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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: NI7Q

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00286

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245566**
2.STATE VENDOR OR MEDICAID NO.
(L2) **844240100**

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **07/20/2015** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

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

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

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

17. SURVEYOR SIGNATURE Date :
Gary Nederhoff, Unit Supervisor 07/28/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 07/28/2015 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
07/27/2015
(L33)

DETERMINATION APPROVAL

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,

Kamala Fiske-Downing

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

cc: Licensing and Certification File

MINNESOTA
MDH
DEPARTMENT OF HEALTH

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,

Kamala Fiske-Downing

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

Enclosure
cc: Licensing and Certification File

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245566	A. Building B. Wing	7/20/2015

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

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

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **F0225** Reg. # **483.13(c)(1)(ii)-(iii), (c)(2) -** LSC	Correction Completed **07/15/2015**	ID Prefix **F0226** Reg. # **483.13(c)** LSC	Correction Completed **07/15/2015**	ID Prefix **F0246** Reg. # **483.15(e)(1)** LSC	Correction Completed **07/15/2015**
ID Prefix **F0249** Reg. # **483.15(f)(2)** LSC	Correction Completed **07/15/2015**	ID Prefix **F0280** Reg. # **483.20(d)(3), 483.10(k)(2)** LSC	Correction Completed **07/15/2015**	ID Prefix **F0309** Reg. # **483.25** LSC	Correction Completed **07/15/2015**
ID Prefix **F0323** Reg. # **483.25(h)** LSC	Correction Completed **07/15/2015**	ID Prefix **F0329** Reg. # **483.25(l)** LSC	Correction Completed **07/15/2015**	ID Prefix **F0333** Reg. # **483.25(m)(2)** LSC	Correction Completed **07/15/2015**
ID Prefix **F0428** Reg. # **483.60(c)** LSC	Correction Completed **07/15/2015**	ID Prefix **F0431** Reg. # **483.60(b), (d), (e)** LSC	Correction Completed **07/15/2015**	ID Prefix **F0441** Reg. # **483.65** LSC	Correction Completed **07/15/2015**
ID Prefix **F0465** Reg. # **483.70(h)** LSC	Correction Completed **07/15/2015**	ID Prefix **F0514** Reg. # **483.75(l)(1)** LSC	Correction Completed **07/15/2015**	ID Prefix Reg. # LSC	Correction Completed

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	GPN/kfd	07/28/2015	10160	07/20/2015
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
6/5/2015			

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction A. Building B. Wing	(Y3) Date of Revisit
245566	01 - VALLEY VIEW NURSING HOME	7/21/2015

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

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

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix Reg. # NFPA 101 LSC K0029	Correction Completed 07/15/2015	ID Prefix Reg. # NFPA 101 LSC K0062	Correction Completed 07/15/2015	ID Prefix Reg. # NFPA 101 LSC K0144	Correction Completed 07/15/2015
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By State Agency	**Reviewed By** PS/kfd	**Date:** 07/28/2015	**Signature of Surveyor:** 25822	**Date:** 07/21/2015
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**
Followup to Survey Completed on: 6/4/2015		**Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?**	**YES**	**NO**

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number
245566

(Y2) Multiple Construction
A. Building
B. Wing
02 - 2011 ADDITION

(Y3) Date of Revisit
7/21/2015

Name of Facility
VALLEY VIEW HEALTHCARE & REHAB

Street Address, City, State, Zip Code
510 EAST CEDAR STREET
HOUSTON, MN 55943

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

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix Reg. # **NFPA 101** LSC K0062	**07/15/2015**	ID Prefix Reg. # **NFPA 101** LSC K0144	**07/15/2015**	ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By State Agency	**Reviewed By** PS/kfd	**Date:** 07/28/2015	**Signature of Surveyor:** 25822	**Date:** 07/21/2015
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**
Followup to Survey Completed on: 6/4/2015		**Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?**	**YES**	**NO**

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: NI7Q

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00286

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245566**
2.STATE VENDOR OR MEDICAID NO.
(L2) **844240100**

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **06/05/2015** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

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

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

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

17. SURVEYOR SIGNATURE Date :
Kathy Sass, HFE NE II 07/17/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 07/22/2015 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 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;

<u>Potential Consequences</u> - the consequences of not attaining substantial compliance 3 and 6

months after the survey date; and

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

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

DEPARTMENT CONTACT

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

Gary Nederhoff
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

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:

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: http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_idr.cfm

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

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

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

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

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245566	A. BUILDING _____ B. WING _____	06/05/2015

JUL 10 2015
MN Dept of Health

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000	This Plan of Correction constitutes my written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by State and Federal Law.	
F 225 SS=E	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).	F 225	**F225 483.13 (C) (1) (II)-(III), (C) (2) – (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS** Valley View Healthcare & Rehab ensures that it does not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. Valley View Healthcare & Rehab management staffs that interview and hires new staff for their departments have been educated on performing reference checks on all individuals prior to hire. Memo sent to all department heads on June 29, 2015 on importance of completing reference checks on potential new hires prior to their start date. The	

APN 7/10/15

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE 7/6/15

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245566	A. BUILDING _____ 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 PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 225	Continued From page 1 The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. 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. This REQUIREMENT is not met as evidenced by: Based on interview and document review, facility failed to adequately screen 5 or 5 newly employed staff (E1, E2, E3, E4, E5) who have direct contact with residents. 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. E2, a dietary assistant, had a hire date of 1/27/15. No reference checks were conducted. E3, a NA, had a hire date of 3/30/15. No reference checks were conducted. E4, a NA, had a hire date of 5/19/15. No	F 225	Vulnerable Adult Policy and Procedure was reviewed and revised. The Business Office Manager will monitor for compliance.	07/15/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245566	A. BUILDING _____ B. WING _____	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 PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 225	Continued From page 2 reference checks were conducted. E5, a NA, had a hire date of 5/28/15. No reference checks were conducted. During an interview on 6/5/15, at 5:26 p.m. the director of nursing (DON) verified that the facility does not do reference checks on newly hired employees, further stating "this is a small town, everyone knows everyone. We know who is good and who isn't." This was also verified by the Human Resources Director. The facility Vulnerable Adult Policy and Procedure revised 7/17/2012, indicated "all new employees are screened through the use of a background check. This includes any nursing staff through the use of external pool agencies. Employees will not be allowed direct resident contact until they have been cleared through the Criminal Background Division of the MDH [Minnesota Department of Health]. The policy lacked direction to include attempting to obtain information from previous and/or current employers.	F 225		
F 226 SS=E	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to develop policies for adequate	F 226	**F226 483.1 (c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES** Valley View Healthcare & Rehab has developed and implemented written policies and procedures that prohibit mistreatment, neglect, and abuse of resident and misappropriation of resident property. Valley View Healthcare & Rehab ensures that it does not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245566	A. BUILDING _____ B. WING _____	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 PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 226	Continued From page 3 screening of 5 or 5 newly employed staff (E1, E2, E3, E4, E5) whose positions included direct contact with residents. Findings include: The facility's Vulnerable Adult Policy and Procedure revised 7/17/12, indicated "all new employees are screened through the use of a background check." That included any nursing staff through the use of external pool agencies. "Employees will not be allowed direct resident contact until they have been cleared through the Criminal Background Division of the MDH [Minnesota Department of Health]. The policy lacked direction to include attempting to obtain information from previous and/or current employers." New employee personnel files were reviewed: E1, a nursing assistant (NA), had a hire date of 4/29/15. No reference checks were conducted. E2, a dietary assistant, had a hire date of 1/27/15. No reference checks were conducted. E3, a NA, had a hire date of 3/30/15. No reference checks were conducted. E4, a NA, had a hire date of 5/19/15. No reference checks were conducted. E5, a NA, had a hire date of 5/28/15. No reference checks were conducted. During an interview on 6/5/15, at 5:26 p.m. the director of nursing (DON) verified the facility does not do reference checks on newly hired employees stating, "this is a small town, everyone	F 226	of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. Valley View Healthcare & Rehab management staffs that interview and hires new staff for their departments have been educated on performing reference checks on all individuals prior to their start date. Memo sent to all department heads on June 29, 2015 on importance of completing reference checks on potential new hires prior to starting their orientation. The Vulnerable Adult Policy and Procedure was reviewed and revised. The Business Office Manager will monitor for compliance.	07/15/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245566	A. BUILDING _____ B. WING _____	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 PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 226	Continued From page 4 knows everyone. We know who is good and who isn't." The Human Resources Director, also present at the time of interview, confirmed this information.	F 226		
F 246 SS=D	483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure the call light was within reach for 1 of 4 residents (R10) in the sample reviewed for accidents. Findings include: R10 was observed in bed on 6/1/15, at 3:31 p.m. The resident's call light was connected to the dresser, approximately 2.5 feet away from the resident and out of his reach. R10 reported he did use his call light to summon assistance. A registered nurse (RN)-C was then asked to verify R10 could not have reached his call light for help. RN-C then moved the call light and attached it to the bed and within R10's reach. R10's 3/19/15 Minimum Data Set assessment indicated the resident was cognitively intact, and	F 246	**F246 483.15(e) (1) REASONABLE ACCOMODATION OF NEEDS/PREFERENCES** Valley View Healthcare & Rehab ensures that the resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. Valley View Healthcare & Rehab implemented call light placement audits on 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 staff assigned to resident is re-educated. If problems are noted additional audits and staff training will be completed. 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. All residents have the potential to be affected by this practice. Monitored by: Director of Nursing or designee	07/15/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245566	A. BUILDING _____ B. WING _____	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 PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 246	Continued From page 5 required extensive assistance of two staff for bed mobility, transfers, and toilet use. The care plan dated 3/24/15, indicated R10 used his call light to call for assistance. On 6/3/15, at 7:47 a.m. a nursing assistant (NA)-A stated R10 used his call light when he needs assistance. The director of nursing stated on 6/5/15, at 1:38 p.m. she expected call lights to be within reach of all residents.	F 246		
F 249 SS=C	483.15(f)(2) QUALIFICATIONS OF ACTIVITY PROFESSIONAL The activities program must be directed by a qualified professional who is a qualified therapeutic recreation specialist or an activities professional who is licensed or registered, if applicable, by the State in which practicing; and is eligible for certification as a therapeutic recreation specialist or as an activities professional by a recognized accrediting body on or after October 1, 1990; or has 2 years of experience in a social or recreational program within the last 5 years, 1 of which was full-time in a patient activities program in a health care setting; or is a qualified occupational therapist or occupational therapy assistant; or has completed a training course approved by the State. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to provide a qualified activity director. This had the potential to affect all 41 residents currently residing in the facility.	F 249	**F 249 483.15 (f) (2) QUALIFICATION OF ACTIVITY PROFESSIONAL** Valley View Healthcare & Rehab ensures that the activities program is directed by a qualified professional who is qualified therapeutic recreation specialist or an activities professional who is licensed or registered, if applicable, by the state in which practicing; and is eligible for certification as a therapeutic recreation specialist of as an activities professional by a recognized accrediting body on or after October 1, 1990; or has years of experience in a social or recreational program within the last 5 years, 1 of which was full-time in a patient activities program in a health care setting; or is a qualified occupational therapist or occupational therapy assistant; or has completed a training course approved by the State. Valley View Healthcare & Rehab contracted with our in-house therapy provider, Therapy Network, with the Occupational Therapist to be our consultant for the activity department. The occupational therapist will oversee the activity director until she becomes either	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245566	A. BUILDING _____ B. WING _____ JUL 10 2015 MN Dept of Health	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 PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 249	Continued From page 6 Findings include: Resident Council Meeting Minutes dated 4/9/15, noted "Administrator did hire [name] as the new Director. She will officially start [date]. She was a social worker coming from other nursing home and will work in capacity of activity director." When interviewed on 6/5/15, at 12:27 p.m. the administrator explained that the activity director was directly involved in activities in social work at another facility, and if anything, was over qualified. On 6/5/15, at 12:32 p.m. the activity director (AD) stated she was a social worker and previously had worked in an activity department that had a combined position. She further stated that she had not worked in activities solely for a full year. The 3/15, Valley View Nursing Home, Activity Director position description indicated, "Job Qualification: The following are federal and state regulations covering the qualifications of the Activity Director: 1. A certified occupational therapist or 2. A certified occupational therapy assistant (COTA) or 3. Two years of work experience in social or recreational activities."	F 249	certified or until has obtained 1 year full-time experience exclusively in activities. Monitored by: Nursing Home Administrator	07/15/15
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.	F 280	**F280 483.20 (d) (3), 483.10 (k) (2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP** Valley View Healthcare & Rehab assures that a comprehensive plan of care must be reviewed and revised by an interdisciplinary team that includes the attending physician, a registered nurse with responsibility for the resident, and	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245566	A. BUILDING _____ B. WING _____	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 PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 280	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. 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). Findings include: 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). A Fall Risk assessment dated 3/15/15, identified R17 had unsteady gait and balance problems, urge incontinence, joint paint, arthritis, and a	F 280	other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, with the participation of the resident, the resident's legal guardian or chosen representative at least quarterly and within seven days of the revision of the comprehensive resident assessment. Reeducation will be provided to licensed staff on July 13, 2015 on thoroughness, follow through of documentation with updating of care plans on findings from assessments. The MDS sections for (C) Cognitive Patterns, (G) Functional Status, and (H) Bowel and Bladder will be printed out for comparison to the care plans with care conferences. Referrals will be made to OT/PT if significant declines in functional abilities noted with comparison. Random audits will be done to ensure care plans have been updated by charge nurse, Social Worker, Director of Nursing, or MDS Coordinator. All residents have the potential to be affected by this practice. MDS Coordinator or designee will monitor for compliance.	07/15/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245566	A. BUILDING _____ B. WING _____	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 PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245566	A. BUILDING _____ B. WING _____	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 PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 280	Continued From page 9 from polymyalgia and directed to refer to therapies as indicated. The care plan directed staff to encourage use of walker with ambulation, and directed independent with transfer, bed mobility and ambulation with walker. The care plan was not updated with the decline in functional abilities from the quarterly MDS dated 12/17/15, to the annual assessment 3/17/15, and to reflect the physical assist of one staff member for transfers and toileting. On 6/5/15, at 12:38 p.m. the DON stated R17 was still her own person, alert, had poly myalagia, always able to alert us if she needed assistance, could and did transfer and toilet by self. The facility failed to update the plan of care or refer R17 to PT/OT when a decline in cognitive and functional abilities was noted the 3/17/15, MDS assessment. In addition on 4/29/15, a nursing progress note indicated a decline in ambulation and indicated a referral to PT/OT should be done.	F 280		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document	F 309	**F309 483.25 PROVIDE CARESERVICES FOR HIGHEST WELL BEING** Valley View Healthcare & Rehab ensures that each resident receives and provides the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Valley View ensures that the resident obtains optimal improvement or does not deteriorate within the limits of a resident's right to refuse treatment, and within the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245566	A. BUILDING _____ B. WING _____	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 PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 10 review, the facility failed to complete an ordered wheelchair positioning assessment for one of one residents (R10) who was reviewed for positioning who had a left hemiplegia and was leaning to the left in the electric wheelchair and was unable to support his left arm and left leg. Findings include: R10 was admitted to the facility on 11/16/11, with admission diagnoses of cerebrovascular accident (CVA) with left sided weakness and hypertension per the Admission Record. On 6/1/15, at 12:29 p.m. R10 was returning from the dining room, he was leaning left in his electric wheelchair (w/c) and his left arm was hanging over the arm rest. On 6/2/15, at 8:40 a.m. R10 was sitting in the w/c leaning to left. The arm rest was there, but he was leaned over so far, you could not see the arm rest. He stated he leaned that way because of the (indicated left arm and leg hemiplegia). The left knee was pointed out and foot was tipped left lean. His left arm hung down. On 6/3/15, at 10:40 a.m. R10 was returning from breakfast, his left leg was turned out to the left side, his left foot was rolled over onto the ankle as it rested on the footrest, and his right arm was hung down. On 6/4/15 at 11:00 R10 was asked if he knew he was leaning in the wheelchair. R10 stated yes, and partially moved himself upright, but was not able to become fully upright by himself. The annual Care Area Assess (CAA), dated	F 309	limits of recognized pathology and the normal aging process. OT was informed of preliminary findings on June 8, 2015. An OT order for w/c positioning and mobility was obtained for resident and provided to Occupational therapy. Final survey findings were provided to therapy department on June 29, 2015 upon arrival in the mail. R10 was referred to OT for w/c positioning and safety. Other resident have the potential to be affected by this practice. Nursing staff will attempt interventions for proper positioning in w/c, if unsuccessful will refer to OT services. Monitored by: Director of Nursing, Occupational therapist, or designee	07/15/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245566	A. BUILDING _____ B. WING _____	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 PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 11 9/30/14, indicated extensive assistance for activities of daily living. The corresponding care plan dated 3/24/15, indicated: R10 was at risk for falls, required an EZ stand for transfers or Hoyer lift with assist of two for transfers with increased weakness. A therapy progress note dated 2/19/15, authorized services for Occupational Therapy (OT). The documentation noted a Plan of Treatment for outpatient rehabilitation (rehab). The treatment noted an evaluation for the electric wheelchair related to allegation of running over roommate's foot. Also noted was w/c mobility as R10 was able to drive on right side of open hallway, within 10-12 inches from wall with some swaying right to left, and he was able to manage his doorway. "W/c assessment for safe driving." At OT physicians order clarification, for therapeutic exercises, therapeutic activities, w/c positioning was signed by physician 3/11/15. At OT therapy order dated 3/2/15, stated reached maximum rehab potential, discontinue OT with last treatment day 3/2/15. An OT assessment for powered wheelchair driving dated 3/2/15, indicated: R10 demonstrated good speed control at lowest speed, demonstrated ability to verbalize "excuse me" and able to use horn. "Safe (to drive) when scooter is set at lowest speed." However, the chart lacked documentation of a w/c assessment for positioning. The quarterly Minimum Data Set (MDS) dated 3/19/15, indicated R10 was cognitively intact, required extensive assist of two with bed mobility, transfers, toilet use, and required the use of a stand assist lift.	F 309		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245566	A. BUILDING _____ B. WING _____	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 PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 12 The care plan dated 3/24/15, indicated deficits in activities of daily living, transfers, bed mobility, and locomotion due to left sided weakness. R10 was dependent upon staff for all cares. A review of the PT file indicated: An undated note on 1/2 of a sheet of computer paper was given to PT-OT on Monday 6/1/15, "I think room 13 needs an evaluation or maybe an adaptive pad of sorts. We've noticed lately that at times in his wheelchair his left leg starts to turn out to the side at times sometimes severely where it looks like his hip is popped out of socket. At these times it also makes it difficult to keep left leg within the EZ stand even when using the leg belt. Not sure if we can add a pad to left of w/c to help keep leg straight." On 6/3/15, at 2:00 p.m. OT-A stated R10 had not been assessed for proper positioning in the electronic w/c, only safe driving. On 6/4/15, at 2:00 p.m. physical therapist (PT)-A stated the note was given to them by a NA, and he changed it to OT for the proper evaluation. PT-A stated "it (wheelchair positioning) has come up in the past before, unfortunately there were not many accessories for electric wheelchairs." On 6/5/15, at 1:38 p.m. the director of nursing (DON) stated that R10 was sometimes leaning in his wheelchair to the left. Staff would then lift him back to bed and get him up after a rest. The facility lacked a wheel chair assessment for positioning for R10, even though it had been ordered.	F 309		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES	F 323		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245566	A. BUILDING _____ B. WING _____	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 PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 13 The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to develop and implement interventions to prevent falls for 2 of 4 residents (R17, R40) who were reviewed for accidents. Findings include: The admission record sheet indicated R17 had been admitted to the facility 3/3/12. R17 R17's Fall Risk assessment dated 3/15/15, described R17 as having an unsteady gait and balance problems, urge incontinence, joint paint, arthritis, and a decline in decision making skills, and the assessment indicated R17 utilized a WW [wheeled walker] or W/C [wheelchair], and was a safety risk due to weakness and deconditioning. An annual Minimum Data Set (MDS) dated 3/17/15, indicated R17 had diagnoses including: short term memory loss, ischemic heart disease (decreased blood flow and oxygen to the heart muscle itself), edema with use of diuretic medications (medications to promote urination), hypertension (high blood pressure), polymyalgia rheumatica (pain and stiffness in shoulders, neck, upper arms and hips), and osteoarthritis	F 323	**F323 483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES** Valley View Healthcare & Rehab ensures that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. All accident/incident internal investigation reports will reflect details of a full investigation including causal factors related to the incident and will be documents as such on the report. All accident/incident reports are screened daily by Nursing and/or Social Services for their applicability to the Vulnerable Adult Reporting guidelines. Facility policy to identify risks, develops interventions consistent with residents' needs, and monitors the effectiveness of interventions. The preliminary survey findings were provided to pharmacist consultant and primary medical doctor on June 17, 2015. Final survey findings were provided to pharmacist consultant and Medical Director on June 29, 2015 upon arrival in the mail. Valley View Healthcare & Rehab resent the pamphlet "The False Assurance of Resident Alarms" all families. The Pamphlet is included in the resident admission packet and is provided to new residents and/or family members on July 3, 2015. Valley View Policy and Procedure: Post-fall Assessment was revised. In-servicing will be provided on July 13, 2015. Staff will be re-education of importance of filling out "event" and the "Understanding the Fall" forms completely. Licensed staff re-educated on ruling out	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245566	A. BUILDING _____ B. WING _____	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 PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 14 (degenerative arthritis). The annual MDS from 3/17/15, indicated R17 had moderately impaired cognition. The MDS further indicated R17 could understand what was communicated and could make herself understood, had no depression or behavior symptoms, was independent with bed mobility, required supervision or cueing and one person physical assist for transfers, toilet use and ambulation in her room. A previous quarterly MDS dated 12/17/14, had indicated R17 had required set up help for transfers, ambulation in the room, and toilet use. The annual MDS from 3/17/15, indicated R17 needed assist with transfers and ambulation in the corridor. The MDS did not indicate the resident had received any restorative nursing or PT/OT. The corresponding 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. The CAA did not indicate whether any referral had been initiated for an evaluation by OT or PT of R17's need for increased assist with transfers and ambulation in the corridor. The Care Plan dated 3/24/15, indicated R17 experienced pain in the right hip and knee from polymyalgia, and indicated R17 would be referred to therapies "as indicated." The care plan also indicated R17 was independent with transfers; bed mobility and ambulation with walker, and indicated staff were to notify the MD (medical doctor) of any significant decline to physical and cognitive functioning and to refer R17 to therapy as indicated. The care plan further indicated R17 was at risk for falls related to degenerative joint	F 323	medical causes as a possibility of causing the fall. Current interventions will be reviewed on a case by case basis with implementation of new interventions if felt appropriate will be attempted after each fall. All falls are reviewed monthly by pharmacist consultant with recommendations forwarded to resident's Primary care provider. Falls are reviewed weekly by the IDT team with therapy involvement to review fall, possible cause of fall, current interventions, interventions implemented and if any other interventions should be attempted. All residents have the potential to be affected by this practice. Monitored by: Director of Nursing, social worker, or designee	07/15/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245566	A. BUILDING _____ B. WING _____	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 PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 15	F 323		

disease, polymyalgia and history of falls. Interventions included for staff to notify the MD of any significant decline in physical or cognitive function, and to refer to therapy as indicated. A hand written note on the care plan dated 4/29/15, indicated R17's cognition was changing, "history of returning to the dining room after lunch and eating off of other resident's plates. Staff were to monitor the dining room, clear plates, redirect resident with fresh coffee and snack." The care plan did not include the use of staff intervention for transfers and ambulation in her room as depicted in the most current MDS dated 3/17/15.

The Physician's Order Report dated 2/11/15 through 4/1/15, indicated R17 should be UP AD LIB (up as tolerated).

Review of R17's Nursing Notes identified a decline in ambulation had been identified for R17 on 4/29/15. On 5/1/15, at approximately 3:15 p.m. the facility had first requested physical therapy (PT) and occupational therapy (OT) services to evaluate R17's decline in ambulation. Nursing notes revealed R17 fell on 5/1/15, at 6:54 p.m. requiring transfer to the hospital emergency room (ER), and that R17 was subsequently diagnosed with a fractured hip. Therapy notes for PT and OT were requested, but none were provided during the survey.

A nursing progress note dated 5/1/15, at 6:45 p.m. indicated R17 "was heard in her room yelling for help. When staff entered she was laying on her back on the floor in her room. Upon examining her we discovered that resident was unable to move her right leg. When staff was feeling her hip she (R17) did state that her right hip hurt, but also said that her right knee hurt.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245566	A. BUILDING _____ B. WING _____	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 PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 16	F 323		

Vital signs stable, staff did send her into ER [emergency room] for x-ray of right hip and leg. Care plan updated, family and doc (doctor) were notified."

A report entitled, Understanding the Fall dated 5/1/15, indicated R17's incident had been "Unwitnessed. Actual time of fall was 6:25 p.m. w/c to floor. Takes self to bathroom, just had supper, has water at bedside. Trying to get into recliner. R [right] hip/leg pain. Last meds at 2:00 p.m., no alarms."

An additional report entitled, Safety Event -Falls dated 5/1/15, was reviewed. The form, documented by licensed practical nurse (LPN)-A, indicated the resident had been sent to the hospital on 5/1/15, and had returned on 5/2/15.

Changes to the care plan dated 5/1/15, indicated the resident had sustained a fractured right hip and had pain, and that there had been no surgical intervention. Interventions included: "Bedrest, with assistance of two staff and Hoyer lift to chair/commode. Dependent on staff for all needs. Bed/chair bound."

On 5/2/15, a nursing progress note indicated the resident required skilled nursing and bedrest, should continue with previous activity, and would transfer bed to chair, chair/bed to commode only with assist. The note included, "was on restorative walking program average 23 feet with SBA [stand by assist] 2WW." The goal was identified as, "ambulate independently in room with 2WW."

An investigative report completed by the social worker on 5/4/15, indicated R17 had experienced

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245566	A. BUILDING _____ B. WING _____	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 PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245566	A. BUILDING _____ B. WING _____	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 PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 18 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 quarterly 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	F 323		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245566	A. BUILDING _____ B. WING _____	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 PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 19 after 15 minute checks had been initiated. In addition, the falls were not always comprehensively assessed for causative factors including medical changes, and new interventions were not always considered. A review of the falls for R40 included: 1. 10/11/14, 12:00 a.m. Unwitnessed fall (staff had responded to alarm). The report included, "Fall in Day room; no injury, had been 1:1 (one to one with staff) for 3 hours. Continue alarms, will do 3 day sleep study." No sleep study results were reviewed in the investigation for this fall. 2. 10/21/14, 9:00 p.m. Witnessed fall on TCU (transitional care unit) while ambulating. "INJURY: bruising, bump back of head. 1:1 Attention when restless get up in chair." No sleep study results were reviewed for the investigation for this fall. 3. 11/1/14, 3:40 a.m. Unwitnessed fall in resident room (staff responded to alarm). No injury, new intervention added after this fall: " Medication adjustment, chart behaviors ." Evaluated in ER (emergency room), memory clinic and PMD in house after adjustment in medications with exacerbation of increased behaviors. Supportive devices [alarms] remain in place and appropriate. 4. 11/8/14, 12:29 p.m. Witnessed fall in hallway (walking in the hall). Documentation indicated, "Combative and aggressive, lowered to the floor while attacking staff hitting and kicking, no longer able to stand and lowered to floor. Sent to ER (emergency room) for evaluation." 5. 11/30/14, 6:09 p.m. Unwitnessed fall in dayroom (staff responded to alarm) INJURY: "has red mark (scratch) on both of her inner forearms " 9 x 0.5 cm (centimeters), 10 cm x 0.4 cm, 3.5x1 cm. Continue alarms.	F 323		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245566	A. BUILDING _____ B. WING _____	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 PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 20 6. 12/13/14, 10:20 p.m. Unwitnessed fall (staff responded to alarm). Slid out of chair to the floor in Lounge. Continue current measures. 7. 1/7/15, at 1:45 p.m. Unwitnessed fall (respond to alarm). "Fell from Broda chair, wanted to go for a walk, alarm sounded. She fell to left side and hit back of head. Injury: abrasion to back of head. Abrasion to back of head, unmeasurable d/t (due to) blood sticking to wound, did not want to wash it and cause it to re-bleed. 1/8/15, c/o headache and tender to touch, weak and shaking when taken to bathroom. Appears weaker and required assistance with eating. In bed and shaking uncontrollably, states she is cold, several blankets on at this time. Continue Broda alarm." 8. 1/14/15, 2:28 p.m. Witnessed fall (staff responded to alarm). Fall in Resident Room was attempting to stand, fell back onto bed and head hit bed wall. "INJURY Scraped off small part of skin covering old head injury, previous lump on head from fall was on 15 minute checks, Temperature 100.1 BP (blood pressure) 96/50." Discussion in investigation included, "Restraints would be next intervention and this is inappropriate; would cause, anxiety, confusion, restricted movements. No Changes. New physician's orders. Monitor for 72 hours, neuro checks, and ice to affected area of injury for 20 minutes four times a day for 3 days. Added a pad to side of wall." 9. 1/18/15, 9:55 p.m. Unwitnessed fall (staff had responded to alarm). Fell while trying to get out of her Broda chair, "alarm was on with new battery and did not work. Alarm was working earlier. Injury 3 centimeter reddened area on right buttock, no c/o tenderness. Continue alarms, alarms checked and are working." No 15 minute check form was provided.	F 323		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245566	A. BUILDING _____ B. WING _____	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 PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 21 10. 2/13/15, 6:15 a.m. Unwitnessed fall in her room (staff responded to alarm). "No injury noted. Continue 15 min (minute) checks and alarms. Found on sensor mat on floor, walked to bathroom no injury. Care plan updated and family notified." 11. 2/25/15, at 1:55 a.m. Unwitnessed fall (staff had responded to alarms). Nurse's note included, "Walking back from the bathroom in her room and fell to the floor." The computer documentation indicated, "bed alarm going off, found scooting towards bed, incontinent of urine. No injury. Continue alarms. No changes continue with current measures." 12. 3/1/15, at 5:00 a.m. Unwitnessed fall (staff responded to alarms). Fell in bedroom while self-transferring. Had been toileted at 2:30 a.m. INJURY right arm scratch, right side back of head bruised, lump abrasion- 3cm X 2cm x 1cm raised, complained of headache after fall. Continue alarms. Resident was in a different environment room change short term due to plumbing project in resident's bathroom. No changes continue with current measures. . 13. 4/11/15, 11:43 p.m. Witnessed fall (staff responded to alarms). R40 fell in her room trying to transfer from chair to bed. A little bit of pain, pointed to top of forehead. The back of the head hit the floor pain score 1/10. Ice bag applied. No apparent injury. OT eval for self-release belt in Broda chair. Supportive devices in place, alarm did sound. On 15 minute checks, routinely toileted. No medications changes. Resident was noted to experience increased restlessness, tearfulness, anxiety after visit with her daughter. Resident has been referred to OT for evaluation and treatment as indicated. Will follow their recommendations. Will continue with current measures. No change to plan of care at this time.	F 323		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245566	A. BUILDING _____ B. WING _____	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 PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 22 No documentation in 15 minute check form related to fall. 14. 4/12/15, at 12:54 p.m. Witnessed fall in dayroom (staff responded to alarm). "Observed on her knees in front of another resident. Resident stated she had stood up and fallen into resident. 4/12/15, 1:04 p.m. sitting 90/70 O2 sats (oxygen saturation) 90%." New interventions added after this fall: this was left blank. "Supportive devices in place, alarm did sound. On 15 minute checks, routinely toileted. No medications changes. Resident was in a different environment room change short term due to plumbing project in resident's bathroom. No changes continue with current measures." 15. 4/12/15, 8:40 p.m. Unwitnessed fall (responding to alarm). Found in lounge face down on the floor " I'm taking a nap, I fell out of my chair and I hit my head " . OT self-release in Broda. Supportive devices in place, alarm did sound. On 15 minute checks, routinely toileted. No medications changes. Resident was in a different environment room change short term d/t plumbing project in resident ' s bathroom. No changes continue with current measures. 16. 5/25/15, 6:30 p.m. Unwitnessed fall (responded to alarm). Found crawling on floor in room 16, stated " going to bed " . A few minutes later she said she fell on her right butt. No injuries seen. Supportive devices in place, alarm did sound. On 15 minute checks, routinely toileted. No medications changes. Resident was in a different environment room change short term due to plumbing project in resident ' s bathroom. Zoloft was increased in recent past after increase in tearfulness. Does have self-releasing belt on per OT evaluation. Currently we will continue with current measures. Staff to encourage resident to get ready for bed by 8 p.m. if noted to be tired.	F 323		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245566	A. BUILDING _____ B. WING _____	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 PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 23 17. 5/27/15, at 8:30 p.m. report indicated, "unhooked her seat belt; got up and laid down on the floor. This was not a fall. Resident laid herself down on floor. Did not slide or fall out of her Broda chair. Unwitnessed fall. Nursing progress note stated: certified nursing assistant (CNA) (responded to alarm), found resident sitting on the floor and preparing to lay down. Opened event because self-releasing seat belt was started recently. Note that she is able to release the belt Staff responded to alarm. Resident unhooked her seat belt; got up and laid down on the floor. This was not 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 responded to alarm). "Found on floor in lounge in front of w/c. '...trying to get into a different chair.' Other residents said she stood and tried to get into recliner. New intervention: offer to get ready for bed by 8:00 p.m." 19. 6/2/15, at 4:40 a.m. Unwitnessed fall (responded to alarm). "Bed alarm sounding and when staff arrived in resident room after alarm sounded for 2 minutes or less. Resident was in the bathroom sitting on the floor by toilet. " misjudged toilet placement when sitting." Event was not yet closed. The facility had a sheet of paper that was documented on every 15 minutes through the day. A review of the 15 minute check forms indicated that the forms were frequently filled out by the same hand, with the same pen for 8-12 hours every 15 minutes. On 6/5/15, at 1:15 p.m. the social worker (SW) was interviewed and stated the 15 minute check	F 323		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245566	A. BUILDING _____ B. WING _____	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 PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 24 forms are given to her when complete. The SW stated that the facility is aware of the research that alarms and 15 minute checks may actually increase falls. The SW had sent out notices to family that the facility is going to try to eliminate alarms, but R40's family insists on the alarms. SW verified that the 15 minute check forms were not always completed. The facility failed to thoroughly investigate and analyze the falls for R40 and did not attempt new interventions with every fall. It was unclear whether medical reasons for the falls was considered, even when elevated temperatures and low blood pressures were recorded on the incident forms.	F 323		
F 329 SS=E	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically	F 329	**F329 483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS** Valley View Healthcare & Rehab ensures that each resident's drug regimen is free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combination of the reasons above. Based on a comprehensive assessment of a resident, Valley View ensures that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245566	A. BUILDING _____ B. WING _____	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 PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 329	Continued From page 25 contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure 4 of 4 residents (R14, R39, R40, R10) who took antipsychotic medication had adequate monitoring. In addition, failed to ensure there was an appropriate indication for continued use of an antibiotic for 1 of 5 residents (R21). Findings include: R14 was observed on 6/3/15, at 7:56 a.m. R14 was observed dressed, calmly sitting in wheelchair at the dining room table independently feeding herself. The Care Area Assessment (CAA) dated 9/24/14 for psychotropic medication use indicated R14 was at risk for side effects including risk for falls. R14's diagnoses included dementia with delusional disorder and anxiety The current Medication Administration Record (MAR) from 12/1/14 through 6/4/15, indicated R14 received daily administration of antidepressants, Celexa and Trazodone and antipsychotic Zyprexa. Review of the Vitals Report from 12/3/14 through 6/1/15, indicated orthostatic blood pressure was taken only two of the six months, on 3/1/15 and	F 329	behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. The resident's drug regime is reviewed by the licensed staff, physician, and consultant pharmacist to assure that medications are not used in excessive doses, for excessive duration, without adequate monitoring, without adequate indications, or in the presence of adverse consequences. Pharmacist consultant reviews medication regime on all residents monthly. The preliminary survey findings were provided to pharmacist consultant and Medical Director on June 17, 2015. Final survey findings were provided to pharmacist consultant and Medical Director on June 29, 2015 upon arrival in the mail. On June 6, 2015 audit performed to ensure that nursing orders were in place on all residents for orthostatic BPs for residents on antipsychotic medications in the electronic record. The pharmacist consultant did make a recommendation for discontinuation of resident's Cephalexin for prophylaxis/neurogenic bladder. LElbsernd, PA-C did discontinue the prophylactic antibiotic on R21. All resident's drug regime is reviewed monthly by consulting pharmacist with recommendations as indicated, and by attending physician/nurse practitioner every 60 days. All residents on antipsychotics have the potential to be affected by this practice. Audit completed on all residents on antipsychotics to ensure a nursing order was in the electronic record for monthly orthostatic blood pressure monitoring was completed on June 8, 2015.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245566	A. BUILDING _____ B. WING _____	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 PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 329	Continued From page 26 6/1/15. The quarterly Minimum Data Set (MDS) dated 3/11/15, indicated R14 had moderate cognitive impairment. R14's care plan dated 3/17/15, indicated R14 was on Zyprexa and to observe for potential side effects and medication effectiveness, monthly medication review by consulting pharmacist and to routinely check vital signs per facility policy. R14's current physician report dated 5/4/15 through 6/4/15, indicated orders for Zyprexa (antipsychotic) 2.5 milligrams (mg) once a day and directed staff to check orthostatic BP [blood pressure] once a day on the 1st of the month. Monthly Medication Regimen Review revealed the consultant pharmacist reviewed R14's medications on 1/21/15 and another consultant pharmacist on 2/20/15, 3/16/15, 4/17/15, and 5/15/15, but did not indicate the lack of adequate monitoring which included orthostatic blood pressure for the antipsychotic medication. During an interview on 6/4/15, at 10:30 a.m. the director of nursing (DON) verified the orthostatic blood pressure should have been completed and was not. R39's was observed on 6/3/15, at 7:59 a.m. R39 was observed dressed, sitting upright in a Broda (type of wheelchair) wheelchair in the dining room, calm, and independently feeding himself. R39 stated "Nice to meet you, I have more food than I need."	F 329	In-servicing will be provided on July 13, 2015, educating licensed staff that residents' on antipsychotic medications must have orthostatic BPs obtained monthly. Valley View Healthcare & Rehab's Policy and Procedures for Psychotropic Medication was updated to include obtaining Orthostatic BP's monthly. Staff compliance with above process will be monitored by the DON/designee and Consultant Pharmacist.	07/15/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245566	A. BUILDING _____ B. WING _____	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 PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 329	Continued From page 27 R39's (CAA) dated 12/11/14, for psychotropic medication use indicated R39 required daily administration of antidepressant (Paxil) and antipsychotic (Seroquel), and was at risk for side effects including risk for falls. The Quarterly MDS dated 3/10/15, indicated R39 had severe cognitive impairment. R39's care plan dated 3/17/15, indicated staff was to observe for potential side effects and medication effectiveness, monthly medication review by consulting pharmacist and to routinely check vital signs per facility policy. R39's diagnoses included dementia with behavioral disturbances of agitation and combative behavior, delusions and hallucinations obtained from the Physician Order Report dated 5/4/15 through 6/4/15. R39's current Physician Report indicated orders for Seroquel (antipsychotic) 50 mg twice a day (BID), (decreased from three times a day (TID) on 5/20/15) and directed staff to check orthostatic BP [blood pressure] once a day on the 15th of the month. The current MAR from 12/1/14 through 6/4/15 indicated R39 received the medication TID from 12/1/14 through 5/20/15, and BID from 5/20/15 through 6/3/15. Review of the Vitals Report from 12/2/14 through 5/28/15, indicated orthostatic blood pressure was taken only one of five months, on 3/15/15. Monthly Medication Regimen Review revealed the consultant pharmacist reviewed R39's medications on 1/21/14 and another consultant	F 329		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245566	A. BUILDING _____ B. WING _____	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 PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 329	Continued From page 28 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,	F 329		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245566	A. BUILDING _____ B. WING _____	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 PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 329	Continued From page 29 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	F 329		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245566	A. BUILDING _____ B. WING _____	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 PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 329	Continued From page 30 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	F 329		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245566	A. BUILDING _____ B. WING _____	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 PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 329	Continued From page 31	F 329		

and indwelling catheter analysis of findings dated 8/21/14, indicated "is at risk for skin irritation and UTI's related to incontinence of urine, will review and continue with care plan."

The Bowel & bladder screening (3-day void) dated 2/4/15 through 2/6/15, additional comments: "is incontinent of bowel and bladder, wears incontinent products which staff change." The
Bowel & bladder screening (3-day void) dated 4/30/15 through 5/2/15, included additional comments: "frequently incontinent of bladder and bowel, wears brief, total assist of 1."

The Physician Orders dated 5/5/15 through 6/5/15, included Keflex capsule 250 mg orally once a day start date 8/1//14, diagnosis: infection, chronic recurrent UTI. Ciprofloxacin HCl 500 mg take 1 tab orally BID for 10 days start date 5/27 and stop date 6/6/15. Bladder scan as needed (PRN) start dated 6/19/13, for bladder discomfort or distension with straight catheter for urine retention of 200 cc or greater.

Care plan dated 5/13/15, indicated "history of urinary tract infection [UTIs], neurogenic bladder. Goal was to not exhibit signs of urinary tract infection. The approaches were to administer Keflex (cephalexin - an antibiotic) per physician (MD) order as prophylactic measure and evaluate, record, and report the effectiveness/adverse side effects. Bladder scan/straight catheterize prn for discomfort or bladder distension. Monitor labs per MD order. Report signs of UTI (acute confusion, urgency, frequency, bladder spasms, nocturia, burning, pain, difficulty urinating, low back/flank pain, malaise, nausea/vomiting, chills, fever, foul odor,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245566	A. BUILDING _____ B. WING _____	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 PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 329	Continued From page 32 concentrated urine, blood in urine) to MD as indicated. On 6/4/15, at 1:49 p.m. registered nurse (RN)-A was interviewed about the Keflex order for antibiotic. When asked if R21 currently had a UTI, she stated no. Her blood sugars had been very high, she went into the hospital, and now they were back to normal. RN-A stated ciprofloxacin was started 5/27/15, for ten days for a urinary tract infection. It cleared up and blood sugars were back to where they should be. She stated R21 was still getting Keflex. On 6/5/15, at 1:06 p.m. DON stated MD-A indicated resident does not have yeasty rash in peri-area. The DON stated prior to resident coming there she had a history of UTI and had been catheterized frequently due to it. While R21 was in the facility it was tapered down, urinary retention stopped, and she had not been catheterized while there. The urologist recommended antibiotic, it was started long ago and she did not know where the documentation would be. It may have been prior to R21 coming to the facility. They did trial off the antibiotic for dose reduction; it was restarted due to UTI and was colonized now. DON further commented R21 was a brittle diabetic and could bottom down frequently. Blood sugars were better controlled than when she came into the facility. They had to wake her during nights and have not had to straight catheterize since she had been there. They could bladder scan first before catheterizing. She had a recent UTI on 5/27/15, when she had elevated blood sugar and was put on an antibiotic. Her blood sugar was better and the UTI was gone. - At 1:17 p.m. DON stated they had a new	F 329		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245566	A. BUILDING _____ B. WING _____	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 PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 329	Continued From page 33 pharmacist consultant. If the pharmacist consultant had no recommendations for the doctor, the resident would have no printout for her chart. The insert package label for cephalexin by ReadyMeds last revised on 5/14, read, " To reduce the development of drug-resistant bacteria and maintain the effectiveness of cephalexin and other antibacterial drugs, cephalexin should be used only to treat or prevent infections that are proven or strongly suspected to be caused by bacteria."	F 329		
F 333 SS=D	483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS The facility must ensure that residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to prevent significant medication error for 1 of 6 residents (R31) observed for medication administration. Findings include: R31 was observed for medication administration on 6/5/15, at 8:49 a.m. and the trained medication aide (TMA)-A crushed the extended release tablet Metoprolol XL (a medication to reduce heart rate and blood pressure). TMA-A then checked the pulse of R31, which was 60 beats per minute, then provided the medications to R31. TMA-A stated she was not aware that the	F 333	**F333 483.25 (m) (2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS** Valley View Healthcare & Rehab ensures that residents are free of any significant medication errors. On June 15, 2015, Do Not Crush labels were obtained from the pharmacy and placed on medication cards that should not be crushed per pharmacy guidelines. Pharmacy services were consulted and will be adding "Do Not Crush" on long-acting or enteric-coated forms of medications that should not be crushed when the new cycle fill of medications is due to be refilled. Mandatory nursing medication training was provided by Health Direct Pharmacy Nurse Consultant on June 23, 2015 which included a topic of Non-crushable medications. Pharmacy staff was performing quarterly med pass audits on random licensed staff and/or TMAs. Pharmacy staff started med pass audits on June 8, 2015 to include all part and full time floor LPNs, RNs, and	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245566	A. BUILDING _____ B. WING _____	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 PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 333	Continued From page 34 Metoprolol XL (extra-long acting) should not be crushed. TMA-A further stated that she had always crushed the Metoprolol XL dose when giving it to R31. R31 was admitted to the facility 4/26/11, with admission diagnoses of chronic kidney disease, hypertension (high blood pressure), and peripheral vascular disease (poor blood flow through the legs) per the Admission Record. The Minimum Data Set (MDS) dated 5/19/15, indicated R31 had severe cognitive impairment, with inattention and disorganized thinking. R31 had minimal depression and no behaviors. R31 required extensive assistance with bed mobility, transfers, and toilet use. A review of a Physician ' s Progress note dated 5/21/15, indicated R31's blood pressure was low and the medication Metoprolol XL would be decreased, and to review the blood pressure and pulse next week on rounds. A review of the medication order dated 3/26/15 through 5/20/15, indicated on 5/21/15, the Metoprolol XL dose was reduced from 100 milligrams (mg) every day to Metoprolol XL 50 mg per day. A recheck was planned for one week later. On 5/28/15, the Metoprolol XL dose was reduced even further to 25 mg every day. The directions for use for Metoprolol XL stated Do Not Crush. On 6/5/15, at 1:30 p.m. a message was left for the consultant pharmacist. On 6/5/15, at 1:38 the director of nursing (DON) stated she was not aware the TMA's were	F 333	TMAs. Pharmacist nurse consultant will then perform a monthly med pass audit x 3 and then quarterly. In-servicing will be provided on July 13, 2015 All residents have the potential to be affected by this practice. Monitored by: Pharmacist consultant, Director of Nursing or designee	07/15/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245566	A. BUILDING _____ B. WING _____	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 PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 333	Continued From page 35 crushing the medication and it should not be crushed. The physician was reducing the dose of the medication because of her decreased blood pressure and heart rate. The physician would be notified that the staff was crushing the Metoprolol XL. The DON stated that currently TMA's were not being audited for medication administration, because they had been doing so well, but audits would begin again. In addition, the DON verified the medication observations of LPN-A and TMA-B should have followed the five rights of medication administration. The Medication Administration-General Guidelines policy dated 2006, directed ...Medications are administered as prescribed in accordance with good nursing principles and practices... a. Long-acting or enteric-coated dosage forms should generally not be crushed an alternative should be sought.	F 333		
F 428 SS=E	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. This REQUIREMENT is not met as evidenced by:	F 428	**F428 483.60 (c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON** Valley View Healthcare & Rehab will ensure the drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. The resident's drug regime is reviewed by the licensed staff, physician, and consultant pharmacist to assure that medications are not used in excessive doses, for excessive duration, without adequate monitoring, without adequate	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245566	A. BUILDING _____ B. WING _____	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 PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 428	Continued From page 36 Based on interview and record review the facility failed to ensure the consultant pharmacist identified irregularities and reported them to the director of nursing and physician for 4 of 4 residents (R14, R39, R40, R10) who took antipsychotic medication had adequate monitoring. In addition, failed to ensure there was an appropriate indication for continued use of an antibiotic for 1 of 5 residents (R21). Findings include: R14 was observed on 6/3/15, at 7:56 a.m. R14 was observed dressed, calmly sitting in wheelchair at the dining room table independently feeding herself. The Care Area Assessment (CAA) dated 9/24/14 for psychotropic medication use indicated R14 was at risk for side effects including risk for falls. R14's diagnoses included dementia with delusional disorder and anxiety The current Medication Administration Record (MAR) from 12/1/14 through 6/4/15, indicated R14 received daily administration of antidepressants, Celexa and Trazodone and antipsychotic Zyprexa. Review of the Vitals Report from 12/3/14 through 6/1/15, indicated orthostatic blood pressure was taken only two of the six months, on 3/1/15 and 6/1/15. The quarterly Minimum Data Set (MDS) dated 3/11/15, indicated R14 had moderate cognitive impairment. R14's care plan dated 3/17/15, indicated R14 was	F 428	indications, or in the presence of adverse consequences. Pharmacist consultant reviews medication regime on all residents monthly. The preliminary survey findings were provided to pharmacist consultant and Medical Director on June 17, 2015. Final survey findings were provided to pharmacist consultant and Medical Director on June 29, 2015 upon arrival in the mail. On June 6, 2015 audit performed to ensure that nursing orders were in place on all residents for orthostatic BPs for residents on antipsychotic medications in the electronic record. The pharmacist consultant did make a recommendation for discontinuation of resident's Cephalexin for prophylaxis/neurogenic bladder. LElbsernd, PA-C did discontinue the prophylactic antibiotic for R21. All resident's drug regime is reviewed monthly by consulting pharmacist with recommendations as indicated, and by attending physician/nurse practitioner every 60 days. All residents on antipsychotics and prophylactic antibiotics have the potential to be affected by this practice. Audit completed on all residents on antipsychotics to ensure a nursing order was in the electronic record for monthly orthostatic blood pressure monitoring was completed on June 8, 2015. In-servicing will be provided on July 13, 2015, educating licensed staff that residents' on antipsychotic medications must have orthostatic BPs obtained monthly. Staff compliance with above process will be monitored by the DON/designee and Consultant Pharmacist.	07/15/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245566	A. BUILDING _____ B. WING _____	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 PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 428	Continued From page 37 on Zyprexa and to observe for potential side effects and medication effectiveness, monthly medication review by consulting pharmacist and to routinely check vital signs per facility policy. R14's current physician report dated 5/4/15 through 6/4/15, indicated orders for Zyprexa (antipsychotic) 2.5 milligrams (mg) once a day and directed staff to check orthostatic BP [blood pressure] once a day on the 1st of the month. Monthly Medication Regimen Review revealed the consultant pharmacist reviewed R14's medications on 1/21/15 and another consultant pharmacist on 2/20/15, 3/16/15, 4/17/15, and 5/15/15, but did not indicate the lack of adequate monitoring which included orthostatic blood pressure for the antipsychotic medication. During an interview on 6/4/15, at 10:30 a.m. the director of nursing (DON) verified the orthostatic blood pressure should have been completed and was not. R39's was observed on 6/3/15, at 7:59 a.m. R39 was observed dressed, sitting upright in a Broda (type of wheelchair) wheelchair in the dining room, calm, and independently feeding himself. R39 stated "Nice to meet you, I have more food than I need." R39's (CAA) dated 12/11/14, for psychotropic medication use indicated R39 required daily administration of antidepressant (Paxil) and antipsychotic (Seroquel), and was at risk for side effects including risk for falls. The Quarterly MDS dated 3/10/15, indicated R39	F 428		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245566	A. BUILDING _____ B. WING _____	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 PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 428	Continued From page 38 had severe cognitive impairment. R39's care plan dated 3/17/15, indicated staff was to observe for potential side effects and medication effectiveness, monthly medication review by consulting pharmacist and to routinely check vital signs per facility policy. R39's diagnoses included dementia with behavioral disturbances of agitation and combative behavior, delusions and hallucinations obtained from the Physician Order Report dated 5/4/15 through 6/4/15. R39's current Physician Report indicated orders for Seroquel (antipsychotic) 50 mg twice a day (BID), (decreased from three times a day (TID) on 5/20/15) and directed staff to check orthostatic BP [blood pressure] once a day on the 15th of the month. The current MAR from 12/1/14 through 6/4/15 indicated R39 received the medication TID from 12/1/14 through 5/20/15, and BID from 5/20/15 through 6/3/15. Review of the Vitals Report from 12/2/14 through 5/28/15, indicated orthostatic blood pressure was taken only one of five months, on 3/15/15. Monthly Medication Regimen Review revealed the consultant pharmacist reviewed R39's medications on 1/21/14 and another consultant 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,	F 428		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245566	A. BUILDING _____ B. WING _____	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 PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 428	Continued From page 39 stating "I would have expected sitting and lying blood pressures for this resident who does not stand."	F 428		

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, 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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245566	A. BUILDING _____ B. WING _____	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 PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 428	Continued From page 40 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 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.	F 428		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245566	A. BUILDING _____ B. WING _____	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 PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 428	Continued From page 41 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. 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. A message was left for the consulting pharmacist on 6/5/15, at 1:36 p.m. The facility's Consultant Pharmacist Reports Medication Regimen Review (monthly report) dated 2006 indicated "the consultant pharmacist performs a comprehensive medication regimen review at least monthly. The MRR [Medication Regimen Review] includes evaluating the resident's response to medication therapy to determine that the resident maintains the highest practicable level of functioning and prevents or minimizes adverse consequences related to medication therapy." 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	F 428		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245566	A. BUILDING _____ B. WING _____	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 PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 428	Continued From page 42 and indwelling catheter analysis of findings dated 8/21/14, indicated "is at risk for skin irritation and UTI's related to incontinence of urine, will review and continue with care plan." The Bowel & bladder screening (3-day void) dated 2/4/15 through 2/6/15, additional comments: "is incontinent of bowel and bladder, wears incontinent products which staff change." The Bowel & bladder screening (3-day void) dated 4/30/15 through 5/2/15, included additional comments: "frequently incontinent of bladder and bowel, wears brief, total assist of 1." The Physician Orders dated 5/5/15 through 6/5/15, included Keflex capsule 250 mg orally once a day start date 8/1//14, diagnosis: infection, chronic recurrent UTI. Ciprofloxacin HCl 500 mg take 1 tab orally BID for 10 days start date 5/27 and stop date 6/6/15. Bladder scan as needed (PRN) start dated 6/19/13, for bladder discomfort or distension with straight catheter for urine retention of 200 cc or greater. Care plan dated 5/13/15, indicated "history of urinary tract infection [UTIs], neurogenic bladder. Goal was to not exhibit signs of urinary tract infection. The approaches were to administer Keflex (cephalexin - an antibiotic) per physician (MD) order as prophylactic measure and evaluate, record, and report the effectiveness/adverse side effects. Bladder scan/straight catheterize prn for discomfort or bladder distension. Monitor labs per MD order. Report signs of UTI (acute confusion, urgency, frequency, bladder spasms, nocturia, burning, pain, difficulty urinating, low back/flank pain, malaise, nausea/vomiting, chills, fever, foul odor,	F 428		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245566	A. BUILDING _____ B. WING _____	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 PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 428	Continued From page 43 concentrated urine, blood in urine) to MD as indicated. Consultant pharmacist medication regimen reviews were completed July 2014 through December 2014 and reviewed. The regimen lacked evidence that the pharmacist had addressed the antibiotic use. On 6/4/15, at 1:49 p.m. registered nurse (RN)-A was interviewed about the Keflex order for antibiotic. When asked if R21 currently had a UTI, she stated no. Her blood sugars had been very high, she went into the hospital, and now they were back to normal. RN-A stated ciprofloxacin was started 5/27/15, for ten days for a urinary tract infection. It cleared up and blood sugars were back to where they should be. She stated R21 was still getting Keflex. On 6/5/15, at 1:06 p.m. DON stated MD-A indicated resident does not have yeasty rash in peri-area. The DON stated prior to resident coming there she had a history of UTI and had been catheterized frequently due to it. While R21 was in the facility it was tapered down, urinary retention stopped, and she had not been catheterized while there. The urologist recommended antibiotic, it was started long ago and she did not know where the documentation would be. It may have been prior to R21 coming to the facility. They did trial off the antibiotic for dose reduction; it was restarted due to UTI and was colonized now. DON further commented R21 was a brittle diabetic and could bottom down frequently. Blood sugars were better controlled than when she came into the facility. They had to wake her during nights and have not had to straight catheterize since she had been there.	F 428		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245566	A. BUILDING _____ B. WING _____	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 PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 428	Continued From page 44 They could bladder scan first before catheterizing. She had a recent UTI on 5/27/15, when she had elevated blood sugar and was put on an antibiotic. Her blood sugar was better and the UTI was gone. - At 1:17 p.m. DON stated they had a new pharmacist consultant. If the pharmacist consultant had no recommendations for the doctor, the resident would have no printout for her chart. The insert package label for cephalexin by ReadyMeds last revised on 5/14, read, "To reduce the development of drug-resistant bacteria and maintain the effectiveness of cephalexin and other antibacterial drugs, cephalexin should be used only to treat or prevent infections that are proven or strongly suspected to be caused by bacteria." A message was left for the consulting pharmacist on 6/5/15, at 1:36 p.m. with no return call.	F 428		
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary	F 431	**F 431 483. (b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS** Valley View Healthcare & Rehab obtains the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Valley View Healthcare & Rehab ensures that accurate labeling of medications to facilitate consideration of precautions and safe administration. Drugs and biologicals used in Valley View are labeled in accordance with currently accepted	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245566	A. BUILDING _____ B. WING _____	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 PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 431	Continued From page 45 instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document 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.	F 431	professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. Mandatory nursing medication training was provided by Health Direct Pharmacy Nurse Consultant on June 23, 2015 which included a topic of insulin: types, dosing schedules, and tips for injecting. A weekly check to be performed by staff was placed electronically in the residents' electronic records that receive insulin as an additional step to check expiration dates. Pharmacist nurse consultant will perform monthly med cart audits. In-servicing will be provided on July 13, 2015, educating licensed staff on checking insulin's expiration date prior to drawing up and administering. All residents on insulin have the potential to be affected by this practice. Monitored by: Pharmacist consultant, Director of Nursing or designee	07/15/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245566	A. BUILDING _____ B. WING _____	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 PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 431	Continued From page 46 The director of nursing (DON) verified that the Humalog insulin vial expired on 5/21/15, and the vial should have been replaced. The Medication Storage in the Facility policy dated 2006, indicated.....outdated, contaminated, or deteriorated medications...are immediately removed...Medication storage conditions are monitored on a monthly basis and corrective action taken if problems are identified.	F 431		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.	F 441	**F441 483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS** Valley View Healthcare & Rehab has established and maintains an infection control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of disease and infection. Valley View Healthcare & Rehab requires staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. All staff have been re-educated through in servicing on infection control, hand washing, and proper glove use and is provided upon hire and annually. Nursing in-service will be provided on July 13, 2015. Weekly audits will be conducted for four weeks to ensure that proper gloving; hand washing is being performed when performing peri-care. If problems are noted additional audits and staff training will be completed.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245566	A. BUILDING _____ B. WING _____	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 PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 47 (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure appropriate hand hygiene and gloving was completed during residents care for 1 of 1 resident (R10). In addition, the facility failed to implement procedures to prevent the possible spread of blood borne infections during blood glucose monitoring performed for 2 of 6 residents (R10, R5) who had blood sugars readings taken with the use of a glucose machine. Findings include: Gloving: On 6/3/15, R10 was observed for morning cares, nursing assistant (NA)-A, did not change gloves as required. On 6/3/15, at 7:47 a.m. cares were observed for R10 NA-A verified that she did provided peri-care, removed her gloves but did not wash her hands. NA-A then lifted R10 out of bed into an electric wheelchair, then donned a new pair of gloves and provided the dentures to R10. NA-A stated she was not aware of the hand washing policy for the	F 441	Mandatory nursing medication training was provided by Health Direct Pharmacy Nurse Consultant on June 23, 2015 which included a topic of insulin: types, dosing schedules, and tips for injecting; insulin administration and blood glucose policy and procedure. The policy and procedure to insulin administration and blood glucose policy and procedure was reviewed and updated. A weekly check to be performed by staff was placed electronically in the residents' electronic records that receive insulin as an additional step to check expiration dates. Pharmacist nurse consultant will perform monthly med cart audits. In-servicing will be provided on July 13, 2015, educating licensed staff on checking insulin's expiration date prior to drawing up and administering. All residents on insulin have the potential to be affected by this practice. Monitored by: Pharmacist consultant, Director of Nursing or designee Director of nursing/designee will monitor for compliance.	07/15/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245566	A. BUILDING _____ B. WING _____	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 PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 48	F 441		

facility, and would have to find out. NA-A had been doing the job for three years.
The quarterly Minimum Data Set (MDS) dated 3/19/15, indicated R10 was cognitively intact, required extensive assist of two with bed mobility, transfers, toilet use, and required the use of a stand assist lift.

The corresponding 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 were due to left sided weakness. The care plan dated 3/24/15, indicated R10 was dependent on the staff for all personal cares.

On 6/5/15, at 1:38 p.m. the director of nursing (DON) verified she expected staff to use appropriate hand hygiene.

The Hand Washing Policy and Procedure dated 2006, indicated hand washing was required.....after removal of gloves.
Blood glucose meter:
On 6/1/15, licensed practical nurse (LPN)-A did not use a sanitary manner while using the blood glucose meter, and did not use the safety syringe as directed by the manufacturer, and did not perform the final lock to prevent needle exposure when the insulin syringe was discarded in the sharps container.

On 6/1/15, at 4:06 p.m. BG procedure was observed for R10, the BG meter was placed on the water pitcher tray in R10's room, and then used to obtain a blood sample. The contaminated machine was then placed directly on top of the medication cart. LPN-A then removed gloves and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245566	A. BUILDING _____ B. WING _____	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 PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 49	F 441		

with a bare hand put the soiled lancet (exposed to blood) in the sharps container. The DON walked past, and said something quietly to LPN-A, who then opened the bottom drawer of the medication cart and cleaned the BG meter with a super sani-wipes, but did not wipe down the already contaminated medication cart. At 4:06 p.m. LPN-A verified her usual practice was to set the BG meter on the top of the medication cart unclean. - At 4:18 p.m. LPN-A stated she had been going to clean the BG meter with alcohol, but the DON walked past and told her to use the super sani-wipes.
-At 4:22 p.m. LPN-A obtained an insulin dose for R5, LPN-A was observed to uncap the insulin needle, then swab the insulin vial after uncapping the syringe, thereby exposing herself to a needle stick. LPN-A then accessed the insulin vial with the insulin needle and drew up 1 unit in the safety syringe, then recapped the needle (again exposing herself to a needle stick). Provided the insulin dose, and then pulled the sheath up on the safety syringe to cover the needle. However, she did not lock the safety syringe by turning the barrel, before she disposed the unlocked syringe in the sharps container (again exposing her or others to a potential for needle stick). LPN-A verified she did not use the safety syringe sheath until she was done with the syringe.
- At 5:00 p.m. the director of nursing (DON) verified a needle should never be recapped, and then used a safety syringe to verify that the barrel of the syringe should be turned to lock it prior to disposal in the sharps container. The DON verified the manufacturer's instructions should be followed while using the safety syringe.

The Infection Control Policy and Procedures dated 2006, directed....All employees are required

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245566	A. BUILDING _____ B. WING _____	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 PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 50 to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice... maintaining a clean working environment by maintaining clean counter, tables....keeping resident's equipment clean,... safe, and sanitary...prevent transmission of disease.	F 441		
F 465 SS=E	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure the floors in resident rooms and common hallways were in good repair. Findings include: During observations of the facility, it was noted that the tile floor was uneven, had peaks, ridges, dimples, circular depressions and buckles in rooms 2, 3, 4, 8, 11, 14, and in the West and South hallways. On 6/5/15, at 2:40 p.m. an environmental tour was conducted with the maintenance manager and the administrator. The administrator stated because of an unplanned project with toilet backups, residents had to be temporarily moved to fix the plumbing	F 465	**F465 483.70 (h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON** Valley View Healthcare & Rehab provides a safe, functional, sanitary, and comfortable environment for residents, staff, and the public. Additional quotes were received by Hiller Carpet from Rochester, MN on July 3, 2015. The details and scope of the repair project will be finalized by July 15th. Nursing has assessed residents to determine whether they are at risk of falling as a result of the current flooring and has determined the flooring does not pose additional risk to residents. Nursing and Environmental Services will continue to monitor the floor, evaluate whether resident safety is at risk and take any necessary steps to minimize identified risks. Monitored by: Environmental Director and Director of Nursing	07/15/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245566	A. BUILDING _____ B. WING _____	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 PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 465	Continued From page 51 and redo the tiles floors. The administrator stated "We had to do an in-house job on the tile after the plumbing had to be repaired, because the professional floor guys are booked out four to six months. The administrator further stated rooms 3 and 14 were scheduled to be repaired during the next week, room 10 [11] would not be fixed because the Board had refused." The Administrator was asked to provide the bids by the professional floor guys. The bid dated 5/25/15, included the South corridor, East corridor, West corridor, Center area, and rooms 3 and 14. Other bids for tile were dated 4/7/15, and 4/23/15, all after the unplanned project was completed. The Administrator verified that not all of the rooms were in the bid to be repaired. Rooms 2, 4, 8, and 11 were not included to be repaired. On 6/5/15, at 3:00 p.m. the physical therapist (PT) stated that none of the residents had fallen because of the uneven flooring, as far as she knew.	F 465		
F 514 SS=F	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any	F 514	**F 514 483.75 (l) (1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE** Valley View Healthcare & Rehab maintains clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245566	A. BUILDING _____ B. WING _____	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 PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 514	Continued From page 52 preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to maintain accurate medical records were complete for 4 of 5 residents (R14, R39, R40, R21) and 2 of 2 discharged residents (R17, R57) reviewed for monthly pharmacist reviews. Findings include: Current Residents: R14's diagnoses included dementia with delusional disorder, anxiety, osteoarthrosis and hypertension obtained from the Resident Admission Record printed 6/4/15. R14 was admitted 10/3/13. Review of the Medication Regimen Review, indicated the last consultant pharmacist review in the medical record 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 pertinent recommendations. Two of the four months, 2/22/15 and 4/19/15, noted irregularities and/or recommendations for R14. R39's diagnoses included dementia with	F 514	conducted by the State; and progress notes. The resident's drug regime is reviewed by the licensed staff, physician, and consultant pharmacist to assure that medications are not used in excessive doses, for excessive duration, without adequate monitoring, without adequate indications, or in the presence of adverse consequences. Pharmacist consultant reviews medication regime on all residents monthly. The preliminary survey findings were provided to pharmacist consultant and Medical Director on June 17, 2015. Final survey findings were provided to pharmacist consultant and Medical Director on June 29, 2015 upon arrival in the mail. All resident's drug regime is reviewed monthly by consulting pharmacist with recommendations as indicated, and by attending physician/nurse practitioner every 60 days. 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. All residents have the potential to be affected by this practice. Monitored by: Pharmacist consultant, Director of Nursing or designee	07/15/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245566	A. BUILDING _____ B. WING _____	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 PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 514	Continued From page 53 behavioral disturbances of agitation and combative behavior, delusions, hallucinations and stroke obtained from the Physician Order Report dated 5/4/15 through 6/4/15. R39 was admitted 12/23/13. Review of the Medication Regimen Review, indicated the last consultant pharmacist review in the medical record 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 R39's chart. Review of a 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 that each review was inclusive for all facility residents along with any pertinent recommendations. One of the four months, 4/19/15 noted irregularities and/or recommendations for R39. During an interview on 6/3/15, at 10:53 a.m. the director of nursing (DON) stated the facility changed to a new pharmacy in February, 2015 and that she meets with the pharmacist on the day she is in the facility to discuss any immediate concerns. A "Consultant Pharmacist's Medication Regimen Review" and any "Note to Attending Physician/prescriber" if needed are sent two to three days later by the pharmacist and then addressed. DON stated the reviews are filed in a binder in the nursing office, not in individual charts however the recommendations if any would be. DON stated the pharmacist was in the facility to conduct pharmacy reviews on 2/20/15, 3/16/15, 4/17/15, and 5/15/15, not the dates that were indicated on the Consultant Pharmacist's	F 514		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245566	A. BUILDING _____ B. WING _____	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 PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 514	Continued From page 54 Medication Regimen Review. DON verified that the all-inclusive pharmacy review was not part of the individual resident's chart and permanent record and that there would be no documentation to indicate that a pharmacist review was completed unless there was a recommendation. A message was left for the consulting pharmacist on 6/5/15, at 1:36 p.m. R40 was admitted to the facility 8/15/12, with admission diagnoses of Alzheimer disease, anxiety state, dementia and weight loss due to Alzheimer disease per the Admission Record. Review of the Medication Regimen Review, indicated the last consultant pharmacist review in the medical record 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 R40'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 pertinent recommendations. R21 was admitted with diagnoses of dementia, depressive disorder, nonorganic psychosis, dysuria, neurogenic bladder, Diabetes Mellitus II, chronic pain and dependent personality disorder obtained from the Resident Admission Record printed 6/4/15. Consultant pharmacist medication regimen reviews were completed July 2014 through December 2014 and filed in R21's medical record. Roster report Valleyview Healthcare (MN)	F 514		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245566	A. BUILDING _____ B. WING _____	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 PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 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 site...if no irregularities are found, consultant pharmacist also documents this in the resident's (active record) and signs and dates such documentation." DISCHARGED RESIDENTS R17's physician orders, signed 4/1/15 identified that R17 had a diagnosis that included hypertension, edema, osteoarthrosis, pain, and polymyalgia rheumatica (inflammatory disorder that causes muscle pain and stiffness). R17 was admitted to the facility 3/3/12 and remained in the facility until 5/12/15; however R17's Medication Regimen Review, indicated the last consultant pharmacist review in the medical record was dated 1/21/15 that indicated no new	F 514		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245566	A. BUILDING _____ B. WING _____	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 PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 514	Continued From page 56	F 514		

irregularities. There was no consultant pharmacist's Medication Regimen Review for February 2015, March 2015, April 2015 and May 2015.

Although, the director of nursing's (DON) progress note dated 4/20/2015 indicated the "Pharmacist consultant was in house on 4/17/2015." R17's consultant pharmacist medication regime reviews, dated 2/22/2015, 3/17/2015, and 4/19/2015 were not in the resident's permanent medical record

When interviewed on 6/3/2015 at 10:53 a.m., the director of nursing (DON) stated the facility switched to HealthDirect in February 2015 and the facility report (for all residents in one document) is filed in a binder in the nursing office, not in individual charts..

When interviewed, on 6/5/2015 at 9:30 a.m., the director of nursing (DON) stated that there wouldn't be anything in the discharge record and that she had no additional information.

R57's physician orders, signed 4/2/2015 identified that R57 had right hip joint replacement with orthopedic aftercare, pain, hyperlipidemia, neuropathy, hypertension, and cardiovascular disease.

R57 was admitted to the facility 2/23/15 and remained in the facility until 4/30/15.
There was no documentation in the medical record that R57's medications were reviewed monthly by a pharmacist for March 2015 and April 2015.

During interview on 6/5/15 9:30 a.m. the director

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245566	A. BUILDING _____ B. WING _____	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 PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 514	Continued From page 57 of nursing (DON) stated that there wasn't anything in the record and there was no additional information.	F 514		

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

F5566024

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245566	A. BUILDING **01 - VALLEY VIEW NURSING HOME** B. WING _____	**06/04/2015**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS 2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THE SUBSTANTIAL COMPLIANCE WITH THE REGULATION HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety - State Fire Marshal Division. At the time of this survey, Valley View Nursing Home was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: Health Care Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St Paul, MN 55101-5145, or	K 000	Pack 7-17-15 RECEIVED JUL 13 2015 MN DEPT. OF PUBLIC SAFETY STATE FIRE MARSHAL DIVISION	

Exit: 6-5-15 DC: 7-15-15

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Valerie Henry-Olson		7/6/15

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245566	A. BUILDING **01 - VALLEY VIEW NURSING HOME** B. WING _____	**06/04/2015**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	Continued From page 1 By email to: Marian.Whitney@state.mn.us and Angela.Kappenman@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. This facility will be surveyed as two separate buildings. Valley View Nursing Home is a 1-story building with no basement. The building was constructed at 3 different times. The original building was constructed in 1967 and was determined to be of Type II(111) construction. In 1973, addition was constructed to the West Wing that was determined to be of Type II(111) construction. In 1989, another addition was added to the South Wing and was determined to be Type II (111). Because the original building and the 2 additions are of the same type of construction and meet the construction type allowed for existing buildings, the facility was surveyed as one building. The building became fully sprinklered. The facility has a fire alarm system with full corridor smoke detection, spaces open to the corridors that is monitored for automatic fire department notification.	K 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245566	A. BUILDING **01 - VALLEY VIEW NURSING HOME** B. WING _____	**06/04/2015**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	Continued From page 2 The facility has a capacity of 45 beds and had a census of 43 at the time of the survey. The requirement at 42 CFR Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 029 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain smoke-resisting partitions and doors in accordance with the following requirements of 2000 NFPA 101, Section 19.3.2.1. The deficient practice could affect 5 out 43 residents. Findings include: On facility tour between 8:00 AM and 10:30 AM on 06/04/2015, observation revealed, that the following was found:	K 029	**K 029 NFPA 101 LIFE SAFETY CODE STANDARD** The installation of new door handles and latches was completed on June 4, 2015 to all doors cited in findings. Environmental Services Director will monitor monthly with fire extinguisher checks. Monitored by Environmental Services Director	07/15/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245566	A. BUILDING **01 - VALLEY VIEW NURSING HOME** B. WING _____	**06/04/2015**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 029	Continued From page 3 1. West wing - soiled utility room will not shut/latch 2. Laundry room - south door will not shut/latch 3. Employee storage room - will not shut and latch These deficient practices were confirmed by the Facility Maintenance Director (DJ) at the time of discovery.	K 029		
K 062 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by: Based on documentation review and staff interview, the facility failed to maintain the fire sprinkler system in accordance with the requirements of 2000 NFPA 101, Sections 19.3.4.1 and 9.6, as well as 1998 NFPA 25, section 2-3.3. This deficient practice could affect all 43 residents. Findings include: On facility tour between 8:00 AM and 10:30 AM on 06/04/2015, a review of the fire sprinkler quarter flow test logs indicated that the 2015 - 1st quarter flow test was not documented. This deficient practice was confirmed by the Facility Maintenance Director (DJ) at the time of	K 062	**K062 NFPA 101 LIFE CODE STANDARD** The Environmental Services Director was reeducated on documentation of quarterly flow test. Environmental Services Director documented missed flow test. Flow tests will be conducted quarterly & documented. Environmental Director and/or Administrator will monitor for compliance.	07/15/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245566	A. BUILDING **01 - VALLEY VIEW NURSING HOME** B. WING _____	**06/04/2015**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 062	Continued From page 4 discovery.	K 062		
K 144 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1. This STANDARD is not met as evidenced by: Based on documentation review and staff interview, the facility failed to inspect the emergency generator in accordance with the requirements of 2000 NFPA 101 - 9.1.3 and 1999 NFPA 110 Chapter 6.4.2 and 6-4.2.2. The deficient practice could affect all 43 residents. Findings include: On facility tour between 8:00 AM and 10:30 AM on 06/04/2015, documentation review of the monthly generator logs revealed the following: 1. No generator transfer time was recorded 2. No generator cool down time was recorded 3. The review of the monthly run test indicated that the generator did not meet one of the following: a. loading that maintains the minimum exhaust gas temperatures as recommended by the manufacturer or b. under load of 30 percent or more of the	K 144	**K144 NPFA 101 LIFE SAFETY CODE STANDARD** A load bank test was completed June 18, 2015. The test indicated the generator was operating above and beyond the requirements of 30% load. Environmental Director will conduct monthly generator load tests. Environmental Director and/or Administrator will monitor for compliance.	07/15/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245566	A. BUILDING **01 - VALLEY VIEW NURSING HOME** B. WING _____	**06/04/2015**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 144	Continued From page 5 nameplate rating of generator or c. 2 hour load bank test (first 30 minutes - 25%, next 30 minutes - 50%, and last 1 hour - 75%) These deficient practices were confirmed by the Facility Maintenance Director (DJ) at the time of discovery. *TEAM COMPOSITION* Gary Schroeder, Life Safety Code Spc.	K 144		

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

F5566024

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245566	A. BUILDING **02 - 2011 ADDITION** B. WING _____	**06/04/2015**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS 2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THE SUBSTANTIAL COMPLIANCE WITH THE REGULATION HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety - State Fire Marshal Division. At the time of this survey, Valley View Nursing Home was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 18 New Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: Health Care Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St Paul, MN 55101-5145, or	K 000	Pack FB 7-17-15	

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

Marie Nurse RDON | 7/6/15

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245566	A. BUILDING **02 - 2011 ADDITION** B. WING _____	**06/04/2015**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	Continued From page 1 By email to: Marian.Whitney@state.mn.us and Angela.Kappenman@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. This facility will be surveyed as two separate buildings. Valley View Nursing Home, 2011 addition is a 1-story building with no basement. The 2011 addition was determined to be of Type II (111) construction. The building is fully sprinklered. The facility has a fire alarm system with full corridor smoke detection, spaces open to the corridors and resident rooms that is monitored for automatic fire department notification. The facility has a capacity of 45 beds and had a census of 43 at the time of the survey. The requirement at 42 CFR Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 062 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are	K 062		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245566	A. BUILDING **02 - 2011 ADDITION** B. WING _____	**06/04/2015**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 062	Continued From page 2 continuously maintained in reliable operating condition and are inspected and tested periodically. 18.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by: Based on documentation review and staff interview, the facility failed to maintain the fire sprinkler system in accordance with the requirements of 2000 NFPA 101, Sections 18.3.4.1 and 9.6, as well as 1998 NFPA 25, section 2-3.3. This deficient practice could affect all 43 residents. Findings include: On facility tour between 8:00 AM and 10:30 AM on 06/04/2015, a review of the fire sprinkler quarter flow test logs indicated that the 2015 - 1st quarter flow test was not documented. This deficient practice was confirmed by the Facility Maintenance Director (DJ) at the time of discovery.	K 062	**K062 NFPA 101 LIFE CODE STANDARD** The Environmental Services Director was reeducated on documentation of quarterly flow test. Environmental Services Director documented missed flow test. Flow tests will be conducted quarterly & documented. Environmental Director and/or Administrator will monitor for compliance.	07/15/15
K 144 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1.	K 144	**K144 NPFA 101 LIFE SAFETY CODE STANDARD** A load bank test was completed June 18, 2015. The test indicated the generator was operating above and beyond the requirements of 30% load. Environmental Director will conduct monthly generator load tests. Environmental Director and/or Administrator will monitor for compliance.	07/15/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245566	A. BUILDING **02 - 2011 ADDITION** B. WING _____	**06/04/2015**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 144	Continued From page 3 This STANDARD is not met as evidenced by: Based on documentation review and staff interview, the facility failed to inspect the emergency generator in accordance with the requirements of 2000 NFPA 101 - 9.1.3 and 1999 NFPA 110 Chapter 6.4.2 and 6-4.2.2. The deficient practice could affect all 43 residents. Findings include: On facility tour between 8:00 AM and 10:30 AM on 06/04/2015, documentation review of the monthly generator logs revealed the following: 1. No generator transfer time was recorded 2. No generator cool down time was recorded 3. The review of the monthly run test indicated that the generator did not meet one of the following: a. loading that maintains the minimum exhaust gas temperatures as recommended by the manufacturer or b. under load of 30 percent or more of the nameplate rating of generator or c. 2 hour load bank test (first 30 minutes - 25%, next 30 minutes - 50%, and last 1 hour - 75%) These deficient practices were confirmed by the Facility Maintenance Director (DJ) at the time of discovery. *TEAM COMPOSITION* Gary Schroeder, Life Safety Code Spc.	K 144		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245566	A. BUILDING **02 - 2011 ADDITION** B. WING _____	**06/04/2015**

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

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

MINNESOTA
MDH
DEPARTMENT OF HEALTH

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 only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the deficiency within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

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.

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

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00286	A. BUILDING: _____ 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 PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: The facility has agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm The State licensing orders are delineated on the attached Minnesota	2 000	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.	

Minnesota Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE 7/6/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00286	A. BUILDING: _____ 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 PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	Continued From page 1 Department of Health orders being submitted electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. Then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health.	2 000	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 which are in violation of the state statute after the statement, "This Rule is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	
2 302	MN State Statute 144.6503 Alzheimer's disease or related disorder train ALZHEIMER'S DISEASE OR RELATED DISORDER TRAINING: MN St. Statute 144.6503 (a) If a nursing facility serves persons with Alzheimer's disease or related disorders, whether in a segregated or general unit, the facility's direct	2 302		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00286	A. BUILDING: _____ 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 PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 302	Continued From page 2 care staff and their supervisors must be trained in dementia care. (b) Areas of required training include: (1) an explanation of Alzheimer's disease and related disorders; (2) assistance with activities of daily living; (3) problem solving with challenging behaviors; and (4) communication skills. (c) The facility shall provide to consumers in written or electronic form a description of the training program, the categories of employees trained, the frequency of training, and the basic topics covered. (d) The facility shall document compliance with this section. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure consumers were provided information regarding Alzheimer's disease and dementia training, including a description of the training program, the categories of employees trained, the frequency of training and the basic topics covered in the training in a written or electronic form. Findings include: During a review of the facility's Alzheimer's training program, there was no information or documentation that indicated the consumers were provided in written or electronic, a description of Alzheimer's training program, the categories of employees trained, the frequency of	2 302		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00286	A. BUILDING: _____ 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 PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 302	Continued From page 3 training and the basic topics covered. When interviewed, on 6/4/15, at 4:00 p.m. the social worker (SW) stated that they have nothing written or electronic that they provide to the consumers. During interview, on 6/4/15, at 4:10 p.m., the director of nursing (DON) stated that she was unaware of information written or electronic for consumers. On 6/5/15, at 9:35 a.m., the DON stated that there was no policy on Alzheimer's training. SUGGESTED METHOD OF CORRECTION: The DON or designee could add information regarding staff training to the resident admission packet for consumer information. The DON or designee could educate staff and conduct audits to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 302		
2 570	MN Rule 4658.0405 Subp. 4 Comprehensive Plan of Care; Revision Subp. 4. Revision. A comprehensive plan of care must be reviewed and revised 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, with the participation of the resident, the resident's legal guardian or chosen representative at least quarterly and within seven days of the revision of the comprehensive resident assessment required	2 570		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00286	A. BUILDING: _____ 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 PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 570	Continued From page 4 by part 4658.0400, subpart 3, item B. This MN Requirement is not met as evidenced by: Based on observation, 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). Findings include: 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). A Fall Risk assessment dated 3/15/15, identified R17 had unsteady gait and balance problems, urge incontinence, joint paint, arthritis, and a 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	2 570		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00286	A. BUILDING: _____ 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 PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 570	Continued From page 5 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 from polymyalgia and directed to refer to therapies as indicated. The care plan directed staff to encourage use of walker with ambulation, and directed independent with transfer, bed mobility and ambulation with walker. The care plan was not updated with the decline in functional abilities from the quarterly MDS dated 12/17/15, to the annual assessment 3/17/15, and to reflect the physical assist of one staff member for transfers and toileting. On 6/5/15, at 12:38 p.m. the DON stated R17 was still her own person, alert, had poly myalagia, always able to alert us if she needed assistance, could and did transfer and toilet by self.	2 570		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00286	A. BUILDING: _____ 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 PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 570	Continued From page 6 The facility failed to update the plan of care or refer R17 to PT/OT when a decline in cognitive and functional abilities was noted the 3/17/15, MDS assessment. In addition on 4/29/15, a nursing progress note indicated a decline in ambulation and indicated a referral to PT/OT should be done. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee could educate staff related to the need to evaluate and update care plans and monitor for compliance. TIME PERIOD FOR CORRECTION: Twenty One (21) days.	2 570		
2 625	MN Rule 4658.0450 Subp. 1 A-P Clinical Record Contents; In General Subpart 1. In general. Each resident's clinical record, including nursing notes, must include: A. the condition of the resident at the time of admission; B. temperature, pulse, respiration, and blood pressure, according to part 4658.0520, subpart 2, item I; C. the resident's height and weight, according to part 4658.0520, subpart 2, item J; D. the resident's general condition, actions, and attitudes; E. observations, assessments, and interventions provided by all disciplines responsible for care of the resident, with the exception of confidential communications with religious personnel; F. significant observations on, for example,	2 625		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00286	A. BUILDING: _____ 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 PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 625	Continued From page 7 behavior, orientation, adjustment to the nursing home, judgment, or moods; G. date, time, quantity of dosage, and method of administration of all medications, and the signature of the nurse or authorized persons who administered the medication; H. a report of a tuberculin test within the three months prior to admission, as described in part 4658.0810; I. reports of laboratory examinations; J. dates and times of all treatments and dressings; K. dates and times of visits by all licensed health care practitioners; L. visits to clinics or hospitals; M. any orders or instructions relative to the comprehensive plan of care; N. any change in the resident's sleeping habits or appetite; O. pertinent factors regarding changes in the resident's general conditions; and P. results of the initial comprehensive resident assessment and all subsequent comprehensive assessments as described in part 4658.0400. This MN Requirement is not met as evidenced by: Based on interview and record review, the facility failed to maintain accurate medical records were complete for 5 of 5 residents (R14, R39, R40, R10, R21) and 2 of 2 discharged residents (R17, R57) reviewed for monthly pharmacist reviews. Findings include: Current Residents: R14's diagnoses included dementia with	2 625		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00286	A. BUILDING: _____ 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 PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 625	Continued From page 8 delusional disorder, anxiety, osteoarthrosis and hypertension obtained from the Resident Admission Record printed 6/4/15. R14 was admitted 10/3/13. Review of the Medication Regimen Review, indicated the last consultant pharmacist review in the medical record 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 pertinent recommendations. Two of the four months, 2/22/15 and 4/19/15, noted irregularities and/or recommendations for R14. R39's diagnoses included dementia with behavioral disturbances of agitation and combative behavior, delusions, hallucinations and stroke obtained from the Physician Order Report dated 5/4/15 through 6/4/15. R39 was admitted 12/23/13. Review of the Medication Regimen Review, indicated the last consultant pharmacist review in the medical record 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 R39's chart. Review of a 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	2 625		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00286	A. BUILDING: _____ 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 PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 625	Continued From page 9 5/18/15, indicated that each review was inclusive for all facility residents along with any pertinent recommendations. One of the four months, 4/19/15 noted irregularities and/or recommendations for R39. During an interview on 6/3/15, at 10:53 a.m. the director of nursing (DON) stated the facility changed to a new pharmacy in February, 2015 and that she meets with the pharmacist on the day she is in the facility to discuss any immediate concerns. A "Consultant Pharmacist's Medication Regimen Review" and any "Note to Attending Physician/prescriber" if needed are sent 2-3 days later by the pharmacist and then addressed. DON stated the reviews are filed in a binder in the nursing office, not in individual charts however the recommendations if any would be. DON stated the pharmacist was in the facility to conduct pharmacy reviews on 2/20/15, 3/16/15, 4/17/15, and 5/15/15, not the dates that were indicated on the Consultant Pharmacist's Medication Regimen Review. DON verified the all-inclusive pharmacy review was not part of the individual resident's chart and permanent record and that there would be no documentation to indicate that a pharmacist review was completed unless there was a recommendation. A message was left for the consulting pharmacist on 6/5/15, at 1:36 p.m. R40 was admitted to the facility 8/15/12, with admission diagnoses of Alzheimer disease, anxiety state, dementia and weight loss due to Alzheimer disease per the Admission Record. Review of the Medication Regimen Review, indicated the last consultant pharmacist review in the medical record was dated 1/21/15. There was	2 625		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00286	A. BUILDING: _____ 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 PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 625	Continued From page 10 no consultant pharmacist's Medication Regimen Review recorded by the pharmacist for February 2015, March 2015, April 2015 and May 2015 in R40'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 pertinent recommendations. R21 was admitted with diagnoses of dementia, depressive disorder, nonorganic psychosis, dysuria, neurogenic bladder, Diabetes Mellitus II, chronic pain and dependent personality disorder obtained from the Resident Admission Record printed 6/4/15. Consultant pharmacist medication regimen reviews were completed July 2014 through December 2014 and filed in R21's medical record. Roster report Valleyview Healthcare (MN) 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	2 625		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00286	A. BUILDING: _____ 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 PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 625	Continued From page 11 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 site...if no irregularities are found, consultant pharmacist also documents this in the resident's (active record) and signs and dates such documentation." DISCHARGED RESIDENTS R17's physician orders, signed 4/1/15, identified that R17 had a diagnosis that included hypertension, edema, osteoarthrosis, pain, and polymyalgia rheumatica (inflammatory disorder that causes muscle pain and stiffness). R17 was admitted to the facility 3/3/12 and remained in the facility until 5/12/15; however R17's Medication Regimen Review, indicated the last consultant pharmacist review in the medical record was dated 1/21/15 that indicated no new irregularities. There was no consultant pharmacist's Medication Regimen Review for February 2015, March 2015, April 2015 and May 2015. Although, the DON's progress note dated 4/20/15, indicated the "Pharmacist consultant was in house on 4/17/15." R17's consultant pharmacist medication regime reviews, dated 2/22/15, 3/17/15, and 4/19/15, were not in the resident's permanent medical record When interviewed on 6/3/15,at 10:53 a.m., the DON stated the facility switched to HealthDirect in February 2015 and the facility report (for all residents in one document) was filed in a binder in the nursing office, not in individual charts..	2 625		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00286	A. BUILDING: _____ 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 PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 625	Continued From page 12 When interviewed, on 6/5/2015 at 9:30 a.m., the DON stated that there wouldn't be anything in the discharge record and that she had no additional information. R57's physician orders, signed 4/2/2015 identified that R57 had right hip joint replacement with orthopedic aftercare, pain, hyperlipidemia, neuropathy, hypertension, and cardiovascular disease. R57 was admitted to the facility 2/23/15 and remained in the facility until 4/30/15. There was no documentation in the medical record that R57's medications were reviewed monthly by a pharmacist for March 2015 and April 2015. During interview on 6/5/15, at 9:30 a.m. the DON stated there was not anything in the record and there was no additional information. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee, could review and revise policies and procedures related to documentation of code status for residents and could provide staff education related to these policies and procedures. The director of nursing or designee could develop an audit tool to ensure appropriate care is provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 625		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and	2 830		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00286	A. BUILDING: _____ 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 PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 830	Continued From page 13 custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to complete an ordered wheelchair positioning assessment for one of one residents (R10) who was reviewed for positioning who had a left hemiplegia and was leaning to the left in the electric wheelchair and was unable to support his left arm and left leg. Findings include: R10 was admitted to the facility on 11/16/11, with admission diagnoses of cerebrovascular accident (CVA) with left sided weakness and hypertension per the Admission Record. On 6/1/15, at 12:29 p.m. R10 was returning from the dining room, he was leaning left in his electric wheelchair (w/c) and his left arm was hanging over the arm rest. On 6/2/15, at 8:40 a.m. R10 was sitting in the w/c leaning to left. The arm rest was there, but he was leaned over so far, you could not see the arm rest. He stated he leaned that way because of the (indicated left arm and leg hemiplegia). The	2 830		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00286	A. BUILDING: _____ 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 PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 830	Continued From page 14 left knee was pointed out and foot was tipped left lean. His left arm hung down. On 6/3/15, at 10:40 a.m. R10 was returning from breakfast, his left leg was turned out to the left side, his left foot was rolled over onto the ankle as it rested on the footrest, and his right arm was hung down. On 6/4/15 at 11:00 R10 was asked if he knew he was leaning in the wheelchair. R10 stated yes, and partially moved himself upright, but was not able to become fully upright by himself. The annual Care Area Assess (CAA), dated 9/30/14, indicated extensive assistance for activities of daily living. The corresponding care plan dated 3/24/15, indicated: R10 was at risk for falls, required an EZ stand for transfers or Hoyer lift with assist of two for transfers with increased weakness. A therapy progress note dated 2/19/15, authorized services for occupational therapy (OT). The documentation noted a Plan of Treatment for outpatient rehabilitation (rehab). The treatment noted an evaluation for the electric wheelchair related to allegation of running over roommate's foot. Also noted was w/c mobility as R10 was able to drive on right side of open hallway, within 10-12 inches from wall with some swaying right to left, and he was able to manage his doorway. "W/c assessment for safe driving." A OT physician's order clarification, for therapeutic exercises, therapeutic activities, w/c positioning was signed by physician on 3/11/15. An OT therapy order dated 3/2/15, stated reached maximum rehab potential, discontinue OT with last treatment day 3/2/15. An OT	2 830		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00286	A. BUILDING: _____ 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 PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 830	Continued From page 15 assessment for powered wheelchair driving dated 3/2/15, indicated: R10 demonstrated good speed control at lowest speed, demonstrated ability to verbalize "excuse me" and able to use horn. " Safe (to drive) when scooter is set at lowest speed." However, the chart lacked documentation of a w/c assessment for positioning. The quarterly Minimum Data Set (MDS) dated 3/19/15, indicated R10 was cognitively intact, required extensive assist of two with bed mobility, transfers, toilet use, and required the use of a stand assist lift. The care plan dated 3/24/15, indicated deficits in activities of daily living, transfers, bed mobility, and locomotion due to left sided weakness. R10 was dependent upon staff for all cares. A review of the PT file indicated: An undated note on 1/2 of a sheet of computer paper was given to PT-OT on Monday 6/1/15, "I think room 13 needs an evaluation or maybe an adaptive pad of sorts. We've noticed lately that at times in his wheelchair his left leg starts to turn out to the side at times sometimes severely where it looks like his hip is popped out of socket. At these times it also makes it difficult to keep left leg within the EZ stand even when using the leg belt. Not sure if we can add a pad to left of w/c to help keep leg straight." On 6/3/15, at 2:00 p.m. OT-A stated R10 had not been assessed for proper positioning in the electronic w/c, only safe driving. On 6/4/15, at 2:00 p.m. physical therapist (PT)-A stated the note was given to them by a CNA, and he changed it to OT for the proper evaluation. PT-A stated "it (wheelchair positioning) has come	2 830		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00286	A. BUILDING: _____ 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 PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 830	Continued From page 16 up in the past before, unfortunately there were not many accessories for electric wheelchairs." On 6/5/15, at 1:38 p.m. the director of nursing (DON) stated that R10 was sometimes leaning in his wheelchair to the left. Staff would then lift him back to bed and get him up after a rest. The facility lacked a wheel chair assessment for positioning for R10, even though it had been ordered. In addition, based on interview and document review, the facility failed to develop and implement interventions to prevent falls for 2 of 4 residents (R17, R40) who were reviewed for accidents. Findings include: The admission record sheet indicated R17 had been admitted to the facility 3/3/12. R17 R17's Fall Risk assessment dated 3/15/15, described R17 as having an unsteady gait and balance problems, urge incontinence, joint paint, arthritis, and a decline in decision making skills, and the assessment indicated R17 utilized a WW [wheeled walker] or W/C [wheelchair], and was a safety risk due to weakness and deconditioning. An annual Minimum Data Set (MDS) dated 3/17/15, indicated R17 had diagnoses including: short term memory loss, ischemic heart disease (decreased blood flow and oxygen to the heart muscle itself), edema with use of diuretic medications (medications to promote urination), hypertension (high blood pressure), polymyalgia rheumatica (pain and stiffness in shoulders, neck, upper arms and hips), and osteoarthritis (degenerative arthritis).	2 830		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00286	A. BUILDING: _____ 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 PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 830	Continued From page 17 The annual MDS from 3/17/15, indicated R17 had moderately impaired cognition. The MDS further indicated R17 could understand what was communicated and could make herself understood, had no depression or behavior symptoms, was independent with bed mobility, required supervision or cueing and one person physical assist for transfers, toilet use and ambulation in her room. A previous quarterly MDS dated 12/17/14, had indicated R17 had required set up help for transfers, ambulation in the room, and toilet use. The annual MDS from 3/17/15, indicated R17 needed assist with transfers and ambulation in the corridor. The MDS did not indicate the resident had received any restorative nursing or PT/OT. The corresponding 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. The CAA did not indicate whether any referral had been initiated for an evaluation by OT or PT of R17's need for increased assist with transfers and ambulation in the corridor. The Care Plan dated 3/24/15, indicated R17 experienced pain in the right hip and knee from polymyalgia, and indicated R17 would be referred to therapies "as indicated." The care plan also indicated R17 was independent with transfers; bed mobility and ambulation with walker, and indicated staff were to notify the MD (medical doctor) of any significant decline to physical and cognitive functioning and to refer R17 to therapy as indicated. The care plan further indicated R17 was at risk for falls related to degenerative joint disease, polymyalgia and history of falls. Interventions included for staff to notify the MD of	2 830		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00286	A. BUILDING: _____ 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 PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 830	Continued From page 18 any significant decline in physical or cognitive function, and to refer to therapy as indicated. A hand written note on the care plan dated 4/29/15, indicated R17's cognition was changing, "history of returning to the dining room after lunch and eating off of other resident's plates. Staff were to monitor the dining room, clear plates, redirect resident with fresh coffee and snack." The care plan did not include the use of staff intervention for transfers and ambulation in her room as depicted in the most current MDS dated 3/17/15. The Physician's Order Report dated 2/11/15 through 4/1/15, indicated R17 should be UP AD LIB (up as tolerated). Review of R17's Nursing Notes identified a decline in ambulation had been identified for R17 on 4/29/15. On 5/1/15, at approximately 3:15 p.m. the facility had first requested physical therapy (PT) and occupational therapy (OT) services to evaluate R17's decline in ambulation. Nursing notes revealed R17 fell on 5/1/15, at 6:54 p.m. requiring transfer to the hospital emergency room (ER), and that R17 was subsequently diagnosed with a fractured hip. Therapy notes for PT and OT were requested, but none were provided during the survey. A nursing progress note dated 5/1/15, at 6:45 p.m. indicated R17 "was heard in her room yelling for help. When staff entered she was laying on her back on the floor in her room. Upon examining her we discovered that resident was unable to move her right leg. When staff was feeling her hip she (R17) did state that her right hip hurt, but also said that her right knee hurt. Vital signs stable, staff did send her into ER [emergency room] for x-ray of right hip and leg. Care plan updated, family and doc (doctor) were	2 830		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00286	A. BUILDING: _____ 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 PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 830	Continued From page 19 notified." A report entitled, Understanding the Fall dated 5/1/15, indicated R17's incident had been "Unwitnessed. Actual time of fall was 6:25 p.m. w/c to floor. Takes self to bathroom, just had supper, has water at bedside. Trying to get into recliner. R [right] hip/leg pain. Last meds at 2:00 p.m., no alarms." An additional report entitled, Safety Event -Falls dated 5/1/15, was reviewed. The form, documented by licensed practical nurse (LPN)-A, indicated the resident had been sent to the hospital on 5/1/15, and had returned on 5/2/15. Changes to the care plan dated 5/1/15, indicated the resident had sustained a fractured right hip and had pain, and that there had been no surgical intervention. Interventions included: "Bedrest, with assistance of two staff and Hoyer lift to chair/commode. Dependent on staff for all needs. Bed/chair bound." On 5/2/15, a nursing progress note indicated the resident required skilled nursing and bedrest, should continue with previous activity, and would transfer bed to chair, chair/bed to commode only with assist. The note included, "was on restorative walking program average 23 feet with SBA [stand by assist] 2WW." The goal was identified as, "ambulate independently in room with 2WW." An investigative report completed by the social worker on 5/4/15, indicated R17 had experienced 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.	2 830		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00286	A. BUILDING: _____ 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 PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 830	Continued From page 20 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. 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.	2 830		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00286	A. BUILDING: _____ 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 PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 830	Continued From page 21 A quarterly 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 after 15 minute checks had been initiated. In addition, the falls were not always comprehensively assessed for causative factors including medical changes, and new interventions were not always considered.	2 830		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00286	A. BUILDING: _____ 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 PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 830	Continued From page 22 A review of the falls for R40 included: 1. 10/11/14, 12:00 a.m. Unwitnessed fall (staff had responded to alarm). The report included, "Fall in Day room; no injury, had been 1:1 (one to one with staff) for 3 hours. Continue alarms, will do 3 day sleep study." No sleep study results were reviewed in the investigation for this fall. 2. 10/21/14, 9:00 p.m. Witnessed fall on TCU (transitional care unit) while ambulating. "INJURY: bruising, bump back of head. 1:1 Attention when restless get up in chair." No sleep study results were reviewed for the investigation for this fall. 3. 11/1/14, 3:40 a.m. Unwitnessed fall in resident room (staff responded to alarm). No injury, new intervention added after this fall: " Medication adjustment, chart behaviors ." Evaluated in ER (emergency room), memory clinic and PMD in house after adjustment in medications with exacerbation of increased behaviors. Supportive devices [alarms] remain in place and appropriate. 4. 11/8/14, 12:29 p.m. Witnessed fall in hallway (walking in the hall). Documentation indicated, "Combative and aggressive, lowered to the floor while attacking staff hitting and kicking, no longer able to stand and lowered to floor. Sent to ER (emergency room) for evaluation." 5. 11/30/14, 6:09 p.m. Unwitnessed fall in dayroom (staff responded to alarm) INJURY: "has red mark (scratch) on both of her inner forearms " 9 x 0.5 cm (centimeters), 10 cm x 0.4 cm, 3.5x1 cm. 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 current measures. 7. 1/7/15, at 1:45 p.m. Unwitnessed fall (respond to alarm). "Fell from Broda chair, wanted to go for a walk, alarm sounded. She fell to left side and hit back of head. Injury: abrasion	2 830		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00286	A. BUILDING: _____ 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 PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 830	Continued From page 23 to back of head. Abrasion to back of head, unmeasurable d/t (due to) blood sticking to wound, did not want to wash it and cause it to re-bleed. 1/8/15, c/o headache and tender to touch, weak and shaking when taken to bathroom. Appears weaker and required assistance with eating. In bed and shaking uncontrollably, states she is cold, several blankets on at this time. Continue Broda alarm." 8. 1/14/15, 2:28 p.m. Witnessed fall (staff responded to alarm). Fall in Resident Room was attempting to stand, fell back onto bed and head hit bed wall. "INJURY Scraped off small part of skin covering old head injury, previous lump on head from fall was on 15 minute checks, Temperature 100.1 BP (blood pressure) 96/50." Discussion in investigation included, "Restraints would be next intervention and this is inappropriate; would cause, anxiety, confusion, restricted movements. No Changes. New physician's orders. Monitor for 72 hours, neuro checks, and ice to affected area of injury for 20 minutes four times a day for 3 days. Added a pad to side of wall." 9. 1/18/15, 9:55 p.m. Unwitnessed fall (staff had responded to alarm). Fell while trying to get out of her Broda chair, "alarm was on with new battery and did not work. Alarm was working earlier. Injury 3 centimeter reddened area on right buttock, no c/o tenderness. Continue alarms, alarms checked and are working." No 15 minute check form was provided. 10. 2/13/15, 6:15 a.m. Unwitnessed fall in her room (staff responded to alarm). "No injury noted. Continue 15 min (minute) checks and alarms. Found on sensor mat on floor, walked to bathroom no injury. Care plan updated and family notified." 11. 2/25/15, at 1:55 a.m. Unwitnessed fall (staff had responded to alarms). Nurse's note included,	2 830		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00286	A. BUILDING: _____ 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 PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 830	Continued From page 24 "Walking back from the bathroom in her room and fell to the floor." The computer documentation indicated, "bed alarm going off, found scooting towards bed, incontinent of urine. No injury. Continue alarms. No changes continue with current measures." 12. 3/1/15, at 5:00 a.m. Unwitnessed fall (staff responded to alarms). Fell in bedroom while self-transferring. Had been toileted at 2:30 a.m. INJURY right arm scratch, right side back of head bruised, lump abrasion- 3cm X 2cm x 1cm raised, complained of headache after fall. Continue alarms. Resident was in a different environment room change short term due to plumbing project in resident's bathroom. No changes continue with current measures. . 13. 4/11/15, 11:43 p.m. Witnessed fall (staff responded to alarms). R40 fell in her room trying to transfer from chair to bed. A little bit of pain, pointed to top of forehead. The back of the head hit the floor pain score 1/10. Ice bag applied. No apparent injury. OT eval for self-release belt in Broda chair. Supportive devices in place, alarm did sound. On 15 minute checks, routinely toileted. No medications changes. Resident was noted to experience increased restlessness, tearfulness, anxiety after visit with her daughter. Resident has been referred to OT for evaluation and treatment as indicated. Will follow their recommendations. Will continue with current measures. No change to plan of care at this time. No documentation in 15 minute check form related to fall. 14. 4/12/15, at 12:54 p.m. Witnessed fall in dayroom (staff responded to alarm). "Observed on her knees in front of another resident. Resident stated she had stood up and fallen into resident. 4/12/15, 1:04 p.m. sitting 90/70 O2 sats (oxygen saturation) 90%." New interventions added after this fall: this was left blank.	2 830		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00286	A. BUILDING: _____ 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 PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 830	Continued From page 25 "Supportive devices in place, alarm did sound. On 15 minute checks, routinely toileted. No medications changes. Resident was in a different environment room change short term due to plumbing project in resident's bathroom. No changes continue with current measures." 15. 4/12/15, 8:40 p.m. Unwitnessed fall (responding to alarm). Found in lounge face down on the floor " I'm taking a nap, I fell out of my chair and I hit my head " . OT self-release in Broda. Supportive devices in place, alarm did sound. On 15 minute checks, routinely toileted. No medications changes. Resident was in a different environment room change short term d/t plumbing project in resident ' s bathroom. No changes continue with current measures. 16. 5/25/15, 6:30 p.m. Unwitnessed fall (responded to alarm). Found crawling on floor in room 16, stated " going to bed " . A few minutes later she said she fell on her right butt. No injuries seen. Supportive devices in place, alarm did sound. On 15 minute checks, routinely toileted. No medications changes. Resident was in a different environment room change short term due to plumbing project in resident ' s bathroom. Zoloft was increased in recent past after increase in tearfulness. Does have self-releasing belt on per OT evaluation. Currently we will continue with current measures. Staff to encourage resident to get ready for bed by 8 p.m. if noted to be tired. 17. 5/27/15, at 8:30 p.m. report indicated, "unhooked her seat belt; got up and laid down on the floor. This was not a fall. Resident laid herself down on floor. Did not slide or fall out of her Broda chair. Unwitnessed fall. Nursing progress note stated: certified nursing assistant (CNA) (responded to alarm), found resident sitting on the floor and preparing to lay down. Opened event because self-releasing seat belt was started recently. Note that she is able to release	2 830		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00286	A. BUILDING: _____ 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 PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 830	Continued From page 26	2 830		

the belt Staff responded to alarm. Resident unhooked her seat belt; got up and laid down on the floor. This was not 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 responded to alarm). "Found on floor in lounge in front of w/c. '...trying to get into a different chair.' Other residents said she stood and tried to get into recliner. New intervention: offer to get ready for bed by 8:00 p.m."
19. 6/2/15, at 4:40 a.m. Unwitnessed fall (responded to alarm). "Bed alarm sounding and when staff arrived in resident room after alarm sounded for 2 minutes or less. Resident was in the bathroom sitting on the floor by toilet. " misjudged toilet placement when sitting." Event was not yet closed.

The facility had a sheet of paper that was documented on every 15 minutes through the day.
A review of the 15 minute check forms indicated that the forms were frequently filled out by the same hand, with the same pen for 8-12 hours every 15 minutes.

On 6/5/15, at 1:15 p.m. the social worker (SW) was interviewed and stated the 15 minute check forms are given to her when complete. The SW stated that the facility is aware of the research that alarms and 15 minute checks may actually increase falls. The SW had sent out notices to family that the facility is going to try to eliminate alarms, but R40's family insists on the alarms. SW verified that the 15 minute check forms were not always completed.

The facility failed to thoroughly investigate and analyze the falls for R40 and did not attempt new

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00286	A. BUILDING: _____ 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 PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 830	Continued From page 27 interventions with every fall. It was unclear whether medical reasons for the falls was considered, even when elevated temperatures and low blood pressures were recorded on the incident forms. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could educate nursing staff regarding providing nursing care and supervision for residents according to the resident's individual needs and assessment. The director of nursing or designee could develop an audit tool to ensure appropriate care is provided. TIME PERIOD FOR CORRECTION: Thirty (30) days.	2 830		
21375	MN Rule 4658.0800 Subp. 1 Infection Control; Program Subpart 1. Infection control program. A nursing home must establish and maintain an infection control program designed to provide a safe and sanitary environment. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure appropriate hand hygiene and gloving was completed during residents care for 1 of 1 resident (R10). In addition, the facility failed to implement procedures to prevent the possible spread of blood borne infections during blood glucose monitoring performed for 2 of 10 residents (R10, R5) who had blood sugars readings taken with the use of a glucose machine.	21375		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00286	A. BUILDING: _____ 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 PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21375	Continued From page 28 Findings include: Gloving: On 6/3/15, R10 was observed for morning cares, nursing assistant (NA)-A, did not change gloves as required. On 6/3/15, at 7:47 a.m. cares were observed for R10 NA-A verified that she did provided peri-care, removed her gloves but did not wash her hands. NA-A then lifted R10 out of bed into an electric wheelchair, then donned a new pair of gloves and provided the dentures to R10. NA-A stated she was not aware of the hand washing policy for the facility, and would have to find out. NA-A had been doing the job for three years. The quarterly Minimum Data Set (MDS) dated 3/19/15, indicated R10 was cognitively intact, required extensive assist of two with bed mobility, transfers, toilet use, and required the use of a stand assist lift. The corresponding 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 were due to left sided weakness. The care plan dated 3/24/15, indicated R10 was dependent on the staff for all personal cares. On 6/5/15, at 1:38 p.m. the director of nursing (DON) verified she expected staff to use appropriate hand hygiene. The Hand Washing Policy and Procedure dated 2006, indicated hand washing was required.....after removal of gloves. Blood glucose meter:	21375		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00286	A. BUILDING: _____ 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 PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21375	Continued From page 29 On 6/1/15, licensed practical nurse (LPN)-A did not use a sanitary manner while using the blood glucose meter, and did not use the safety syringe as directed by the manufacturer, and did not perform the final lock to prevent needle exposure when the insulin syringe was discarded in the sharps container. On 6/1/15, at 4:06 p.m. BG procedure was observed for R10, the BG meter was placed on the water pitcher tray in R10's room, and then used to obtain a blood sample. The contaminated machine was then placed directly on top of the medication cart. LPN-A then removed gloves and with a bare hand put the soiled lancet (exposed to blood) in the sharps container. The DON walked past, and said something quietly to LPN-A, who then opened the bottom drawer of the medication cart and cleaned the BG meter with a super sani-wipes, but did not wipe down the already contaminated medication cart. At 4:06 p.m. LPN-A verified her usual practice was to set the BG meter on the top of the medication cart unclean. - At 4:18 p.m. LPN-A stated she had been going to clean the BG meter with alcohol, but the DON walked past and told her to use the super sani-wipes. -At 4:22 p.m. LPN-A obtained an insulin dose for R5, LPN-A was observed to uncap the insulin needle, then swab the insulin vial after uncapping the syringe, thereby exposing herself to a needle stick. LPN-A then accessed the insulin vial with the insulin needle and drew up 1 unit in the safety syringe, then recapped the needle (again exposing herself to a needle stick). Provided the insulin dose, and then pulled the sheath up on the safety syringe to cover the needle. However, she did not lock the safety syringe by turning the barrel, before she disposed the unlocked syringe in the sharps container (again exposing her or	21375		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00286	A. BUILDING: _____ 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 PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21375	Continued From page 30 others to a potential for needle stick). LPN-A verified she did not use the safety syringe sheath until she was done with the syringe. - At 5:00 p.m. the director of nursing (DON) verified a needle should never be recapped, and then used a safety syringe to verify that the barrel of the syringe should be turned to lock it prior to disposal in the sharps container. The DON verified the manufacturer ' s instructions should be followed while using the safety syringe. The Infection Control Policy and Procedures dated 2006, directed....All employees are required to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice... maintaining a clean working environment by maintaining clean counter, tables....keeping resident's equipment clean,... safe, and sanitary...prevent transmission of disease. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee could educate staff on the appropriate cleaning of multiple patient use equipment to prevent cross contamination, recapping of syringes, and proper handwashing and glovong. The director of nursing or designee could then monitor for compliance. TIME PERIOD FOR CORRECTION: Twenty One (21) days.	21375		
21426	MN St. Statute 144A.04 Subd. 3 Tuberculosis Prevention And Control (a) A nursing home provider must establish and maintain a comprehensive tuberculosis infection control program according to the most	21426		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00286	A. BUILDING: _____ 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 PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21426	Continued From page 31 current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in CDC's Morbidity and Mortality Weekly Report (MMWR). This program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, residents, and volunteers. The Department of Health shall provide technical assistance regarding implementation of the guidelines. (b) Written compliance with this subdivision must be maintained by the nursing home. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility did not ensure tuberculosis (TB) symptom screening was completed for 1 of 5 employees (E2) and for 5 of 5 residents (R66, R63, R66, R64, R57). In addition, 2 of 5 employees did not receive a timely second step two-step tuberculin skin test (TST). Findings include: EMPLOYEES E2's date of hire was 1/27/15. Upon review of E2's employee record, E2 received a first step TST on 1/19/15, read on 1/22/15. A second step TST was received on 3/6/15, 43 days later. A TB symptom assessment also was not completed for R67.	21426		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00286	A. BUILDING: _____ 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 PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21426	Continued From page 32 E4's date of hire was 3/18/15. Upon review of E4's employee record, E4 received a first step TST on 3/18/15, read on 3/20/15. A second step TST was received on 5/18/15, 59 days later. RESIDENTS R65 was admitted to the facility on 5/19/15. R65's record revealed that a first step TST was given on 5/19/15, read on 5/21/15. A second step was given on 6/1/15, read on 6/3/15. A TB symptom assessment was not completed for R65. R63 was admitted to the facility on 5/26/15. R63's record revealed that a first step TST was given on 5/26/15, read on 5/28/15. Director of nursing (DON) stated R63 was scheduled for a second TST on 6/8/15. A TB symptom assessment was not completed for R63. R66 was admitted to the facility on 5/27/15. R66's record revealed that a first step TST was given on 5/27/15, read on 5/29/15. DON stated R66 was scheduled for a second TST on 6/9/15. A TB symptom assessment was not completed for R66. R64 was admitted to the facility on 5/29/15. R64's record revealed that a first step TST was given on 5/29/15, read on 5/31/15. DON stated R64 was scheduled for a second TST on 6/12/15. A TB symptom assessment was not completed for R64. R57 was admitted to the facility on 2/23/15 and remained in the facility until 4/30/15. R57's record revealed that a first step TST was given on 2/23/15, read on 2/25/15. A second step was given on 3/9/15, read on 3/11/15. A TB symptom assessment was not completed for	21426		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00286	A. BUILDING: _____ 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 PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21426	Continued From page 33 R57. During an interview on 6/1/15, at 11:42 a.m. staff coordinator (SC) stated she gave TB symptom screens to all five employees and verified the symptom screen for E2 was blank and that E2 should have filled it out and signed it. During an interview on 6/5/15, at 2:25 p.m. DON stated SC did help and sets up the initial TST and reminded employees when they are due for the next one. DON verified the second TST should be done within two weeks per facility policy, further stating that symptom screening for residents was done only for those that have a positive TST. The facility Tuberculosis/Mantoux undated policy was reviewed. The policy directed "Valley View Healthcare & Rehab to ensure freedom from tuberculosis for all staff (given and read before working with residents), residents (within 48 hours of admission if resident has not received within last three months) and volunteers (who are in facility more than three hours per week, prior to volunteering in the facility), by administering a tuberculin skin test (2 step) on admission/hire/volunteering and (single step) annually thereafter." The procedure directed the facility to repeat the above procedure in two (2) weeks from the reading for first time administration. The policy did not include symptom assessments for staff/residents/volunteers.	21426		
21445	MN Rule 4658.0900 Subp. 3 Activity and Recreation Program; Director Subp. 3. Activity and recreation program director. The activity and recreation program director must	21445		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00286	A. BUILDING: _____ 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 PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21445	Continued From page 34 be a person who is trained or experienced to direct the activity and recreation staff and program at that nursing home. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to provide a qualified activity director. This had the potential to affect all 41 residents currently residing in the facility. Findings include: A review of the Resident Council Meeting Minutes, dated 4/9/15, identified the "Administrator did hire [name] as the new Director. She will officially start [date]. She was a social worker coming from other nursing home and will work in capacity of activity director." When interviewed on 6/5/15, at 12:27 p.m. the administrator stated the activity director was directly involved in activities in social work at another facility and if anything she was over qualified. On 6/5/15, at 12:32 p.m. when interviewed the activity director (AD) stated she was a social worker and previously had worked in an activity department that was a combined position doing social work and helping with activities. She further stated she did not work in activities solely for a full year. The Valley View Nursing Home, Activity Director position description, revised, 3/2015, indicated the "Job Qualification: The following are federal and state regulations covering the qualifications of the Activity Director: 1. A certified occupational therapist or 2. A certified occupational therapy	21445		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00286	A. BUILDING: _____ 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 PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21445	Continued From page 35 assistant (COTA) or 3. Two years of work experience in social or recreational activities." A SUGGESTED METHOD FOR CORRECTION: The administrator or designee, could review and revise policies and procedures related to ensuring an Activity Director meets the qualifications necessary to direct organized activities and recreation in a health care setting. TIME PERIOD FOR CORRECTION: Twenty one (21) days.	21445		
21530	MN Rule 4658.1310 A.B.C Drug Regimen Review A. The drug regimen of each resident must be reviewed at least monthly by a pharmacist currently licensed by the Board of Pharmacy. This review must be done in accordance with Appendix N of the State Operations Manual, Surveyor Procedures for Pharmaceutical Service Requirements in Long-Term Care, published by the Department of Health and Human Services, Health Care Financing Administration, April 1992. This standard is incorporated by reference. It is available through the Minitex interlibrary loan system. It is not subject to frequent change. B. The pharmacist must report any irregularities to the director of nursing services and the attending physician, and these reports must be acted upon by the time of the next physician visit, or sooner, if indicated by the pharmacist. For purposes of this part, "acted upon" means the acceptance or rejection of the report and the signing or initialing by the director of nursing services and the attending physician. C. If the attending physician does not concur with the pharmacist's recommendation, or does not provide adequate justification, and the	21530		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00286	A. BUILDING: _____ 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 PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21530	Continued From page 36 pharmacist believes the resident's quality of life is being adversely affected, the pharmacist must refer the matter to the medical director for review if the medical director is not the attending physician. If the medical director determines that the attending physician does not have adequate justification for the order and if the attending physician does not change the order, the matter must be referred for review to the quality assessment and assurance committee required by part 4658.0070. If the attending physician is the medical director, the consulting pharmacist must refer the matter directly to the quality assessment and assurance committee. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure the consultant pharmacist identified irregularities and reported them to the director of nursing and physician for 4 of 4 residents (R14, R39, R40, R10) who took antipsychotic medication had adequate monitoring. In addition, failed to ensure there was an appropriate indication for continued use of an antibiotic for 1 of 5 residents (R21). Findings include: R14 was observed on 6/3/15, at 7:56 a.m. R14 was observed dressed, calmly sitting in wheelchair at the dining room table independently feeding herself. The Care Area Assessment (CAA) dated 9/24/14 for psychotropic medication use indicated R14 was at risk for side effects including risk for falls. R14's diagnoses included dementia with delusional disorder and anxiety	21530		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00286	A. BUILDING: _____ 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 PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21530	Continued From page 37 The current Medication Administration Record (MAR) from 12/1/14 through 6/4/15, indicated R14 received daily administration of antidepressants, Celexa and Trazodone and antipsychotic Zyprexa. Review of the Vitals Report from 12/3/14 through 6/1/15, indicated orthostatic blood pressure was taken only two of the six months, on 3/1/15 and 6/1/15. The quarterly Minimum Data Set (MDS) dated 3/11/15, indicated R14 had moderate cognitive impairment. R14's care plan dated 3/17/15, indicated R14 was on Zyprexa and to observe for potential side effects and medication effectiveness, monthly medication review by consulting pharmacist and to routinely check vital signs per facility policy. R14's current physician report dated 5/4/15 through 6/4/15, indicated orders for Zyprexa (antipsychotic) 2.5 milligrams (mg) once a day and directed staff to check orthostatic BP [blood pressure] once a day on the 1st of the month. Monthly Medication Regimen Review revealed the consultant pharmacist reviewed R14's medications on 1/21/15 and another consultant pharmacist on 2/20/15, 3/16/15, 4/17/15, and 5/15/15, but did not indicate the lack of adequate monitoring which included orthostatic blood pressure for the antipsychotic medication. During an interview on 6/4/15, at 10:30 a.m. the director of nursing (DON) verified the orthostatic blood pressure should have been completed and was not.	21530		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00286	A. BUILDING: _____ 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 PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21530	Continued From page 38 R39's was observed on 6/3/15, at 7:59 a.m. R39 was observed dressed, sitting upright in a Broda (type of wheelchair) wheelchair in the dining room, calm, and independently feeding himself. R39 stated "Nice to meet you, I have more food than I need." R39's (CAA) dated 12/11/14, for psychotropic medication use indicated R39 required daily administration of antidepressant (Paxil) and antipsychotic (Seroquel), and was at risk for side effects including risk for falls. The Quarterly MDS dated 3/10/15, indicated R39 had severe cognitive impairment. R39's care plan dated 3/17/15, indicated staff was to observe for potential side effects and medication effectiveness, monthly medication review by consulting pharmacist and to routinely check vital signs per facility policy. R39's diagnoses included dementia with behavioral disturbances of agitation and combative behavior, delusions and hallucinations obtained from the Physician Order Report dated 5/4/15 through 6/4/15. R39's current Physician Report indicated orders for Seroquel (antipsychotic) 50 mg twice a day (BID), (decreased from three times a day (TID) on 5/20/15) and directed staff to check orthostatic BP [blood pressure] once a day on the 15th of the month. The current MAR from 12/1/14 through 6/4/15 indicated R39 received the medication TID from 12/1/14 through 5/20/15, and BID from 5/20/15 through 6/3/15.	21530		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00286	A. BUILDING: _____ 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 PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21530	Continued From page 39 Review of the Vitals Report from 12/2/14 through 5/28/15, indicated orthostatic blood pressure was taken only one of five months, on 3/15/15. Monthly Medication Regimen Review revealed the consultant pharmacist reviewed R39's medications on 1/21/14 and another consultant 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." Wong, Becky 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, 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	21530		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00286	A. BUILDING: _____ 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 PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21530	Continued From page 40 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, Zyprexia 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 25mg TID and 100 mg 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	21530		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00286	A. BUILDING: _____ 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 PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21530	Continued From page 41 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. 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. A message was left for the consulting pharmacist on 6/5/15, at 1:36 p.m. The facility's Consultant Pharmacist Reports Medication Regimen Review (monthly report) dated 2006 indicated "the consultant pharmacist performs a comprehensive medication regimen review at least monthly. The MRR [Medication Regimen Review] includes evaluating the	21530		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00286	A. BUILDING: _____ 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 PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21530	Continued From page 42 resident's response to medication therapy to determine that the resident maintains the highest practicable level of functioning and prevents or minimizes adverse consequences related to medication therapy." Wentkiewicz, Cynthia 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 and indwelling catheter analysis of findings dated 8/21/14, indicated "is at risk for skin irritation and UTI's related to incontinence of urine, will review and continue with care plan." The Bowel & bladder screening (3-day void) dated 2/4/15 through 2/6/15, additional comments: "is incontinent of bowel and bladder, wears incontinent products which staff change." The Bowel & bladder screening (3-day void) dated 4/30/15 through 5/2/15, included additional comments: "frequently incontinent of bladder and bowel, wears brief, total assist of 1." The Physician Orders dated 5/5/15 through 6/5/15, included Keflex capsule 250 mg orally once a day start date 8/1//14, diagnosis: infection, chronic recurrent UTI. Ciprofloxacin HCl 500 mg take 1 tab orally BID for 10 days start date 5/27 and stop date 6/6/15. Bladder scan as needed	21530		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00286	A. BUILDING: _____ 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 PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21530	Continued From page 43 (PRN) start dated 6/19/13, for bladder discomfort or distension with straight catheter for urine retention of 200 cc or greater. Care plan dated 5/13/15, indicated "history of urinary tract infection [UTIs], neurogenic bladder. Goal was to not exhibit signs of urinary tract infection. The approaches were to administer Keflex (cephalexin - an antibiotic) per physician (MD) order as prophylactic measure and evaluate, record, and report the effectiveness/adverse side effects. Bladder scan/straight catheterize prn for discomfort or bladder distension. Monitor labs per MD order. Report signs of UTI (acute confusion, urgency, frequency, bladder spasms, nocturia, burning, pain, difficulty urinating, low back/flank pain, malaise, nausea/vomiting, chills, fever, foul odor, concentrated urine, blood in urine) to MD as indicated. Consultant pharmacist medication regimen reviews were completed July 2014 through December 2014 and reviewed. The regimen lacked evidence that the pharmacist had addressed the antibiotic use. On 6/4/15, at 1:49 p.m. registered nurse (RN)-A was interviewed about the Keflex order for antibiotic. When asked if R21 currently had a UTI, she stated no. Her blood sugars had been very high, she went into the hospital, and now they were back to normal. RN-A stated ciprofloxacin was started 5/27/15, for ten days for a urinary tract infection. It cleared up and blood sugars were back to where they should be. She stated R21 was still getting Keflex. On 6/5/15, at 1:06 p.m. DON stated MD-A indicated resident does not have yeasty rash in	21530		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00286	A. BUILDING: _____ 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 PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21530	Continued From page 44 peri-area. The DON stated prior to resident coming there she had a history of UTI and had been catheterized frequently due to it. While R21 was in the facility it was tapered down, urinary retention stopped, and she had not been catheterized while there. The urologist recommended antibiotic, it was started long ago and she did not know where the documentation would be. It may have been prior to R21 coming to the facility. They did trial off the antibiotic for dose reduction; it was restarted due to UTI and was colonized now. DON further commented R21 was a brittle diabetic and could bottom down frequently. Blood sugars were better controlled than when she came into the facility. They had to wake her during nights and have not had to straight catheterize since she had been there. They could bladder scan first before catheterizing. She had a recent UTI on 5/27/15, when she had elevated blood sugar and was put on an antibiotic. Her blood sugar was better and the UTI was gone. - At 1:17 p.m. DON stated they had a new pharmacist consultant. If the pharmacist consultant had no recommendations for the doctor, the resident would have no printout for her chart. The insert package label for cephalexin by ReadyMeds last revised on 5/14, read, "To reduce the development of drug-resistant bacteria and maintain the effectiveness of cephalexin and other antibacterial drugs, cephalexin should be used only to treat or prevent infections that are proven or strongly suspected to be caused by bacteria." A message was left for the consulting pharmacist on 6/5/15, at 1:36 p.m. with no retrun call.	21530		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00286	A. BUILDING: _____ 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 PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21540	Continued From page 45	21540		
21540	MN Rule 4658.1315 Subp. 2 Unnecessary Drug Usage; Monitoring Subp. 2. Monitoring. A nursing home must monitor each resident's drug regimen for unnecessary drug usage, based on the nursing home's policies and procedures, and the pharmacist must report any irregularity to the resident's attending physician. If the attending physician does not concur with the nursing home's recommendation, or does not provide adequate justification, and the pharmacist believes the resident's quality of life is being adversely affected, the pharmacist must refer the matter to the medical director for review if the medical director is not the attending physician. If the medical director determines that the attending physician does not have adequate justification for the order and if the attending physician does not change the order, the matter must be referred for review to the Quality Assurance and Assessment (QAA) committee required by part 4658.0070. If the attending physician is the medical director, the consulting pharmacist shall refer the matter directly to the QAA. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure 4 of 4 residents (R14, R39, R40, R10) who took antipsychotic medication had adequate monitoring. In addition, failed to ensure there was an appropriate indication for continued use of an antibiotic for 1 of 5 residents (R21). Findings include:	21540		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00286	A. BUILDING: _____ 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 PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21540	Continued From page 46 R14 was observed on 6/3/15, at 7:56 a.m. R14 was observed dressed, calmly sitting in wheelchair at the dining room table independently feeding herself. The Care Area Assessment (CAA) dated 9/24/14 for psychotropic medication use indicated R14 was at risk for side effects including risk for falls. R14's diagnoses included dementia with delusional disorder and anxiety The current Medication Administration Record (MAR) from 12/1/14 through 6/4/15, indicated R14 received daily administration of antidepressants, Celexa and Trazodone and antipsychotic Zyprexa. Review of the Vitals Report from 12/3/14 through 6/1/15, indicated orthostatic blood pressure was taken only two of the six months, on 3/1/15 and 6/1/15. The quarterly Minimum Data Set (MDS) dated 3/11/15, indicated R14 had moderate cognitive impairment. R14's care plan dated 3/17/15, indicated R14 was on Zyprexa and to observe for potential side effects and medication effectiveness, monthly medication review by consulting pharmacist and to routinely check vital signs per facility policy. R14's current physician report dated 5/4/15 through 6/4/15, indicated orders for Zyprexa (antipsychotic) 2.5 milligrams (mg) once a day and directed staff to check orthostatic BP [blood pressure] once a day on the 1st of the month. Monthly Medication Regimen Review revealed the consultant pharmacist reviewed R14's	21540		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00286	A. BUILDING: _____ 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 PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21540	Continued From page 47 medications on 1/21/15 and another consultant pharmacist on 2/20/15, 3/16/15, 4/17/15, and 5/15/15, but did not indicate the lack of adequate monitoring which included orthostatic blood pressure for the antipsychotic medication. During an interview on 6/4/15, at 10:30 a.m. the director of nursing (DON) verified the orthostatic blood pressure should have been completed and was not. R39's was observed on 6/3/15, at 7:59 a.m. R39 was observed dressed, sitting upright in a Broda (type of wheelchair) wheelchair in the dining room, calm, and independently feeding himself. R39 stated "Nice to meet you, I have more food than I need." R39's (CAA) dated 12/11/14, for psychotropic medication use indicated R39 required daily administration of antidepressant (Paxil) and antipsychotic (Seroquel), and was at risk for side effects including risk for falls. The Quarterly MDS dated 3/10/15, indicated R39 had severe cognitive impairment. R39's care plan dated 3/17/15, indicated staff was to observe for potential side effects and medication effectiveness, monthly medication review by consulting pharmacist and to routinely check vital signs per facility policy. R39's diagnoses included dementia with behavioral disturbances of agitation and combative behavior, delusions and hallucinations obtained from the Physician Order Report dated 5/4/15 through 6/4/15. R39's current Physician Report indicated orders for Seroquel (antipsychotic) 50 mg twice a day (BID),	21540		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00286	A. BUILDING: _____ 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 PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21540	Continued From page 48 (decreased from three times a day (TID) on 5/20/15) and directed staff to check orthostatic BP [blood pressure] once a day on the 15th of the month. The current MAR from 12/1/14 through 6/4/15 indicated R39 received the medication TID from 12/1/14 through 5/20/15, and BID from 5/20/15 through 6/3/15. Review of the Vitals Report from 12/2/14 through 5/28/15, indicated orthostatic blood pressure was taken only one of five months, on 3/15/15. Monthly Medication Regimen Review revealed the consultant pharmacist reviewed R39's medications on 1/21/14 and another consultant 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." 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, required extensive assist of two with bed mobility, transfers, toilet use, and required the use of a stand assist lift.	21540		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00286	A. BUILDING: _____ 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 PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21540	Continued From page 49 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, Zyprexia 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 25mg TID and 100 mg 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.	21540		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00286	A. BUILDING: _____ 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 PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21540	Continued From page 50 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. 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. R21's quarterly MDS dated 5/6/15, indicated moderate cognitive impairment. R21 also had diagnoses of neurogenic bladder, and diabetes mellitus	21540		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00286	A. BUILDING: _____ 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 PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21540	Continued From page 51 The CAA summary report urinary incontinence and indwelling catheter analysis of findings dated 8/21/14, indicated "is at risk for skin irritation and UTI's related to incontinence of urine, will review and continue with care plan." The Bowel & bladder screening (3-day void) dated 2/4/15 through 2/6/15, additional comments: "is incontinent of bowel and bladder, wears incontinent products which staff change." The Bowel & bladder screening (3-day void) dated 4/30/15 through 5/2/15, included additional comments: "frequently incontinent of bladder and bowel, wears brief, total assist of 1." The Physician Orders dated 5/5/15 through 6/5/15, included Keflex capsule 250 mg orally once a day start date 8/1//14, diagnosis: infection, chronic recurrent UTI. Ciprofloxacin HCl 500 mg take 1 tab orally BID for 10 days start date 5/27 and stop date 6/6/15. Bladder scan as needed (PRN) start dated 6/19/13, for bladder discomfort or distension with straight catheter for urine retention of 200 cc or greater. Care plan dated 5/13/15, indicated "history of urinary tract infection [UTIs], neurogenic bladder. Goal was to not exhibit signs of urinary tract infection. The approaches were to administer Keflex (cephalexin - an antibiotic) per physician (MD) order as prophylactic measure and evaluate, record, and report the effectiveness/adverse side effects. Bladder scan/straight catheterize prn for discomfort or bladder distension. Monitor labs per MD order. Report signs of UTI (acute confusion, urgency, frequency, bladder spasms, nocturia, burning, pain, difficulty urinating, low back/flank pain,	21540		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00286	A. BUILDING: _____ 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 PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21540	Continued From page 52 malaise, nausea/vomiting, chills, fever, foul odor, concentrated urine, blood in urine) to MD as indicated. Consultant pharmacist medication regimen reviews were completed July 2014 through December 2014 and reviewed. The regimen lacked evidence that the pharmacist had addressed the antibiotic use. On 6/4/15, at 1:49 p.m. registered nurse (RN)-A was interviewed about the Keflex order for antibiotic. When asked if R21 currently had a UTI, she stated no. Her blood sugars had been very high, she went into the hospital, and now they were back to normal. RN-A stated ciprofloxacin was started 5/27/15, for ten days for a urinary tract infection. It cleared up and blood sugars were back to where they should be. She stated R21 was still getting Keflex. On 6/5/15, at 1:06 p.m. DON stated MD-A indicated resident does not have yeasty rash in peri-area. The DON stated prior to resident coming there she had a history of UTI and had been catheterized frequently due to it. While R21 was in the facility it was tapered down, urinary retention stopped, and she had not been catheterized while there. The urologist recommended antibiotic, it was started long ago and she did not know where the documentation would be. It may have been prior to R21 coming to the facility. They did trial off the antibiotic for dose reduction; it was restarted due to UTI and was colonized now. DON further commented R21 was a brittle diabetic and could bottom down frequently. Blood sugars were better controlled than when she came into the facility. They had to wake her during nights and have not had to straight catheterize since she had been there.	21540		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00286	A. BUILDING: _____ 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 PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21540	Continued From page 53 They could bladder scan first before catheterizing. She had a recent UTI on 5/27/15, when she had elevated blood sugar and was put on an antibiotic. Her blood sugar was better and the UTI was gone. - At 1:17 p.m. DON stated they had a new pharmacist consultant. If the pharmacist consultant had no recommendations for the doctor, the resident would have no printout for her chart. The insert package label for cephalexin by ReadyMeds last revised on 5/14, read, "To reduce the development of drug-resistant bacteria and maintain the effectiveness of cephalexin and other antibacterial drugs, cephalexin should be used only to treat or prevent infections that are proven or strongly suspected to be caused by bacteria." A message was left for the consulting pharmacist on 6/5/15, at 1:36 p.m. with no retrun call. SUGGESTED METHOD OF CORRECTION: The pharmacist/director of nursing could evaluate current system of monthly pharmacy review to determine what could be changed to address resident medication irregularities. TIME PERIOD FOR CORRECTION: Twenty One (21) days.	21540		
21545	MN Rule 4658.1320 A.B.C Medication Errors A nursing home must ensure that: A. Its medication error rate is less than five percent as described in the Interpretive Guidelines for Code of Federal Regulations, title 42, section 483.25 (m), found in Appendix P of	21545		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00286	A. BUILDING: _____ 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 PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21545	Continued From page 54 the State Operations Manual, Guidance to Surveyors for Long-Term Care Facilities, which is incorporated by reference in part 4658.1315. For purposes of this part, a medication error means: (1) a discrepancy between what was prescribed and what medications are actually administered to residents in the nursing home; or (2) the administration of expired medications. B. It is free of any significant medication error. A significant medication error is: (1) an error which causes the resident discomfort or jeopardizes the resident's health or safety; or (2) medication from a category that usually requires the medication in the resident's blood to be titrated to a specific blood level and a single medication error could alter that level and precipitate a reoccurrence of symptoms or toxicity. All medications are administered as prescribed. An incident report or medication error report must be filed for any medication error that occurs. Any significant medication errors or resident reactions must be reported to the physician or the physician's designee and the resident or the resident's legal guardian or designated representative and an explanation must be made in the resident's clinical record. C. All medications are administered as prescribed. An incident report or medication error report must be filed for any medication error that occurs. Any significant medication errors or resident reactions must be reported to the physician or the physician's designee and the resident or the resident's legal guardian or designated representative and an explanation must be made in the resident's clinical record.	21545		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00286	A. BUILDING: _____ 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 PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21545	Continued From page 55 This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to prevent significant medication error for 1 of 6 residents (R31) observed for medication administration. Findings include: R31 was observed for medication administration on 6/5/15, at 8:49 a.m. and the trained medication aide (TMA)-A crushed the extended release tablet Metoprolol XL (a medication to reduce heart rate and blood pressure). TMA-A then checked the pulse of R31, which was 60 beats per minute, then provided the medications to R31. TMA-A stated she was not aware that the Metoprolol XL (extra-long acting) should not be crushed. TMA-A further stated that she had always crushed the Metoprolol XL dose when giving it to R31. R31 was admitted to the facility 4/26/11, with admission diagnoses of chronic kidney disease, hypertension (high blood pressure), and peripheral vascular disease (poor blood flow through the legs) per the Admission Record. The Minimum Data Set (MDS) dated 5/19/15, indicated R31 had severe cognitive impairment, with inattention and disorganized thinking. R31 had minimal depression and no behaviors. R31 required extensive assistance with bed mobility, transfers, and toilet use. A review of a Physician ' s Progress note dated 5/21/15, indicated R31's blood pressure was low and the medication Metoprolol XL would be	21545		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00286	A. BUILDING: _____ 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 PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21545	Continued From page 56 decreased, and to review the blood pressure and pulse next week on rounds. A review of the medication order dated 3/26/15 through 5/20/15, indicated on 5/21/15, the Metoprolol XL dose was reduced from 100 milligrams (mg) every day to Metoprolol XL 50 mg per day. A recheck was planned for one week later. On 5/28/15, the Metoprolol XL dose was reduced even further to 25 mg every day. The directions for use for Metoprolol XL stated Do Not Crush. On 6/5/15, at 1:30 p.m. a message was left for the consultant pharmacist. On 6/5/15, at 1:38 the director of nursing (DON) stated she was not aware the TMA's were crushing the medication and it should not be crushed. The physician was reducing the dose of the medication because of her decreased blood pressure and heart rate. The physician would be notified that the staff was crushing the Metoprolol XL. The DON stated that currently TMA's were not being audited for medication administration, because they had been doing so well, but audits would begin again. In addition, the DON verified the medication observations of LPN-A and TMA-B should have followed the five rights of medication administration. The Medication Administration-General Guidelines policy dated 2006, directed ...Medications are administered as prescribed in accordance with good nursing principles and practices... a. Long-acting or enteric-coated dosage forms should generally not be crushed an alternative should be sought.	21545		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00286	A. BUILDING: _____ 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 PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21545	Continued From page 57 SUGGESTED METHOD OF CORRECTION: The administrator and consultant pharmacist could review and revise policies and procedures to ensure facility was free of medication errors. The consultant pharmacist could inservice licensed staff to provide medications without error. The director of nursing could monitor staff compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21545		
21665	MN Rule 4658.1400 Physical Environment A nursing home must provide a safe, clean, functional, comfortable, and homelike physical environment, allowing the resident to use personal belongings to the extent possible. This MN Requirement is not met as evidenced by: F323	21665		
21685	MN Rule 4658.1415 Subp. 2 Plant Housekeeping, Operation, & Maintenance Subp. 2. Physical plant. The physical plant, including walls, floors, ceilings, all furnishings, systems, and equipment must be kept in a continuous state of good repair and operation with regard to the health, comfort, safety, and well-being of the residents according to a written routine maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation, interview and document	21685		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00286	A. BUILDING: _____ 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 PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21685	Continued From page 58 review, the facility failed to ensure the floors in resident rooms and common hallways were in good repair. Findings include: During observations of the facility, it was noted that the tile floor was uneven, had peaks, ridges, dimples, circular depressions and buckles in rooms 2, 3, 4, 8, 11, 14, and in the West and South hallways. On 6/5/15, at 2:40 p.m. an environmental tour was conducted with the maintenance manager and the administrator. The administrator stated because of an unplanned project with toilet backups, residents had to be temporarily moved to fix the plumbing and redo the tiles floors. The administrator stated "We had to do an in-house job on the tile after the plumbing had to be repaired, because the professional floor guys are booked out four to six months. The administrator further stated rooms 3 and 14 were scheduled to be repaired during the next week, room 10 [11] would not be fixed because the Board had refused." The Administrator was asked to provide the bids by the professional floor guys. The bid dated 5/25/15, included the South corridor, East corridor, West corridor, Center area, and rooms 3 and 14. Other bids for tile were dated 4/7/15, and 4/23/15, all after the unplanned project was completed. The Administrator verified that not all of the rooms were in the bid to be repaired. Rooms 2, 4, 8, and 11 were not included to be repaired. On 6/5/15, at 3:00 p.m. the physical therapist	21685		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00286	A. BUILDING: _____ 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 PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21685	Continued From page 59 (PT) stated that none of the residents had fallen because of the uneven flooring, as far as she knew. SUGGESTED METHOD OF CORRECTION: The administrator or designee could develop a maintenance program to ensure damaged floors are repaired to maintain a safe, clean, homelike environment. The administrator or designee could educate all appropriate staff on the program, and could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-One (21) Days.	21685		
21810	MN St. Statute 144.651 Subd. 6 Patients & Residents of HC Fac.Bill of Rights Subd. 6. Appropriate health care. Patients and residents shall have the right to appropriate medical and personal care based on individual needs. Appropriate care for residents means care designed to enable residents to achieve their highest level of physical and mental functioning. This right is limited where the service is not reimbursable by public or private resources. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure the call light was within reach for one of 30 residents (R10) in the sample. Findings include: R10 was observed in bed on 6/1/15, at 3:31 p.m.	21810		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00286	A. BUILDING: _____ 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 PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21810	Continued From page 60 The resident's call light was connected to the dresser, approximately 2.5 feet away from the resident and out of his reach. R10 reported he did use his call light to summon assistance. A registered nurse (RN)-C was then asked to verify R10 could not have reached his call light for help. RN-C then moved the call light and attached it to the bed and within R10's reach. R10's 3/19/15 Minimum Data Set assessment indicated the resident was cognitively intact, and required extensive assistance of two staff for bed mobility, transfers, and toilet use. The care plan dated 3/24/15, indicated R10 used his call light to call for assistance. On 6/3/15, at 7:47 a.m. a nursing assistant (NA)-A stated R10 used his call light when he needs assistance. The director of nursing stated on 6/5/15, at 1:38 p.m. she expected call lights to be within reach of all residents. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could develop, review, and/or revise policies and procedures to ensure call lights are kept within resident reach. The director of nursing (DON) or designee could educate all appropriate staff on the policies and procedures. The director of nursing (DON) or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21810		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00286	A. BUILDING: _____ 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 PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21995	Continued From page 61	21995		
21995	MN St. Statute 626.557 Subd. 4a Reporting - Maltreatment of Vulnerable Adults Subd. 4a. Internal reporting of maltreatment. (a) Each facility shall establish and enforce an ongoing written procedure in compliance with applicable licensing rules to ensure that all cases of suspected maltreatment are reported. If a facility has an internal reporting procedure, a mandated reporter may meet the reporting requirements of this section by reporting internally. However, the facility remains responsible for complying with the immediate reporting requirements of this section. This MN Requirement is not met as evidenced by: Based on interview and document review, facility failed to adequately screen 5 or 5 newly employed staff (E1, E2, E3, E4, E5). 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. E2, a dietary assistant, had a hire date of 1/27/15. No reference checks were conducted. E3, a NA, had a hire date of 3/30/15. No reference checks were conducted. E4, a NA, had a hire date of 5/19/15. No reference checks were conducted.	21995		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00286	A. BUILDING: _____ 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 PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21995	Continued From page 62 E5, a NA, had a hire date of 5/28/15. No reference checks were conducted. During an interview on 6/5/15, at 5:26 p.m. the director of nursing (DON) verified that the facility does not do reference checks on newly hired employees, further stating "this is a small town, everyone knows everyone. We know who is good and who isn't." This was also verified by the Human Resources Director. The facility Vulnerable Adult Policy and Procedure revised 7/17/2012, indicated "all new employees are screened through the use of a background check. This includes any nursing staff through the use of external pool agencies. Employees will not be allowed direct resident contact until they have been cleared through the Criminal Background Division of the MDH [Minnesota Department of Health]. The policy lacked direction to include attempting to obtain information from previous and/or current employers. SUGGESTED METHOD OF CORRECTION: The administrator could in-service all staff on the need to immediately reporting suspected abuse/neglect to the designated state agency/common entry point. The director of nurses' could monitor incident reports for implementation of this requirement. TIME PERIOD FOR CORRECTION: Fourteen (14) days.	21995		
22000	MN St. Statute 626.557 Subd. 14 (a)-(c) Reporting - Maltreatment of Vulnerable Adults Subd. 14. Abuse prevention plans. (a) Each	22000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00286	A. BUILDING: _____ 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 PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
22000	Continued From page 63 facility, except home health agencies and personal care attendant services providers, shall establish and enforce an ongoing written abuse prevention plan. The plan shall contain an assessment of the physical plant, its 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 providers, shall develop an individual abuse prevention plan for each vulnerable adult residing there or receiving services from them. The plan shall contain an individualized assessment of: (1) the person's susceptibility to abuse by other individuals, including other vulnerable adults; (2) the person's risk of abusing other vulnerable adults; and (3) statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For the purposes of this paragraph, the term "abuse" includes self-abuse. (c) If the facility, except home health agencies and personal care attendant services providers, knows that the vulnerable adult has committed a violent crime or an act 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 outside the facility, if unsupervised. Under this section, a facility knows of a vulnerable adult's history of criminal misconduct or physical aggression if it receives such information from a law enforcement	22000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00286	A. BUILDING: _____ 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 PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
22000	Continued From page 64 authority or through a medical record prepared by another facility, another health care provider, or the facility's ongoing assessments of the vulnerable adult. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to develop policies for adequate screening of 5 or 5 newly employed staff (E1, E2, E3, E4, E5) whose positions included direct contact with residents. Findings include: The facility's Vulnerable Adult Policy and Procedure revised 7/17/12, indicated "all new employees are screened through the use of a background check." That included any nursing staff through the use of external pool agencies. "Employees will not be allowed direct resident contact until they have been cleared through the Criminal Background Division of the MDH [Minnesota Department of Health]. The policy lacked direction to include attempting to obtain information from previous and/or current employers." New employee personnel files were reviewed: E1, a nursing assistant (NA), had a hire date of 4/29/15. No reference checks were conducted. E2, a dietary assistant, had a hire date of 1/27/15. No reference checks were conducted.	22000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00286	A. BUILDING: _____ 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 PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
22000	Continued From page 65 E3, a NA, had a hire date of 3/30/15. No reference checks were conducted. E4, a NA, had a hire date of 5/19/15. No reference checks were conducted. E5, a NA, had a hire date of 5/28/15. No reference checks were conducted. During an interview on 6/5/15, at 5:26 p.m. the director of nursing (DON) verified the facility does not do reference checks on newly hired employees stating, "this is a small town, everyone knows everyone. We know who is good and who isn't." The Human Resources Director, also present at the time of interview, confirmed this information. SUGGESTED METHOD OF CORRECTION: The administrator or designee could assess all residents in the facility for vulnerability of abuse risk factors and develop individual abuse prevention plans to minimize each residents risks for abuse. The administrator or designee could monitor for compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	22000		