STREET DUSTON, MN 55943		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPL	ETIO
F 333	page	e 35 on and it should not be	F 333			
	the medication becau pressure and heart ra notified that the staff XL. The DON stated not being audited for because they had be would begin again. In the medication observe	an was reducing the dose of use of her decreased blood the. The physician would be was crushing the Metoprolol that currently TMA's were medication administration, en doing so well, but audits addition, the DON verified vations of LPN-A and TMA-B the five rights of medication				
F 428 SS=E	accordance with good practices a. Long-acting or forms should general alternative should be 483.60(c) DRUG REC	ed 2006, directed ministered as prescribed in I nursing principles and r enteric-coated dosage y not be crushed an sought. GIMEN REVIEW, REPORT	F 428	F428 483.60 (c) DRUG REGIME REVIEW, REPORT IRREGULAF		
	reviewed at least once pharmacist. The pharmacist must the attending physicia	each resident must be e a month by a licensed report any irregularities to n, and the director of ports must be acted upon.		Neview, REPORT IRREGULAR ON Valley View Healthcare & Re ensure the drug regimen of eacl must be reviewed at least once by a licensed pharmacist. The p must report any irregularities attending physician, and the d nursing, and these reports must upon.	ehab will n resident a month harmacist to the irector of	
	This REQUIREMENT	is not met as evidenced		The resident's drug regime is re the licensed staff, physici consultant pharmacist to as medications are not used in doses, for excessive duration adequate monitoring, without	an, and sure that excessive , without	

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FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING 245566 B WING 06/05/2015 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **510 EAST CEDAR STREET** VALLEY VIEW HEALTHCARE & REHAB HOUSTON, MN 55943 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID ID (X5) (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETION PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) DATE TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) indications, or in the presence of adverse F 428 Continued From page 36 F 428 Pharmacist consultant consequences. Based on interview and record review the facility reviews medication regime on all residents failed to ensure the consultant pharmacist monthly. The preliminary survey findings identified irregularities and reported them to the were provided to pharmacist consultant director of nursing and physician for 4 of 4 and Medical Director on June 17, 2015. Final survey findings were provided to residents (R14, R39, R40, R10) who took pharmacist consultant and Medical antipsychotic medication had adequate Director on June 29, 2015 upon arrival in monitoring. In addition, failed to ensure there was the mail. an appropriate indication for continued use of an antibiotic for 1 of 5 residents (R21). On June 6, 2015 audit performed to ensure that nursing orders were in place on all residents for orthostatic BPs for Findings include: residents on antipsychotic medications in the electronic record. The pharmacist R14 was observed on 6/3/15, at 7:56 a.m. R14 consultant did make a recommendation for was observed dressed, calmly sitting in discontinuation of resident's Cephalexin wheelchair at the dining room table independently prophylaxis/neurogenic bladder. for feeding herself. LEIbsernd, PA-C did discontinue the prophylactic antibiotic for R21. All resident's drug regime is reviewed The Care Area Assessment (CAA) dated 9/24/14 monthly by consulting pharmacist with for psychotropic medication use indicated R14 recommendations as indicated, and by was at risk for side effects including risk for falls. attending physician/nurse practitioner R14's diagnoses included dementia with every 60 days. delusional disorder and anxiety All residents on antipsychotics and prophylactic antibiotics have the potential The current Medication Administration Record to be affected by this practice. Audit (MAR) from 12/1/14 through 6/4/15, indicated residents completed on all on R14 received daily administration of antipsychotics to ensure a nursing order antidepressants, Celexa and Trazodone and was in the electronic record for monthly antipsychotic Zyprexa. orthostatic blood pressure monitoring was completed on June 8, 2015. Review of the Vitals Report from 12/3/14 through In-servicing will be provided on July 13, 6/1/15, indicated orthostatic blood pressure was 2015, educating licensed staff that taken only two of the six months, on 3/1/15 and residents' on antipsychotic medications 6/1/15. must have orthostatic BPs obtained monthly. The quarterly Minimum Data Set (MDS) dated Staff compliance with above process will 3/11/15, indicated R14 had moderate cognitive be monitored by the DON/designee and impairment. Consultant Pharmacist. 07/15/15 R14's care plan dated 3/17/15, indicated R14 was

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

Facility ID: 00286

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		E & MEDICAID SERVICES					<u> </u>
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					E SURVEY PLETED
		245566	B. WING_			06	/05/2015
NAME OF P	ROVIDER OR SUPPLIER			STI	REET ADDRESS, CITY, STATE, ZIP CODE		
VALLEY V	IEW HEALTHCARE 8	& REHAB			) EAST CEDAR STREET DUSTON, MN 55943		
(X4) ID PREFIX TAG	(EACH DEFICI	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETIC DATE
F 428	Continued From p	age 37	F 4	128			
		observe for potential side					
		ation effectiveness, monthly					
		by consulting pharmacist and vital signs per facility policy.					
	R14's current phys	sician report dated 5/4/15					
	through 6/4/15, ind	dicated orders for Zyprexa					
		milligrams (mg) once a day					
		to check orthostatic BP [blood day on the 1st of the month.					
	Monthly Medicatio	n Regimen Review revealed					
	the consultant pha	irmacist reviewed R14's					
		21/15 and another consultant					
	5/15/15, but did no monitoring which i	0/15, 3/16/15, 4/17/15, and ot indicate the lack of adequate ncluded orthostatic blood ntipsychotic medication.					
	pressure for the al	hipsycholic medication.					
		w on 6/4/15, at 10:30 a.m. the					
		(DON) verified the orthostatic ould have been completed and					
	was not.	und have been completed and					
	R39's was observe	ed on 6/3/15, at 7:59 a.m. R39					
		ssed, sitting upright in a Broda					
		r) wheelchair in the dining dependently feeding himself.					
		o meet you, I have more food					
		I 12/11/14, for psychotropic					
		licated R39 required daily ntidepressant (Paxil) and					
		oquel), and was at risk for side					
	The Quarterly MDS						

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### DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTER	S FOR MEDICARE &	MEDICAID SERVICES					<u>). 0938-0391</u>
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		CONSTRUCTION		E SURVEY PLETED
		245566	B. WING			06	/05/2015
	ROVIDER OR SUPPLIER	ЕНАВ		51	TREET ADDRESS, CITY, STATE, ZIP CODE 10 EAST CEDAR STREET OUSTON, MN 55943		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 428	Continued From page had severe cognitive		F	428			
	to observe for potenti medication effectiven	ess, monthly medication bharmacist and to routinely					
	obtained from the Phy 5/4/15 through 6/4/15 Report indicated orde (antipsychotic) 50 mg (decreased from three 5/20/15) and directed	es of agitation and delusions and hallucinations ysician Order Report dated . R39's current Physician rs for Seroquel					
	indicated R39 receive	n 12/1/14 through 6/4/15 ed the medication TID from 15, and BID from 5/20/15					
		Report from 12/2/14 through nostatic blood pressure was months, on 3/15/15.					
	the consultant pharma medications on 1/21/1 pharmacist on 2/20/1 5/15/15, but did not in monitoring for the ant	4 and another consultant 5, 3/16/15, 4/17/15, and dicate lack of adequate ipsychotic medication.					
	DON verified the ortho should have been cor	npleted and were not,	1				
URIVI UNIS-256	7(02-99) Previous Versions Obs	olete Event ID: NI7Q		гас	ility ID: 00286 If conti	iuation shee	t Page 39 of 58

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERV/ICES

PRINTED: 06/25/2015 FORM APPROVED OMB NO. 0938-0391

Sixtenew or percentages AND PLANE OF PROFILE ADDITION         (N) percentages and the of produces of supplies in the intermediation Multicles addition         (N) percentages addition         (N) percentages addition <t< th=""><th>CENTER</th><th>S FOR MEDICARE &amp;</th><th>MEDICAID SERVICES</th><th></th><th></th><th></th><th></th><th>0.0930-0391</th></t<>	CENTER	S FOR MEDICARE &	MEDICAID SERVICES					0.0930-0391
NAME OF PROMODER OR SUPPLIER     STREET ADDRESS, CITY, STATE, 2P COOLE STREET ADDRESS, STREET PROMODER OR STREET TAG F428 F42	STATEMENT (	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA					
NULLEY VIEW HEALTHCARE & REHAB       SUBARY STATEMENT OF DEFICIENCIES         OPAID PROFERSION OF DEFICIENCIES         PREFIX       SUBARY STATEMENT OF DEFICIENCIES       Dimension       Dimension       Colspan="2">Converting Subary Statement of Deficiences         PAID       SUBARY STATEMENT OF DEFICIENCIES       Dimension       Dimension       Converting Subary Statement of Deficiences       Converting Statement of Deficiences         F 428       Continued From page 39 stating '' would have expected sitting and lying block pressures for this resident who does not stand.''       F 428       F 428       F 410 Was admitted to the facility on 11/18/11, with admitsion diagnoses of cerebrovascular accident (C/A) with left sited weakness and hypertension, and bjolar disease.       F 428			245566	B. WING			06/	05/2015
HOUSTON, MN 55843       PALETY VIEW HEALTHCARE & REMAB     HOUSTON, MN 55843       PARETK TAG     SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY WIST ET REACEDED BY FULL REGULTIONY OR LSCIENTIFYING INFORMATION)     D PRETK TAG     PROMIDER'S PLAN OF CORRECTION CROSS-REFERENCIENC AND CORRECTION SHOULD BE CROSS-REFERENCIENC AND CORRECTION SHOULD BE CROSS-REFERENCIENC AND CORRECTION SHOULD BE CROSS-REFERENCIENC AND CORRECTION SHOULD BE CROSS-REFERENCIENCE TO THE APPROPRIATE     Officit Continued CROSS-REFERENCIENC AND CORRECTION SHOULD BE CROSS-REFERENCIENCE TO THE APPROPRIATE     Officit Continued CROSS-REFERENCIENCE AND CROSS-REFERENCIENCE AND CROSS-REFERENCIENCE AND CROSS-REFERENCIENCE AND CROSS-REFERENCE AND CROSS-REFERENCIENCE AND CROSS-REFERENCE AND CROSS-REFERENCE STATUS AND CROSS-REFERENCE AND CROSS-REFERENCE AND CROSS-REFERENCE AND CROSS-REFEREN	NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
PHODE TOR, MM 5943         PROVIDERS PLAN OF CORRECTION (EACH CORRECTION REGULATORY OR LSC IDENTIFYING INFORMATION)         Description (EACH CORRECTIVE ACTION SHOULD BE (EACH CORRECTIVE ACTION SHOULD BE (EACH CORRECTIVE ACTION SHOULD BE CROSS REFERENCED TO THE APPROPRIATE DEFICIENCY)         099 (EACH CORRECTIVE ACTION SHOULD BE (EACH CORRECTIVE ACTION SHOULD BE (EACH CORRECTIVE ACTION SHOULD BE DEFICIENCY)         099 (EACH CORRECTIVE ACTION SHOULD BE (EACH CORRECTION TO SHOULD BE DEFICIENCY)         099 (EACH CORRECTION (EACH CORRECTION TO SHOULD BE DEFICIENCY)         099 (EACH CORRECTION (EACH CORRECTION SHOULD BE DEFICIENCY)         099 (EACH CORRECTION (EACH CORRECTION SHOULD BE DEFICIENCY)         099 (EACH CORRECTION (EACH CORRECTION (EACH CORRECTION (EACH CORRECTION (EACH CORRECTION)         090 (EACH CORRECTION (EACH CORRECTION (EACH CORRECTION)         090 (EACH CORRECTION)         090 (E					5	10 EAST CEDAR STREET		
Preprint TAG         CREAT CORPORTING X SUBJECT OF PRECIDED BY FULL REGULTORY OR LSC IDENTIFYING INFORMATION)         PRETRX TAG         CREAT CORPORTING ATTOR SHOULD BE CROSS-REFERENCE TO THE APPROPRIATE         COMMENTION DEFICIENCY           F 428         Continued From page 39 stating "I would have expected sitting and lying blod pressures for this resident who does not stand."         F 428           R10 was admitted to the facility on 11/16/11, with admission diagnoses of carebrovascular accident (CVA) with left sided weakness and hypertension, and bipolar disease.         F 428           The quarterly Minimum Data Set (MDS) dated 3/19/15, indicated R10 was cognitively intact, required extensive assist of 2 with bed mobility, transfers, tollet use, and required the use of a stand assist lift.         The care plan dated 3/24/15, indicated: R10 was at risk for falls, EZ stand for transfers, or Hoyer IIIt with assist of two for transfers with increased weakness. Deficits in transfers, bed mobility, and locomotion due to left sided weakness.           The Physician Orders dated 5/5/15, included Depakote extended release for bipolar disorder, Zyprexa for bipolar disorder R10's Orthostatic BP's were recorded for Sept 2014, October 2014, March 2015, April 2015, May 2015, The physician orders were followed 5 of 11 months.         F 100 Natated that R10 should have had the ordered orthostatic blood pressure checks to ensure adequate side effect         F 2014	VALLEYV	IEW HEALTHCARE & RE			Н	IOUSTON, MN 55943		
stating "I would have expected sitting and lying blood pressures for this resident who does not stand."         R10 was admitted to the facility on 11/16/11, with admission diagnoses of cerebrovascular accident (CVA) with left sided weakness and hypertension, and bipolar disease.         The quarterly Minimum Data Set (MDS) dated 3/19/15, indicated R10 was cognitive assist of 2 with bed mobility, transfers, toilet use, and required the use of a stand assist lift.         The care plan dated 3/24/15, indicated: R10 was at sits for fails, EZ stand for transfers, or Hoyer lift with assist of two for transfers, bed mobility, and locomotion due to left sided weakness.         The Physician Orders dated 5/5/15, included Depakote extended release for bipolar disorder, Zyprexa for bipolar disorder         R10's Orthostatic BP's were recorded for Sept 2014, October 2014, March 2015, April 2015, May 2015, The physician orders were followed 5 of 11 months.         On 6/5/15, at 1:38 p.m. the DON stated that R10 should have had the ordered orthostatic blood pressure checks to ensure adequate side effect	PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREF		(EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI		COMPLETION
admission diagnoses of cerebrovascular accident (CVA) with left sided weakness and hypertension, and bipolar disease.         The quarterly Minimum Data Set (MDS) dated 3/19/15, indicated R10 was cognitively intact, required extensive assist of 2 with bed mobility, transfers, toilet use, and required the use of a stand assist lift.         The care plan dated 3/24/15, indicated: R10 was at risk for falls, EZ stand for transfers, or Hoyer lift with assist of two for transfers, bed mobility, and locomotion due to left sided weakness.         The Physician Orders dated 5/5/15, included Depakote extended release for bipolar disorder, Zyprexa for bipolar disorder         R10's Orthostatic BP's were recorded for Sept 2014, October 2014, March 2015, April 2015, May 2015, The physician orders were followed 5 of 11 months.         On 6/5/15, at 1:38 p.m. the DON stated that R10 should have had the ordered orthostatic blood pressure checks to ensure adequate side effect	F 428	stating "I would have blood pressures for th stand."	expected sitting and lying his resident who does not	F	428			
of 11 months. On 6/5/15, at 1:38 p.m. the DON stated that R10 should have had the ordered orthostatic blood pressure checks to ensure adequate side effect		admission diagnoses (CVA) with left sided y and bipolar disease. The quarterly Minimu 3/19/15, indicated R1 required extensive as transfers, toilet use, a stand assist lift. The care plan dated 3 at risk for falls, EZ sta with assist of two for f weakness. Deficits in locomotion due to left The Physician Orders Depakote extended re Zyprexa for bipolar di R10's Orthostatic BP	of cerebrovascular accident weakness and hypertension, m Data Set (MDS) dated 0 was cognitively intact, sist of 2 with bed mobility, and required the use of a 3/24/15, indicated: R10 was and for transfers, or Hoyer lift transfers with increased transfers, bed mobility, and t sided weakness. s dated 5/5/15, included elease for bipolar disorder, sorder					
CORM CMS 3557(02.00) Dravious Versions Obsoleto Event ID: NIZO11 Eacility ID: 00286 If continuation sheet Page 40 of 58		of 11 months. On 6/5/15, at 1:38 p.r should have had the pressure checks to en	n. the DON stated that R10 ordered orthostatic blood nsure adequate side effect completed.					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			ONSTRUCTION	(X3) DAT	I <u>O. 0938-0391</u> TE SURVEY IPLETED
		A. BUILD				
NAME OF PROVIDER OR SUPPLIER	245566	B. WING		REET ADDRESS, CITY, STATE, ZIP CODE	06	6/05/2015
VALLEY VIEW HEALTHCARE &	REHAB		510	EAST CEDAR STREET USTON, MN 55943		
PREFIX (EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRC DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 428 Continued From pa	ge 40	F	428			
admission diagnose anxiety state, deme Physician review of - 7/31/14, Lorazepa lorazepam 0.5 mg. - 10/30/14, Seroque mg at HS discontinu - 11/3/14, Seroquel HS discontinued 11. - 11/13/14, Seroque at HS. The annual CAA da memory, mood and aware of needs or s elopement. Depend The care plan, dated history of tossing ar goal was to sleep for night. Observe for s Zoloft was given for	Give 25 mg TID and 75 mg at /13/14. I Give 25 mg TID and 100 mg ted 1/6/15, indicated R40 had behaviors issues, was not afety, was at risk for falls and ent on staff to meet needs. d 1/6/15, indicated R40 had a id turning every night and the our consecutive hours every ide effects and effectiveness. depression, and the staff was					
document targeted given for anxiety/ag for effectiveness an monitor mood in res	s/record effectiveness, and behaviors. Lorazepam was itation. Staff was to monitor d adverse consequences, ponse to lorazepam. The vas to review monthly and					
cognitive impairment behaviors of wander	-		Ec-34	y ID: 00286 If cor	A1	et Page 41 of 58

If continuation sheet Page 41 of 58

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

PRINTED: 06/25/2015 FORM APPROVED

STATEMENT C	F DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	FIPLE CO	DNSTRUCTION	(X3) DA	TE SURVEY
	CORRECTION	IDENTIFICATION NUMBER:					MPLETED
		245566	B. WING			0	6/05/2015
	ROVIDER OR SUPPLIER	EHAB		510	EET ADDRESS, CITY, STATE, ZIP CODE EAST CEDAR STREET		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	JSTON, MN 55943 PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	IOULD BE	(X5) COMPLETIO DATE
F 428	on Seroquel, and DO record lacked evidend monitoring which wou blood pressures. The Valley View Nurs Procedures for Psych June 20, 2006 indicat	n. the DON stated R40 was N was aware the medical ce of adequate side effect Id have included orthostatic ing Home Policy and otropic Medication updated ed the registered nurse will	F	428			
	and "will developmen Psychotropic Medicat mediation [medicatior adjustment recommendirection for vital sign	or the consulting pharmacist					
	Medication Regimen dated 2006 indicated performs a comprehe review at least month Regimen Review] incl resident's response to determine that the res practicable level of fun	ant Pharmacist Reports Review (monthly report) "the consultant pharmacist nsive medication regimen ly. The MRR [Medication ludes evaluating the o medication therapy to sident maintains the highest nctioning and prevents or nsequences related to					
	moderate cognitive in	dated 5/6/15, indicated pairment. R21 also had nic bladder, and diabetes					
	The CAA summary re	port urinary incontinence					

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Facility ID: 00286

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CENTER	S FOR MEDICARE &	MEDICAID SERVICES			OMB NO	1 APPROV 0. 0938-03
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		ECONSTRUCTION	(X3) DATE COMP	
		245566	B. WING	1	06/	05/2015
NAME OF P	ROVIDER OR SUPPLIER	•	S	TREET ADDRESS, CITY, STATE, ZIP CODE		
	/IEW HEALTHCARE & RI	ΞHΔB	5	10 EAST CEDAR STREET		
			F	IOUSTON, MN 55943		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETIC DATE
F 428	Continued From page	× 40	E 400			
1 420	· · · · · · · · · · · · · · · · ·		F 428			
	8/21/14, indicated "is	er analysis of findings dated at risk for skin irritation and tinence of urine, will review				
	I he Bowel & bladder dated 2/4/15 through	screening (3-day void)				
		nent of bowel and bladder,				
		ducts which staff change."				
	The	<b>3</b> / -				
		ening (3-day void) dated				
		5, included additional				
	comments: "frequentl bowel, wears brief, to	y incontinent of bladder and tal assist of 1."				
		dated 5/5/15 through				
		x capsule 250 mg orally				
	-	8/1//14, diagnosis: infection, Ciprofloxacin HCI 500 mg				
		for 10 days start date 5/27				
		Bladder scan as needed				
ſ	(PRN) start dated 6/1	9/13, for bladder discomfort		•		
	or distension with stra	•				
	retention of 200 cc or	greater.				
	Care plan dated 5/13/	15, indicated "history of				
		[UTIs], neurogenic bladder.				
		it signs of urinary tract				
		ches were to administer				
		n antibiotic) per physician				
	(MD) order as prophy					
	evaluate, record, and					
	effectiveness/adverse	ize prn for discomfort or				
		onitor labs per MD order.				
		icute confusion, urgency,				
		asms, nocturia, burning,				
		g, low back/flank pain,				
	malaise, nausea/vomi					

PRINTED: 06/25/2015 FORM APPROVED OMB NO. 093<u>8-0391</u>

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

CENTER	<u>S FOR MEDICARE &amp;</u>	MEDICAID SERVICES					<u> </u>
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION		E SURVEY PLETED
		245566	B. WING			06	/05/2015
NAME OF PF	ROVIDER OR SUPPLIER			s	TREET ADDRESS, CITY, STATE, ZIP CODE		
				5	10 EAST CEDAR STREET		
VALLEY VI	IEW HEALTHCARE & R	EHAB		н	IOUSTON, MN 55943		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 428	Continued From page	e 43	F	428			
		lood in urine) to MD as		0			
	indicated.	iood in drife) to MD as					
	indicated.						
	Consultant pharmaci	st medication regimen					
		ted July 2014 through					
		reviewed. The regimen					
	lacked evidence that	-					
	addressed the antibio	-					
		m. registered nurse (RN)-A					
	was interviewed about						
		ed if R21 currently had a UTI,					
		ood sugars had been very					
	-	e hospital, and now they					
		RN-A stated ciprofloxacin					
		for ten days for a urinary					
		red up and blood sugars					
	R21 was still getting	hey should be. She stated					
	R21 was suit getting	Kellex.					
	On 6/5/15, at 1:06 p.r	n. DON stated MD-A					
	indicated resident do	es not have yeasty rash in					
	peri-area. The DON s	stated prior to resident					
		d a history of UTI and had					
		quently due to it. While R21					
	•	as tapered down, urinary					
	retention stopped, an						
	catheterized while the	-					
		otic, it was started long ago					
		where the documentation					
		e been prior to R21 coming					
		id trial off the antibiotic for s restarted due to UTI and					
		OON further commented R21					
		and could bottom down					
		ars were better controlled					
		into the facility. They had to					
		ts and have not had to					
		ince she had been there.					
	7(02-99) Previous Versions Obs				lility ID: 00286 If co		t Page 44 of

Event ID: NI7Q11

		ND HUMAN SERVICES		·	PRINTED: 06/25/20 FORM APPROVE OMB NO. 0938-039
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED
		245566	B. WING		06/05/2015
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	00/00/2010
VALLEY V	IEW HEALTHCARE & RE	EHAB		510 EAST CEDAR STREET HOUSTON, MN 55943	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE COMPLETIO
F 431 SS=D	when she had elevate on an antibiotic. Her b the UTI was gone. - At 1:17 p.m. DON sta pharmacist consultant consultant had no reco doctor, the resident wo chart. The insert package lat ReadyMeds last revise reduce the developme bacteria and maintain cephalexin and other a cephalexin should be u infections that are prov to be caused by bacter A message was left for on 6/5/15, at 1:36 p.m. 483.60(b), (d), (e) DRL LABEL/STORE DRUG	can first before d a recent UTI on 5/27/15, d blood sugar and was put lood sugar was better and ated they had a new . If the pharmacist commendations for the build have no printout for her build have no printout for her bel for cephalexin by ed on 5/14, read, "To int of drug-resistant the effectiveness of antibacterial drugs, used only to treat or prevent ven or strongly suspected ria." The consulting pharmacist with no return call. JG RECORDS, S & BIOLOGICALS by or obtain the services of who establishes a system	F 43	F 431 483. (b), (d), (e) DRUG RE	b obtains acist who of receipt drugs in
1 1 1 1	records are in order an controlled drugs is mair reconciled. Drugs and biologicals u			reconciliation; and determines records are in order and that an of all controlled drugs is mainta periodically reconciled. Valley View Healthcare & Rehat that accurate labeling of medic facilitate consideration of precau safe administration. Drugs and b used in Valley View are la accordance with currently	n account ained and o ensures ations to tions and iologicals

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Facility ID: 00286

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DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES COMPLETED **IDENTIFICATION NUMBER:** AND PLAN OF CORRECTION A. BUILDING 245566 B. WING 06/05/2015 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER **510 EAST CEDAR STREET** VALLEY VIEW HEALTHCARE & REHAB HOUSTON, MN 55943 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION SUMMARY STATEMENT OF DEFICIENCIES ID (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) professional principles, and include the F 431 F 431 Continued From page 45 appropriate accessory and cautionary instructions, and the expiration date when instructions, and the expiration date when applicable. applicable. Mandatory nursing medication training was provided by Health Direct Pharmacy In accordance with State and Federal laws, the Nurse Consultant on June 23, 2015 which facility must store all drugs and biologicals in included a topic of insulin: types, dosing locked compartments under proper temperature schedules, and tips for injecting. controls, and permit only authorized personnel to have access to the keys. A weekly check to be performed by staff was placed electronically in the residents' electronic records that receive insulin as The facility must provide separately locked, an additional step to check expiration permanently affixed compartments for storage of dates. Pharmacist nurse consultant will controlled drugs listed in Schedule II of the perform monthly med cart audits. Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to In-servicing will be provided on July 13, abuse, except when the facility uses single unit 2015, educating licensed staff on checking insulin's expiration date prior to drawing package drug distribution systems in which the up and administering. quantity stored is minimal and a missing dose can be readily detected. All residents on insulin have the potential to be affected by this practice. Monitored by: Pharmacist consultant, This REQUIREMENT is not met as evidenced Director of Nursing or designee hv: 07/15/15 Based on observation, interview and document review, the facility failed to ensure expired medication was disposed of for 1 of 6 residents (R30) reviewed for medication. This resulted in 1 of 6 residents (R30) receiving expired medication. Findings include: On 6/4/15, at 10:24 a.m. the West medication cart was observed for medication storage. A vial of Humalog insulin for R30 was noted to be opened on 4/24/15, which would have expired May 21st. The Humalog vial continued to be used for a noon dose of Humalog insulin for R30 14 days after it had expired.

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Event ID: NI7Q11

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

	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTR		(X3) DATE SURVE COMPLETED	
		245566	B. WING_			06/0	5/2015
NAME OF P	ROVIDER OR SUPPLIER	· ·		STREET AD	DRESS, CITY, STATE, ZIP CODE		
				510 EAST	CEDAR STREET		
VALLEY	IEW HEALTHCARE & R			HOUSTO	N, MN 55943		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETIC DATE
F 431	Continued From pag	e 46	F4	31			
1 401	pg			.51			
		ng (DON) verified that the					
		expired on 5/21/15, and the					
	vial should have bee						
	The Medication Stor	age in the Facility policy					
		doutdated, contaminated,					
		cationsare immediately					
		n storage conditions are					
		thly basis and corrective					
	action taken if proble						
F 441		CONTROL, PREVENT	F4	41			
SS=D	SPREAD, LINENS	• •			441 483.65 INFECTION CONTRO REVENT SPREAD, LINENS	DL,	
	The facility must esta	ablish and maintain an		Va	alley View Healthcare & Reh	ah has	
		gram designed to provide a			stablished and maintains an in		
		mfortable environment and		co	ontrol program designed to pro		
	to help prevent the d	evelopment and transmission			·····	fortable	
	of disease and infect	tion.		de	nvironment and to help preve evelopment and transmission of		
	(a) Infection Control	Program		ar	nd infection.		
		ablish an Infection Control		Va	alley View Healthcare & Rehab r	eauires	
	Program under whic				aff to wash their hands after eac		
		trols, and prevents infections			sident contact for which hand wa		
	in the facility;				dicated by accepted profe	essional	
		cedures, such as isolation,		pr	actice.		
		an individual resident; and		AI	I staff have been re-educated thr	ough in	
		d of incidents and corrective			rvicing on infection control,		
	actions related to info			wa	ashing, and proper glove use	and is	
					ovided upon hire and annually.		
	(b) Preventing Sprea	d of Infection			-service will be provided on J )15.	uiy 13,	
	(1) When the Infection	-		20			
		sident needs isolation to		W	eekly audits will be conducted	for four	
	•	f infection, the facility must		we	eeks to ensure that proper glovin	g; hand	
	isolate the resident.				ashing is being performed		
		prohibit employees with a			erforming peri-care. If problem oted additional audits and staff		
		se or infected skin lesions			Il be completed.	aaning	
		vith residents or their food, if					
	direct contact will tra	nsmit the disease.					

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

PRINTED: 06/25/2015 FORM APPROVED

STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	IPLE C	ONSTRUCTION	OMB NO. 0938-03 (X3) DATE SURVEY	
	F CORRECTION	IDENTIFICATION NUMBER:				- r /	PLETED
		245566	B. WING_			06	/05/2015
NAME OF F	PROVIDER OR SUPPLIER			STR	EET ADDRESS, CITY, STATE, ZIP CODE		
VALLEY	VIEW HEALTHCARE & R	EHAB			EAST CEDAR STREET USTON, MN 55943		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETIC DATE
F 441	<ul> <li>(3) The facility must r hands after each dire hand washing is indic professional practice</li> <li>(c) Linens Personnel must hand transport linens so as infection.</li> <li>This REQUIREMENT by: Based on observatio review, the facility fail hand hygiene and glo residents care for 1 o addition, the facility fail hand hygiene and glo residents care for 1 o addition, the facility fail procedures to preven blood borne infection monitoring performed R5) who had blood so the use of a glucose in Findings include:</li> <li>Gloving: On 6/3/15, R10 was of nursing assistant (NA as required.</li> <li>On 6/3/15, at 7:47 a.r. R10 NA-A verified that removed her gloves to NA-A then lifted R10 wheelchair, then dom provided the dentures</li> </ul>	require staff to wash their act resident contact for which cated by accepted dle, store, process and s to prevent the spread of Γ is not met as evidenced on, interview and document led to ensure appropriate bying was completed during of 1 resident (R10). In ailed to implement to the possible spread of s during blood glucose d for 2 of 6 residents (R10, ugars readings taken with	F	441	Mandatory nursing medication was provided by Health Direct PH Nurse Consultant on June 23, 201 included a topic of insulin: types, schedules, and tips for injecting; administration and blood glucose and procedure. The policy and pr to insulin administration and blood policy and procedure was review updated. A weekly check to be performed was placed electronically in the re- electronic records that receive in an additional step to check et dates. Pharmacist nurse consul perform monthly med cart audits. In-servicing will be provided on 2015, educating licensed staff on of insulin's expiration date prior to up and administering. All residents on insulin have the to be affected by this practice. Monitored by: Pharmacist co Director of Nursing or designee Director of nursing/designee will for compliance.	armacy 5 which dosing insulin e policy ocedure glucose red and by staff sidents' sulin as cpiration tant will July 13, checking drawing potential nsultant,	07/15/1

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	OF DEFICIENCIES	MEDICAID SERVICES	(X2) MUL	TIPLE CON	ISTRUCTION	(X3) DA	TE SURVEY
	CORRECTION	IDENTIFICATION NUMBER:					MPLETED
		245566	B. WING				6/05/2015
NAME OF P	ROVIDER OR SUPPLIER			STREE	ET ADDRESS, CITY, STATE, ZIP CODE		
VALLEY V	IEW HEALTHCARE & R	EHAB			AST CEDAR STREET		
	r			HOUS	STON, MN 55943		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE
F 441	Continued From page	e 48	F.	441			
		ve to find out. NA-A had					
	been doing the job fo						
	The quarterly Minimu	ım Data Set (MDS) dated					
	-	I0 was cognitively intact,					
		ssist of two with bed mobility,					
	transfers, toilet use, a stand assist lift.	and required the use of a					
	รเลทน สรรเรีย แแ						
	The corresponding ca	are plan dated 3/24/15,					
		risk for falls, EZ stand for					
		t with assist of two for					
		ed weakness. Deficits in					
		y, and locomotion were due					
		s. The care plan dated					
	staff for all personal of	0 was dependent on the					
	On 6/5/15, at 1:38 p.r	n. the director of nursing					
	(DON) verified she ex						
	appropriate hand hyg	jiene.					
	The Hand Washing P	olicy and Procedure dated					
	2006, indicated hand						
	requiredafter remo	-					
	Blood glucose meter:						
		practical nurse (LPN)-A did					
		anner while using the blood					
		id not use the safety syringe anufacturer, and did not					
	-	to prevent needle exposure					
		ige was discarded in the					
	sharps container.	-					
	On 6/1/15, at 4:06 p.r	n. BG procedure was					
		BG meter was placed on					
		in R10's room, and then					
		d sample. The contaminated					
		aced directly on top of the					
	medication cart. LPN-	-A then removed gloves and					

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Event ID: NI7Q11

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ATEMENT (	OF DEFICIENCIES	MEDICAID SERVICES	(X2) MULT	FIPLE CO	NSTRUCTION	(X3) DA	NO. 0938-03 TE SURVEY	
U PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDI	NG	······································		MPLETED	
		245566	B. WING_			0	06/05/2015	
AME OF PI	ROVIDER OR SUPPLIER				ET ADDRESS, CITY, STATE, ZIP COD	E		
ALLEY V	IEW HEALTHCARE & RE	ЕНАВ			AST CEDAR STREET STON, MN 55943			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETIO DATE	
F 441	Continued From page	2 4 9	E	441	14 14 14 14 14 14 14 14 14 14 14 14 14 1			
1 771		the soiled lancet (exposed to		+41				
		container. The DON walked						
		hing quietly to LPN-A, who						
		om drawer of the medication						
		BG meter with a super ot wipe down the already						
	• •	tion cart. At 4:06 p.m.						
		ual practice was to set the						
		of the medication cart						
	•	n. LPN-A stated she had he BG meter with alcohol,						
		past and told her to use the						
	super sani-wipes.						4	
	-	obtained an insulin dose for						
		ved to uncap the insulin e insulin vial after uncapping						
		exposing herself to a needle				·		
		essed the insulin vial with						
		d drew up 1 unit in the safety						
	syringe, then recappe							
		needle stick). Provided the n pulled the sheath up on the						
		er the needle. However, she						
		syringe by turning the						
		posed the unlocked syringe						
		er (again exposing her or or needle stick). LPN-A						
	•	se the safety syringe sheath						
	until she was done wi	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,						
		ctor of nursing (DON)						
		uld never be recapped, and						
		ringe to verify that the barrel be turned to lock it prior to						
	disposal in the sharps							
	•	urer's instructions should be						
	The Infection Control	Policy and Procedures						
	The Infection Control	FOUCY and Procedures	1				1	

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Facility ID: 00286

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		ID HUMAN SERVICES MEDICAID SERVICES				. FOR	D: 06/25/2018 M APPROVED D. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION		E SURVEY PLETED
		245566	B. WING			06	/05/2015
NAME OF P	ROVIDER OR SUPPLIER	L <sub></sub>			STREET ADDRESS, CITY, STATE, ZIP CODE		
VALLEY V	IEW HEALTHCARE & RE	EHAB		1	510 EAST CEDAR STREET		
				Ľ	HOUSTON, MN 55943		T
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 441	contact for which han accepted professiona	fter each direct resident d washing is indicated by l practice maintaining a	ŕ	441	1		
F 465 SS=E	counter, tableskeep clean, safe, and sar of disease. 483.70(h) SAFE/FUNCTIONAL/	ment by maintaining clean bing resident's equipment hitaryprevent transmission SANITARY/COMFORTABL	F	465	<sup>5</sup> F465 483.70 (h) SAFE/FUNCTIONAL/SANITARY/C RTABLE ENVIRON	OMFO	2.
	E ENVIRON The facility must provi sanitary, and comforta residents, staff and the	able environment for			Valley View Healthcare & Rehab p a safe, functional, sanitary, comfortable environment for res staff, and the public.	and idents,	
	by: Based on observatior review, the facility faile	is not met as evidenced n, interview and document ed to ensure the floors in ommon hallways were in			Additional quotes were received by Carpet from Rochester, MN on 2015. The details and scope of the project will be finalized by Jul Nursing has assessed resider determine whether they are at falling as a result of the current and has determined the flooring do pose additional risk to residents.	July 3, repair / 15 <sup>th</sup> . hts to risk of looring bes not lursing	
	that the tile floor was u dimples, circular depre	f the facility, it was noted ineven, had peaks, ridges, essions and buckles in 4, and in the West and			and Environmental Services will co to monitor the floor, evaluate w resident safety is at risk and tal necessary steps to minimize id risks. Monitored by: Environmental Direct Director of Nursing	whether any entified	
	On 6/5/15, at 2:40 p.m	i. an environmental tour e maintenance manager					07/15/15
		ed because of an i toilet backups, residents moved to fix the plumbing					
ORM CMS-2567		moved to fix the plumbing	11	Fa	acility ID: 00286 If continua	ition sheet	Page 51 of t

TATEMENT	DF DEFICIENCIES CORRECTION	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTII A. BUILDIN	PLE CONSTRUCTION		E SURVEY PLETED
		245566	B. WING		06	/05/2015
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
VALLEY	IEW HEALTHCARE &	REHAB		510 EAST CEDAR STREET HOUSTON, MN 55943		
(X4) ID PREFJX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR	HOULD BE	(X5) COMPLETIO DATE
F 465	"We had to do an in plumbing had to be professional floor gu months. The admini and 14 were schedu	oors. The administrator stated -house job on the tile after the repaired, because the uys are booked out four to six strator further stated rooms 3 uled to be repaired during the [11] would not be fixed	F 46	55		
	by the professional 5/25/15, included th corridor, West corrid and 14. Other bids f 4/23/15, all after the completed. The Adm of the rooms were in	as asked to provide the bids floor guys. The bid dated e South corridor, East lor, Center area, and rooms 3 for tile were dated 4/7/15, and unplanned project was hinistrator verified that not all the bid to be repaired. 11 were not included to be				
F 514 SS=F <sup>-</sup>	(PT) stated that non because of the unev knew. 483.75(I)(1) RES	m. the physical therapist e of the residents had fallen en flooring, as far as she ETE/ACCURATE/ACCESSIB	7 F 51	COMPLETE/ACCURATE/A	CCESSIBLE	
	The facility must ma resident in accordan standards and practi accurately documen systematically organ The clinical record m information to identif	nust contain sufficient y the resident; a record of the nts; the plan of care and		Valley View Healthcare maintains clinical records on in accordance with accepte standards and practices that accurately documented accessible; and systematica The clinical record must co information to identify the record of the resident's ass plan of care and services results of any preadmiss	each resident d professional are complete; d; readily lly organized. ntain sufficient e resident; a essments; the provided; the	

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(EACH DEFICIENC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245566 EHAB ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	A. BUILD	NG STR <b>510</b>	EET ADDRESS, CITY, STATE, ZIP CODE EAST CEDAR STREET USTON, MN 55943		SURVEY LETED 05/2015
IEW HEALTHCARE & RE SUMMARY ST, (EACH DEFICIENC' REGULATORY OR I	THAB ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFI	STR 510	EAST CEDAR STREET	06/	05/2015
IEW HEALTHCARE & RE SUMMARY ST, (EACH DEFICIENC' REGULATORY OR I	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	PREFI	510	EAST CEDAR STREET		
SUMMARY ST, (EACH DEFICIENC' REGULATORY OR I	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	PREFI				
(EACH DEFICIENC REGULATORY OR L	Y MUST BE PRECEDED BY FULL	PREFI				
Continued From page		TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)		(X5) COMPLETION DATE
preadmission screeni and progress notes. This REQUIREMENT by: Based on interview a failed to maintain acci complete for 4 of 5 re: R21) and 2 of 2 disch reviewed for monthly Findings include: Current Residents: R14's diagnoses inclu delusional disorder, an hypertension obtained Admission Record prin R14 was admitted 10/ Medication Regimen F consultant pharmacist record was dated 1/21 consultant pharmacist Review recorded by th 2015, March 2015, Ap R14's chart.	ng conducted by the State; is not met as evidenced nd record review, the facility urate medical records were sidents (R14, R39, R40, arged residents (R17, R57) pharmacist reviews. ded dementia with nxiety, osteoarthrosis and from the Resident nted 6/4/15. 3/13. Review of the Review, indicated the last review in the medical I/15. There was no 's Medication Regimen he pharmacist for February wil 2015 and May 2015 in ant Pharmacist's	F	514	Director on June 29, 2015 upon arrive the mail. All resident's drug regime is revie monthly by consulting pharmacist recommendations as indicated, and attending physician/nurse practitie every 60 days. Pharmacist consultant was in house June 17, 2015 for the monthly review of residents. Pharmacist consultant sig off on each individual resident's record the Medication Regimen Review log each individual resident chart. All residents have the potential to affected by this practice.	d by and that ssive hout uate erse litant lents lings litant 015. d to dical al in swed with l by oner e on of all gned d on g in be	
the nursing office date and 5/18/15, indicated inclusive for all facility pertinent recommenda months, 2/22/15 and 4	d 2/22/15, 3/17/15, 4/19/15, each monthly review was residents along with any ations. Two of the four l/19/15, noted irregularities			Director of Nursing or designee	c	)7/15/2015
NoroF2F FNtlairpn	Medication Regimen F consultant pharmacist consultant pharmacist Review recorded by th 2015, March 2015, Ap R14's chart. Review of the Consult Medication Regimen F the nursing office date and 5/18/15, indicated inclusive for all facility ertinent recommendation norths, 2/22/15 and 4 nd/or recommendation	R14 was admitted 10/3/13. Review of the Medication Regimen Review, indicated the last consultant pharmacist review in the medical ecord was dated 1/21/15. There was no consultant pharmacist's Medication Regimen Review recorded by the pharmacist for February 2015, March 2015, April 2015 and May 2015 in R14's chart. Review of the Consultant Pharmacist's Medication Regimen Review kept in a binder in the nursing office dated 2/22/15, 3/17/15, 4/19/15, and 5/18/15, indicated each monthly review was inclusive for all facility residents along with any vertinent recommendations. Two of the four nonths, 2/22/15 and 4/19/15, noted irregularities ind/or recommendations for R14.	Medication Regimen Review, indicated the last consultant pharmacist review in the medical ecord was dated 1/21/15. There was no consultant pharmacist's Medication Regimen Review recorded by the pharmacist for February 2015, March 2015, April 2015 and May 2015 in R14's chart. Review of the Consultant Pharmacist's Medication Regimen Review kept in a binder in the nursing office dated 2/22/15, 3/17/15, 4/19/15, and 5/18/15, indicated each monthly review was inclusive for all facility residents along with any ertinent recommendations. Two of the four nonths, 2/22/15 and 4/19/15, noted irregularities ind/or recommendations for R14.	Medication Regimen Review, indicated the last consultant pharmacist review in the medical ecord was dated 1/21/15. There was no consultant pharmacist's Medication Regimen Review recorded by the pharmacist for February 2015, March 2015, April 2015 and May 2015 in R14's chart. Review of the Consultant Pharmacist's Medication Regimen Review kept in a binder in the nursing office dated 2/22/15, 3/17/15, 4/19/15, and 5/18/15, indicated each monthly review was inclusive for all facility residents along with any ertinent recommendations. Two of the four nonths, 2/22/15 and 4/19/15, noted irregularities	<ul> <li>R14 was admitted 10/3/13. Review of the Medication Regimen Review, indicated the last consultant pharmacist review in the medical ecord was dated 1/21/15. There was no consultant pharmacist's Medication Regimen Review recorded by the pharmacist for February 2015, March 2015, April 2015 and May 2015 in R14's chart.</li> <li>Review of the Consultant Pharmacist's Medication Regimen Review kept in a binder in ne nursing office dated 2/22/15, 3/17/15, 4/19/15, and 5/18/15, indicated each monthly review was nclusive for all facility residents along with any ertinent recommendations. Two of the four nonths, 2/22/15 and 4/19/15, noted irregularities</li> <li>every 60 days.</li> <li>Pharmacist consultant was in house June 17, 2015 for the monthly review of residents. Pharmacist consultant sig off on each individual resident's recor- the Medication Regimen Review loc each individual resident chart.</li> <li>All residents have the potential to affected by this practice.</li> <li>Monitored by: Pharmacist consult Director of Nursing or designee</li> </ul>	<ul> <li>R14 was admitted 10/3/13. Review of the Medication Regimen Review, indicated the last consultant pharmacist review in the medical ecord was dated 1/21/15. There was no consultant pharmacist's Medication Regimen Review recorded by the pharmacist for February 2015, March 2015, April 2015 and May 2015 in R14's chart.</li> <li>Review of the Consultant Pharmacist's Medication Regimen Review kept in a binder in ne nursing office dated 2/22/15, 3/17/15, 4/19/15, and 5/18/15, indicated each monthly review was nclusive for all facility residents along with any ertinent recommendations. Two of the four nonths, 2/22/15 and 4/19/15, noted irregularities nd/or recommendations for R14.</li> <li>every 60 days.</li> <li>Pharmacist consultant was in house on June 17, 2015 for the monthly review of all residents. Pharmacist consultant signed off on each individual resident's record on the Medication Regimen Review log in each individual resident chart.</li> <li>All residents have the potential to be affected by this practice.</li> <li>Monitored by: Pharmacist consultant, Director of Nursing or designee</li> </ul>

Event ID: NI7Q11

Facility ID: 00286

If continuation sheet Page 53 of 58

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES EDS FOR MEDICARE & MEDICAID SERVICES

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	S FOR MEDICARE &						NO. 0938-039
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION				(X2) MULTIPLE CONSTRUCTION A. BUILDING			TE SURVEY MPLETED
		245566	B. WING_				6/05/2015
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRES	SS, CITY, STATE, ZIP CODE		
VALLEY	IEW HEALTHCARE & RI	ЕНАВ		510 EAST CEDA HOUSTON, MI			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	( (EA	PROVIDER'S PLAN OF CORRE CH CORRECTIVE ACTION SH SS-REFERENCED TO THE API DEFICIENCY)	IOULD BE	(X5) COMPLETIO DATE
F 514	behavioral disturbanc combative behavior, stroke obtained from dated 5/4/15 through R39 was admitted 12 Medication Regimen consultant pharmacis record was dated 1/2 consultant pharmacis record was dated 1/2 consultant pharmacis Review recorded by 1 2015, March 2015, A R39's chart. Review of a Consulta Regimen Review kep office dated 2/22/15, 5/18/15, indicated that for all facility resident recommendations. O 4/19/15 noted irregula recommendations for During an interview o director of nursing (D changed to a new ph and that she meets w day she is in the facil concerns. A "Consult Regimen Review" an Physician/prescriber" three days later by th addressed. DON state binder in the nursing charts however the re- would be. DON state	the Physician Order Report 6/4/15. /23/13. Review of the Review, indicated the last the review in the medical 1/15. There was no the pharmacist for February pril 2015 and May 2015 in the pharmacist's Medication the nursing 3/17/15, 4/19/15, and at each review was inclusive s along with any pertinent ne of the four months, arities and/or	F	514			

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# DEPARTMENT OF HEALTH AND HUMAN SERVICES

STATEMENT OF DEFICIENCIES ( AND PLAN OF CORRECTION				IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		245566	B. WING_			06/05/2015		
NAME OF PROVIDER OR SUPPLIER VALLEY VIEW HEALTHCARE & REHAB				STREET ADDRESS, CITY, STATE, Z 510 EAST CEDAR STREET HOUSTON, MN 55943	IP CODE			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	X (EACH CORRECTIVE CROSS-REFERENCED		(X5) COMPLETION DATE		
F 514	the all-inclusive phar the individual resider record and that there to indicate that a pha completed unless that A message was left fi on 6/5/15, at 1:36 p.1 R40 was admitted to admission diagnoses anxiety state, demer Alzheimer disease p Review of the Medici indicated the last cou- the medical record w no consultant pharm Review recorded by 2015, March 2015, A R40's chart. Review of the Consu- Medication Regimer the nursing office da and 5/18/15, indicate inclusive for all facili pertinent recommen R21 was admitted w depressive disorder, dysuria, neurogenic chronic pain and dej obtained from the R printed 6/4/15. Consultant pharmac reviews were compl December 2014 and	Review. DON verified that macy review was not part of it's chart and permanent e would be no documentation irmacist review was ere was a recommendation. For the consulting pharmacist m. the facility 8/15/12, with s of Alzheimer disease, the facility 8/15/12, wi	F	514				

PRINTED: 06/25/2015 FORM APPROVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING				<u>0. 0938-03</u> E SURVEY PLETED
		245566	B. WING		00/05/00/1		
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY		06/05/2015	
VALLEY V	/IEW HEALTHCARE & R	ЕНАВ		510 EAST CEDAR STR HOUSTON, MN 5594	EET		
(X4) ID PREFIX TAG	IX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	ID PROVIDER'S PL/ PREFIX (EACH CORRECTIV TAG CROSS-REFERENCE		N OF CORRECTION ACTION SHOULD BE TO THE APPROPRIATE JIENCY)	
F 514	Continued From page 55 was completed December 22, 2014 through January 21, 2015. That was not individualized in R21's medical record. Review of consultant pharmacist's medication regimen reviews in three-ring binder included monthly reports for February 2015 through May 2015. These were not individualized in R21's medical record. On 6/5/15, at 1:17 p.m. DON stated they had a new pharmacist consultant. If pharmacist had no recommendations for the doctor, the resident would have no printout for her chart. The facility's Consultant Pharmacist Reports policy under Documentation and Communication of Consultant Pharmacist Recommendations dated 2006 indicated "Documentation of the date each medication regimen review is completed on the appropriate form and notation of the findings in the medical record or other designated siteif no irregularities are found, consultant pharmacist also documents this in the resident's (active		F 5	14			
	that R17 had a diagno hypertension, edema,	s, signed 4/1/15 identified sis that included osteoarthrosis, pain, and ca (inflammatory disorder					
	R17 was admitted to ti remained in the facility R17's Medication Reg last consultant pharma	,					

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

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED		
	·	245566	B. WING		00/05/2045		
NAME OF PROVIDER OR SUPPLIER VALLEY VIEW HEALTHCARE & REHAB				STREET ADDRESS, CITY, STATE, ZIP CODE 510 EAST CEDAR STREET HOUSTON, MN 55943	06/05/2015		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE COMPLET		
F 514	irregularities. There pharmacist's Medica February 2015, Mari 2015. Although, the directo progress note dated "Pharmacist consulta 4/17/2015." R17's co medication regime re 3/17/2015, and 4/19, resident's permanen When interviewed or director of nursing (E switched to HealthDi the facility report (for document) is filed in office, not in individu When interviewed, o director of nursing (E wouldn't be anything that she had no addi R57's physician orde that R57 had right hip orthopedic aftercare, neuropathy, hyperter disease. R57 was admitted to remained in the facilit There was no docum record that R57's me	was no consultant ation Regimen Review for ch 2015, April 2015 and May or of nursing's (DON) 4/20/2015 indicated the ant was in house on onsultant pharmacist eviews, dated 2/22/2015, /2015 were not in the t medical record n 6/3/2015 at 10:53 a.m., the DON) stated the facility irect in February 2015 and r all residents in one or a binder in the nursing al charts n 6/5/2015 at 9:30 a.m., the DON) stated that there in the discharge record and tional information. ers, signed 4/2/2015 identified o joint replacement with pain, hyperlipidemia, nsion, and cardiovascular the facility 2/23/15 and ty until 4/30/15. lentation in the medical dications were reviewed icist for March 2015 and April	F 51	4			

		ND HUMAN SERVICES			(		APPROVED 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION		(X3) DATE S COMPL	SURVEY
		245566	B. WING			06/0	5/2015
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STAT	E, ZIP CODE		
VALLEY V	IEW HEALTHCARE & RI	ЕНАВ		510 EAST CEDAR STREET HOUSTON, MN 55943			
(X4) ID PREFIX TAG	REFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL			(EACH CORRECTI CROSS-REFERENCI	LAN OF CORRECTION VE ACTION SHOULD BE ED TO THE APPROPRIA FICIENCY)	N SHOULD BE CC E APPROPRIATE	
F 514	Continued From page of nursing (DON) stat anything in the record information.		F 5	14			
FORM CMS-256	7(02-99) Previous Versions Obs	solete Event ID: NI70	211	Facility ID: 00286	If continu	ation sheet	Page 58 of 58

FEELINA

		D HUMAN SERVICES MEDICAID SERVICES		F5566024	FOR	D: 06/25/2015 MAPPROVED D: 0938-0391
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		245566	B. WING	······································	06/	04/2015
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
VALLEY V	IEW HEALTHCARE & RE	HAB		510 EAST CEDAR STREET HOUSTON, MN 55943		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		ULD BE	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS		к	000		
Exit: 653 20: 7.15-15	ALLEGATION OF CO DEPARTMENT'S ACC SIGNATURE AT THE PAGE OF THE CMS 2 USED AS VERIFICAT UPON RECEIPT OF 2 ONSITE REVISIT OF CONDUCTED TO VA SUBSTANTIAL COMP REGULATION HAS B ACCORDANCE WITH A Life Safety Code Su Minnesota Departmen Fire Marshal Division. Valley View Nursing H substantial complianc participation in Medica Subpart 483.70(a), Lif 2000 edition of Nation Association (NFPA) S	BOTTOM OF THE FIRST 2567 FORM WILL BE TON OF COMPLIANCE. AN ACCEPTABLE POC, AN YOUR FACILITY MAY BE LIDATE THE PLIANCE WITH THE BEEN ATTAINED IN 1 YOUR VERIFICATION. Invey was conducted by the not of Public Safety - State At the time of this survey, Home was found not in e with the requirements for are/Medicaid at 42 CFR, the Safety from Fire, and the hal Fire Protection tandard 101, Life Safety 19 Existing Health Care. HE PLAN OF THE FIRE SAFETY ections vision uite 145		POCA POCA PRANIS PRANIS IN DEPT. OF PUBLIC STATE FIRE MARSHALL	5	
10001000	<u> </u>	l				
	allere (	UPPLIER REPRESENTATIVE'S SIGNATURE		TITLE	7/61	(X6) DATE
				ay be excused from correcting providing it is determ ing homes, the findings stated above are disclosab		

other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable to days following the date of survey whether or not a plan of sorrection 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.

FORM CMS-2567(02-99) Previous Versions Obsolete

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CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA			(X2) MULT	IPLE CONSTRUCTION	(X3) DAT	E SURVEY
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		NG 01 - VALLEY VIEW NURSING HOME	L CON	IPLETED
		245566	B. WING		0	6/04/2015
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP	CODE	
VALLEY V	VIEW HEALTHCARE & R	EHAB		510 EAST CEDAR STREET HOUSTON, MN 55943		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETIO DATE
K 000	Continued From pag By email to: Marian.Whitney@sta Angela.Kappenman@	ate.mn.us and	K	000		
		RECTION FOR EACH INCLUDE ALL OF THE RMATION:				
	1. A description of will to correct the deficient	hat has been, or will be, done ncy.				
	2. The actual, or prop	posed, completion date.				
	3. The name and/or t responsible for corre prevent a reoccurren	ction and monitoring to			2	
	buildings. Valley Vie building with no base constructed at 3 diffe building was constru determined to be of 1973, addition was construined	arveyed as two separate w Nursing Home is a 1-story ement. The building was erent times. The original cted in 1967 and was Type II(111) construction. In constructed to the West Wing to be of Type II(111) 9, another addition was				
	added to the South V be Type II (111). Bec the 2 additions are of construction and mer allowed for existing b surveyed as one built The building became	Wing and was determined to ause the original building and f the same type of et the construction type buildings, the facility was iding.				
5.		em with full corridor smoke en to the corridors that is atic fire department				

CENTER	S FOR MEDICARE &	MEDICAID SERVICES				ONB NC	0.0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION 1 - VALLEY VIEW NURSING HOME	(X3) DATE COMP	SURVEY
		245566	B, WING			06/	04/2015
	ROVIDER OR SUPPLIER	ЕНАВ		5	TREET ADDRESS, CITY, STATE, ZIP CODE 10 EAST CEDAR STREET IOUSTON, MN 55943		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
K 000 K 029 SS=D	census of 43 at the tin The requirement at 42 NOT MET as evidend NFPA 101 LIFE SAFE One hour fire rated co fire-rated doors) or ar extinguishing system and/or 19.3.5.4 protect the approved automa option is used, the are other spaces by smol doors. Doors are self field-applied protectiv 48 inches from the bo permitted. 19.3.2.1 This STANDARD is r Based on observatio facility failed to mainta partitions and doors in following requirement Section 19.3.2.1. The affect 5 out 43 residen Findings include: On facility tour between	acity of 45 beds and had a me of the survey. 2 CFR Subpart 483.70(a) is ed by: ETY CODE STANDARD onstruction (with ¾ hour approved automatic fire in accordance with 8.4.1 cts hazardous areas. When tic fire extinguishing system eas are separated from ke resisting partitions and f-closing and non-rated or e plates that do not exceed ottom of the door are not met as evidenced by: n and staff interview, the ain smoke-resisting n accordance with the s of 2000 NFPA 101, e deficient practice could nts. en 8:00 AM and 10:30 AM vation revealed, that the	ĸ	000 029	K 029 NFPA 101 LIFE SAFETY COL STANDARD The installation of new door handles i latches was completed on June 4, 20 all doors cited in findings. Environmental Services Director will monitor monthly with fire extinguisher checks. Monitored by Environmental Services Director	and 15 to	07/15/2015 eet Page 3 of 6

PRINTED: 06/25/2015 FORM APPROVED OMB NO. 0938-0391

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

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			ONSTRUCTION VALLEY VIEW NURSING HOME	(X3) DATE COMF	SURVEY
		245566	B WING			06/	04/2015
	ROVIDER OR SUPPLIER	EHAB		510	EET ADDRESS, CITY, STATE, ZIP CODE EAST CEDAR STREET USTON, MN 55943		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
K 029 K 062 SS=D	3. Employee storage latch These deficient pract Facility Maintenance discovery. NFPA 101 LIFE SAFE Required automatic s	l utility room will not buth door will not shut/latch room - will not shut and ices were confirmed by the Director (DJ) at the time of ETY CODE STANDARD		029	K062 NFPA 101 LIFE CODE ST The Environmental Services Dire	ector was	
	condition and are ins	re inspected and tested 19.7.6, 4.6.12, NFPA 13, NFPA 25,			reeducated on documentation of flow test. Environmental Services Director documented missed flow test. Flow tests will be conducted qua documented.		
	Based on documenta interview, the facility f sprinkler system in ac requirements of 2000 19.3.4.1 and 9.6, as y				Environmental Director and/or Administrator will monitor for co	npliance,	07/15/15
	on 06/04/2015, a revi quarter flow test logs quarter flow test was This deficient practice	en 8:00 AM and 10:30 AM ew of the fire sprinkler indicated that the 2015 - 1st not documented. e was confirmed by the Director (DJ) at the time of					

CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/25/2015 FORM APPROVED OMB NO. 0938-0391

OLNILIN	S FOR MEDICARE &	MEDIONID OLIVIOLO				OND NO	0. 0938-039
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			NSTRUCTION IALLEY VIEW NURSING HOME	(X3) DATE COMF	SURVEY
		245566	B. WING			06/	/04/2015
NAME OF P	ROVIDER OR SUPPLIER	•		STRE	ET ADDRESS, CITY, STATE, ZIP CODE	11	
VALLEY V	IEW HEALTHCARE & R	EHAB			AST CEDAR STREET		
				HOU	STON, MN 55943		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETIC DATE
K 062	Continued From page	ə <b>4</b>	ĸ	062			
K 144 SS=F	NFPA 101 LIFE SAFI	ETY CODE STANDARD	ĸ	144	K144 NPFA 101 LIFE SAFETY STANDARD	CODE	
	under load for 30 mir accordance with NFF				A load bank test was completed 2015. The test indicated the gen operating above and beyond the requirements of 30% load.	erator was	
					Environmental Director will cond monthly generator load tests.	luct	
					Environmental Director and/or Administrator will monitor for co	mpliance.	07/15/
	Based on documenta interview, the facility emergency generato requirements of 2000 NFPA 110 Chapter 6.	r in accordance with the ) NFPA 101 - 9.1.3 and 1999					
	Findings include:						
	on 06/04/2015, docu	en 8:00 AM and 10:30 AM mentation review of the gs revealed the following:					
	<ol> <li>No generator constraints</li> <li>The review of the rev</li></ol>	ansfer time was recorded bol down time was recorded he monthly run test indicated					
	that the generator dic following: a. loading that r	not meet one of the naintains the minimum					
	exhaust gas tempera the manufacturer or	f 30 percent or more of the					

PRINTED: 06/25/2015 FORM APPROVED OMB NO. 0938-0391

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

STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION 1 - VALLEY VIEW NURSING HOME	(X3) DATE SURVEY COMPLETED	
		245566	B, WING		06/04/201	5
	ROVIDER OR SUPPLIER	ЕНАВ	51	IREET ADDRESS, CITY, STATE, ZIP CODE I <b>0 EAST CEDAR STREET</b> OUSTON, MN 55943		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		ETION
K 144	nameplate rating of g c. 2 hour load b		К 144			
		ices were confirmed by the Director (DJ) at the time of				
	*TEAM COMPOSITIC Gary Schroeder, Life					
	7/02.001 Draviaus Vasciano Obs	alaia Eurot 10.007				

FORM CMS-2567(02-99) Previous Versions Obsolete

If continuation sheet Page 6 of 6

FEC66024

ULNIER	S FOR WEDIGARE &	VIEDICAID SERVICES			7 / 1	CINID NC	1. 0900-0091
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION 02 - 2011 ADDITION	(X3) DATE COMP	SURVEY
		245566	B. WING			06/	04/2015
NAME OF P	ROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE		
				5	510 EAST CEDAR STREET		
VALLETV	IEW HEALTHCARE & RE			ŀ	HOUSTON, MN 55943		
(X4) ID		ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		Y MUST BE PRECEDED BY FULL _SC IDENTIFYING INFORMATION)	PREFI TAG		(EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI		COMPLETION DATE
TAG					DEFICIENCY)		
к 000	INITIAL COMMENTS		K	000			
					1		
	FIRE SAFETY				Pock 18 7-17-15		
	THE FACILITY'S POO	C WILL SERVE AS YOUR			PACE		
		MPLIANCE UPON THE					
	DEPARTMENT'S AC	-			11-11		
		BOTTOM OF THE FIRST			O M		
		2567 FORM WILL BE FION OF COMPLIANCE.			$\left  \left( X \right) \right $		
		HON OF COMPLIANCE.					
	UPON RECEIPT OF	AN ACCEPTABLE POC, AN					
		YOUR FACILITY MAY BE					
	CONDUCTED TO VA						
	SUBSTANTIAL COM						
	REGULATION HAS E						
	ACCORDANCE WITH	H YOUR VERIFICATION.					
	A Life Safety Code Si	urvey was conducted by the					
		nt of Public Safety - State					
		At the time of this survey,					
	Valley View Nursing H	lome was found not in					
		e with the requirements for					
		are/Medicaid at 42 CFR,					
		fe Safety from Fire, and the					
	2000 edition of Nation	Standard 101, Life Safety					
	Code (LSC), Chapter						
	PLEASE RETURN TH	HE PLAN OF					
	CORRECTION FOR	THE FIRE SAFETY					
	DEFICIENCIES						
	( K-TAGS) TO:						
	Health Care Fire Insp	ections					
	State Fire Marshal Di						
	445 Minnesota St., Si						
	St Paul, MN 55101-5	145, or					
		SUPPLIER REPRESENTATIVE'S SIGNATURE		_			(X6) DATE
LABORATORY	DIREPUCE OR PROVIDERA	HI T PICK ALL ALL ALL ALL ALL ALL ALL ALL ALL AL	)			-	
1	merce	ULDUTA INON	)	_	1611	2	
Any deficiency	statement ending with an as	sterisk (*) denotes a deficiency which the i	nstitution ma	ay be	excused from correcting providing it is determined	that	

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

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			NSTRUCTION		TE SURVEY
IND PLAN UP	OURRECTION	IDENTIFICATION NUMBER:	A, BUILDI	NG <b>02 - 2</b>	011 ADDITION		
		245566	B. WING			0	6/04/2015
NAME OF P	ROVIDER OR SUPPLIER				ET ADDRESS, CITY, STATE, ZIP CODE		
VALLEY V	IEW HEALTHCARE & F	REHAB			AST CEDAR STREET STON, MN 55943		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	<	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETIC DATE
K 000	Continued From pag	je 1	к	000			
	By email to:						
	Marian.Whitney@sta						
	Angela.Kappenman	@state.mn.us					
		RECTION FOR EACH					
		INCLUDE ALL OF THE					
	FOLLOWING INFOR	RMATION:					
		hat has been as will be also					
	to correct the deficie	hat has been, or will be, done ncy.					
	2. The actual, or pro	posed, completion date,					
		title of the person ection and monitoring to nee of the deficiency.					
	buildings. Valley Vie addition is a 1-story The 2011 addition w	urveyed as two separate aw Nursing Home, 2011 building with no basement. as determined to be of Type					
	II (111) construction.						
	fire alarm system wit detection, spaces op	sprinklered. The facility has a th full corridor smoke ben to the corridors and is monitored for automatic ication.					
	The facility has a cap census of 43 at the t	pacity of 45 beds and had a ime of the survey.					
	The requirement at 4 NOT MET as eviden	42 CFR Subpart 483.70(a) is ced by:					
K 062	NFPA 101 LIFE SAF	ETY CODE STANDARD	ĸ	62			
SS=D	Required automatic	sprinkler systems are					

PRINTED: 06/25/2015 FORM APPROVED

	OF DEFICIENCIES	MEDICAID SERVICES	(¥2) MILU		CONSTRUCTION	OMB NO. 0938-03 (X3) DATE SURVEY	
	CORRECTION	IDENTIFICATION NUMBER:			- 2011 ADDITION		LETED
		245566	B. WING			06/	04/2015
NAME OF PF	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		
VALLEY V	IEW HEALTHCARE & RI	ЕНАВ			EAST CEDAR STREET OUSTON, MN 55943		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETIC DATE
K 062	condition and are insperiodically. 18.7.6, 9.7.5	ned in reliable operating	к	062	K062 NFPA 101 LIFE CODE STAN The Environmental Services Director reeducated on documentation of qu flow test. Environmental Services Director documented missed flow test. Flow tests will be conducted quarter documented.	or was arterly	
	sprinkler system in ac requirements of 2000 18.3.4.1 and 9.6, as v	failed to maintain the fire ccordance with the 0 NFPA 101, Sections well as 1998 NFPA 25, eficient practice could affect			Environmental Director and/or Administrator will monitor for compli	iance.	07/15/ <sup>.</sup>
K 144 SS=F	on 06/04/2015, a revi quarter flow test logs quarter flow test was This deficient practice Facility Maintenance discovery. NFPA 101 LIFE SAFE	e was confirmed by the Director (DJ) at the time of ETY CODE STANDARD cted weekly and exercised jutes per month in	к	144	K144 NPFA 101 LIFE SAFETY CO STANDARD A load bank test was completed Jur 2015. The test indicated the genera operating above and beyond the requirements of 30% load. Environmental Director will conduct monthly generator load tests. Environmental Director and/or	ne 18, tor was	
		8.			Administrator will monitor for compl	iance.	07/15/ <sup>,</sup>

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: NI7Q21

Facility ID: 00286

If continuation sheet Page 3 of 5

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CENTER	S FOR MEDICARE &	MEDICAID SERVICES				OMB NC	0. 0938-0391
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION 22 - 2011 ADDITION	(X3) DATE COMF	SURVEY PLETED
		245566	B. WING	-		06/	/04/2015
NAME OF PI	ROVIDER OR SUPPLIER			8	STREET ADDRESS, CITY, STATE, ZIP CODE		
				5	10 EAST CEDAR STREET		
VALLEY V	IEW HEALTHCARE & R	EHAB		۱.	OUSTON, MN 55943		
-			10	<u> </u>	·		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	3E	(X5) COMPLETION DATE
K 144	Continued From page	e 3 not met as evidenced by:	к	144			
	Based on document interview, the facility emergency generator	ation review and staff					
		4.2 and 6-4.2.2. The Id affect all 43 residents.					
	Findings include:						
	On facility tour between 8:00 AM and 10: on 06/04/2015, documentation review of monthly generator logs revealed the follo	mentation review of the					
	2. No generator co	ansfer time was recorded ool down time was recorded ne monthly run test indicated I not meet one of the					
	exhaust gas tempera the manufacturer or	naintains the minimum tures as recommended by f 30 percent or more of the					
	nameplate rating of g c. 2 hour load b	•					
		ices were confirmed by the Director (DJ) at the time of					
	*TEAM COMPOSITIC Gary Schroeder, Life						
FORM CMS-256	7(02-99) Previous Versions Obs		21	Fa	Incility ID: 00286 If cor	tinuation sh	eet Page 4 of 5

CENTER	S FOR MEDICARE &	MEDICAID SERVICES				OMB NO. 0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCT		(X3) DATE SURVEY COMPLETED
		245566	B. WING			06/04/2015
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRI	ESS, CITY, STATE, ZIP CODE	
				510 EAST CED	DAR STREET	
VALLEY	IEW HEALTHCARE & R	EHAB		HOUSTON, N	VIN 55943	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION EACH CORRECTIVE ACTION SHOULD B DSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
OTTIVI OIVI3-200	7(02-99) Previous Versions Obs	olele Event ID: NI7Q2	. 1	Facility ID: 00286	if conti	nuation sheet Page 5 of 5



Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7010 0780 0000 9011 4835 June 25, 2015

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

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5566026

Dear Mr. Reindl:

The above facility was surveyed on June 1, 2015 through June 5, 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 <u>only a suggestion</u> 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.

The State licensing orders are delineated on the attached Minnesota Department of Health order form (attached). 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.

Valley View Healthcare & Rehab June 25, 2015 Page 2

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.

When all orders are corrected, the order form should be signed and returned to this office at Minnesota Department of Health, 18 Wood Lake Dr. SE, Rochester, MN 55904. 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 me.

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,

Kate JohnsTon, Program Specialist Licensing and Certification Program Health Regulations Division Telephone: (651) 201-3992 Fax: (651) 215-9697 Enclosure (s) cc: Licensing and Certification File

STATEMENT	a Department of Healt OF DEFICIENCIES OF CORRECTION	n (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		00286	B. WING		06/05/2015
NAME OF PF	ROVIDER OR SUPPLIER		DDRESS, CITY, STA		
VALLEY V	IEW HEALTHCARE & RI	FHΔB	N, MN 55943	-1	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE
2 000	Initial Comments		2 000		
	*****ATTEN	ITION*****			r
-	NH LICENSING C	ORRECTION ORDER			
		linnesota Statute, section ion order has been issued			
	pursuant to a survey.	If, upon reinspection, it is not not find the second second second second second second second second second se			
	herein are not correc	ted, a fine for each violation			
		e assessed in accordance les promulgated by rule of tment of Health.			
	Determination of whe corrected requires co	ether a violation has been			
	requirements of the r	ule provided at the tag			
		e number indicated below. s several items, failure to			
		ne items will be considered Lack of compliance upon			
	re-inspection with an	y item of multi-part rule will nent of a fine even if the item			
	that was violated dur	ing the initial inspection was			
	corrected.		. Marco		
		earing on any assessments non-compliance with these	SPI		
	orders provided that	a written request is made to in 15 days of receipt of a	7/10/14		
		t for non-compliance.	1,1,0,15		
	INITIAL COMMENTS			Minneedte Department of Health is	
		ed to participate in the State licensure orders		Minnesota Department of Health is documenting the State Licensing	
	consistent with the M	linnesota Department of		Correction Orders using federal soft Tag numbers have been assigned to	vare.
		Bulletin 14-01, available at ate.mn.us/divs/fpc/profinfo/inf		Minnesota state statutes/rules for Nu	rsing
	obul.htm The State	-		Homes.	
Minnesete	delineated on the att				
LABORATORY	epartment of Health DIRECTOR'S OR PROVIDER	SUPPLIER REPRESENTATIVE'S SIGNATUR	RE	TITLE	
STATE FORM	_ alera	XIIIIAN 4 XOIL	<u>XX</u> 6899	NI7Q11	If continuation sheet 1 of 6

NI7Q11

STATE FORM

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		(X3) DATE SURVEY COMPLETED	
		00286	B. WING		06/05/2015	
	ROVIDER OR SUPPLIER	EHAB 510 EAS	ADDRESS, CITY, ST ST CEDAR STRE ON, MN 55943			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COMPLE	
2 000	Department of Health electronically. Althou necessary for State S the word "corrected" Then indicate in the e	n orders being submitted ugh no plan of correction is Statutes/Rules, please enter in the box available for text. electronic State licensure eading completion date, the be corrected prior to ing to the Minnesota	2 000	The assigned tag number appears in far left column entitled "ID Prefix Tag The state statute/rule number and th corresponding text of the state statut 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 w are in violation of the state statute aff statement, "This Rule is not met as evidenced by." Following the survey findings are the Suggested Method of Correction and the Time Period For Correction. PLEASE DISREGARD THE HEADIN THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. TH WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION VIOLATIONS OF MINNESOTA STAT STATUTES/RULES.	g." e e/rule " hich ter the rors f IG OF HIS	
2 302	MN State Statute 144 or related disorder tra	I.6503 Alzheimer's disease ain	2 302			
	ALZHEIMER'S DISE/ DISORDER TRAININ MN St. Statute 144.6	IG:				
	(a) If a nursing facility Alzheimer's disease or related dis segregated or genera					

STATE FORM

6899 NI7Q11

If continuation sheet 2 of 66

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING:			E SURVEY PLETED
		00286	B. WING		06	/05/2015
NAME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	E, ZIP CODE		
		510 EAS	T CEDAR STREET			
VALLET	IEW HEALTHCARE & R	HOUST	ON, MN 55943			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLE <sup>-</sup> DATE
2 302	Continued From pag	e 2	2 302			
	care staff	s must be trained in dementia				
	care.					
	(b) Areas of required					
	· ·	Alzheimer's disease and				
	related disorders;	ctivities of daily living;				
		with challenging behaviors;				
	and					
	(4) communication s	kills.				
	• • •	provide to consumers in				
		form a description of the				
		e categories of employees by of training, and the basic				
	topics covered.	y of training, and the basic				
		document compliance with				
	This MN Requirement	nt is not met as evidenced		•		
	by:					
	Based on interview a	and document review, the				
	•	re consumers were provided				
		g Alzheimer's disease and				
		cluding a description of the categories of employees				
		cy of training and the basic				
		training in a written or				
	electronic form.	-				
	Findings include:					
		e facility's Alzheimer's				
	training program, the	ere was no information or				
		ndicated the consumers				
	were provided in writ					
	aescription of Alzheii	mer's training program, the				1

Minnesota Department of Health STATE FORM

6899

NI7Q11

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If continuation sheet 3 of 66

	F OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED
		00286	B. WING			05/2045
NAME OF P	ROVIDER OR SUPPLIER		ADDRESS, CITY, STATE	, ZIP CODE	1 00	05/2015
ALLEY V	IEW HEALTHCARE & R	FHAB	T CEDAR STREET			
		HOUSTO	ON, MN 55943			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLE DATE
2 302	Continued From page	e 3	2 302			
	training and the basic	c topics covered.				
	social worker (SW) s	n 6/4/15, at 4:00 p.m. the tated that they have nothing hat they provide to the				
	director of nursing (D	6/4/15, at 4:10 p.m., the ON) stated that she was on written or electronic for				
		n., the DON stated that n Alzheimer's training.				
	DON or designee coustaff training to the reconsumer information	OD OF CORRECTION: The uld add information regarding sident admission packet for n. The DON or designee nd conduct audits to ensure				
	TIME PERIOD FOR ( (21) days.	CORRECTION: Twenty-one				
2 570	MN Rule 4658.0405 S Plan of Care; Revisio	Subp. 4 Comprehensive n	2 570			
	care must be reviewed interdisciplinary team physician, a registere for the resident, and o disciplines as determ and, to the extent pra participation of the re- guardian or chosen re- quarterly and within s	that includes the attending d nurse with responsibility other appropriate staff in ined by the resident's needs, acticable, with the sident, the resident's legal				

STATE FORM

NI7Q11

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		E SURVEY PLETED
		00286	B. WING		06	/05/2015
NAME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE		
		510 EAS	T CEDAR STREET			
VALLEYV	IEW HEALTHCARE & R	HAB HOUSTO	DN, MN 55943			
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF		(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	THE APPROPRIATE	COMPLET DATE
2 570	Continued From page	e 4	2 570			
	by part 4658.0400, s	subpart 3, item B.				
		nt is not met as evidenced				
	by:					
		n, interview, and document				
		ed to update the plan of care cline in ambulation for 1 of 4				
	residents reviewed for					
	Findings include:					
	D17 was admitted to	the facility 2/2/12 and had				
		the facility 3/3/12, and had 3/17/15, with diagnoses of				
		oss, ischemic heart disease				
	•	w and oxygen to the heart				
	muscle itself) with ed					
	,	tion to promote urination),				
	•	ood pressure), polymyalgia				
	••••••	l stiffness in shoulders, neck,				
	upper arms and hips)	) and osteoarthritis				
	(degenerative arthritis	s).				
	A Fall Risk assessme	ent dated 3/15/15, identified				
	R17 had unsteady ga	ait and balance problems,				
	-	int paint, arthritis, and a	1			
		aking skills. R17 used a				
		] or W/C [wheelchair], and				
	was a safety risk due					
	the care plan after thi	acility lacked any changes in s fall assessment.				
	The appuel Minimum	Data Set (MDS) dated				
		gnitive impairment. R17 had				
	no depression or beh					
	independent with bed					
		and one person physical				
	assist for transfers an					
		lp only in ambulation in her				
		he was assessed to require				

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			B. WING			
***		00286	B. WING		06	/05/2015
ame of PF	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE			
ALLEY V	IEW HEALTHCARE & R	FHAR	T CEDAR STREET N, MN 55943			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES 3Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ( (EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE ) THE APPROPRIATE	(X5) COMPLE DATE
2 570	Continued From pag	e 5	2 570			
	toileting, which was a from the 12/17/15, q	assist with transfers and a decline in functional abilities uarterly MDS. R17 also had a ability to moderately impaired IDS.				
	indicated R17 had is loss, dementia, activ -functional status, ur nutritional status. Ac	ssment (CAA) dated 3/17/15, sues with delirium, cognitive ities of daily living (ADL) inary incontinence, falls and cording to the CAA summary, incontinence were not e plan.				
	ambulation with walk of significant decline functioning and refer R17 was at risk for fa joint disease, polymy directed staff to notif physical or cognitive therapies as indicate her recliner. Pain in	nsfers, bed mobility and ser, directed staff to notify MD to physical and cognitive to therapies as indicated. alls related to degenerative valgia and history of falls and y MD of significant decline in function, and refer to sd. R17 preferred to sleep in the right hip and right knee				
	staff to encourage us and directed indeper mobility and ambulat The care plan was n functional abilities fro 12/17/15, to the ann	ed. The care plan directed se of walker with ambulation, indent with transfer, bed tion with walker. ot updated with the decline in om the quarterly MDS dated ual assessment 3/17/15, and al assist of one staff member				
	was still her own per	o.m. the DON stated R17 son, alert, had poly myalagia, us if she needed assistance, ar and toilet by self				

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If continuation sheet 6 of 66

STATEMENT	a Department of Healt OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C			E SURVEY PLETED
	5. JORREOHON		A. BUILDING:			
		00286	B. WING		06	6/05/2015
NAME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE		
	IEW HEALTHCARE & R		T CEDAR STREET			
VALLET	IEW HEALTHCARE & R	HOUSTO	ON, MN 55943			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 570	Continued From page	e 6	2 570			
	refer R17 to PT/OT v and functional abilitie MDS assessment. In nursing progress not ambulation and indic should be done. SUGGESTED METH The director of nursin staff related to the ne care plans and monit	apdate the plan of care or when a decline in cognitive as was noted the 3/17/15, addition on 4/29/15, a e indicated a decline in ated a referral to PT/OT HOD OF CORRECTION: ng or designee could educate add to evaluate and update tor for compliance. CORRECTION: Twenty One				
2 625	MN Rule 4658.0450 Contents; In Genera	Subp. 1 A-P Clinical Record I	2 625			
	record, including nu A. the condition admission; B. temperature, pressure, according subpart 2, item C. the resident's according to part 46 D. the resident's and attitudes; E. observations interventions provide responsible for care of the re confidential commun- religious persor	l; s height and weight, 558.0520, subpart 2, item J; s general condition, actions, , assessments, and ed by all disciplines esident, with the exception of nications with				

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If continuation sheet 7 of 66

	FOF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING:		E SURVEY PLETED	
		00286	B. WING		06	/05/2015
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE		an a
		510 EAS	T CEDAR STREET			
ALLETV	IEW HEALTHCARE &	HOUST	DN, MN 55943			
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF		(X5)
PREFIX TAG		NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	THE APPROPRIATE	COMPLE DATE
2 625	Continued From pa	ge 7	2 625			
	behavior, orientatio	n, adjustment to the				
	nursing home, judgment, or moods;					
		quantity of dosage, and				
		ration of all medications, and				
	-	f the nurse or authorized				
		istered the medication; tuberculin test within the				
		to admission, as described				
	in part 4658.08					
		oratory examinations;		· · · · ·		
		nes of all treatments and				
	dressings;					
		nes of visits by all licensed				
	health care practitio L. visits to clinic					
		or instructions relative to the				
	comprehensive plar					
		in the resident's sleeping				
	habits or appetite;					
		tors regarding changes in the				
	resident's general c					
		e initial comprehensive It and all subsequent				
		assessments as described in				
	part 4658.0400.					
	•	nt is not met as evidenced				
	by:					
		and record review, the facility curate medical records were				
		esidents (R14, R39, R40,				
		2 discharged residents (R17,				
		onthly pharmacist reviews.				
	Findings include:					
	Current Residents:					
	R14's diagnoses inc					1

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If continuation sheet 8 of 66

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C		(X3) DATE SU COMPLE	
			A. BUILDING:	JUT 10 2015		
		00286	B. WING	Jan Lord Coller	06/05	/2015
IAME OF P	ROVIDER OR SUPPLIER		ADDRESS, CITY, STATE			
ALLEY V	VIEW HEALTHCARE & R	REHAB	ST CEDAR STREET ON, MN 55943			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLE DATE
2 625	Continued From pag	je 8	2 625			
		anxiety, osteoarthrosis and ed from the Resident rinted 6/4/15.				
	Medication Regimen consultant pharmacia record was dated 1/2 consultant pharmacia Review recorded by	D/3/13. Review of the I Review, indicated the last st review in the medical 21/15. There was no st's Medication Regimen the pharmacist for February April 2015 and May 2015 in				
	the nursing office dat and 5/18/15, indicate inclusive for all facilit pertinent recommend	Review kept in a binder in ted 2/22/15, 3/17/15, 4/19/15, ed each monthly review was ty residents along with any dations. Two of the four 4/19/15, noted irregularities				
		ces of agitation and delusions, hallucinations and the Physician Order Report				
	Medication Regimen consultant pharmacis record was dated 1/2 consultant pharmacis Review recorded by	2/23/13. Review of the Review, indicated the last st review in the medical 21/15. There was no st's Medication Regimen the pharmacist for February april 2015 and May 2015 in				
	Regimen Review kep	ant Pharmacist's Medication ot in a binder in the nursing 3/17/15, 4/19/15, and				

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING:			E SURVEY PLETED	
			A Boilbirto				
		00286	00286 B. WING		06	6/05/2015	
NAME OF PF	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE	E, ZIP CODE			
ALLEY V	IEW HEALTHCARE & R	EHAB	ST CEDAR STREET DN, MN 55943				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE	(X5) COMPLE DATE	
2 625	Continued From page	e 9	2 625	·			
	for all facility resident						
	director of nursing (D changed to a new ph and that she meets w day she is in the facil concerns. A "Consult Regimen Review" an Physician/prescriber" later by the pharmaci stated the reviews are nursing office, not in recommendations if a the pharmacist was in pharmacy reviews on and 5/15/15, not the of the Consultant Pharm Review. DON verified review was not part of chart and permanent be no documentation	as completed unless there					
	A message was left fo on 6/5/15, at 1:36 p.n	or the consulting pharmacist n.					
	admission diagnoses anxiety state, dement	the facility 8/15/12, with of Alzheimer disease, tia and weight loss due to er the Admission Record.	î X				
	indicated the last con	tion Regimen Review, sultant pharmacist review in as dated 1/21/15. There was					

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING:			E SURVEY PLETED
		00286	B. WING		06	6/05/2015
NAME OF P	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE	, ZIP CODE		
VALLEY V	/IEW HEALTHCARE & R	EHAB	ST CEDAR STREET ON, MN 55943			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TON SHOULD BE THE APPROPRIATE	(X5) COMPLE DATE
2 625	Continued From pag	e 10	2 625			
	Review recorded by	acist's Medication Regimen the pharmacist for February spril 2015 and May 2015 in				
	the nursing office dat and 5/18/15, indicate	Review kept in a binder in ted 2/22/15, 3/17/15, 4/19/15, ad each monthly review was y residents along with any				
	depressive disorder, dysuria, neurogenic b chronic pain and dep	th diagnoses of dementia, nonorganic psychosis, oladder, Diabetes Mellitus II, endent personality disorder sident Admission Record				
	reviews were comple December 2014 and record. Roster report was completed Dece	st medication regimen ted July 2014 through filed in R21's medical Valleyview Healthcare (MN) mber 22, 2014 through lat was not individualized in				
	regimen reviews in th monthly reports for Fe	pharmacist's medication ree-ring binder included ebruary 2015 through May t individualized in R21's				
	new pharmacist cons	n. DON stated they had a ultant. If pharmacist had no the doctor, the resident ut for her chart.				
		ant Pharmacist Reports ntation and Communication				

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TATEMEN	a Department of Healt FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:		(X3) DATE SURVEY COMPLETED
		00286	B. WING		06/05/2015
AME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE	
ALLEY V	IEW HEALTHCARE & R		T CEDAR STREET N, MN 55943		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLET
2 625	of Consultant Pharma dated 2006 indicated each medication regi the appropriate form in the medical record no irregularities are for also documents this in record) and signs and documentation." DISCHARGED RESI R17's physician orde that R17 had a diagn hypertension, edema polymyalgia rheumat that causes muscle p R17 was admitted to remained in the facilit R17's Medication Re last consultant pharm record was dated 1/2 irregularities. There w pharmacist's Medicat February 2015, Marc 2015. Although, the DON's 4/20/15, indicated the in house on 4/17/15.' pharmacist medicatio 2/22/15, 3/17/15, and resident's permanent When interviewed or DON stated the facilit February 2015 and the	acist Recommendations "Documentation of the date men review is completed on and notation of the findings or other designated siteif bund, consultant pharmacist in the resident's (active d dates such DENTS rs, signed 4/1/15, identified osis that included a, osteoarthrosis, pain, and ica (inflammatory disorder bain and stiffness). the facility 3/3/12 and ty until 5/12/15; however gimen Review, indicated the nacist review in the medical 1/15 that indicated no new was no consultant tion Regimen Review for ch 2015, April 2015 and May progress note dated e "Pharmacist consultant was " R17's consultant on regime reviews, dated d 4/19/15, were not in the	2 625		

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C		(X3) DATE COMF	SURVEY PLETED				
		00286	B. WING		06/05/2015					
AME OF PI	ROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, STATE	, ZIP CODE						
ALLEY V	IEW HEALTHCARE & R	EHAB	ST CEDAR STREET DN, MN 55943							
(X4) ID PREFIX TAG			IX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		(EACH DEFICIENCY MUST BE PRECEDED BY FULL PF		(EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE A		N SHOULD BE	(X5) COMPLE DATE
2 625	Continued From pag	e 12	2 625							
	DON stated that ther	n 6/5/2015 at 9:30 a.m., the e wouldn't be anything in the d that she had no additional								
	that R57 had right hi orthopedic aftercare,	ers, signed 4/2/2015 identified p joint replacement with pain, hyperlipidemia, nsion, and cardiovascular								
	remained in the facili There was no docum record that R57's me	the facility 2/23/15 and ity until 4/30/15. nentation in the medical edications were reviewed acist for March 2015 and April								
	-	6/5/15, at 9:30 a.m. the DON anything in the record and nal information.								
	The director of nursin and revise policies a documentation of co- could provide staff ed policies and procedu	HOD OF CORRECTION: ng or designee, could review nd procedures related to de status for residents and ducation related to these res. The director of nursing evelop an audit tool to ensure rovided.								
	TIME PERIOD FOR (21) days.	CORRECTION: Twenty-one								
2 830	MN Rule 4658.0520 Proper Nursing Care	Subp. 1 Adequate and ; General	2 830							
		eneral. A resident must and treatment, personal and								

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING:	ONSTRUCTION		E.SURVEY PLETED
		00286	В. WING			/05/2015
	ROVIDER OR SUPPLIER		ADDRESS, CITY, STATE		00	05/2015
			ST CEDAR STREET			
ALLEY V	IEW HEALTHCARE & F	REHAB	ON, MN 55943			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE	(X5) COMPLE DATE
2 830	Continued From page	ge 13	2 830			
	individual needs and the comprehensive plan of care as des 4658.0405. A nursir of bed as much as p written order from th	supervision based on d preferences as identified in resident assessment and cribed in parts 4658.0400 and ng home resident must be out bossible unless there is a re attending physician that the n in bed or the resident bed.				
	by: Based on observation review, the facility fat wheelchair positioning residents (R10) who who had a left heming	nt is not met as evidenced on, interview and document iled to complete an ordered ng assessment for one of one was reviewed for positioning olegia and was leaning to the eelchair and was unable to and left leg.				
	Findings include:					
	admission diagnoses	the facility on 11/16/11, with s of cerebrovascular accident weakness and hypertension ecord.				
	the dining room, he v	o.m. R10 was returning from was leaning left in his electric his left arm was hanging				
	leaning to left. The at was leaned over so f arm rest. He stated h	m. R10 was sitting in the w/c rm rest was there, but he ar, you could not see the le leaned that way because arm and leg hemiplegia). The				

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	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C			E SURVEY PLETED	
			B. WING				
		00286	00/03/20				
AME OF P	ROVIDER OR SUPPLIER		ADDRESS, CITY, STATE				
ALLEY V	IEW HEALTHCARE & F	REHAB	ST CEDAR STREET DN, MN 55943				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLE DATE	
2 830	Continued From pag	ge 14	2 830				
	left knee was pointe lean. His left arm hu	d out and foot was tipped left ng down.					
		a.m. R10 was returning from g was turned out to the left					
		s rolled over onto the ankle ootrest, and his right arm was					
	was leaning in the w	R10 was asked if he knew he heelchair. R10 stated yes, himself upright, but was not upright by himself.					
	9/30/14, indicated ex activities of daily livin plan dated 3/24/15, falls, required an EZ	ea Assess (CAA), dated ktensive assistance for ng. The corresponding care indicated: R10 was at risk for stand for transfers or Hoyer for transfers with increased					
	(OT). The document Treatment for outpat The treatment noted wheelchair related to roommate's foot. Als R10 was able to driv hallway, within 10-12 swaying right to left,	note dated 2/19/15, for occupational therapy ration noted a Plan of tient rehabilitation (rehab). an evaluation for the electric ballegation of running over to noted was w/c mobility as re on right side of open 2 inches from wall with some and he was able to manage ssessment for safe driving."					
	positioning was sign An OT therapy order	s, therapeutic activities, w/c ed by physician on 3/11/15. · dated 3/2/15, stated ehab potential, discontinue					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED
	00286	B. WING		06/05/2015	
NAME OF PROVIDER OR SUPPLIER		ADDRESS, CITY, STATE, 2	ZIP CODE		
VALLEY VIEW HEALTHCARE &	REHAB	ST CEDAR STREET ON, MN 55943			
PREFIX (EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
<ul> <li>3/2/15, indicated: R control at lowest sp verbalize "excuse n Safe (to drive) when speed." However, th of a w/c assessment.</li> <li>The quarterly Minim 3/19/15, indicated F required extensive a transfers, toilet use, stand assist lift.</li> <li>The care plan dated activities of daily livit and locomotion due was dependent upor A review of the PT f on 1/2 of a sheet of PT-OT on Monday 6 an evaluation or ma We've noticed lately wheelchair his left le at times sometimes his hip is popped ou also makes it difficut stand even when us can add a pad to lef straight."</li> <li>On 6/3/15, at 2:00 p been assessed for p electronic w/c, only</li> <li>On 6/4/15, at 2:00 p stated the note was</li> </ul>	vered wheelchair driving dated 10 demonstrated good speed eed, demonstrated ability to ne" and able to use horn. " in scooter is set at lowest ne chart lacked documentation it for positioning. hum Data Set (MDS) dated R10 was cognitively intact, assist of two with bed mobility, and required the use of a 13/24/15, indicated deficits in ng, transfers, bed mobility, to left sided weakness. R10 in staff for all cares. ile indicated: An undated note computer paper was given to 6/1/15, "I think room 13 needs ybe an adaptive pad of sorts. that at times in his eg starts to turn out to the side severely where it looks like it of socket. At these times it It to keep left leg within the EZ ing the leg belt. Not sure if we it of w/c to help keep leg OT-A stated R10 had not proper positioning in the				

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	F OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C			E SURVEY PLETED
		00286	B. WING		06/05/201	
NAME OF P	ROVIDER OR SUPPLIER	5. <b>1</b>	ADDRESS, CITY, STATE	, ZIP CODE		
		510 EAS	T CEDAR STREET			
VALLEY V	IEW HEALTHCARE & R	EHAB HOUSTO	ON, MN 55943			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE	(X5) COMPLE DATE
2 830	Continued From pag	e 16	2 830			
	up in the past before	, unfortunately there were not r electric wheelchairs."				
	(DON) stated that R1 his wheelchair to the back to bed and get facility lacked a whee	m. the director of nursing 10 was sometimes leaning in left. Staff would then lift him him up after a rest. The el chair assessment for even though it had been				
	review, the facility fai implement intervention	interview and document led to develop and ons to prevent falls for 2 of 4 who were reviewed for				
	Findings include:					
	been admitted to the R17 R17's Fall Risk asses described R17 as ha balance problems, ur arthritis, and a declin and the assessment [wheeled walker] or W	d sheet indicated R17 had facility 3/3/12. ssment dated 3/15/15, ving an unsteady gait and rge incontinence, joint paint, e in decision making skills, indicated R17 utilized a VWV N/C [wheelchair], and was a akness and deconditioning.				
	3/17/15, indicated R1 short term memory lo (decreased blood flow muscle itself), edema medications (medicat hypertension (high bl	tions to promote urination), ood pressure), polymyalgia I stiffness in shoulders, neck, ), and osteoarthritis				

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PPLIER	00286	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
PPLIER	00288	B. WING		06	/05/2015
	STREET A	DDRESS, CITY, STATE	E, ZIP CODE		
	510 EAS	T CEDAR STREET			
CARE & F	HOUSTC	DN, MN 55943			
	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF C		(X5)
	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	E APPROPRIATE	COMPLE DATE
rom pag	je 17	2 830			
impaired 17 could ted and to had no was indepervision ist for tra- in her roo 12/17/14 up help nd toilet to icated R d ambula t indicate ive nursi ng Care 15, indica gnitive lo ADL) -fu e, falls ar ate whet an evalu- reased an n the could of the could	m 3/17/15, indicated R17 had l cognition. The MDS further understand what was could make herself depression or behavior pendent with bed mobility, or cueing and one person ansfers, toilet use and om. A previous quarterly b, had indicated R17 had for transfers, ambulation in use. The annual MDS from 17 needed assist with ation in the corridor. The e the resident had received ng or PT/OT. The Area Assessment (CAA) ated R17 had issues with ss, dementia, activities of nctional status, urinary nd nutritional status. The CAA ther any referral had been ation by OT or PT of R17's ssist with transfers and rridor.				
pain in , and ind "as indic 7 was ir	the right hip and knee from icated R17 would be referred cated." The care plan also idependent with transfers;				
ny signific actioning . The car or falls re	cant decline to physical and and to refer R17 to therapy re plan further indicated R17 elated to degenerative joint				
	7 was ir and aml aff were t ny signifio nctioning . The car or falls re ymyalgia s include	7 was independent with transfers; and ambulation with walker, and aff were to notify the MD (medical by significant decline to physical and notioning and to refer R17 to therapy . The care plan further indicated R17 or falls related to degenerative joint ymyalgia and history of falls. s included for staff to notify the MD of	7 was independent with transfers; and ambulation with walker, and aff were to notify the MD (medical by significant decline to physical and notioning and to refer R17 to therapy . The care plan further indicated R17 or falls related to degenerative joint ymyalgia and history of falls. s included for staff to notify the MD of	17 was independent with transfers; and ambulation with walker, and aff were to notify the MD (medical by significant decline to physical and notioning and to refer R17 to therapy . The care plan further indicated R17 or falls related to degenerative joint ymyalgia and history of falls.	17 was independent with transfers;         and ambulation with walker, and         aff were to notify the MD (medical         by significant decline to physical and         inctioning and to refer R17 to therapy         . The care plan further indicated R17         or falls related to degenerative joint         ymyalgia and history of falls.         s included for staff to notify the MD of

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO			E SURVEY PLETED
				A. BUILDING:		
	00286		B. WING		06	6/05/2015
IAME OF P	ROVIDER OR SUPPLIER	STREET	DDRESS, CITY, STATE	, ZIP CODE		
ALLEY V	IEW HEALTHCARE & R	EHAB	T CEDAR STREET DN, MN 55943			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE THE APPROPRIATE	(X5) COMPLE DATE
2 830	Continued From pag	e 18	2 830			
	function, and to refer hand written note on indicated R17's cogn of returning to the dir eating off of other res monitor the dining ro resident with fresh co plan did not include t for transfers and amb depicted in the most The Physician's Orde through 4/1/15, indic. LIB (up as tolerated). Review of R17's Nur-	e in physical or cognitive to therapy as indicated. A the care plan dated 4/29/15, ition was changing, "history ning room after lunch and sident's plates. Staff were to om, clear plates, redirect offee and snack." The care he use of staff intervention bulation in her room as current MDS dated 3/17/15. er Report dated 2/11/15 ated R17 should be UP AD sing Notes identified a had been identified for R17 5, at approximately 3:15 p.m.				
	the facility had first re (PT) and occupational evaluate R17's declin notes revealed R17 f requiring transfer to t (ER), and that R17 w with a fractured hip.	equested physical therapy al therapy (OT) services to be in ambulation. Nursing iell on 5/1/15, at 6:54 p.m. he hospital emergency room vas subsequently diagnosed Therapy notes for PT and OT none were provided during				
	p.m. indicated R17 "V for help. When staff e her back on the floor examining her we dis unable to move her ri feeling her hip she (F hip hurt, but also said Vital signs stable, sta	ote dated 5/1/15, at 6:45 was heard in her room yelling entered she was laying on in her room. Upon covered that resident was ight leg. When staff was R17) did state that her right I that her right knee hurt. Iff did send her into ER r x-ray of right hip and leg.				

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If continuation sheet 19 of 66

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING:		(X3) DATE SURVEY COMPLETED
		00000	B. WING		
		00286			06/05/2015
AME OF P	ROVIDER OR SUPPLIER		ADDRESS, CITY, STATE		
ALLEY V	IEW HEALTHCARE & F	REHAB	ON, MN 55943		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE COMPLE
2 830	Continued From pag	je 19	2 830		
	notified."				
	5/1/15, indicated R1 "Unwitnessed. Actua w/c to floor. Takes se supper, has water at	derstanding the Fall dated 7's incident had been al time of fall was 6:25 p.m. elf to bathroom, just had bedside. Trying to get into /leg pain. Last meds at 2:00			
	dated 5/1/15, was re documented by licen indicated the residen	entitled, Safety Event -Falls viewed. The form, used practical nurse (LPN)-A, it had been sent to the nd had returned on 5/2/15.			
	the resident had sust and had pain, and th intervention. Interven with assistance of tw	plan dated 5/1/15, indicated tained a fractured right hip at there had been no surgical ntions included: "Bedrest, o staff and Hoyer lift to pendent on staff for all needs.			
	resident required skil should continue with transfer bed to chair, with assist. The note restorative walking p SBA [stand by assist]	progress note indicated the led nursing and bedrest, previous activity, and would chair/bed to commode only included, "was on rogram average 23 feet with ] 2WW." The goal was ate independently in room			
	worker on 5/4/15, ind an unwitnessed fall ir report indicated that p	rt completed by the social licated R17 had experienced n her room on 5/1/15. The per the care plan R17 had tly with her walker at the time ble to use her call light.			

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If continuation sheet 20 of 66

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING:			E SURVEY PLETED
		00286	B. WING	06	6/05/2015	
AME OF P	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE			
ALLEY V	VIEW HEALTHCARE & R	EHAB	ST CEDAR STREET DN, MN 55943			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES DY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 830	Continued From pag	e 20	2 830			
	Details of the report documented that R17 had					
		and had been diagnosed				
	• .	re, that R17 had spent one				
		and after it had been decided				
		al intervention, R17 had y on 5/2/15, with orders for				
		nce with transfers to chair or				
	commode. The inves	tigative report further				
		ued to be alert, have a joking				
		led easily and expressed				
	interest in activities a	nd eating.				
		o.m. the director of nursing				
		vas still her own person, she				
		yalgia, was always able to				
		d assistance, and could and by herself. After the fall the				
	family opted not to do	•				
		amily because we had to do				
		which was going to cause the				
		med like quite a surprise to				
		e would be an option, and				
		Hospice. We kept the family t getting up and was eating				
		ry little, did not want to take				
	•	er medical doctor (MD)-A				
	saw her, he ordered a	a Hospice referral." In				
		ited the usual process for				
		to report to the nurse who				
		ident, document an event a post fall assessment form.				
		interdisciplinary team (IDT)				
	would review every fa					
		d to determine whether				
	therapy should be inv	olved.				
		the facility 8/15/12, with				
	admission diagnoses					
		e, dementia and weight loss				
	due to Alzheimer dise	ase.				

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C		(X3) DATE SURVEY COMPLETED	
	00286		B. WING		06	/05/2015
NAME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE		
ALLEY V	IEW HEALTHCARE & RE	HΔR	T CEDAR STREET			
		HOUSIC	DN, MN 55943			0.00
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE	(X5) COMPLET DATE
2 830	Continued From page	21	2 830			
	severe cognitive impa depression, behaviors of care, and that R40	s of wandering and refusal				/
	indicated R40 had me issues, was not awar	nent (CAA) dated 1/6/15, emory, mood and behaviors e of needs or safety, was at ement. Dependent on staff				
	been on 15 minute ch other interventions in- the potential for injury plan further indicated related to impulsivene Fall precautions in pla sensor pad, chair ala the resident was iden wandering and elope memory and not beir Interventions included location and activity, wrist and ankle which	ment related to poor ng aware of safety issues. d 15 minute checks daily for and a watchmate band on were to be checked for ery shift, and proper function				
	between 10/11/14 an were bed and chair a after 15 minute check addition, the falls wer comprehensively ass	essed for causative factors anges, and new interventions				

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TATEMENT	a Department of Healt OF DEFICIENCIES OF CORRECTION	n (X1) Provider/Supplier/Clia Identification Number:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED
	00286		B. WING		06	/05/2015
JAME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE		
			T CEDAR STREET			
ALLEY V	IEW HEALTHCARE & R	EHAB HOUSTO	N, MN 55943			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ( (EACH CORRECTIVE A) CROSS-REFERENCED T( DEFICIE)	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLET DATE
2 830	Continued From pag	e 22	2 830			
2 000						
	A review of the falls f					
1		0 a.m. Unwitnessed fall (staff				
		arm). The report included,				
	Fall in Day room; no	o injury, had been 1:1 (one to				
		nours. Continue alarms, will				
		"." No sleep study results				
	were reviewed in the	investigation for this fall.				
		o.m. Witnessed fall on TCU				
	(transitional care uni					
		oump back of head. 1:1 ess get up in chair." No sleep				
	Attention when result	eviewed for the investigation				
		wewed for the investigation				
	for this fall.	m. Unwitnessed fall in				
	resident room (staff responded to alarm). No injury, new intervention added after this fall: "					
		ent, chart behaviors ."				
		nergency room), memory				
	clinic and PMD in ho	ouse after adjustment in				
	medications with exa	acerbation of increased				
		ve devices [alarms] remain in				
	place and appropriat					
		o.m. Witnessed fall in hallway				
	(walking in the hall)	Documentation indicated,				
		ressive, lowered to the floor				
		hitting and kicking, no longer				
	able to stand and low	wered to floor. Sent to ER				
	(emergency room) for					
		o.m. Unwitnessed fall in				
	dayroom (staff resp	onded to alarm) INJURY:				
	"has red mark (scrat	tch) on both of her inner				
	forearms " 9 x 0.5	cm (centimeters), 10 cm x				
	0.4 cm, 3.5x1 cm. 0	Continue alarms.				
	6. 12/13/14, 10:20	) p.m. Unwitnessed fall (staff				
	responded to alarm)	). Slid out of chair to the floor				
	in Lounge. Continue					
	7. 1/7/15, at 1:45	p.m. Unwitnessed fall				
	(respond to alarm).	"Fell from Broda chair,				
	wanted to go for a w	valk, alarm sounded. She fell				
	to left side and hit b	ack of head. Injury: abrasion				

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If continuation sheet 23 of 66

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING:			E SURVEY PLETED
		00286	B. WING		06	6/05/2015
NAME OF P	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE	E, ZIP CODE		
		510 EAS	T CEDAR STREET			
VALLEY	/IEW HEALTHCARE & F	HOUST	ON, MN 55943			
(X4) ID		STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF	CORRECTION	(X5)
PREFIX TAG		CY MUST BE PRECEDED BY FULL & LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	HE APPROPRIATE	COMPLE
2 830	Continued From pag	ge 23	2 830			
	to back of head. Abr	asion to back of head,				
		ue to) blood sticking to				
		to wash it and cause it to				
		headache and tender to				
	touch, weak and sha					
	bathroom. Appears weaker and required					
	assistance with eatir	ng. In bed and shaking				
		s she is cold, several				
		me. Continue Broda alarm."				
		m. Witnessed fall (staff				
		. Fall in Resident Room was				
		fell back onto bed and head				
		Y Scraped off small part of				
		ad injury, previous lump on				
	head from fall was of	n 15 minute checks,				
		BP (blood pressure) 96/50."				
	would be next interve	gation included, "Restraints				
		cause, anxiety, confusion,				
	restricted movement					
		Ionitor for 72 hours, neuro				
		fected area of injury for 20				
		day for 3 days. Added a pad				
	to side of wall."	,,				
		n. Unwitnessed fall (staff				
		arm). Fell while trying to get				
		ir, "alarm was on with new				
	battery and did not w					
		meter reddened area on				
	right buttock, no c/o t					
		ed and are working." No 15				
	minute check form wa					
		n. Unwitnessed fall in her				
		d to alarm). "No injury noted.				
		nute) checks and alarms.				
	Found on sensor mat					
	notified."	Care plan updated and family				
1		a multipage of fall (staff				
		a.m. Unwitnessed fall (staff				
	nau respondeu to ala	rms). Nurse's note included,	1			1

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING:			E SURVEY PLETED
		00286		B. WING		105/2045
			ADDRESS, CITY, STATE		I 00	/05/2015
			ST CEDAR STREET			
ALLEY V	IEW HEALTHCARE & F	REHAB	ON, MN 55943			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLE DATE
2 830	Continued From pag	ge 24	2 830		1999 (1999) (199	
	"Walking back from and fell to the floor." documentation indic found scooting towa No injury. Continue with current measure 12. 3/1/15, at 5:00 a responded to alarms self-transferring. Hau INJURY right arm sc bruised, lump abrasi complained of heada alarms. Resident wa room change short t in resident's bathroo with current measure 13. 4/11/15, 11:43 p responded to alarms to transfer from chai pointed to top of fore hit the floor pain sco apparent injury. OT Broda chair. Suppor did sound. On 15 mi toileted. No medicati noted to experience tearfulness, anxiety a Resident has been r and treatment as ind recommendations. V measures. No chang No documentation in related to fall. 14. 4/12/15, at 12:5 dayroom (staff respo on her knees in front	the bathroom in her room The computer ated, "bed alarm going off, rds bed, incontinent of urine. alarms. No changes continue es." a.m. Unwitnessed fall (staff b). Fell in bedroom while d been toileted at 2:30 a.m. bratch, right side back of head on- 3cm X 2cm x 1cm raised, ache after fall. Continue as in a different environment erm due to plumbing project m. No changes continue es o.m. Witnessed fall (staff b). R40 fell in her room trying r to bed. A little bit of pain, shead. The back of the head re 1/10. Ice bag applied. No eval for self-release belt in tive devices in place, alarm nute checks, routinely ons changes. Resident was increased restlessness, after visit with her daughter. eferred to OT for evaluation icated. Will follow their Vill continue with current le to plan of care at this time. 15 minute check form 4 p.m. Witnessed fall in nded to alarm). "Observed of another resident.				
	resident. 4/12/15, 1:0	had stood up and fallen into 04 p.m. sitting 90/70 O2 sats 00%." New interventions this was left blank.				

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING:		(X3) DATE COMP	SURVEY LETED
	and the second	00286	B. WING		06/05/2015	
AME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE		
	IEW HEALTHCARE & R	EHAB 510 EAS	T CEDAR STREET			
ALLLIV	ILW HEALTHOAKE & K	HOUSTC	N, MN 55943			
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF		(X5)
PREFIX		CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTI CROSS-REFERENCED TO T		COMPLE DATE
TAG			IAG	DEFICIENC		
2 830	Continued From pag	e 25	2 830			
	"Supportive devices i	in place, alarm did sound. On				
	15 minute checks, ro	-				
		s. Resident was in a different				
	-	hange short term due to				
		esident's bathroom. No				
		th current measures."				
	15. 4/12/15, 8:40 p.r					
		i). Found in lounge face down				
		ing a nap, I fell out of my				
		ad " . OT self-release in				
		evices in place, alarm did				
		e checks, routinely toileted.				
		nges. Resident was in a				
	different environmen	t room change short term d/t				
	plumbing project in re	esident ' s bathroom. No				
	changes continue wit	th current measures.				
	16. 5/25/15, 6:30 p.r	m. Unwitnessed fall				
		). Found crawling on floor in				
		ping to bed " . A few minutes				
		ll on her right butt. No injuries				
		vices in place, alarm did				
		checks, routinely toileted.				
		nges. Resident was in a				
		t room change short term				
		ect in resident 's bathroom.				
		l in recent past after increase				
		have self-releasing belt on Currently we will continue with				
		taff to encourage resident to				
		8 p.m. if noted to be tired.				
		p.m. report indicated,				
		belt; got up and laid down on				
		ot a fall. Resident laid herself				
		ot slide or fall out of her				
		essed fall. Nursing progress				
		nursing assistant (CNA)				
		), found resident sitting on				
	· · · /	ng to lay down. Opened				
		eleasing seat belt was				
		e that she is able to release				

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING:			E SURVEY PLETED	
		00286	B. WING		06	06/05/2015	
NAME OF P	ROVIDER OR SUPPLIER		ADDRESS, CITY, STATE	, ZIP CODE			
		510 EAS	ST CEDAR STREET				
VALLEY V	IEW HEALTHCARE & R	EHAB HOUST	ON, MN 55943				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE	(X5) COMPLE DATE	
2 830	Continued From page	e 26	2 830				
	unhooked her seat be the floor. This was no down on the floor did chair. No fall. 18. 5/28/15, at 8:00 responded to alarm). front of w/c. 'trying Other residents said into recliner. New inte for bed by 8:00 p.m." 19. 6/2/15, at 4:40 a (responded to alarm) when staff arrived in sounded for 2 minute the bathroom sitting of						
	day. A review of the 15 mi that the forms were fr same hand, with the s every 15 minutes. On 6/5/15, at 1:15 p.r was interviewed and forms are given to he	y 15 minutes through the nute check forms indicated requently filled out by the same pen for 8-12 hours m. the social worker (SW) stated the 15 minute check or when complete. The SW					
	that alarms and 15 m increase falls. The SV family that the facility alarms, but R40's fan SW verified that the 1 not always completed The facility failed to th	is aware of the research inute checks may actually <i>N</i> had sent out notices to is going to try to eliminate nily insists on the alarms. I5 minute check forms were d. horoughly investigate and R40 and did not attempt new					

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00286	B. WING		00/05/0045	
NAME OF PF			ADDRESS, CITY, STATE	, ZIP CODE	00	5/05/2015
VALLEY V	IEW HEALTHCARE & RI	EHAB	ST CEDAR STREET ON, MN 55943			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 830	whether medical reas considered, even whe	ery fall. It was unclear	2 830			
	The director of nursin educate nursing staff care and supervision the resident's individu	OD OF CORRECTION: g (DON) or designee could regarding providing nursing for residents according to ual needs and assessment. g or designee could develop e appropriate care is				
	TIME PERIOD FOR ( days.	CORRECTION: Thirty (30)				
21375	MN Rule 4658.0800 S Program	Subp. 1 Infection Control;	21375			
	home must establish	control program. A nursing and maintain an infection gned to provide a safe and				
	by: Based on observation review, the facility fail hand hygiene and glo residents care for 1 of addition, the facility fa procedures to prevent blood borne infections monitoring performed	iled to implement t the possible spread of s during blood glucose for 2 of 10 residents (R10, ugars readings taken with				

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	F OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C			E SURVEY PLETED	
		00286	B. WING		06	05/2015	
AME OF P	ROVIDER OR SUPPLIER		ADDRESS, CITY, STATE				
ALLEY V	IEW HEALTHCARE & R	EHAB	ST CEDAR STREET ON, MN 55943				
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLE DATE	
21375	Continued From pag	e 28	21375				
	Findings include:						
		observed for morning cares, A)-A, did not change gloves					
	R10 NA-A verified the removed her gloves NA-A then lifted R10 wheelchair, then dom provided the denture was not aware of the facility, and would have been doing the job for The quarterly Minimu 3/19/15, indicated R2 required extensive as transfers, toilet use, a	m. cares were observed for at she did provided peri-care, but did not wash her hands. out of bed into an electric uned a new pair of gloves and as to R10. NA-A stated she hand washing policy for the ave to find out. NA-A had or three years. um Data Set (MDS) dated 10 was cognitively intact, ssist of two with bed mobility, and required the use of a		· · · · · · · · · · · · · · · · · · ·		C.	
	indicated R10 was at transfers, or Hoyer lift transfers with increas transfers, bed mobilit to left sided weaknes	are plan dated 3/24/15, t risk for falls, EZ stand for ft with assist of two for sed weakness. Deficits in ty, and locomotion were due ss. The care plan dated 10 was dependent on the cares.					
	(DON) verified she ex appropriate hand hyp	giene.					
	The Hand Washing F 2006, indicated hand requiredafter remo Blood glucose meter:	oval of gloves.					

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING:			E SURVEY PLETED
		00286	B. WING		06/05/2015	
NAME OF PI	ROVIDER OR SUPPLIER		ADDRESS, CITY, STATE	, ZIP CODE		510512015
VALLEY V	IEW HEALTHCARE & R	EHAB	ST CEDAR STREET			
040.15		ATEMENT OF DEFICIENCIES	ON, MN 55943			
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TH DEFICIENC\	ON SHOULD BE HE APPROPRIATE	(X5) COMPLE DATE
21375	Continued From page	e 29	21375			
	On 6/1/15, licensed p not use a sanitary ma glucose meter, and d as directed by the ma perform the final lock when the insulin syrir sharps container. On 6/1/15, at 4:06 p.r observed for R10, the the water pitcher tray used to obtain a bloo machine was then pla medication cart. LPN with a bare hand put blood) in the sharps of past, and said somet then opened the botto cart and cleaned the sani-wipes, but did no contaminated medica LPN-A verified her us BG meter on the top unclean At 4:18 p.n been going to clean ti but the DON walked p super sani-wipes. -At 4:22 p.m. LPN-A of R5, LPN-A was obser needle, then swab the the syringe, thereby e stick. LPN-A then acc the insulin needle and syringe, then recapped	practical nurse (LPN)-A did anner while using the blood id not use the safety syringe anufacturer, and did not to prevent needle exposure ange was discarded in the m. BG procedure was e BG meter was placed on in R10's room, and then d sample. The contaminated aced directly on top of the -A then removed gloves and the soiled lancet (exposed to container. The DON walked hing quietly to LPN-A, who bom drawer of the medication BG meter with a super ot wipe down the already tion cart. At 4:06 p.m. ual practice was to set the of the medication cart h. LPN-A stated she had he BG meter with alcohol, bast and told her to use the obtained an insulin dose for ved to uncap the insulin e insulin vial after uncapping exposing herself to a needle uessed the insulin vial with d drew up 1 unit in the safety				
	insulin dose, and ther safety syringe to cove did not lock the safety	n pulled the sheath up on the er the needle. However, she v syringe by turning the posed the unlocked syringe				

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	FOF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:	ONSTRUCTION		E SURVEY PLETED
		00286	B. WING		06/05/2015	
NAME OF P	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE,	, ZIP CODE		
ALLEY V	IEW HEALTHCARE & R	EHAB	T CEDAR STREET DN, MN 55943			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
21375	verified she did not u until she was done w - At 5:00 p.m. the dir verified a needle sho then used a safety sy of the syringe should disposal in the sharp verified the manufact be followed while usi The Infection Control dated 2006, directed to wash their hands a contact for which har accepted professiona clean working enviro counter, tableskee	for needle stick). LPN-A ise the safety syringe sheath	21375			
	The director of nursir staff on the appropria patient use equipmer contamination, recap handwashing and glo nursing or designee of compliance.	OD OF CORRECTION: ng or designee could educate ate cleaning of multiple nt to prevent cross oping of syringes, and proper ovong. The director of could then monitor for CORRECTION: Twenty One				
21426	Prevention And Cont (a) A nursing home maintain a comprehe	provider must establish and	21426			

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If continuation sheet 31 of 66

STATEMEN	a Department of Healt T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:		(X3) DATE SURVEY COMPLETED 06/05/2015		
		00286	B. WING				
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE			
		510 EAS	T CEDAR STREET				
VALLEY V	VIEW HEALTHCARE & R	EHAB HOUSTO	ON, MN 55943				
(X4) ID PREFIX TAG			(EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CO		PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETI DATE
21426	current tuberculosis i issued by the United Control and Preventie Tuberculosis Elimina Morbidity and Mortali This program must ir infection control plan unpaid employees, c residents, and volunt Health shall provide to regarding implementa	nfection control guidelines States Centers for Disease on (CDC), Division of tion, as published in CDC's ty Weekly Report (MMWR). Include a tuberculosis that covers all paid and ontractors, students, eers. The Department of technical assistance ation of the guidelines.	21426				
	by: Based on interview a facility did not ensure screening was comp (E2) and for 5 of 5 re R64, R57). In additio receive a timely secc skin test (TST). Findings include: EMPLOYEES E2's date of hire was E2's employee record TST on 1/19/15, read TST was received or	nt is not met as evidenced ind document review, the e tuberculosis (TB) symptom leted for 1 of 5 employees sidents (R66, R63, R66, n, 2 of 5 employees did not and step two-step tuberculin 1/27/15. Upon review of d, E2 received a first step t on 1/22/15. A second step a 3/6/15, 43 days later. A TB at also was not completed for					

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STATEMENT	a Department of Healt OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00286	B. WING		06/05/2015	
NAME OF PR	ROVIDER OR SUPPLIER	STREE	TADDRESS, CITY, STATE	E, ZIP CODE		
			AST CEDAR STREET			
ALLEY V	IEW HEALTHCARE & R	EHAB HOUS	TON, MN 55943			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COMPLE	
21426	Continued From pag	e 32	21426			
	E4's employee recor TST on 3/18/15, read	3/18/15. Upon review of d, E4 received a first step d on 3/20/15. A second step n 5/18/15, 59 days later.				
	R65's record reveale given on 5/19/15, rea was given on 6/1/15	the facility on 5/19/15. In that a first step TST was ad on 5/21/15. A second step read on 6/3/15. A TB In twas not completed for				
	record revealed that 5/26/15, read on 5/2 (DON) stated R63 w	the facility on 5/26/15. R63's a first step TST was given on 8/15. Director of nursing as scheduled for a second symptom assessment was 63.				
	record revealed that 5/27/15, read on 5/2 scheduled for a seco	o the facility on 5/27/15. R66's a first step TST was given on 9/15. DON stated R66 was ond TST on 6/9/15. A TB nt was not completed for				
	record revealed that 5/29/15, read on 5/3 scheduled for a seco	o the facility on 5/29/15. R64's a first step TST was given on 1/15. DON stated R64 was ond TST on 6/12/15. A TB nt was not completed for				
	remained in the faci R57's record reveal given on 2/23/15, re was given on 3/9/15	o the facility on 2/23/15 and lity until 4/30/15. ed that a first step TST was ad on 2/25/15. A second step 5, read on 3/11/15. A TB ent was not completed for				

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	FOF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING:			E SURVEY PLETED
		00286	B. WING			
AME OF P	ROVIDER OR SUPPLIER		ADDRESS, CITY, STATE		1 00	6/05/2015
		510 FAS	ST CEDAR STREET			
ALLEY V	IEW HEALTHCARE &	REHAB	ON, MN 55943			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES JCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ( (EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPL DATE
21426	Continued From pa R57.	ge 33	21426			
	coordinator (SC) sta screens to all five e	on 6/1/15, at 11:42 a.m. staff ated she gave TB symptom mployees and verified the E2 was blank and that E2 out and signed it.				
	stated SC did help a reminded employee next one. DON verif done within two wee stating that symptor	on 6/5/15, at 2:25 p.m. DON and sets up the initial TST and s when they are due for the ïed the second TST should be eks per facility policy, further n screening for residents was that have a positive TST.				
	was reviewed. The p Healthcare & Rehat tuberculosis for all s working with resider hours of admission i within last three mor in facility more than volunteering in the fa tuberculin skin test ( admission/hire/volur annually thereafter." facility to repeat the weeks from the read	nteering and (single step) The procedure directed the above procedure in two (2) ling for first time policy did not include nts for				
21445	MN Rule 4658.0900 Recreation Program	Subp. 3 Activity and ; Director	21445			
		d recreation program director. eation program director must				

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING			E SURVEY PLETED
		00286			06/05/2015	
	ROVIDER OR SUPPLIER	and <b>b</b> een and the second s			00	05/2015
	ROUDER OR SOFFLIER		ADDRESS, CITY, STATE <b>ST CEDAR STREET</b>			
ALLEY V	IEW HEALTHCARE &	REHAB	ON, 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 (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLE DATE
21445	Continued From pa	ige 34	21445			
		trained or experienced to nd recreation staff and sing home.				
	by: Based on interview facility failed to prov	ent is not met as evidenced and document review, the vide a qualified activity director. ial to affect all 41 residents the facility.				
	Findings include:					
	Minutes, dated 4/9/ "Administrator did h Director. She will of social worker comir	ident Council Meeting 15, identified the ire [name] as the new ficially start [date]. She was a ng from other nursing home nacity of activity director."				
	administrator stated directly involved in a	on 6/5/15, at 12:27 p.m. the I the activity director was activities in social work at if anything she was over				
	activity director (AD worker and previous department that was social work and help	p.m. when interviewed the ) stated she was a social sly had worked in an activity s a combined position doing ping with activities. She further vork in activities solely for a full				
	position description the "Job Qualification and state regulation	rsing Home, Activity Director revised, 3/2015, indicated m: The following are federal s covering the qualifications or: 1. A certified occupational				

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C			E SURVEY PLETED
		00286	B. WING		06	/05/2015
AME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE		
ALLEY V	IEW HEALTHCARE & R	EHAB	T CEDAR STREET DN, MN 55943			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ( (EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE D THE APPROPRIATE	(X5) COMPLE DATE
21445	Continued From pag	e 35	21445			-
	assistant (COTA) or a experience in social	3. Two years of work or recreational activities."				
	A SUGGESTED ME	THOD FOR CORRECTION:				
		designee, could review and rocedures related to ensuring				
	•	eets the qualifications rganized activities and				
	recreation in a health	÷				
	TIME PERIOD FOR (21) days.	CORRECTION: Twenty one				
21530	MN Rule 4658.1310	A.B.C Drug Regimen Review	21530			
		n of each resident must be				
		nthly by a pharmacist the Board of Pharmacy.				
		done in accordance with				
		ate Operations Manual,				
	•	for Pharmaceutical Service				
		g-Term Care, published by				
	•	ealth and Human Services,				
		g Administration, April 1992.				
		prporated by reference. It is				
		Minitex interlibrary loan ect to frequent change.				
		st must report any				
	•	rector of nursing services				
	-	vsician, and these reports				
	• • •	by the time of the next				
		oner, if indicated by the				
		ooses of this part, "acted				
		eptance or rejection of the				
		or initialing by the director				
	• •	nd the attending physician.				1
		g physician does not concur				
	with the pharmacist's	recommendation, or does				
	not provide adequate	justification and the				

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	F OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING:			E SURVEY PLETED
		00286	B. WING			/05/2015
NÁME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	E, ZIP CODE		
ALLEY V	IEW HEALTHCARE & R	EHAB	T CEDAR STREET DN, MN 55943			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
21530	being adversely affect refer the matter to the if the medical directo physician. If the medical justification for the or physician does not cl must be referred for in assessment and assis by part 4658.0070. If the medical director, must refer the matter assessment and assis This MN Requirement by: Based on interview a facility failed to ensur- identified irregularities director of nursing an residents (R14, R39, antipsychotic medica monitoring. In additio	the resident's quality of life is cted, the pharmacist must e medical director for review r is not the attending dical director determines that an does not have adequate der and if the attending hange the order, the matter review to the quality urance committee required f the attending physician is the consulting pharmacist directly to the quality urance committee. At is not met as evidenced ind document review, the re the consultant pharmacist s and reported them to the d physician for 4 of 4 R40, R10) who took tion had adequate n, failed to ensure there was tion for continued use of an	21530	DEFICIEN		
	was observed dresse	n 6/3/15, at 7:56 a.m. R14 d, calmly sitting in ing room table independently				
	for psychotropic medi					

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C		(X3) DATE SURVEY COMPLETED	
		00286		06	/05/2015	
AME OF PI	ROVIDER OR SUPPLIER		ADDRESS, CITY, STATE	, ZIP CODE		
ALLEY V	IEW HEALTHCARE & R	FHAB	ST CEDAR STREET DN, MN 55943			
(X4) ID PREFIX	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO	TION SHOULD BE	(X5) COMPLE DATE
TAG			TAG	DEFICIENC		
21530	Continued From pag	e 37	21530			
	The current Medicati	on Administration Record				
		through 6/4/15, indicated				
	R14 received daily a					
	antipsychotic Zyprex	lexa and Trazodone and a.				
	Review of the Vitals	Report from 12/3/14 through				
		nostatic blood pressure was				
	taken only two of the 6/1/15.	six months, on 3/1/15 and				
	The quarterly Minimu	um Data Set (MDS) dated				
		14 had moderate cognitive				
		d 3/17/15, indicated R14 was				
		oserve for potential side				
		on effectiveness, monthly / consulting pharmacist and				
	•	al signs per facility policy.				
	R14's current physic	ian report dated 5/4/15				
		ated orders for Zyprexa				
		iilligrams (mg) once a day check orthostatic BP [blood				
		on the 1st of the month.				
	Monthly Medication I	Regimen Review revealed				
		nacist reviewed R14's				
		/15 and another consultant I5, 3/16/15, 4/17/15, and				
		ndicate the lack of adequate				
	monitoring which inc	luded orthostatic blood				
	pressure for the antip	osychotic medication.				
		on 6/4/15, at 10:30 a.m. the				
		OON) verified the orthostatic				
	blood pressure shou was not.	ld have been completed and				

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TATEMENT	a Department of Healt OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C			E SURVEY PLETED
AND PLAN C	IF CORRECTION		A. BUILDING:			
		00286	B. WING			/05/2015
NAME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE		
	IEW HEALTHCARE & RI	EHAR	T CEDAR STREET			
		HOUSIC	ON, MN 55943			(17)
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN (EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	ACTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLET DATE
21530	Continued From page	e 38	21530			
ļ	was observed dresse (type of wheelchair) v room, calm, and inde	on 6/3/15, at 7:59 a.m. R39 ed, sitting upright in a Broda wheelchair in the dining ependently feeding himself. neet you, I have more food				
	medication use indic administration of anti	2/11/14, for psychotropic ated R39 required daily idepressant (Paxil) and uel), and was at risk for side for falls.				
	The Quarterly MDS of had severe cognitive	dated 3/10/15, indicated R39 impairment.				
	to observe for potent medication effectiver	ness, monthly medication pharmacist and to routinely				
	obtained from the PH 5/4/15 through 6/4/1 Report indicated ord (antipsychotic) 50 m (decreased from thre 5/20/15) and directe	ces of agitation and delusions and hallucinations nysician Order Report dated 5. R39's current Physician ers for Seroquel				
	indicated R39 receiv	om 12/1/14 through 6/4/15 ved the medication TID from 0/15, and BID from 5/20/15				

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	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING:		(X3) DATE SURVEY COMPLETED
		00286	B. WING	06/05/2015	
IAME OF PI	ROVIDER OR SUPPLIER	STREET	DDRESS, CITY, STATE	E, ZIP CODE	
ALLEY V	IEW HEALTHCARE & R	EHAB	T CEDAR STREET DN, MN 55943		
(X4) ID PREFIX TAG	· (EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE COMP THE APPROPRIATE DAT
21530	Continued From page	e 39	21530		
	5/28/15, indicated ort taken only one of five Monthly Medication F the consultant pharm medications on 1/21/ pharmacist on 2/20/1 5/15/15, but did not ir monitoring for the ant During an interview o DON verified the orth should have been con stating "I would have	Regimen Review revealed			
	admission diagnoses (CVA) with left sided v and bipolar disease. The quarterly Minimum 3/19/15, indicated R10 required extensive as	the facility on 11/16/11, with of cerebrovascular accident weakness and hypertension, m Data Set (MDS) dated 0 was cognitively intact, sist of 2 with bed mobility, nd required the use of a			
	at risk for falls, EZ sta	3/24/15, indicated: R10 was nd for transfers, or Hoyer lift ransfers with increased			

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING:			E SURVEY PLETED
		00286	B. WING		06/05/2015	
JAME OF P	ROVIDER OR SUPPLIER		ADDRESS, CITY, STATE			103/2013
		510 EAS	T CEDAR STREET			
ALLEY V	IEW HEALTHCARE & R	EHAB	ON, MN 55943			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES DY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE	(X5) COMPLE DATE
21530	Continued From pag	e 40	21530			
	weakness. Deficits ir locomotion due to let	n transfers, bed mobility, and ft sided weakness.				
		s dated 5/5/15, included release for bipolar disorder, lisorder				
	2014, October 2014,	's were recorded for Sept March 2015, April 2015, ician orders were followed 5				
	should have had the	m. the DON stated that R10 ordered orthostatic blood nsure adequate side effect g completed.				
		the facility 8/15/12, with of Alzheimer ' s disease, tia and weight loss.				
	- 7/31/14, Lorazepan lorazepam 0.5 mg.	nedications was as follows: n 0.5 mg at bed time and 25 mg in afternoon and 50				
	mg at HS discontinue - 11/3/14, Seroquel G HS discontinued 11/1	ed 11/3/14. Give 25 mg TID and 75 mg at I3/14.				
	at HS.	Give 25mg TID and 100 mg				
	memory, mood and b	ed 1/6/15, indicated R40 had behaviors issues, was not				
		fety, was at risk for falls and nt on staff to meet needs.				
	history of tossing and	1/6/15, indicated R40 had a I turning every night and the Ir consecutive hours every				

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C			E SURVEY PLETED
		00286	B. WING		00/07/07/07	
	ROVIDER OR SUPPLIER	and a second	ADDRESS, CITY, STATE		0	/05/2015
				, ZI OODE		
ALLEY V	IEW HEALTHCARE & F	REHAB	DN, MN 55943			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE APPROPRIATE	(X5) COMPLE DATE
21530	Continued From pag	ge 41	21530			
	night. Observe for si Zoloft was given for to monitor for assess document targeted b given for anxiety/agi for effectiveness and monitor mood in res primary consultant w notify physician. The MDS dated 4/1/ cognitive impairment behaviors of wander	ide effects and effectiveness. depression, and the staff was s/record effectiveness, and behaviors. Lorazepam was tation. Staff was to monitor d adverse consequences, ponse to lorazepam. The vas to review monthly and 15, indicated severe t, moderate depression, ing and refusal of care. R40 ssistance of one staff for all				
	on Seroquel, and DC record lacked evider	m. the DON stated R40 was DN was aware the medical nee of adequate side effect uld have included orthostatic				
	Procedures for Psyc June 20, 2006 indica manage the psychot and "will developmen Psychotropic Medica mediation [medication adjustment recommed direction for vital sign	or the consulting pharmacist				
	Medication Regimen dated 2006 indicated performs a comprehe	ant Pharmacist Reports Review (monthly report) I "the consultant pharmacist ensive medication regimen nly. The MRR [Medication				

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	OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING:			E SURVEY PLETED
		00286	B. WING		06/05/2015	
NAME OF PI	ROVIDER OR SUPPLIER	STREET	DDRESS, CITY, STATE	, ZIP CODE		
ALLEY V	IEW HEALTHCARE & R	EHAB	T CEDAR STREET DN, MN 55943			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
21530	Continued From page	<u>4</u> 2	21530			
	resident's response to determine that the re practicable level of fu	o medication therapy to sident maintains the highest nctioning and prevents or onsequences related to				
	Wentkiewicz, Cynthia					
	moderate cognitive in	dated 5/6/15, indicated npairment. R21 also had enic bladder, and diabetes				
	and indwelling cathet 8/21/14, indicated "is	eport urinary incontinence er analysis of findings dated at risk for skin irritation and tinence of urine, will review e plan."				
	dated 2/4/15 through comments: "is inconti	screening (3-day void) 2/6/15, additional nent of bowel and bladder, ducts which staff change."				
	4/30/15 through 5/2/1	ening (3-day void) dated 5, included additional y incontinent of bladder and tal assist of 1."				
	6/5/15, included Kefle once a day start date chronic recurrent UTI	a dated 5/5/15 through ex capsule 250 mg orally 8/1//14, diagnosis: infection, . Ciprofloxacin HCI 500 mg for 10 days start date 5/27				

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	FOF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING:			E SURVEY PLETED
		00286	00286 B. WING			
NAME OF P	ROVIDER OR SUPPLIER	-	ADDRESS, CITY, STATE	, ZIP CODE		6/05/2015
		510 EAS	T CEDAR STREET			
ALLEY V	IEW HEALTHCARE & R	HAB HOUST	ON, MN 55943			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES DY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE	(X5) COMPLE DATE
21530	Continued From pag	e 43	21530			
		19/13, for bladder discomfort aight catheter for urine r greater.				
	urinary tract infection Goal was to not exhili infection. The approa Keflex (cephalexin - a (MD) order as prophy evaluate, record, and effectiveness/adverse scan/straight cathete bladder distension. M Report signs of UTI ( frequency, bladder sp pain, difficulty urinatin malaise, nausea/vom concentrated urine, b indicated.					
	lacked evidence that addressed the antibio On 6/4/15, at 1:49 p.r	•				
	antibiotic. When aske she stated no. Her bl high, she went into th were back to normal.	ed if R21 currently had a UTI, ood sugars had been very he hospital, and now they RN-A stated ciprofloxacin for ten days for a urinary				
	were back to where t R21 was still getting I					
	On 6/5/15, at 1:06 p.r indicated resident do	n. DON stated MD-A es not have yeasty rash in				

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STATEMENT	a Department of Healt OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			A. BUILDING:			
		00286	B. WING		06/05/2015	
NAME OF PR	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE		
ALLEY V	IEW HEALTHCARE & RI	FHAR	T CEDAR STREET N. MN 55943			
		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN O	E CORRECTION	(X5)
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE	COMPLE DATE
21530	Continued From page	e 44	21530			
	peri-area. The DON s	stated prior to resident				
		d a history of UTI and had				
		quently due to it. While R21				
		as tapered down, urinary				
	retention stopped, an	•				
	catheterized while the					
		otic, it was started long ago				
		where the documentation				
	-	e been prior to R21 coming				
	• •	id trial off the antibiotic for				
		s restarted due to UTI and DON further commented R21				
		and could bottom down	×			
		ars were better controlled				
		into the facility. They had to				
		ts and have not had to				
		ince she had been there.				
	They could bladder s					
	catheterizing. She ha	id a recent UTI on 5/27/15,				
	when she had elevate	ed blood sugar and was put				
	on an antibiotic. Her l	blood sugar was better and				
	the UTI was gone.		s			
	- At 1:17 p.m. DON s					
	pharmacist consultar					
		commendations for the vould have no printout for her				
	chart.	vouid have no printout for her				
	The insert package is	abel for cephalexin by				
		sed on 5/14, read, "To				
	reduce the developm					
	bacteria and maintair					
	cephalexin and other					
		used only to treat or prevent				
		oven or strongly suspected				
	to be caused by bact	eria."				
	A message was left f	or the consulting pharmacist				
	-	or the concurring prismacies				

	F OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED		
				· ·			
		00286				06/05/2015	
AME OF PI	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE				
ALLEY V	IEW HEALTHCARE & R	EHAB	T CEDAR STREET DN, MN 55943				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ( (EACH CORRECTIVE A) CROSS-REFERENCED TO DEFICIEI	CTION SHOULD BE THE APPROPRIATE	(X5) COMPLE DATE	
21540	Continued From page	e 45	21540	алаан ал			
21540 MN Rule 4658.1315 Subp. 2 Unnecessar Usage; Monitoring		Subp. 2 Unnecessary Drug	21540				
	monitor each residen unnecessary drug us home's policies and p pharmacist must repor- resident's attending p physician does not co- home's recommenda adequate justification believes the resident' adversely affected, the matter to the medical medical director is no the medical director of physician does not hav the order and if the afficient change the order, the review to the Quality J (QAA) committee req the attending physici	age, based on the nursing procedures, and the ort any irregularity to the physician. If the attending poncur with the nursing tion, or does not provide					
	by: Based on observation review, the facility fail (R14, R39, R40, R10)	t is not met as evidenced n, interview and document ed to ensure 4 of 4 residents ) who took antipsychotic uate monitoring. In addition,					
	failed to ensure there	•					
	Findings include:						
						1	

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If continuation sheet 46 of 66

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING:			E SURVEY PLETED
		00286	B. WING		06/05/2015	
	ROVIDER OR SUPPLIER		ADDRESS, CITY, STATE			000/2013
		510 EAS	ST CEDAR STREET			
ALLEY V	IEW HEALTHCARE &	REHAB	ON, MN 55943			
(X4) ID PREFIX TĄG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLE DATE
21540	Continued From pa	ge 46	21540			
	was observed dress	on 6/3/15, at 7:56 a.m. R14 sed, calmly sitting in ning room table independently				
	for psychotropic me was at risk for side	essment (CAA) dated 9/24/14 dication use indicated R14 effects including risk for falls. cluded dementia with and anxiety				
	(MAR) from 12/1/14 R14 received daily a	elexa and Trazodone and				
	6/1/15, indicated ort	Report from 12/3/14 through hostatic blood pressure was e six months, on 3/1/15 and				
		um Data Set (MDS) dated 14 had moderate cognitive				
	on Zyprexa and to o effects and medicati medication review b	ed 3/17/15, indicated R14 was bserve for potential side on effectiveness, monthly y consulting pharmacist and tal signs per facility policy.				
	through 6/4/15, indic (antipsychotic) 2.5 n and directed staff to	cian report dated 5/4/15 cated orders for Zyprexa nilligrams (mg) once a day check orthostatic BP [blood y on the 1st of the month.				
		Regimen Review revealed nacist reviewed R14's				

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If continuation sheet 47 of 66

STATEMENT	a Department of Healt OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING:			E SURVEY PLETED
		00286	B. WING		06/05/2015	
NAME OF PR	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE	E, ZIP CODE		
ALLEY V	IEW HEALTHCARE & RI	EHAB	T CEDAR STREET			
			DN, MN 55943			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OI (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLE <sup>-</sup> DATE
21540	1.0	e 47 15 and another consultant	21540			
	5/15/15, but did not ir monitoring which incl	5, 3/16/15, 4/17/15, and ndicate the lack of adequate uded orthostatic blood				
		n 6/4/15, at 10:30 a.m. the ON) verified the orthostatic				
		d have been completed and				
	was observed dresse (type of wheelchair) v room, calm, and inde R39 stated "Nice to n	on 6/3/15, at 7:59 a.m. R39 d, sitting upright in a Broda vheelchair in the dining pendently feeding himself. neet you, I have more food				
	medication use indica administration of anti	2/11/14, for psychotropic ated R39 required daily depressant (Paxil) and uel), and was at risk for side for falls.				
	The Quarterly MDS d had severe cognitive	lated 3/10/15, indicated R39 impairment.				
	to observe for potenti medication effectiven	ess, monthly medication pharmacist and to routinely				
		. R39's current Physician ers for Seroquel				

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED
		00286	B. WING		06	6/05/2015
AME OF PF	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE		
ALLEY V	IEW HEALTHCARE & RI	EHAB	T CEDAR STREET			
	9444-9-1-1-1-1-1-1-1-1-1-1-1-1-1-1-1-1-1	HOUSTO	N, MN 55943			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
21540	Continued From page	9 48	21540			
	5/20/15) and directed	e times a day (TID) on staff to check orthostatic once a day on the 15th of the				
	indicated R39 receive	n 12/1/14 through 6/4/15 d the medication TID from 15, and BID from 5/20/15				
		Report from 12/2/14 through hostatic blood pressure was months, on 3/15/15.				
	the consultant pharm medications on 1/21/ pharmacist on 2/20/1 5/15/15, but did not in	egimen Review revealed acist reviewed R39's 14 and another consultant 5, 3/16/15, 4/17/15, and idicate lack of adequate ipsychotic medication.				
	DON verified the orth should have been cor stating "I would have	n 6/4/15, at 9:35 a.m. the ostatic blood pressure npleted and were not, expected sitting and lying his resident who does not				
	admission diagnoses	the facility on 11/16/11, with of cerebrovascular accident weakness and hypertension,				
	3/19/15, indicated R1 required extensive as	m Data Set (MDS) dated 0 was cognitively intact, sist of two with bed mobility, nd required the use of a				

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		
		00286	B. WING	00	06/05/2015	
AME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE	1 00	103/2013
ALLEY \	/IEW HEALTHCARE & R	(EHAB	T CEDAR STREET			
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	N, MN 55943	PROVIDER'S PLAN OF		
PREFIX TAG	(EACH DEFICIENC	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLE DATE
21540	Continued From pag	e 49	21540			
	at risk for falls, EZ st with assist of two for weakness. Deficits ir locomotion due to lef The Physician Order Depakote extended r Zyprexia for bipolar of R10's Orthostatic BP 2014, October 2014, May 2015, The physi of 11 months. On 6/5/15, at 1:38 p.r should have had the	s dated 5/5/15, included release for bipolar disorder, lisorder 's were recorded for Sept March 2015, April 2015, cian orders were followed 5 m. the DON stated that R10 ordered orthostatic blood nsure adequate side effect				
	admission diagnoses anxiety state, dement Physician review of m - 7/31/14, Lorazepam lorazepam 0.5 mg. - 10/30/14, Seroquel 2 mg at HS discontinue - 11/3/14, Seroquel G HS discontinued 11/1 - 11/13/14, Seroquel C at HS. The annual CAA date memory, mood and be aware of needs or saf	nedications was as follows: 0.5 mg at bed time and 25 mg in afternoon and 50 d 11/3/14. ive 25 mg TID and 75 mg at				

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING:			E SURVEY PLETED
		00286	B. WING		06	6/05/2015
				ADDRESS, CITY, STATE, ZIP CODE		
ANIE OF PI	ROVIDER OR SUPPLIER					
ALLEY V	IEW HEALTHCARE & R	FHAB	STON, MN 55943			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ( (EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLE DATE
21540	Continued From pag	je 50	21540			
	history of tossing and goal was to sleep for night. Observe for si Zoloft was given for to monitor for assess document targeted b given for anxiety/agit for effectiveness and monitor mood in resp primary consultant w notify physician. The MDS dated 4/1/ cognitive impairment behaviors of wander required extensive a activities of daily livir On 6/5/15, at 1:39 p. on Seroquel, and DC	t, moderate depression, ing and refusal of care. R40 ssistance of one staff for all				
	blood pressures. The Valley View Nur Procedures for Psyc June 20, 2006 indica manage the psychot and "will development	sing Home Policy and hotropic Medication updated ated the registered nurse will ropic medication program nt, implement and maintain a				
	mediation [medication adjustment recomme direction for vital sign R21's quarterly MDS moderate cognitive i	ation Flow Sheet to document on] monitoring and dosing endations." The policy lacked n monitoring. 6 dated 5/6/15, indicated mpairment. R21 also had genic bladder, and diabetes				

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	FOF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C			E SURVEY PLETED
		00286	B. WING		06/05/2015	
NAME OF P	ROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, STATE	, ZIP CODE		
		510 FAS	T CEDAR STREET			
ALLEY V	IEW HEALTHCARE & F	REHAB	ON, MN 55943			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ( (EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETE DATE
21540	Continued From pag	e 51	21540			
	and indwelling cathe 8/21/14, indicated "is	eport urinary incontinence ter analysis of findings dated s at risk for skin irritation and ntinence of urine, will review re plan."				
	dated 2/4/15 through comments: "is incont wears incontinent pro The	inent of bowel and bladder, oducts which staff change."				
	4/30/15 through 5/2/	eening (3-day void) dated 15, included additional ly incontinent of bladder and otal assist of 1."				
	6/5/15, included Kefl once a day start date chronic recurrent UT take 1 tab orally BID and stop date 6/6/15 (PRN) start dated 6/1	s dated 5/5/15 through ex capsule 250 mg orally e 8/1//14, diagnosis: infection, I. Ciprofloxacin HCI 500 mg for 10 days start date 5/27 . Bladder scan as needed 19/13, for bladder discomfort aight catheter for urine r greater.				
	urinary tract infection Goal was to not exhili infection. The approa Keflex (cephalexin - a (MD) order as prophy evaluate, record, and effectiveness/adverse scan/straight cathete bladder distension. M	l report the e side effects. Bladder rize prn for discomfort or lonitor labs per MD order.				
	frequency, bladder sp	acute confusion, urgency, pasms, nocturia, burning, ng, low back/flank pain,				

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	OF DEFICIENCIES OF CORRECTION	n (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00286	B. WING		06	6/05/2015
NAME OF PF	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE		
			T CEDAR STREET			
ALLEY V	IEW HEALTHCARE & RE	EHAB HOUSTO	ON, MN 55943			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE AC CROSS-REFERENCED TC DEFICIE!	CTION SHOULD BE ) THE APPROPRIATE	(X5) COMPLETI DATE
21540	Continued From page	52	21540			
21540	malaise, nausea/vom	iting, chills, fever, foul odor, lood in urine) to MD as				
	reviews were comple					
	was interviewed about antibiotic. When asket she stated no. Her blu high, she went into the were back to normal. was started 5/27/15, tract infection. It clean	ed if R21 currently had a UTI, ood sugars had been very he hospital, and now they RN-A stated ciprofloxacin for ten days for a urinary red up and blood sugars hey should be. She stated				
	peri-area. The DON s coming there she had been catheterized fre was in the facility it w retention stopped, an catheterized while the recommended antibid and she did not know would be. It may hav to the facility. They d dose reduction; it was was colonized now. It was a brittle diabetic frequently. Blood sug	es not have yeasty rash in stated prior to resident d a history of UTI and had equently due to it. While R21 ras tapered down, urinary nd she had not been			ι.	

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED	
		00286	B. WING			06/05/2045	
AME OF P	ROVIDER OR SUPPLIER		ADDRESS, CITY, STAT	[06	06/05/2015		
	IEW HEALTHCARE & R	510 FAS	ST CEDAR STREE				
		HOUST	ON, MN 55943				
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN (EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLE DATE	
21540	Continued From pag	e 53	21540				
	when she had elevat on an antibiotic. Her the UTI was gone. - At 1:17 p.m. DON s pharmacist consultar	ad a recent UTI on 5/27/15, ed blood sugar and was put blood sugar was better and tated they had a new		•			
	chart. The insert package la ReadyMeds last revis reduce the developm bacteria and maintair cephalexin and other	n the effectiveness of antibacterial drugs,					
	infections that are pro to be caused by bact A message was left for	or the consulting pharmacist					
	on 6/5/15, at 1:36 p.n						
	pharmacist/director o current system of mo	OD OF CORRECTION: The f nursing could evaluate nthly pharmacy review to I be changed to address regularities.					
	TIME PERIOD FOR ( (21) days.	CORRECTION: Twenty One					
21545	MN Rule 4658.1320	A.B.C Medication Errors	21545				
	percent as described Guidelines for Code of	error rate is less than five					

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TATEMENT	a Department of Healt OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED
		00286	B. WING		06/05/2015	
IAME OF PI	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE			
	IEW HEALTHCARE & R	FHAR	T CEDAR STREET			
		HOUSTO	ON, MN 55943			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ( (EACH CORRECTIVE A CROSS-REFERENCED TI DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLET DATE
21545	Continued From pag	e 54	21545			
	the State Operations	Manual, Guidance to				
		Term Care Facilities, which is				
	Surveyors for Long-	rence in part 4658.1315. For				
		a medication error means:				
		cy between what was				
		medications are actually				
		dents in the nursing home; or				
		tration of expired				
	medications.					
		ny significant medication				
	error. A significant n					
		hich causes the resident				
		dizes the resident's health or				
	safety; or					
		n from a category that usually				
		tion in the resident's blood to				
	be titrated to a speci	ific blood level and a single				
	medication error cou	ld alter that level and				
		rrence of symptoms or				
		ons are administered as				
		dent report or medication				
	error report must be	filed for any medication error				
		nificant medication errors or				
		lust be reported to the				
	physician or the phy	sician's designee and the				
		ent's legal guardian or				
	designated represer	ntative and an explanation e resident's clinical record.				
		ns are administered as				
		lent report or medication error				
	report must be filed	for any medication error that				
		ant medication errors or				
		nust be reported to the				
		sician's designee and the				
		ent's legal guardian or				
		ntative and an explanation				
	must be made in the	e resident's clinical record.				

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	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING:			E SURVEY PLETED
		00286	B. WING		06/05/2015	
NAME OF P	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE	, ZIP CODE		
ALLEY V	IEW HEALTHCARE & RE	EHAB	T CEDAR STREET			
			DN, MN 55943			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLET DATE
21545	Continued From page	9 55	21545			
	by:	t is not met as evidenced				
	Based on observation review the facility faile medication error for 1 observed for medicati					
	Findings include:					
	on 6/5/15, at 8:49 a.m aide (TMA)-A crushed Metoprolol XL (a medi and blood pressure).	medication administration and the trained medication the extended release tablet ication to reduce heart rate TMA-A then checked the as 60 beats per minute, dications to R31.				
	crushed. TMA-A furthe	ong acting) should not be				
		sease (poor blood flow				
	indicated R31 had sev with inattention and dis had minimal depression	et (MDS) dated 5/19/15, ere cognitive impairment, sorganized thinking. R31 on and no behaviors. R31 sistance with bed mobility, e.				
		n ' s Progress note dated 's blood pressure was low stoprolol XL would be				

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	FOF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	IDENTIFICATION NUMBER: A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00286			06/0	5/2015
IAME OF P	ROVIDER OR SUPPLIER		ADDRESS, CITY, STATE,	, ZIP CODE	• • • • • • • • • • • • • • • • • • • •	
		510 EAS	ST CEDAR STREET			
ALLEYV	IEW HEALTHCARE & R	HOUST	ON, MN 55943			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE THE APPROPRIATE	(X5) COMPLE DATE
21545	Continued From page	ə 56	21545			
	decreased, and to republic next week on re	view the blood pressure and ounds.				
	through 5/20/15, india Metoprolol XL dose w milligrams (mg) every per day. A recheck w later. On 5/28/15, the reduced even further	cation order dated 3/26/15 cated on 5/21/15, the vas reduced from 100 y day to Metoprolol XL 50 mg as planned for one week Metoprolol XL dose was to 25 mg every day. The Metoprolol XL stated Do Not				
	On 6/5/15, at 1:30 p.r the consultant pharm	n. a message was left for acist.				
	stated she was not av crushing the medicati crushed. The physicia the medication becau pressure and heart ra notified that the staff XL. The DON stated not being audited for because they had be would begin again. In the medication obser	e director of nursing (DON) ware the TMA's were ion and it should not be an was reducing the dose of use of her decreased blood ate. The physician would be was crushing the Metoprolol that currently TMA's were medication administration, en doing so well, but audits addition, the DON verified vations of LPN-A and TMA-B the five rights of medication				
	accordance with good practices	ed 2006, directed ministered as prescribed in d nursing principles and r enteric-coated dosage ly not be crushed an				

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING:			E SURVEY PLETED
		00286	B. WING		06	/05/2015
NAME OF F	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE	, ZIP CODE		
ALLEY \	/IEW HEALTHCARE & R	EHAB	ST CEDAR STREET ON, MN 55943			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLE DATE
21545	Continued From page	e 57	21545			-
	The administrator and could review and revi to ensure facility was The consultant pharm licensed staff to provi error. The director of compliance.	OD OF CORRECTION: d consultant pharmacist ise policies and procedures free of medication errors. nacist could inservice ide medications without nursing could monitor staff				
21665		t provide a safe, clean, le, and homelike physical g the resident to use	21665			
	This MN Requiremen by: F323	t is not met as evidenced				
21685	MN Rule 4658.1415 S Housekeeping, Opera		21685			
	including walls, floors, systems, and equipme continuous state of go with regard to the hea	ood repair and operation lth, comfort, safety, and dents according to a written				
	This MN Requirement by: Based on observation	is not met as evidenced				

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING		(X3) DATE SURVEY COMPLETED 06/05/2015	
		00286				
AME OF PI	ROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, STATE	, ZIP CODE		
		510 EAS	T CEDAR STREET			
ALLEY V	IEW HEALTHCARE & R	EHAB HOUST	ON, MN 55943			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLE DATE
21685	Continued From pag	e 58	21685			
		led to ensure the floors in common hallways were in				
	Findings include:					
	that the tile floor was dimples, circular dep	of the facility, it was noted uneven, had peaks, ridges, ressions and buckles in 14, and in the West and				
		m. an environmental tour the maintenance manager r.				
	had to be temporarily and redo the tiles floo "We had to do an in- plumbing had to be n professional floor guy months. The adminis and 14 were schedul	th toilet backups, residents r moved to fix the plumbing ors. The administrator stated house job on the tile after the epaired, because the ys are booked out four to six strator further stated rooms 3 led to be repaired during the [11] would not be fixed				
	by the professional fl 5/25/15, included the corridor, West corrido and 14. Other bids fc 4/23/15, all after the completed. The Adm of the rooms were in	as asked to provide the bids oor guys. The bid dated a South corridor, East or, Center area, and rooms 3 or tile were dated 4/7/15, and unplanned project was inistrator verified that not all the bid to be repaired. 1 were not included to be				
	On 6/5/15, at 3:00 p.					

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		E SURVEY PLETED	
		00286	B. WING		06	6/05/2015	
IAME OF P	ROVIDER OR SUPPLIER	STREET A	T ADDRESS, CITY, STATE, ZIP CODE				
ALLEY V	/IEW HEALTHCARE & R	EHAB	ST CEDAR STREET ON, MN 55943				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ( (EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE D THE APPROPRIATE	(X5) COMPLE <sup>-</sup> DATE	
21685	Continued From pag	e 59	21685				
	because of the unever knew. SUGGESTED METH The administrator or maintenance program are repaired to maint environment. The ad educate all appropria could develop monito ongoing compliance. TIME PERIOD FOR Twenty-One (21) Day	/s.					
21810	residents shall have t medical and persona needs. Appropriate of care designed to ena highest level of physi This right is limited w		21810				
	by: Based on observatior review, the facility fail was within reach for o the sample.	t is not met as evidenced n, interview, and document led to ensure the call light one of 30 residents (R10) in			,		
	Findings include:						
	R10 was observed in	bed on 6/1/15, at 3:31 p.m.					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			SURVEY	
		00286	B. WING		06	/05/2015
AME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE		
ALLEY V	IEW HEALTHCARE & R	FHAR	T CEDAR STREET DN, MN 55943			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
21810	The resident's call lig dresser, approximate resident and out of hi use his call light to su A registered nurse (R verify R10 could not f help. RN-C then mov it to the bed and within R10's 3/19/15 Minimu indicated the resident required extensive as mobility, transfers, an dated 3/24/15, indicar call for assistance. On 6/3/15, at 7:47 a.r (NA)-A stated R10 us needs assistance. The director of nursin p.m. she expected ca all residents. SUGGESTED METH The director of nursin develop, review, and/ procedures to ensure resident reach. The d designee could educa the policies and proce The director of nursin develop monitoring sy compliance.	ht was connected to the ly 2.5 feet away from the s reach. R10 reported he did ummon assistance. 2N)-C was then asked to have reached his call light for ed the call light and attached in R10's reach. 2010 Data Set assessment t was cognitively intact, and assistance of two staff for bed do toilet use. The care plan ted R10 used his call light to 2010 Millight when he and his call light when he and his call light when he and toilet to be within reach of 2010 F CORRECTION: 1010 OF COR	21810			
	TIME PERIOD FOR ( (21) days.	CORRECTION: Twenty-one				

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING:		(X3) DATE SURVEY COMPLETED	
	00286 B. WING		B. WING		06	/05/2015
NAME OF P	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE	, ZIP CODE		
ALLEY V	IEW HEALTHCARE & RE	:HAB	ST CEDAR STREET ON, MN 55943			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLET DATE
21995	Continued From page	61	21995			
21995	MN St. Statute 626.55 Maltreatment of Vulne	57 Subd. 4a Reporting - erable Adults	21995			
	(a) Each facility shall ongoing written proce applicable licensing ru of suspected maltreat facility has an internal mandated reporter ma requirements of this se internally. However, ti responsible for comply reporting requirements This MN Requirement by:	ection by reporting he facility remains ving with the immediate s of this section. is not met as evidenced d document review, facility creen 5 or 5 newly				
	revealed the facility ha checks to determine w had any past history of E1, a nursing assistant	les for newly hired staff d not conducted reference hether 5 of 5 new hires f criminal prosecutions. t (NA), had a hire date of				
	E2, a dietary assistant, 1/27/15. No reference E3, a NA, had a hire da	checks were conducted. ate of 3/30/15. No				
	reference checks were E4, a NA, had a hire da reference checks were artment of Health	ate of 5/19/15. No				

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TATEMENT	a Department of Healt OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CC A. BUILDING:			E SURVEY PLETED	
		00286	B. WING		06	06/05/2015	
	ROVIDER OR SUPPLIER	FHAB 510 EAS	ADDRESS, CITY, STATE,	ZIP CODE			
(X4) ID PREFIX TAG	SUMMARY ST (EACH DEFICIENC	HOUST( ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	DN, MN 55943	PROVIDER'S PLAN (EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	CTION SHOULD BE	(X5) COMPLET DATE	
21995	Continued From page	ə 62	21995				
	E5, a NA, had a hire reference checks we						
	director of nursing (D does not do reference employees, further st everyone knows ever	on 6/5/15, at 5:26 p.m. the ON) verified that the facility e checks on newly hired ating "this is a small town, ryone. We know who is good vas also verified by the irector.					
	revised 7/17/2012, in are screened through check. This includes use of external pool a be allowed direct resi been cleared through Division of the MDH [ Health]. The policy la	e Adult Policy and Procedure dicated "all new employees in the use of a background any nursing staff through the agencies. Employees will not ident contact until they have in the Criminal Background (Minnesota Department of acked direction to include information from previous yers.					
	The administrator counced to immediately abuse/neglect to the	designated state y point. The director of r incident reports for					
	TIME PERIOD FOR ( (14) days.	CORRECTION: Fourteen					
22000	MN St. Statute 626.5 Reporting - Maltreatn	557 Subd. 14 (a)-(c) nent of Vulnerable Adults	22000				
	Subd 14 Abuse pr	evention plans. (a) Each					

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
00286			B. WING				
				06	/05/2015		
	NOVIDER OR SOFFEIER		DDRESS, CITY, STATE				
ALLEY V	IEW HEALTHCARE & R	EHAB	DN, MN 55943				
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN O		(X5)	
PREFIX TAG		LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	THE APPROPRIATE	COMPLE DATE	
22000	Continued From pag	e 63	22000				
	facility, except home	health agencies and					
	personal care attend	ant services providers, shall					
	establish and enforce	e an ongoing written abuse					
		e plan shall contain an					
	assessment of the pl						
	environment, and its population identifying						
	factors which may encourage or permit abuse,						
	and a statement of specific measures to be taken						
	to minimize the risk of abuse. The plan shall						
	comply with any rules governing the plan promulgated by the licensing agency.						
	(b) Each facility, including a home health care						
	agency and personal care attendant services						
		op an individual abuse					
	prevention plan for ea	ach vulnerable adult					
	residing there or receiving services from them.						
	The plan shall contain						
		ne person's susceptibility to					
	abuse by other individ						
		the person's risk of abusing ts; and (3) statements of the					
		be taken to minimize the					
		person and other vulnerable					
		ses of this paragraph, the					
	term "abuse" includes						
	(c) If the facility, ex	cept home health agencies					
		endant services providers,					
		able adult has committed a					
		t of physical aggression					
	toward others, the individual abuse prevention plan must detail the measures to be taken to minimize the risk that the vulnerable adult might reasonably be expected to pose to visitors to the						
	facility and persons of						
		this section, a facility knows					
	of a vulnerable adult's						
		al aggression if it receives					
1	such information from						

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	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING:	CONSTRUCTION		E SURVEY PLETED
		00286	B. WING		06	6/05/2015
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	E, ZIP CODE		
ALLEY V	IEW HEALTHCARE & RI	FHAR	T CEDAR STREET N, MN 55943	-		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENT	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
22000		a medical record prepared by her health care provider, or	22000		7	
	by: Based on observatior review, the facility fail					
	employees are screen background check." T staff through the use "Employees will not b contact until they have Criminal Background [Minnesota Departme	17/12, indicated "all new ned through the use of a That included any nursing of external pool agencies e allowed direct resident e been cleared through the Division of the MDH ent of Health]. The policy clude attempting to obtain				
	E1, a nursing assistar 4/29/15. No reference E2, a dietary assistan	nnel files were reviewed: nt (NA), had a hire date of e checks were conducted. t, had a hire date of e checks were conducted.				

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00286	B. WING		06/	05/2015	
iame of Pf	ROVIDER OR SUPPLIER		ADDRESS, CITY, STATE				
ALLEY V	IEW HEALTHCARE & R	FHAB	ON, MN 55943				
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLE DATE	
22000	director of nursing (D not do reference che employees stating, "t knows everyone. We isn't." The Human Re present at the time or information. SUGGESTED METH The administrator or residents in the facilit risk factors and deve prevention plans to n for abuse. The admir monitor for compliant	date of 3/30/15. No re conducted. date of 5/19/15. No re conducted. date of 5/28/15. No re conducted. on 6/5/15, at 5:26 p.m. the OON) verified the facility does cks on newly hired this is a small town, everyone e know who is good and who esources Director, also f interview, confirmed this HOD OF CORRECTION: designee could assess all ty for vulnerability of abuse lop individual abuse ninimize each residents risks nistrator or designee could					

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