

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Certified Mail # 7015 0640 0003 5695 1493

October 24, 2017

Mr. Mark Rustad, Administrator Valley Care and Rehab Llc 600 Fifth Street Southeast, Box 129 Barnesville, MN 56514

Subject: Valley Care and Rehab Lic - IDR

CCN# 245281

Project # H5281029 & S5281027

Dear Mr. Rustad:

This is in response to your letter of May 5, 2017, in regard to your request for an informal dispute resolution (IDR) for the federal deficiency at tag F309 issued pursuant to the survey event NQV412, completed on April 6, 2017.

The information presented with your letter, the CMS 2567 dated 4/6/17, and corresponding Plan of Correction, as well as survey documents and discussion with representatives of L&C staff have been carefully considered and the following determination has been made:

F309 S/S-G § 483.25 Quality of care

Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices, including but not limited to the following:

§483.25(k) Pain Management.

The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences.

Summary of the facility's reason for IDR of this tag: The facility staff assert they did not cause harm to R32 who had pre-existing chronic pain and skin breakdown along with numerous other comorbidities. They assert they had identified, assessed, monitored, developed and implemented interventions to aid in preventing development of moisture related skin breakdown, and had implemented measures to treat and prevent pain for R32.

Valley Care And Rehab Llc October 24, 2017 Page 2

Summary of facts:

R32's medical record indicated R32 had been admitted to the nursing home 11/18/16 with a history of skin breakdown in the peri-rectal area due to ongoing issues with incontinence of bowel and bladder. The record also indicated R32 had required hospitalization from 3/14/17 to 3/20/17 for diagnoses including: lack of water as cause of dehydration, cardiomyopathy and atrial fibrillation. In addition, a hospital note dated 3/14/17, indicated when R32 had presented to the hospital she was lethargic and had multiple open wounds and significant pain to the inner buttocks. The note further indicated R32 had required referral to a wound specialist and utilized intravenous pain medications while hospitalized to treat the pain in her rectal area, where the wounds were located.

During observations of care on 4/5/17, the skin around R32's rectal area was noted to be excoriated with four small open areas located near the rectum. At the time, R32 expressed discomfort when repositioned and when staff cleansed the peri-rectal area following an incontinent episode. The resident verbally expressed pain while her rectal area was cleansed, and made moaning type sounds of discomfort.

Neither before, nor following the resident's hospitalization, had the facility conducted a comprehensive evaluation of the resident's incontinence, pain or treatment and services necessary, to determine whether there were appropriate and effective interventions being implemented to ensure pain management, healing of the wounds, and to prevent further incidence of these concerns. The plan for treatment was identified after the resident was hospitalized.

Summary of findings: Following review of the CMS 2567, information submitted by the facility, a telephone conference with facility staff, review of MDH surveyor documentation, and discussion with licensing and certification staff, it was determined this is a valid deficiency at this tag and at the correct scope and severity of (G).

This concludes the Minnesota Department of Health informal dispute resolution process.

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

Sincerely,

Gary Nederhoff, Unit Supervisor Licensing and Certification Program

Health Regulation Division

Lary gederhoff

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

cc: Office of Ombudsman for Long-Term Care Maria King, Assistant Program Manager

Licensing and Certification File

Gail Anderson, Fergus Falls District Office Unit Supervisor

S5281029 & H5281029ltr

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

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

ID:	NQV4	
Faci	ility ID:	00968

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1. MEDICARE/MEDICAID PROVIDER NO. (L1) 245281 3. NAME AND ADDRESS OF FACIL (L3) VALLEY CARE AND REHA						4. TYPE OF ACTION	ON: <u>7 (</u> L8)
(L1) 245281 2.STATE VENDOR OR MEDICAID	NO	(L4) 600 FIFTH S			ROV 120	1. Initial	2. Recertification
(L2) 198148100	NO.	(L5) BARNESVII		IIIEASI,	(L6) 56514	3. Termination 5. Validation	4. CHOW 6. Complaint
	COMPLETE			ionr.		7. On-Site Visit	9. Other
5. EFFECTIVE DATE CHANGE OF (L9) 11/01/2015	OWNERSHIP	7. PROVIDER/SU 01 Hospital	O5 HHA	ORY 09 ESRD	<u>02</u> (L7) 13 PTIP 22 CLIA	8. Full Survey Afte	er Complaint
	0/2017 (L34)	02 SNF/NF/Dual	06 PRTF	10 NF	14 CORF		
8. ACCREDITATION STATUS:	(L10)	03 SNF/NF/Distinct	07 X-Ray	11 ICF/IID	15 ASC	FISCAL YEAR ENDI	ING DATE: (L35)
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· /		Compliance	*		3. 24 Hour RN	7. Medical D	
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13. Total Certified Beds	55 (E17)		and/or Applied V	-	* Code: A*	(L12)	
14. LTC CERTIFIED BED BREAKDO	OWN				15. FACILITY MEETS		
18 SNF 18/19 SNF	19 SNF	ICF	IID		1861 (e) (1) or 1861 (j) (1):	(L15)	
35							
(L37) (L38)	(L39)	(L42)	(L43)				
16. STATE SURVEY AGENCY REM	MARKS (IF APPLICA	BLE SHOW LTC CA	NCELLATION I	DATE):			
See Attached Remarks							
17. SURVEYOR SIGNATURE		Date :			18. STATE SURVEY AGENCY	Y APPROVAL	Date:
Denise Erickson, HFE NEII 09/12/2017							
Denise Erickson, HFE I	NEII	0	9/12/2017		Mark Meath	, Enforcement Spec	ialist 09/12/2017
				(L19)	#14005#10400 10		ialist 09/12/2017 (L20)
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DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

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

Facility ID: 00968

C&T REMARKS - CMS 1539 FORM

STATE AGENCY REMARKS

CCN: 24 5281

On May 30, 2017, the Minnesota Department of Health completed a PCR to verify that the facility had achieved and maintained compliance with federal certification deficiencies and the complaint investigation number H5281029 substantiated at F157, F309 and F315 issued pursuant to a PCR, completed on April 6, 2017. We presumed, based on their plan of correction, that your facility had corrected these deficiencies as of May 8, 2017. Based on our visit, we have determined that the facility has corrected the deficiencies issued pursuant to our PCR, completed on April 6, 2017, effective May 8, 2017. As a result of the revisit findings, the Department is discontinuing the Category 1 remedy of state monitoring, effective May 8, 2017.

In addition, the Department recommended to the Centers for Medicare and Medicaid Services (CMS) Region V Office the following actions related to the remedies outlined in our letters of March 2, 2017 and April 25, 2017. The CMS Region V Office concurs and has authorized this Department to notify you of these actions:

• Mandatory denial of payment for new Medicare and Medicaid admissions, effective May 10, 2017, be rescinded. (42 CFR 488.417 (b))

In addition, the Department recommended the following enforcement action to the Centers for Medicare and Medicaid Services (CMS) as it relates to the remedies outlined in our letters of March 2, 2017 and April 25, 2017:

- Civil money penalty for the deficiency cited at F314, be imposed. (42 CFR 488.430 through 488.444)
- Civil money penalty for the deficiency cited at F309, be imposed. (42 CFR 488.430 through 488.444)

Furthermore, in our letters of March 2, 2017 and April 25, 2017, we advised the facility, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), the facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from May 10, 2017, due to denial of payment for new admissions. Since your facility attained substantial compliance on May 8, 2017, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded.

Effective May 8, 2017, the facility is certified for 35 skilled nursing facility beds.



PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

CMS Certification Number (CCN): 245281

September 12, 2017

Mr. Mark Rustad, Administrator Valley Care and Rehabilitation, LLC 600 Fifth Street Southeast, Box 129 Barnesville, MN 56514

Dear Mr. Rustad:

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 May 8, 2017 the above facility is certified for:

35 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 35 skilled nursing facility beds.

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

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

Feel free to contact me if you have questions related to this letter.

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist Program Assurance Unit Licensing and Certification Program Health Regulation Division

Email: mark.meath@state.mn.us

Phone: (651) 201-4118 Fax: (651) 215-9697

cc: Licensing and Certification File



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

September 12, 2017

Mr. Mark Rustad, Administrator Valley Care And Rehab LLC 600 Fifth Street Southeast, Box 129 Barnesville, MN 56514

RE: Project Number S5281027 and H5281029

Dear Mr. Rustad:

On March 2, 2017 and April 25, 2017, as authorized by the CMS Region V Office (CMS), the Department informed you that the following enforcement remedies were being imposed:

- State Monitoring effective March 7, 2017. (42 CFR 488.422)
- Mandatory denial of payment for new Medicare and Medicaid admissions effective May 10, 2017. (42 CFR 488.417 (b))

In Addition, on March 2, 2017, the Department recommended to the Centers for Medicare and Medicaid Services (CMS) that the following enforcement remedy be imposed:

• Civil money penalty for the deficiency cited at F314. (42 CFR 488.430 through 488.444)

Further, On April 25, 2017, the Department recommended to the CMS Region V Office that the following additional enforcement remedy be imposed:

• Civil money penalty for the deficiency cited at F309. (42 CFR 488.430 through 488.444)

Furthermore, the Department notified you in our letters of March 2, 2017 and April 25, 2017, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from May 10, 2017.

This was based on the deficiencies cited by this Department for a standard survey completed on February 10, 2017, and failure to achieve substantial compliance at the Post Certification Revisit (PCR) completed on April 6, 2017, that included an investigation of complaint number H5281029, substantiated at F157, F309 and F315. The most serious deficiencies at the time of the revisit were found to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G), whereby corrections were required.

Valley Care And Rehabilitation LLC September 12, 2017 Page 2

On May 30, 2017, the Minnesota Department of Health completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies and the complaint investigation number H5281029 substantiated at F157, F309 and F315 issued pursuant to a PCR, completed on April 6, 2017. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of May 8, 2017. Based on our visit, we have determined that your facility has corrected the deficiencies issued pursuant to our PCR, completed on April 6, 2017, effective May 8, 2017. As a result of the revisit findings, the Department is discontinuing the Category 1 remedy of state monitoring, effective May 8, 2017.

In addition, the Department recommended to the Centers for Medicare and Medicaid Services (CMS) Region V Office the following actions related to the remedies outlined in our letters of March 2, 2017 and April 25, 2017. The CMS Region V Office concurs and has authorized this Department to notify you of these actions:

• Mandatory denial of payment for new Medicare and Medicaid admissions, effective May 10, 2017, be rescinded. (42 CFR 488.417 (b))

The CMS Region V Office will notify your fiscal intermediary that the denial of payment for new Medicare admissions, effective May 10, 2017, is to be rescinded. They will also notify the State Medicaid Agency that the denial of payment for all Medicaid admissions, effective May 10, 2017, is to be rescinded.

Further, the Department recommended the following enforcement action to the Centers for Medicare and Medicaid Services (CMS) as it relates to the remedies outlined in our letters of March 2, 2017 and April 25, 2017:

- Civil money penalty for the deficiency cited at F314, be imposed. (42 CFR 488.430 through 488.444)
- Civil money penalty for the deficiency cited at F309, be imposed. (42 CFR 488.430 through 488.444)

Furthermore, in our letters of March 2, 2017 and April 25, 2017, we advised you that, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from May 10, 2017, due to denial of payment for new admissions. Since your facility attained substantial compliance on May 8, 2017, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded.

Valley Care And Rehabilitation LLC September 12, 2017 Page 3

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

Feel free to contact me if you have questions related to this letter.

Sincerely,

Mark Weath

Mark Meath, Enforcement Specialist Program Assurance Unit Licensing and Certification Program Health Regulation Division Minnesota Department of Health

Email: <u>mark.meath@state.mn.us</u> Phone: (651) 201-4118 Fax: (651) 215-9697

cc: Licensing and Certification File



Protecting, Maintaining and Improving the Health of All Minnesotans

NOTICE OF TOTAL AMOUNT OF ASSESSMENT FOR NURSING HOMES

Electronically Delivered September 12, 2017

Mr. Mark Rustad, Administrator Valley Care and Rehabilitation LLC 600 Fifth Street Southeast, Box 129 Barnesville, MN 56514

RE: Project Number S5281027 and H5281029

Dear Mr. Rustad:

On April 25, 2017, a Notice of Assessment for Noncompliance with Correction Orders was issued to the above facility. That notice, which was electronically delivered, imposed a daily fine in the amount of \$700.00.

A reinspection was held on May 30, 2017 and it was determined that compliance with the licensing rules was attained.

Therefore, the total amount of the assessment is \$700.00. In accordance with Minnesota Statutes, section 144A.10, subdivision 7, the costs of the reinspection, totaling \$1,131.00, are to be added to the total amount of the assessment. You are required to submit a check, made payable to the Commissioner of Finance, Treasury Division, in the amount of \$1,831.00 within 15 days of the receipt of this notice. That check should be forwarded to the Department of Health, Health Regulation Division, 85 East Seventh Place, Suite 220, P.O. Box 64900, St. Paul, Minnesota 55164-0900.

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

Feel free to contact me if you have questions related to this letter.

Sincerely,

Mark Weath

Mark Meath, Enforcement Specialist Program Assurance Unit Licensing and Certification Program Health Regulation Division

Email: mark.meath@state.mn.us

Phone: (651) 201-4118 Fax: (651) 215-9697

cc: Shellae Dietrich, Licensing and Certification Program
Penalty Assessment Deposit Staff

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

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

ID.	NQ V4
Fac	ility ID: 00968

1. MEDICARE/MEDICAID PROVI	IDER NO.	3. NAME AND AI (L3) VALLEY C A				4. TYPE OF ACT	ION: <u>7 (</u> L8)
2.STATE VENDOR OR MEDICAL	D NO	(L4) 600 FIFTH S			BOX 129	1. Initial	2. Recertification
(L2) 198148100	D 110.	(L5) BARNESVI		11121101,	(L6) 56514	3. Termination 5. Validation	4. CHOW 6. Complaint
			<u> </u>			7. On-Site Visit	9. Other
5. EFFECTIVE DATE CHANGE C (L9) 11/01/2015	OF OWNERSHIP	7. PROVIDER/SU 01 Hospital	JPPLIER CATEG 05 HHA	ORY 09 ESRD	02 (L7) 13 PTIP 22 CLIA	8. Full Survey Af	ter Complaint
o. Bill of bolt El	/ 06/2017 (L34)	02 SNF/NF/Dual	06 PRTF	10 NF	14 CORF	FISCAL YEAR ENI	DING DATE: (L35)
8. ACCREDITATION STATUS:	(L10)	03 SNF/NF/Distinct	07 X-Ray	11 ICF/IID		12/31	
0 Unaccredited 1 TJC 2 AOA 3 Othe	r	04 SNF	08 OPT/SP	12 RHC	16 HOSPICE	12/31	
11LTC PERIOD OF CERTIFICAT	ION	10.THE FACILITY	IS CERTIFIED	AS:		L	
From (a):		A. In Complia	ance With		And/Or Approved Waivers O	f The Following Require	ments:
To (b):		_	equirements e Based On:		2. Technical Personne 3. 24 Hour RN	el 6. Scope of 7. Medical I	
		1. A	cceptable POC		4. 7-Day RN (Rural S		
12. Total Facility Beds	35 (L18)		· ·		5. Life Safety Code	9. Beds/Roo	
13.Total Certified Beds	35 (L17)	X B. Not in Con Requirements	npliance with Prog and/or Applied V	-	* Code: B *	(L12)	
14. LTC CERTIFIED BED BREAKI	DOWN				15. FACILITY MEETS		
18 SNF 18/19 SN 35	F 19 SNF	ICF	IID		1861 (e) (1) or 1861 (j) (1):	(L15)	
(L37) (L38)	(L39)	(L42)	(L43)				
16. STATE SURVEY AGENCY RE	EMARKS (IF APPLICA	ABLE SHOW LTC CA	ANCELLATION I	DATE):			
See Attached Remarks	`			,			
17. SURVEYOR SIGNATURE		Date :			18. STATE SURVEY AGENC	Y APPROVAL	Date:
Denise Erickson, HFE	NEII	0	04/14/2017	(L19)	Mark Meath	, Enforcement Spec	ialist 07/25/2017 (L20)
P	ART II - TO BE	COMPLETED I	BY HCFA RE	GIONAL	OFFICE OR SINGLE	STATE AGENCY	
19. DETERMINATION OF ELIGIE	BILITY		IPLIANCE WITH	H CIVIL	21. 1. Statement of Fin	• •	
X 1. Facility is Eligible t	o Participate	RIGHTS ACT:		 Ownership/Control Interest Disclosure Stmt (HCFA-1513) Both of the Above : 			
2. Facility is not Eligi							
	(L21)						
22. ORIGINAL DATE	23. LTC AGREE	MENT 24	4. LTC AGREEN	MENT	26. TERMINATION ACTION	N:	(L30)
OF PARTICIPATION	BEGINNING	G DATE	ENDING DA	ГЕ	VOLUNTARY 0	<u>INVOLU</u>	<u>JNTARY</u>
07/01/1985					01-Merger, Closure	05-Fail t	o Meet Health/Safety
(L24)	(L41)		(L25)		02-Dissatisfaction W/ Reimbur	rsement 06-Fail t	o Meet Agreement
25. LTC EXTENSION DATE:	27. ALTERNATI	VE SANCTIONS			03-Risk of Involuntary Terminat	ion OTHER	
	A. Suspension	n of Admissions:			04-Other Reason for Withdrawa	l 07-Prov	der Status Change
(7.05)			(L44)			00-Activ	ve .
(L27)	B. Rescind St	uspension Date:					
			(L45)				
28. TERMINATION DATE:	29	D. INTERMEDIARY	/CARRIER NO.		30. REMARKS		
		06201					
	(L28)			(L31)			
31. RO RECEIPT OF CMS-1539	32	2. DETERMINATION	OF APPROVAL	DATE			
31. RO RECEIPT OF CMS-1539		2. DETERMINATION 04/17/2017	N OF APPROVAL	DATE			
31. RO RECEIPT OF CMS-1539	(L32)		OF APPROVAL	DATE (L33)	DETERMINATION APP	PROVAL	

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00968

C&T REMARKS - CMS 1539 FORM

STATE AGENCY REMARKS

CCN: 24 5281

On April 6, 2017, the Minnesota Department of Health completed a Post Certification Revisit to verify that the facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on February 10, 2017 and to investigate complaint number H5281029 which was found to be substantiated at F157, F309 and F315. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of March 13, 2017. Based on our visit, we have determined that the facility has not obtained substantial compliance with the deficiencies issued pursuant to our standard survey, completed on February 10, 2017. The deficiencies not corrected are as follows:

F0157 -- S/S: D -- 483.10(g)(14) -- Notify Of Changes (injury/decline/room, Etc) F0309 -- S/S: G -- 483.24, 483.25(k)(l) -- Provide Care/services For Highest Well Being

In addition, at the time of this revisit, we identified the following deficiency:

F0315 -- S/S: D -- 483.25(e)(1)-(3) -- No Catheter, Prevent Uti, Restore Bladder

The most serious deficiencies in the facility was found to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G), whereby corrections were required. As a result of the revisit findings, the Category 1 remedy of state monitoring will remain in effect.

In addition, this Department recommended to the CMS Region V Office the following actions related to the remedies in our letter of March 2, 2017:

- Civil money penalty for the deficiency cited at F314, be imposed. (42 CFR 488.430 through 488.444)
- Mandatory denial of payment for new Medicare and Medicaid admissions effective May 10, 2017, remain in effect. (42 CFR 488.417 (b))

Based on the findings of this visit, we recommended to the CMS Region V Office the following additional remedy for imposition:

• Civil money penalty for the deficiency cited at F309. (42 CFR 488.430 through 488.444)

Post Certification Revisit (PCR) to follow.



PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered April 25, 2017

Mr. Mark Rustad, Administrator Valley Care And Rehabilitation LLC 600 Fifth Street Southeast, Box 129 Barnesville, Minnesota 56514

RE: Project Numbers S5281027 and H5281029

Dear Mr. Rustad:

On March 2, 2017, as authorized by the Centers for Medicare and Medicaid (CMS) Region V Office, we informed you that the following enforcement remedies were being imposed:

- State Monitoring effective March 7, 2017. (42 CFR 488.422)
- Mandatory denial of payment for new Medicare and Medicaid admissions effective May 10, 2017. (42 CFR 488.417 (b))

In addition, on March 2, 2017, the Department recommended to the Centers for Medicare and Medicaid Services (CMS) that the following enforcement remedy be imposed:

• Civil money penalty for the deficiency cited at F314. (42 CFR 488.430 through 488.444)

Furthermore, as we notified you in our letter of March 2, 2017, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from May 10, 2017.

This was based on the deficiencies cited by this Department for a standard survey completed on February 10, 2017. The most serious deficiencies were found to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G), whereby corrections were required.

On April 6, 2017, the Minnesota Department of Health completed a Post Certification Revisit to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on February 10, 2017 and to investigate complaint number H5281029 which was found to be substantiated at F157, F309 and F315. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of March 13, 2017.

Based on our visit, we have determined that your facility has not obtained substantial compliance with the deficiencies issued pursuant to our standard survey, completed on February 10, 2017. The deficiencies not corrected are as follows:

In addition, at the time of this revisit, we identified the following deficiency:

The most serious deficiencies in your facility were found to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G), whereby corrections are required.

As a result of the revisit findings, the Category 1 remedy of state monitoring will remain in effect.

In addition, this Department recommended to the CMS Region V Office the following actions related to the remedies in our letter of March 2, 2017:

- Civil money penalty for the deficiency cited at F314, be imposed. (42 CFR 488.430 through 488.444)
- Mandatory denial of payment for new Medicare and Medicaid admissions effective May 10, 2017, remain in effect. (42 CFR 488.417 (b))

Based on the findings of this visit, we recommended to the CMS Region V Office the following additional remedy for imposition:

• Civil money penalty for the deficiency cited at F309. (42 CFR 488.430 through 488.444)

The CMS Region V Office will notify you of their determination regarding the imposed remedies, Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) prohibition, and appeal rights.

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.

A copy of the Post Certification Revisit Form, (CMS-2567B) from this visit is being electronically delivered.

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:

Gail Anderson, Unit Supervisor
Fergus Falls Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
1505 Pebble Lake Road, Suite 300
Fergus Falls, Minnesota 56537-3858
Email: gail.anderson@state.mn.us

Phone: (218) 332-5140 Fax: (218) 332-5196

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

The state agency may, in lieu of a revisit, determine correction and compliance by accepting the facility's ePoC if the ePoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a revisit of your facility will be conducted to verify that substantial compliance with the regulations has been attained. The revisit 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 we will recommend that the remedies imposed be discontinued effective the date of the on-site verification. Compliance is certified as of the date of the second revisit or the date confirmed by the acceptable evidence, whichever is sooner.

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

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 August 10, 2017 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

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

Mr. Tom Linhoff, Fire Safety Supervisor Health Care Fire Inspections Minnesota Department of Public Safety State Fire Marshal Division 445 Minnesota Street, Suite 145 St. Paul, Minnesota 55101-5145 Email: tom.linhoff@state.mn.us

Fax: (651) 215-0525

Telephone: (651) 430-3012

Feel free to contact me if you have questions related to this eNotice.

Sincerely,

Mark Meeth

Mark Meath, Enforcement Specialist Program Assurance Unit Licensing and Certification Program Health Regulation Division Minnesota Department of Health Email: mark.meath@state.mn.us

Telephone: (651) 201-4118 Fax: (651) 215-9697

cc: Licensing and Certification File

PRINTED: 05/17/2017 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		LE CONSTRUCTION		E SURVEY IPLETED
		245281	B. WING	i			R 06/2017
	PROVIDER OR SUPPLIER CARE AND REHAB L	LC		•	STREET ADDRESS, CITY, STATE, ZIP CODE 500 FIFTH STREET SOUTHEAST, BOX 129 BARNESVILLE, MN 56514		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
{F 000}	INITIAL COMMEN ⁻	ΓS	{F 00	00}			
	completed on 4/5/1 tags that were corre CMS2567B. Also the	rification revisit (PCR) was 7, and 4/6/17. The certification ected can be found on the nere are tags that were not the time of onsite PCR which CMS2567.					
	signature is not req page of the CMS-2	nrolled in ePOC, your uired at the bottom of the first 567 form. Your electronic POC will be used as bliance.					
	on-site revisit of you validate that substa	acceptable electronic POC, an ur facility will be conducted to antial compliance with the en attained in accordance with					
{F 157} SS=D	and substantiated a the on-site revisit.		{F 1	57}			5/8/17
	(g)(14) Notification	of Changes.					
	consult with the res	imediately inform the resident; sident's physician; and notify, or her authority, the resident then there is-					
		olving the resident which I has the potential for requiring on;					
	(B) A significant cha	ange in the resident's physical,					
	V DIRECTOR'S OR PROVID	DER/SLIPPLIER REPRESENTATIVE'S SIGI	NATURE		TITI F		(X6) DATE

Electronically Signed 05/04/2017

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that

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

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		245281	B. WING				3	
NAME OF I	PROVIDER OR SUPPLIER	243201	B. WING		ADDRESS, CITY, STATE, ZIP CODE	04/0	06/2017	
NAIVIE OF I	PROVIDER OR SUPPLIER				TH STREET SOUTHEAST, BOX 129			
VALLEY	CARE AND REHAB L	LC			SVILLE, MN 56514			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE	
{F 157}	deterioration in hea status in either life-clinical complication (C) A need to alter a need to discontin treatment due to accommence a new f (D) A decision to traresident from the fa §483.15(c)(1)(ii). (ii) When making n (14)(i) of this sectionall pertinent informatic available and prophysician. (iii) The facility must	ocial status (that is, a lth, mental, or psychosocial threatening conditions or	{F 15	57}	DEFICIENCY)			
	as specified in §483 (B) A change in res	ident rights under Federal or tions as specified in paragraph						
	(iv) The facility musupdate the address phone number of the This REQUIREMED by: Based on interview facility failed to ens	st record and periodically (mailing and email) and he resident representative(s). NT is not met as evidenced and document review, the ure a primary physician was expected of condition for 1 of 1		phys	R32 has been seen by her prim sician with documentation of th Il residents were reviewed for c	e visit.		

	OF DEFICIENCIES OF CORRECTION			(X3) DATE SURVEY COMPLETED R			
		245281	B. WING				⊣ 06/2017
	PROVIDER OR SUPPLIER CARE AND REHAB L	LC		6	TREET ADDRESS, CITY, STATE, ZIP CODE 00 FIFTH STREET SOUTHEAST, BOX 129 BARNESVILLE, MN 56514	1 0 1/4	50,2011
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
{F 157}	catheter to assist we Findings includes: Review of R32's pro 3/31/17, revealed the -On 2/20/17, R32 hand knee pain. The buttocks was red at cream was applied. been encouraged to oftenOn 2/22/17, a buttered rash, bleeding it and A&D ointment with indicated R32 had of difficulty with transfet to off load more often umber of open are wounds. The note opharmacological paperi-rectal woundsOn 2/25/17, indicated bowel and bladder, and irritated. The note indicated R32 and it was effective -On 2/26/17, a pain completed with R32 reported constant payrounding skin, ray	utilized an indwelling urinary ith wound healing. ogress notes from 2/20/17, to be following: ad complained of butt pain note further revealed R32's and bleeding in areas and a The note indicated R32 had oget off her buttocks more orfly wound around the anus, an some areas was observed was applied. The note complained of pain, had ers and should be encouraged en. The note lacked the eas and measurements of the lid not indicate non in interventions for R32's atted R32 was incontinent of and her rectal area was red one at hat was constant and had 8 on a numeric scale. The received Tylenol for the pain	{F 1!	57}	in status. All residents are reviewe daily shift reports. Any resident who have a status change or require interventions by required physician is reported to their primary physicial determination of further assessment reatment. 3. Policies & procedures were reviewed and updated as needed. All nursing have been re-educated on the need report any changes noted in reside status. Licensed staff were further educated on the need to verify report changes in resident status, receive appropriate verbal or written orders necessary interventions/procedures follow facility protocols for provider notification. 4. The DON will monitor & review a shift reports and required follow-up staff & providers as needed. These audits will be done daily for 90 days until 100% compliance is achieved audit outcomes will be submitted to QAA Committee for comment &/or	order; in for a ant or ewed g staff d to nt orted as for s, and with e daily s or . The other	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		LE CONSTRUCTION		SURVEY PLETED
		245281	B. WING				R 06/ 2017
	PROVIDER OR SUPPLIER CARE AND REHAB L	LC		6	STREET ADDRESS, CITY, STATE, ZIP CODE 100 FIFTH STREET SOUTHEAST, BOX 129 BARNESVILLE, MN 56514		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
{F 157}	complained of pain moving, pain in che note revealed R32 was constant and of The note further increquested somethir revealed the DON in physician and obtain milligrams (mg) everaged for day. A later note the medication and time she has had reverseled a new custom wheelchair. -On 2/27/17, R32 with bladder. The note in had diffuse red street bleeding. The note encourage R32 not periods, turn and resure priods, turn and resure priods and had correctum was red and further identified the on rounds the next. -On 2/28/17, R32 with bladder and had been of the every other day bladder and the ski her rectum. The no complained of pain	in her buttock with sitting and in her buttock with sitting and in her buttock with sitting and ist, ribs and abdomen. The had rated the pain at a 10, did not get relief from Tylenol. dicated R32 and her family had not get relief from Tylenol. dicated R32 and her family had not get for pain. A later note had contacted R32's primary ned an order for Tramadol 50 ery 4 hours with a maximum of othe revealed R32 had received had stated this was the first elief from the pain. The note shion had been placed in R32's was incontinent of bowel and notindicated R32's peri-rectal area taking, was intact and had not indicated staff were to a sit in wheelchair for prolonged exposition every 2 hours and and zinc-oxide. The notes the physician would be notified morning. Was incontinent of bowel and melandary and received a dose of complaints of overall pain. A fed Diflucan had been started. Ordered every day for 4 days,	{F 1!	57}			

	OF DEFICIENCIES OF CORRECTION	· · ·		(X3) DATE SURVEY COMPLETED			
		245281	B. WING				R 06/ 2017
	PROVIDER OR SUPPLIER CARE AND REHAB L	LC		60	TREET ADDRESS, CITY, STATE, ZIP CODE 00 FIFTH STREET SOUTHEAST, BOX 129 BARNESVILLE, MN 56514		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
{F 157}	used for buttocks p On 3/2/17, R32 was bladder and had an area, and had complegs and buttocks. interview had been revealed R32 report buttocks area, rated note further revealed hydrocortisone created. The second	to treat hemorrhoids) were ain. Its incontinent of bowel and a open wound on her buttock blained of pain in her back. A further note indicated a pain completed with R32, which ted constant pain in her da 7 on a numeric scale. The ed barrier cream, am were used at that time. Souttocks area was noted to be he note did not identify any s of R32's peri-rectal area. A R32 was incontinent of bowel and complained of buttocks. In R32 was incontinent of and her peri-rectal area was and her peri-rectal area was and her peri-rectal area was applied. In R32 had open skin on the cks, was red, open and indicated R32 complained of eam was applied. In R32 had of pain in her red barrier cream and buttocks remained excoriated	{F 1	57}			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION NG		PLETED
		245281	B. WING	·····	04/0	{)6/2017
	PROVIDER OR SUPPLIER CARE AND REHAB L	LC		STREET ADDRESS, CITY, STATE, ZIP CODE 600 FIFTH STREET SOUTHEAST, BOX 12 BARNESVILLE, MN 56514	•	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUND CROSS-REFERENCED TO THE APPRODE DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
{F 157}	R32's peri-rectal wo with worsening pair Tramadol and Tyler Diflucan. R32's recophysician had been wounds, and worse Further, R7's clinical documentation she hospital on 3/15/17. Review of R32's hospital on 3/20/17, revealed a catheter to prevent. Review of R32's prorevealed R32 had cand had no relief from an an edication). Turinary output from further revealed R32 had voided foll and expressed relief The note indicated monitored for wetnes whether R32's physicatheter removal or notified of the remoon of 4/5/17, at 10:35 stated R32 needed cares except for ea R32 had an indwell returned from the hoatheter had recent	nical progress notes indicated bunds continued to worsen, a despite the use of as needed hol and a scheduled dose of ord lacked documentation the notified of the worsening ening pain reports for R7. All record lacked had been admitted to the spital discharge orders dated in order to continue with Foley further perineal ulcers. Ogress note dated 3/31/17, complained of abdominal pain om Tramadol (non-narcotic he note revealed R32 had no her urinary catheter. The note 2's catheter had been eplaced. The note indicated owing the catheter removal, of from the abdominal pain. R32's briefs would be ess. The note did not identify sician had ordered R32's if R32's physician had been oval. a.m. nursing assistant (NA)-B assistance with all of her ting and drinking. NA-B stated ing catheter when she ospital and stated R32's ty been removed. NA-B stated continent of bowel and bladder	{F 15	57}		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,		CONSTRUCTION	COM	(X3) DATE SURVEY COMPLETED	
		245281	B. WING				R 06/2017	
_	PROVIDER OR SUPPLIER CARE AND REHAB L	LC		600	REET ADDRESS, CITY, STATE, ZIP CODE D FIFTH STREET SOUTHEAST, BOX 129 RNESVILLE, MN 56514	<u> U-1/1</u>	00/2017	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE	
{F 157}	family member (FM catheter placed durheal the peri-rectal been discharged to and she came to vis was gone. FM-B state the time of the visthe catheter had be that time, she had a with the director of person, regarding hereceived no responto have concerns at as recently as this properties. On 4/6/17, at 11:56 reviewed with the Donard R32's Foremoved on 3/31/17 facility nurse. She cophysician had not gone notified of R32 until 4/4/17. The Donardice would be toorder for the catheter on 4/14/17, during p.m., R32's primary expect the facility to to remove the indwer R32 needed incontinual ing the peri-receives considering a reatheter placement.	o.m. during a phone interview, al)-B stated R32 had a urinary ing her hospitalization to help sores. FM-B stated R32 had the facility with the catheter sit one day and the catheter ated the facility nurse on duty sit, was unsure of when or why ten removed. FM-B stated at attempted to make contact nursing (DON) by email and in ter concerns, though had se. FM-B stated she continued bout R32's skin and indicated the position for over 3. Ta.m. R32's clinical record was bone and another confirmed R32's primary iven an order to nor had he 2's Foley catheter had been an order to nor had he 2's Foley catheter removal on otify and obtain physicians her removal. Ta telephone interview at 1:05 or physician stated he would on otify him and have an order telling catheter. He confirmed the preferral for possible suprapubic	{F 1	57}				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		COMPLETED		
		245281	B. WING				R 06/2017
	PROVIDER OR SUPPLIER CARE AND REHAB L	LC		600 F	EET ADDRESS, CITY, STATE, ZIP CODE FIFTH STREET SOUTHEAST, BOX 129 RNESVILLE, MN 56514	1 04/	00/2011
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
{F 157} {F 309} SS=G	Physician Notification Condition Guideline a residents primary party of changes in 483.24, 483.25(k)(l)	on of Resident Change of es, directed the facility to notify physician and responsible condition. PROVIDE CARE/SERVICES	{F 1!				5/8/17
	applies to all care a residents. Each res facility must provide services to attain or practicable physica well-being, consiste	e indamental principle that and services provided to facility sident must receive and the the necessary care and maintain the highest l, mental, and psychosocial ent with the resident's ressment and plan of care.					
	applies to all treatm facility residents. Be assessment of a re that residents recei- accordance with pro- practice, the compr	fundamental principle that tent and care provided to ased on the comprehensive sident, the facility must ensure we treatment and care in ofessional standards of ehensive person-centered residents' choices, including					
	provided to resident consistent with profithe comprehensive	ent. Isure that pain management is the who require such services, the essional standards of practice, person-centered care plan, goals and preferences.					
	residents who requi	cility must ensure that ire dialysis receive such t with professional standards					

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION IG	(X3) DATE SURVEY COMPLETED	
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	PROVIDER OR SUPPLIER CARE AND REHAB L	LC		STREET ADDRESS, CITY, STATE, ZIP CODE 600 FIFTH STREET SOUTHEAST, BOX 129 BARNESVILLE, MN 56514	•	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROVIDENCY)	D BE	(X5) COMPLETION DATE
{F 309}	care plan, and the opreferences. This REQUIREMENT by: Based on observative, the facility of assess and monitor incontinence for 1 of for skin conditions at the facility failed to worsening pain for reviewed for pain. The resulted in actual howersening of skin bowith non-pressure services. Findings include: R32 was incontined developed multiple caused severe pair any incontinence can comprehensively as peri-rectal sores defurther sores from the healing. R32 was incontinence can be aling. R32 was incontinence can be aline to the latest the peri-rectal sorted in actual howers.	prehensive person-centered residents' goals and NT is not met as evidenced and incon, interview and document ailed to comprehensively reskin breakdown related to of 3 residents (R32) reviewed and incontinence. In addition, comprehensively reassess 1 of 3 residents (R32) These deficient practices arm for R32 who experienced treakdown and increasing pain skin breakdown. In the facility had not are. The facility had not are. The facility had not assessed R32's skin when the eveloped in order to prevent developing and promote of comprehensively sening pain to manage of pain for R32. Although the pain analgesics that provided ad ongoing pain that she severe. In addition, R32's atheter was discontinued tion, despite being ordered to	{F 309	1. R32 has been assessed and c interventions for skin breakdown, worsening pain, and decline in bot bladder incorporated into the plan Additionally, her existing non-presskin breakdown continues to be m for healing along with adequacy or coverage. 2. All residents at risk for worsening and/or decline in bowel and bladd secondary to diagnosis, accidents medication regimens have been mand comprehensive assessments completed to identify actual or pot skin breakdown and baseline characteristics. All residents were reviewed for worsening pain and comprehensive assessments com Care plans were updated with dire modalities of pharmalogical and non-pharmalogical interventions for control. Hereafter, all residents wire monitored weekly for worsening, a breakthrough pain and/or change habits to determine underlying call interventions. 3. The DON or designee will also all daily pain progress notes and Fadministration notes for 90 days to monitor for non-pharmalogical approaches trialed and efficacy ur compliance is achieved & maintain	wel and of care. sure nonitored f pain ng pain er, or eviewed ential apleted. ected or pain th be acute, or in bowel use and review PRN or exit 100%	
	3/3/17, identified R	32 had moderate cognitive d diagnoses which included		Pain will be monitored daily by rev daily progress notes and weekly p	iew of	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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	PROVIDER OR SUPPLIER CARE AND REHAB L	LC		60	REET ADDRESS, CITY, STATE, ZIP CODE 10 FIFTH STREET SOUTHEAST, BOX 129 ARNESVILLE, MN 56514	0 170	7072011
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
{F 309}	congestive heart far gastroenteritis and R32 required exten of daily living (ADL' personal hygiene. If frequently incontine of bowel (which wa previous MDS comon a toileting prograincontinence. The frequent pain, rated scale of 0-10 (0 indindicating the worst received as needed non-pharmacologic received scheduled further identified R3 skin damage (MAS ointment. The MDS any physician presciphysician visits with Review of R32's carevealed R32 requitoileting by one staff and required check repositioning every directed staff to proand to complete peepisode. R32's care peri-rectal skin ulcomoisture and incomplan did not identify sustained). R32's comonitor and documand complete week plan identified the transport of the staff and peru Casto daily incomplete week plan identified the transport of the staff and peru Casto daily incomplete week plan identified the transport of the staff and peru Casto daily incomplete week plan identified the transport of the staff and peru Casto daily incomplete week plan identified the transport of the staff and peru Casto daily incomplete week plan identified the transport of the staff and peru Casto daily incomplete week plan identified the transport of the staff and peru Casto daily incomplete week plan identified the transport of the staff and peru Casto daily incomplete week plan identified the transport of the staff and peru Casto daily incomplete week plan identified the transport of the staff and peru Casto daily incomplete week plan identified the transport of the staff and peru Casto daily incomplete week plan identified the transport of the staff and peru Casto daily incomplete week plan identified the transport of the staff and peru Casto daily incomplete week plan identified the transport of the staff and peru Casto daily incomplete week plan identified the transport of the staff and peru Casto daily incomplete week plan identified the transport of the staff and peru Casto daily incomplete week plan identified the transport of the staff and peru Casto daily incomplete wee	illure, non-infective colitis. The MDS identified sive assistance with activities is) including toileting and the MDS identified R32 was ent of urine, always incontinent is increase in frequency from pleted 12/1/16) and was not am for urinary or bowel MDS identified R32 had if a five (5) on a numerical icating no pain and 10 in pain imaginable) had interventions and had not if pain medications. The MDS is all interventions and had not if pain medications. The MDS is all interventions and had not if pain medications. The MDS is all interventions and had not if pain medications. The MDS is all interventions and had not if pain medications. The MDS is all interventions and had not if pain medications are plan revised a topical in the last 14 days. The plan revised 3/28/17, are dextensive assistance with if, was incontinent of bowel	{F 30	09}	notes and Administered PRN Listin Report to monitor for increasing us PRN analgesic. Bowel habits will be reviewed daily by reviewing Urinary Output and Bowel Management Lo Back Reports looking specifically for change in resident ability and signs constipation or ongoing loose stool 4. All staff providing direct cares to residents has been educated on the monitoring protocols to assure any change in bowel/bladder habits is immediately reported and recorded Direct care staff educated on the importance of charting all bowel movements for accurate monitoring needed any medication administrated Additionally, all nursing staff was educated on use and documentation criteria for pain, pharmalogical and non-pharmalogical interventions. In staff also educated on indications for change in bowel and bladder habits associated potential for non-pressubreakdown for at risk residents as updated policies and procedures for accurate, consistent monitoring of non-pressure skin conditions. 5. Implementation of coordinated approach to resident needs assess hourly pain, position, potty, and placement. The DON or designee review/audit rounding daily for 7 dat then, 2X a week for 30 days or unticompliance is achieved to assure compliance. Additionally, the DON designee will do unannounced, observational audits on select residually to assure consistency in rounding daily to assure consistency in rounding the polyment of t	e of e of e ok or of s. o e pain or . g and, if ion. lursing or s and ire skin well as or ing will ys; I 100% or lents	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245281	B. WING			64/0	? 06/ 2017
NAME OF I	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE	. 04/0	30/2017
					600 FIFTH STREET SOUTHEAST, BOX 129		
VALLEY	CARE AND REHAB L	LC			BARNESVILLE, MN 56514		
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{F 309}	Review of the untitle the current nursing R32 required assist incontinent brief, was every 2 hours, and The form identified incontinent of stool, barrier cream to so During observation was seated in a who Nursing assistant (Nowith cares and procoroom. At that time a full mechanical lift wheelchair with the R32 if she was sore NA-B and NA-A assisted mechanical lift. down on the bed, R moaned as she was NA-B and NA-A renunderneath R32. Now reassurance they was incontinent of a and a moderate ambowel. At that time, incontinent of bowe characteristics of th NA-A then proceed R32's peri-rectal are time, a deep guttura R32. NA-B patted F	wheelchair and in bed. ed facility form identified as aide care sheet, identified ance of one staff, utilized a as to be checked and changed had a foley catheter in place. R32 was frequently and to contact nurse for	{F 30	09}	7 days. All audit outcomes shall be presented to the QAA Committee for review &/or comment. 6. Policies & procedures for pain management were reviewed and u to include non-pharmalogical approximate individualized to each resident as when indications for comprehensive review is warranted. 7. Policies and procedures for non-pressure skin integrity breakdowere developed and reviewed to in physician notification, comprehensive review to establish risks and root coweekly monitoring for new concernaudit for decline in ADL function or increased pain associated with new non-pressure concerns.	pdated paches well as e own clude ive ause, s, and	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				COM	E SURVEY PLETED
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{F 309}	R32's bowel were of off her skin. R32's buttocks had peri-rectal area, two o'clock position and and 3 o'clock positi went to the hospital than 4 open areas stated she felt R32 open areas. NA-A plastic cup to all formoaned during the had obtained the oil was to help heal the proceeded to apply her slacks and assi position. R32 expredone and stated she Review of R32's Sk dated 2/21/17, revet the crease of her bill Review of R32's Sk dated 3/10/17, revearea which measurem. However, a con R32's skin condition worsening of the period Review of R32's Sk dated 3/20/17, revening of the period Review of R32's Sk dated 3/20/17, revening as a shared-pink wound becomes an intaction of the period Ray of R32's Sk dated 3/20/17, revening as a shared-pink wound becomes an intaction of the period Ray of R32's Sk dated 3/20/17, revening as a shared-pink wound becomes an intaction of the period Ray of R32's Sk dated 3/20/17, revening as a shared-pink wound becomes an intaction of the period Ray of R32's Sk dated 3/20/17, revening as a shared-pink wound becomes an intaction of the period Ray of R32's Sk dated 3/20/17, revening as a shared-pink wound becomes an intaction of the period Ray of R32's Sk dated 3/20/17, revening as a shared-pink wound becomes an intaction of the period Ray of R32's Sk dated 3/20/17, revening as a shared-pink wound becomes an intaction of the period Ray of R32's Sk dated 3/20/17, revening as a shared-pink wound becomes an intaction of the period R32's Sk dated 3/20/17, revening R32's S	four open areas on her on the left side at the 8 d two on the right side at the 2 on. NA-A stated before R32 in March, she had had more which would bleed. NA-A had a lot of pain from the then applied an ointment in a sur of R32's open areas. R32 application. NA-A stated she ntment from the nurse and it is open areas. NA-A and NA-B a clean brief to R32, pulled up isted to her to a right side lying essed relief the cares were e wanted to sleep. Sin Observation Tool form taled R32 had an irritation in auttocks. Sin Observation Tool form taled R32 had a red rectal ed 6 centimeters (cm) by 6 mprehensive assessment of n was not conducted despite	{F 30	9			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X3) DATE SURVEY COMPLETED			
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	PROVIDER OR SUPPLIER CARE AND REHAB L	LC		STREET ADDRESS, CITY, STATE 600 FIFTH STREET SOUTHEA BARNESVILLE, MN 56514	AST, BOX 129		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN ((EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	ACTION SHOULD O THE APPROPE	BE	(X5) COMPLETION DATE
{F 309}	buttocks pressure user with .1 cm in decm in depth. The lemeasured .5 cm by 2 cm to the lack of a com the wounds were unto pressure or mois. Review of R32's We form dated 3/23/17, pressure areas on which had worsens (mm) by 22 mm by treatment included Peru-Castrol Oil Oir times a day for mois reposition every 2 ha Foley urinary cath. Review of R32's quisigned 2/21/17, idea pain in the rectal areactivities, which she scale. R32 reported exacerbated the pareactivities, which she scale. R32 experienced in incontinent of bowe assessment reveals in place such as, Tybarrier cream. The had relief from the from repositioning. No further compreheassessments were	the left buttock. The right alcers measured .3 cm by .3 pth and .5 cm by .5 cm with .1 ft buttocks pressure ulcers .5 cm and .1 cm in depth and 1 cm in depth. (However, due prehensive skin assessment, hable to be determined related ture). Beekly Wound Observation tool identified R32 had a stage 2 her buttocks near the anus ed and measured 22 millimeter 1 mm. The form indicated the an application of Balsam nument to R32's buttocks three sture associated open areas, ours, wheelchair cushion and leter. Barterly Pain Assessment intified R32 reported burning ea which limited day to day e rated a 6 on a numeric pain I bowel movements in. The assessment indicated termittent rectal pain when	{F 30	09}			

AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION ING	COMPLETED	
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	PROVIDER OR SUPPLIER CARE AND REHAB L	LC		STREET ADDRESS, CITY, STATE, ZIP CODE 600 FIFTH STREET SOUTHEAST, BOX 129 BARNESVILLE, MN 56514	•	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		D BE	(X5) COMPLETION DATE
{F 309}	eating and drinking indwelling urinary control to the hospital arrecently been remonalways incontinent of a brief daily. NA-B change R32 every the NA-B stated R32 not R32 required a full approximately Decepast R32 had utilized movements and state for R32 to use the state the sores. NA-B state peri-rectal area stare and at times had be R32 had several mobefore she went to NA-B stated she felperi-rectal area were was aware R32 had peri-cares. NA-B stated she felperi-rectal area were was aware R32 had peri-cares. NA-B stated she felperi-rectal area were was aware R32 had peri-cares. NA-B stated she stare to R32's continuent or cream and continuent or cream and concerns. R32 stated the staff too much be to lay in bed. R32 stated the staff too much be to lay in bed. R32 stated the staff too much be to lay in bed. R32 stated to lay in bed. R32	with all of her cares except for NA-B stated R32 had an atheter when she returned and stated R32's catheter had wed. NA-B stated R32 was of bowel and bladder and wore stated staff were to check and wo hours for incontinence. In longer used the toilet since mechanical lift, since ember. NA-B stated in the ed a bedpan for bowel ated she felt it was too painful bedpan presently because of sted R32's sores around her ted at the end of February een bleeding. She indicated one areas that had been open the hospital in mid-March. It the open sores on R32's every painful for her and she doften complained of pain with ated there have been no heck and change program ted, other than applying	{F 36	09}		

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(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		ON SHOULD HE APPROPR	BE	(X5) COMPLETION DATE
{F 309}	aware the sores on her. R32 stated she in her body such as stated she received was effective some not been offered of (non-pharmacologishe still had signific felt it was better sin hospital. R32 stated changes in her care hospital. During a telephone p.m. FM-B indicate sores on her bottor nurse had explaine were a common restated she felt R32 developed a seriou confused and disor had voiced her contold she would be a contold she would be a complained extensive except for eating. Now with checking and devery two hours an both bowel and blacomplained of pain felt it was due to the NA-C stated R32 happroximately two been open and blee R32 used to use the become too painful	owever, she felt staff was her bottom were painful for had ongoing pain elsewhere sher back, and joints and dimedication for the pain and it of the time. R32 stated she her types of pain interventions cal). R32 stated that although cant pain from the sores, she her return from the dishe was unaware of any esince her return from the dishe was aware R32 had in February and stated the dishe was aware R32 had in February and stated the dishe was aware R32 had in February and stated the dishe was aware R32 had in February and stated the dishe was aware R32 had in February and stated the dishe was aware R32 had in February and stated the dishe was aware R32 had in February and stated the dishe was always and had become itented. FM-B stated she again cerns to facility staff and was updated with any changes. a.m. NA- C stated R32 was assisted changing her incontinent brief dishe was always incontinent of disher. NA-C stated R32 with all peri-rectal cares and the sores on her peri-rectal area, and the peri-rectal sores for months and the sores had beding at times. NA-C stated the bedpan, however it had for her so they no longer used the R32 had returned from the	{F 3	09}			

	ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED			
		245281	B. WING		04	R / 06/2017
	PROVIDER OR SUPPLIER CARE AND REHAB L	LC	STREET ADDRESS, CITY, STATE, ZIP CODE 600 FIFTH STREET SOUTHEAST, BOX 129 BARNESVILLE, MN 56514			700/2017
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		ULD BE	(X5) COMPLETION DATE
{F 309}	On 4/6/17, at 10:33 always incontinent or required routine, ever change. NA-A state allowing staff to corrof her incontinent buse the toilet approago, however, felt declined, she required stated prior to R32's constant stooling in had soft incontinent developed sores armid-February and hitmes. NA-A stated all peri-rectal hygiet sores. NA-A stated since R32's return from R32 continued to his stated she was unaplan of care since hindicated a couple or requesting R32 recomorning cares wou had not discussed to On 4/6/17, at 11:08 (LPN)-A stated R32 started out as red lebarrier cream. LPN pinpoint open areas to her hospitalization unsure of how man time. She felt R32's improving since her LPN-A stated in the	ge 15 been no changes in her care. Da.m. NA-A stated R32 was of bowel and bladder and ery two hour check and d R32 was compliant with implete checking and changing rief. NA-A stated R32 used to eximately three to four months since R32's health has red a full mechanical lift. NA-A is hospitalization, she had her brief, and at present R32 tound her peri-rectal area had been open and bleeding at R32 complained of pain with the, and felt it was due to the felt the sores had improved from the hospital, though felt have pain with cares. NA-A ware of any changes in R32's her hospital return. NA-A of the NAs had considered every pain medication prior to did help R32 with her pain, but his with the nurse at present. a.m. licensed practical nurse its peri-rectal wounds had esions that were treated with a each stated R32 had small in the peri-rectal region prior in March, though was y areas were open at that the peri rectal sores have been return from the hospital. weeks before R32 went to the R32 had experienced an each stated experienced each stated experienced an each stated experienced each experienced	{F 3(09}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER.			LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245281	B. WING				R 06/2017
NAME OF	PROVIDER OR SUPPLIER		<u> </u>		STREET ADDRESS, CITY, STATE, ZIP CODE	04/0	J0/201 <i>1</i>
					500 FIFTH STREET SOUTHEAST, BOX 129		
VALLEY	CARE AND REHAB L	LC			BARNESVILLE, MN 56514		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
{F 309}	stated R32 currentl Tramadol (non-opic pain and every 4 he stated the schedule started on 3/21/17, She stated prior to R32 had only PRN stated she felt R32 pain from the perischeduled Tramado On 4/6/17, at 11:25 stated she was awaredness prior to hel however was not awher peri-rectal area aware the area was stated she was respectly wound assecompleted a compr for R32's peri-rectal return on 3/21/17, (wounds were first in stated R32 had 4 or region, 2 on the left her rectum. RN-A sof correction from the improve the facility' monitoring. RN-A sof correction from the improve the facility' monitoring. RN-A sof correction from the improve the facility monitoring. RN-A sof correctal wounds shospital return. RN R32's peri-rectal wounds hospital return. RN R32's peri-rectal wobowel incontinence	ge 16 Incontinence. LPN-A further by received scheduled bid analgesic) twice daily for burs as needed (PRN.) LPN-A and dosing for Tramadol was following her hospitalization. Being hospitalized on 3/14/17, Tramadol and Tylenol. LPN-A continued to have frequent ectal sores, though felt the bid gave R32 some relief. In a.m. registered nurse (RN)-A are R32 had peri-rectal rhospitalization on 3/14/17, ware R32 had open sores in sereddened and sore. RN-A consible for the facility's resments and had not ehensive wound assessment I wounds until her hospital 30 days after R32's peri-rectal side and 2 on the right side of tated part of the facility's plan he recent survey was to se wound assessments and tated she had not had a sea comprehensive wound 2's peri-rectal wounds before and indicated the most she had completed for R32's was on 3/23/17, after R32's land stated there had not been to R32's checking and	{F 3	09}			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	,			
		245281	B. WING				R 06/2017
	PROVIDER OR SUPPLIER CARE AND REHAB L	LC		600	REET ADDRESS, CITY, STATE, ZIP CODE FIFTH STREET SOUTHEAST, BOX 129 RNESVILLE, MN 56514		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
{F 309}	R32 had been compain and felt it was sores. RN-A stated medications scheduler were effective. During observation director of nursing (R32's room to comquiet, lying in bed tiwith a blanket. The from over R32 and her left side. R32 alturned. RN-A proceareas around R32's open areas on the Imeasured approximately 0.3 odepth. RN-A indicated that were on the righad indicated she for RN-A then proceed peri-rectal areas. FRN-A provided peri ointment to the perion Review of R32's programment of R32's programment to the perion R32's buttocks was and a cream was a had been encouragemore often.	that time. RN-A further stated plaining of frequent buttocks it was due to the peri-rectal R32 now had oral pain uled and prn, which she felt on 4/6/17, at 1:42 p.m. the DON) and RN-A entered plete wound care. R32 was lted on her left side, covered DON removed the blanket assisted R32 to turn fully on oruptly groaned when she was eded to visualize the open a rectum and stated R32 had 2 eft side of her rectum which nately 1.7 cm by 1.2 cm by 0.3 open area measured cm by 0.4 cm and had no ed the previous 2 open areas ht side were now only red, she elt those areas had healed. ed to apply an ointment to all 4 l32 continued to groan while cares and applied the rectal areas.	{F 30)9}			

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	TIPLE CONSTRUCTION ING		(X3) DATE SURVEY COMPLETED	
		245281	B. WING		04	R / 06/2017
	PROVIDER OR SUPPLIER CARE AND REHAB L	LC	STREET ADDRESS, CITY, STATE, ZIP CODE 600 FIFTH STREET SOUTHEAST, BOX 129 BARNESVILLE, MN 56514			700/2011
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		ULD BE	(X5) COMPLETION DATE
{F 309}	and A&D ointment vindicated R32 had of difficulty with transfet to off load more often number of open are wounds. The note opharmacological paperi-rectal wounds. -On 2/25/17, indicated bowel and bladder, and irritated. The note around her rectal around her rectal around her rectal around it was effective. -On 2/26/17, a pain completed with R32 and it was effective. -On 2/26/17, a pain completed with R32 reported constant parounding skin, rastated the Tylenol with the pain away. A la complained of pain moving, pain in che note revealed R32 was constant and difference the DON in physician and obtain milligrams (mg) even for day. A later note medication and time she has had recompleted was constant and obtain milligrams (mg) even for day. A later note medication and time she has had recompleted with the medication and time she has had recompleted.	n some areas was observed was applied. The note complained of pain, had ers and should be encouraged en. The note lacked the eas and measurements of the lid not indicate non in interventions for R32's and her rectal area was red on the revealed R32 had pain rea that was constant and had 8 on a numeric scale. The received Tylenol for the pain	{F 30	09}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		L L L L L L L L L L L L L L L L L L L		TIPLE	(X3) DATE SURVEY COMPLETED		
		245281	B. WING				ີ 06/ 2017
	PROVIDER OR SUPPLIER CARE AND REHAB L			600	REET ADDRESS, CITY, STATE, ZIP CODE 0 FIFTH STREET SOUTHEAST, BOX 129 ARNESVILLE, MN 56514		50/2017
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
{F 309}	bladder. The note in had diffuse red stree bleeding. The note encourage R32 not periods, turn and reuse prn Tramadol a further identified the on rounds the next. On 2/28/17, R32 w bladder and had corectum was red and of prn Tramadol for further note indicate Diflucan (anti-funga for 4 days, then every complained of pain received Tramadol corticosteroid used used for buttocks puttocks area, and had complegs and buttocks. interview had been revealed R32 report buttocks area, rated note further revealed hydrocortisone creations.	vas incontinent of bowel and indicated R32's peri-rectal area eaking, was intact and had no indicated staff were to a sit in wheelchair for prolonged exposition every 2 hours and and zinc-oxide. The notes is physician would be notified morning. vas incontinent of bowel and implained of rectal pain, here it irritated and received a dose of complaints of overall pain. A sed Diflucan had been started. All had been ordered every day erry other day thereafter. as incontinent of bowel and in was red and irritated around the further revealed R32 around her rectum and and Anusol (topical to treat hemorrhoids) were eain. as incontinent of bowel and in open wound on her buttock plained of pain in her back. A further note indicated a pain completed with R32, which ited constant pain in here in a 7 on a numeric scale. The	{F 3)9}			

` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	` '	E SURVEY PLETED
		245281	B. WING				ີ 06/ 2017
NAME OF I	PROVIDER OR SUPPLIER	2.020.			STREET ADDRESS, CITY, STATE, ZIP CODE	04/0	00/2017
10.000	THO VIBERT OF TOOL TELEFT				600 FIFTH STREET SOUTHEAST, BOX 129		
VALLEY	CARE AND REHAB L	LC			BARNESVILLE, MN 56514		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
{F 309}	and bladder and ha painOn 3/3/17, reveale	ge 20 R32 was incontinent of bowel of complained of buttocks d R32 was incontinent of and her peri-rectal area was	{F 3	09}			
	red and irritated. -On 3/9/17, reveale crease of her buttoo	d R32 had open skin on the cks, was red, open and indicated R32 complained of					
		omplained of pain in her red barrier cream and					
	-On 3/12/17, R32's and barrier cream h	buttocks remained excoriated nad been applied.					
	-On 3/13/17, R32 re over pain.	eceived pain medication for all					
	R32's peri-rectal wo with worsening pair Tramadol and Tyler Diflucan. R32's reco physician had been wounds, and worse Further, R7's clinica	had been admitted to the					
	R32's transfer to th 3/20/17 indicated R	ord lacked documentation of e hospital. However, a note on 32 had returned from the y and had been assisted to					

STATEMENT OF DEFICIENCIES (X' AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245281	B. WING				3
NAME OF I	PROVIDER OR SUPPLIER	243201	B. W. (4)		STREET ADDRESS, CITY, STATE, ZIP CODE	04/0	06/2017
					600 FIFTH STREET SOUTHEAST, BOX 129		
VALLEY	CARE AND REHAB L	LC			BARNESVILLE, MN 56514		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
{F 309}	Continued From pa	nge 21	{F 3	09}			
	R32's primary phys	entry for 3/21/17, indicated ician had been updated on alization, and open areas to					
	sore to buttocks, ar Ointment was to be	ad moisture associated open nd Balsam Peru-Castor Oil applied to buttocks topically or moisture associated open					
	-On 3/24/17, R32 was seen by her primary provider regarding peri-rectal area, the note indicated R32's wounds were showing improvement. The note further revealed R32's urinary catheter was to remain in place as her wounds continued to heal.						
	right buttocks with tand characteristics measured 1.0 cm be red granular tissue, cm by 1.5 cm and hote did not identify	ad wounds on her left and the following measurements; right buttocks wound by 0.5 cm by 0.5 cm and had left buttocks measured 2.0 had red granular tissue. The vany depth, drainage or pain 2's peri-rectal wounds.					
	physician for a follo	vas seen by her primary ow up of "skin ulcer" and tinue current therapy as					
	completed with R32 daily, almost consta a 7 out of 10 on a r	interview had been 2 and revealed R32 reported ant pain of her buttocks, rated numeric scale and indicated N medications were effective.					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		LE CONSTRUCTION		E SURVEY PLETED
		245281	B. WING			R 04/06/2017	
	PROVIDER OR SUPPLIER CARE AND REHAB L	LC		6	STREET ADDRESS, CITY, STATE, ZIP CODE 600 FIFTH STREET SOUTHEAST, BOX 129 BARNESVILLE, MN 56514	<u> </u>	50/2011
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		BE	(X5) COMPLETION DATE			
{F 309}	pain and had no rel revealed R32 had nurinary catheter. The catheter had been in The note indicated catheter removal, a abdominal pain. The would be monitored identify whether R3 R32's catheter remobeen notified of the Review of R32's hogh 3/14/17, togh 3/20/17, -3/14/17, R32 was adiagnoses which into indicate of the diagnoses which into its dehydration. A hospita R32 presented to the multiple open woun inner buttocks. The was referred to a with the	nad complained of abdominal ief from Tramadol. The note to urinary output from her note note further revealed R32's removed and not replaced. R32 had voided following the note indicated R32's briefs of for wetness. The note did not 2's physician had ordered oval or if R32's physician had removal. spitalization records from identified the following: admitted to the hospital with cluded: lack of water as cause diomyopathy and atrial al note dated 3/14/17, revealed the hospital lethargic, with ids and significant pain to note further revealed R32 ound specialist and was nous Tramadol (non-opioid	{F 36	09}			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245281	B. WING		R 04/06/2017		
	PROVIDER OR SUPPLIER CARE AND REHAB L	LC		STREET ADDRESS, CITY, STATE, ZIP CODE 600 FIFTH STREET SOUTHEAST, BOX BARNESVILLE, MN 56514			
(X4) ID PREFIX TAG				ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE	
{F 309}	trauma to the wound border foam dressin note revealed R32 pain of her buttocks Fentanyl (opioid and manage R32's pain -On 3/16/17, reveal discussed with R32 upon due to R32's plife. A further note reimprovement of pain -On 3/17/17, reveal included Hospice sto the facility with the further perineal ulceincontinence. -On 3/20/17, R32 whospital and returned orders which included catheter to prevent Tramadol 50 milligrevery 4 hours as near her rect bleeding on 2/20/17 unsure of how man peri-rectal area at they were more like she felt the cause of was moisture, as a	used to minimize pain and dand surrounding skin,) ng for prevention. A further continued to have significant s, and intravenous (IV) algesic) was required to	{F 3	09}			

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245281	B. WING _			R / 06/2017
	PROVIDER OR SUPPLIER CARE AND REHAB L	LC		STREET ADDRESS, CITY, STATE, ZIP COE 600 FIFTH STREET SOUTHEAST, BOX BARNESVILLE, MN 56514	DE .	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
{F 309}	identified R32's per confirmed the tool I characteristics of the expected R32's per weekly and stated so nursing staff on impound assessment The DON confirmed considered any characterist documen stated she felt R32 to the peri-rectal would had managed R32'. Further, the DON so had been notified of 2/26/17, and Trama administered as ne felt R32 was responded to a scheduled pain regord management. The staff to offer non-phinterventions in add and confirmed R32 documentation of notine interventions attem stated she was away was given to R32 here. Further, DON confibeen removed on 3 facility nurse. She cophysician had not gother to the staff of R32 here.	ge 24 d on 3/10/17, which had also in interestal wounds. The DON acked measurements and any it is wounds. She stated she interestal wound to be monitored she had been working with her proving pain management and its, monitoring and treatment. It is the facility had not larges in R32's incontinence since the peri-rectal wounds ted on 2/20/17. The DON had experienced pain related bunds and she felt the facility is pain appropriately. Itated R32's primary physician of an increase in R32's pain on adol had been ordered to be eded. The DON indicated she insible to ask for pain is he felt she needed them. The ility had not considered a iment to aid in R32's pain DON stated she would expect in its pain medication to R32 is medical record lacked on-pharmacological pain lition to pain medication to R32 is medical record lacked on-pharmacological pted for R32's pain. The DON are the pain medication that ad not always been effective. In the pain medication that and not always been effective. In the pain medication that and not always been effective. In the pain medication that and not always been effective. In the pain medication that and not always been effective. In the pain medication that and not always been effective. In the pain medication that and not always been effective. In the pain medication that and not always been effective. In the pain medication that and not always been effective. In the pain medication that and not always been effective.	{F 30	9}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245281	B. WING			R 04/06/2017	
	PROVIDER OR SUPPLIER CARE AND REHAB L			6	STREET ADDRESS, CITY, STATE, ZIP CODE 500 FIFTH STREET SOUTHEAST, BOX 129 BARNESVILLE, MN 56514	1 04/0	50/2017
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
{F 309}	order for the cathet On 4/6/17, at 12:19 was left for R32's p No return phone ca exit. On 4/14/17, at 1:02 interview, R32's pri could not recall who R32's peri-rectal wo stated he would hav complete a compre identify a potential of continually monitor which included peri incontinence. Review of R32's Marecord (MAR) from 2017, revealed the -Review of R32's F order dated 11/18/1 mouth every 4 hour exceed 4000 mg in revealed an order of mg by mouth every pain, with a max of MAR identified the effective. -Review of R32's M received Tylenol for (severe pain) on for The MAR revealed PRN for pain rated	p.m. a telephone message orimary physician for interview. Il had been received before p.m. during a telephone mary physician indicated he either he had been notified of bunds. R32's primary physician we expected the facilty to hensive assessment to cause, interventions and to any changes in condition rectal sores, pain and edication Administration a February 2017, to March	{F 3	09}			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245281	B. WING				R 06/2017
NAME OF I	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	1 04/0	00/2017
VALLEY	CADE AND DELIAR I	1.0		(600 FIFTH STREET SOUTHEAST, BOX 129		
VALLEY	CARE AND REHAB L	LC			BARNESVILLE, MN 56514		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PREFIX (EACH CORRECTIVE ACTION SHOULD BE			(X5) COMPLETION DATE
{F 309}	Records (TAR) from 2017, revealed the 2017, revealed the -R32's February TA 2/27/17, for Barrier moisture associated encourage resident reposition every 2 horder dated 12/29/1 note and pain note skin and pain. -R32's March TAR 2/28/17, to ensure I while awake every dermatitis. The TAF receive barrier crea MASD, encourage turn and reposition -R32's April TAR reto complete skin and for skin and pain. Tassessments were revealed an order to reposition R32 off coshift for moisture as Review of a physici 2/21/17, revealed Fixisit. The note reveweakness, weight conte indicated R32	eatment Administration m February 2017, to April 6th, following; R revealed an order dated cream to peri-rectal area for d skin damage (MASD,) to be off buttocks, turn and fours. The TAR revealed an 6, to complete skin/wound every day shift Thursday for revealed an order dated R32 was toileted every 2 hours day and evening related to R revealed R32 continued to im to peri-rectal area for resident to be off buttocks,	{F 30	09)	·		
	weakness, weight on note indicated R32 weeks or sooner. T	yain and deconditioning. The was to be seen again in 2 he note did not identify R32's ad assessed R32's peri-rectal					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
						ı	R
		245281	B. WING			04/	06/2017
	PROVIDER OR SUPPLIER CARE AND REHAB L	LC		60	TREET ADDRESS, CITY, STATE, ZIP CODE 00 FIFTH STREET SOUTHEAST, BOX 129 ARNESVILLE, MN 56514		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	Х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
{F 309}	Continued From pa		(F 3	09}			
	3/4/17, identified the properly identify an at risk for impaired procedure identified assessment and mowith any new skin is	policy and procedure revised e facility's purpose was to ad assess residents that were skin integrity. The policy and d an ongoing wound onitoring would be completed ssues and the primary notified of the condition and ny changes.					
F 315 SS=D	requested on 4/6/17	CATHETER, PREVENT UTI,	F3	315			5/8/17
	continent of bladder receives services a continence unless h	t ensure that resident who is r and bowel on admission nd assistance to maintain nis or her clinical condition is nat continence is not possible					
	. ,	th urinary incontinence, based imprehensive assessment, the that-					
	indwelling catheter	nters the facility without an is not catheterized unless the ondition demonstrates that necessary;					
	indwelling catheter is assessed for remas possible unless	enters the facility with an or subsequently receives one noval of the catheter as soon the resident's clinical condition catheterization is necessary					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
		245281	B. WING		R 04/06/2	R ∕06/2017	
	PROVIDER OR SUPPLIER	LC		STREET ADDRESS, CITY, STATE, ZIP CODE 600 FIFTH STREET SOUTHEAST, BOX 129 BARNESVILLE, MN 56514			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE CO	(X5) OMPLETION DATE	
F 315	receives appropriate prevent urinary trace continence to the ed (3) For a resident won the resident's continent of the resident's continent of bowel function as properties. This REQUIREMED by: Based on observative review, the facility for re-assess bowel incompositure associated the following include: Review of R32's que (MDS) dated 12/1/moderate cognitive diagnosis which incognitive diagnosis which incognitive diagnosis was frequently review of R32's quently review review review review review review review review review revie	is incontinent of bladder the treatment and services to est infections and to restore extent possible. With fecal incontinence, based comprehensive assessment, the extent a resident who is extracted to restore as much normal cossible. Nor is not met as evidenced Ition, interview and document ailed to comprehensively continence following onset of d skin breakdown (MASD) for extracted with a change in It is extracted with a change in It is extracted with a data cluded non-infective colitis. The MDS identified sive assistance with toileting incontinent of bowel. It is incontinent of bowel. It is incontinent of incontinent incontin	F 315	,	plan lcer in of eted sidents ent e in to s and der r pdated		
	gastroenteritis and R32 continued to re	colitis. The MDS identified equire extensive assistance and R32 was now		toileting times are offered, proper incontinence product is being used, appropriate interventions to maintai integrity are being utilized. Staff wil	, and in skin		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245281	B. WING _			R 06/2017	
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COI		00/2011	
VALLEY	CADE AND DELIAD I	1.0		600 FIFTH STREET SOUTHEAST, BOX	HEAST, BOX 129		
VALLEY	CARE AND REHAB L	LC		BARNESVILLE, MN 56514			
(X4) ID		TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORR		(X5)	
PREFIX TAG		/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)		COMPLETION DATE	
F 315	Continued From pa	ge 29	F 31				
				document toileting times, atte			
		re plan revised 3/28/17,		refusals on each resident with			
		red extensive assistance with		resident point of care system.			
		and was incontinent of bowel		Care plans were updated with			
		d physical limitations. R32's		modalities or interventions for bladder monitoring. Hereafte			
		acility staff to check R32 every with toileting as needed,		residents will have bowel and			
		mmode and to provide peri		habits monitored monthly thro			
	care after each inco			generated in point of care sys			
				comprehensive assessment			
	Review of the untitle	ed facility form identified as		completed for any change in			
		aide care sheet, identified		4. DON or designee will revie			
		tance of one staff, utilized a		bowel/bladder look back repo			
		as to be checked and changed		toileting habits. All staff provi			
		had a Foley catheter in place.		cares to residents have been			
		R32 was frequently		the monitoring protocols to as			
		, and to contact nurse for		change in bowel and bladder			
	barrier cream to so	re on bottom.		skin breakdown other integun involvement is immediately re			
	Review of R32's RI	adder/Bowel Continence		recorded. Additionally, all nurs			
		19/17, revealed R32 was		was educated on use and do			
	incontinent of bowe			criteria for bowel and bladder			
		ed R32 had an unknown		the prevention for residents a			
	onset of bowel inco	ntinence which fluctuated over		issues.			
	the past six months	s, and had been present for		5. The DON or designee will i	eview/audit		
		essment lacked any frequency		all daily shift reports for 7 day			
		vements. The note further		week for 30 days or until 100°			
	revealed R32's peri	ineum skin was intact.		compliance is achieved to ass			
	No foutbox Dloddox/	David Continence Evaluation		compliance. The DON or des	•		
		Bowel Continence Evaluation		audit to ensure comprehensiv			
		n R32's clinical record, despite ency of bowel incontinence		assessments are completed to residents at admission, annual			
	causing MASD.	chey of bower incontinence		significant change in bowel a			
	Jaconing Wirtob.			habits. All audit outcomes sh			
	During observation	on 4/5/17, at 10:27 a.m. R32		presented to the QAA Commi			
		eelchair, in the dining room.		review &/or comment.			
		NA)-A offered R32 assistance		6. Policies & procedures for in	ncontinence		
		ceeded to wheel R32 to her		assessment and managemer			
		NA-B entered R32's room with		reviewed and updated as nee			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MUL A. BUILD		(X3) DATE SURVEY COMPLETED		
		245281	B. WING				R 06/2017
	PROVIDER OR SUPPLIER CARE AND REHAB L	LC	STREET ADDRESS, CITY, STATE, ZIP CODE 600 FIFTH STREET SOUTHEAST, BOX 129 BARNESVILLE, MN 56514				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 315	a full mechanical lift wheelchair with the R32 if she was sore NA-B and NA-A ass the mechanical lift. down on the bed, RNA-A proceeded to incontinent brief. R3 moderate amount of amount of formed, NA-A stated R32 w and bladder and the were typical for R32 wipe the stool away with a wet wipe. At groan had emanate R32's shoulder and done shortly. R32 gperi-rectal cleansing were often sticky and R32's buttocks had peri-rectal area, two o'clock position and and 3 o'clock position and a plastic cup to all f moaned during the had obtained the oi was to help heal the proceeded to apply her slacks and assi position. R32 expredone and stated sh	t. As NA-B lifted R32 out of the lift, R32 groaned. NA-A asked and R32 responded she was. sisted R32 over to the bed with As NA-B and NA-A laid R32 l32 groaned again. NA-B and remove R32's slacks and 32 was incontinent of a of urine and a moderate soft, sticky bowel. At that time, as always incontinent of bowel a characteristics of the bowel 2. NA-A then proceeded to a from R32's peri-rectal area that time, a deep guttural and from R32. NA-B patted a reassured her they would be groaned throughout the groaned throughout throughout the groaned thr	F3	15	nursing staff have been re-educate the need to report any changes not resident status. Licensed staff wer further educated on the need to ve reported changes in resident status follow facility protocols for provider notification.	ed in e rify s, and	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		. ,	PLE CONSTRUCTION	COM	(X3) DATE SURVEY COMPLETED	
		245281	B. WING			R 06/2017
	PROVIDER OR SUPPLIER CARE AND REHAB L	LC		STREET ADDRESS, CITY, STATE, ZIP CODE 600 FIFTH STREET SOUTHEAST, BOX 129 BARNESVILLE, MN 56514	•	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROVIDENCY)	D BE	(X5) COMPLETION DATE
F 315	eating and drinking indwelling urinary confrom the hospital arrecently been remonal always incontinent of a brief daily. NA-B change R32 every that NA-B stated R32 us bowel movements be peri-rectal area device was too painful for because of the sore been no changes to program since the sapplying ointment of the sapplying staff to coro of her incontinent bunaware of any character of the sapplying ointment of the sapplying staff to coro of her incontinent bunaware of any character of the sapplying ointment of the sapplying staff to coro of her incontinent bunaware of any character of the sapplying staff to coro of her incontinent bunaware of any character of the sapplying staff to coro of her incontinent bunaware of any character of the sapplying staff to coro of her incontinent bunaware of any character of the sapplying staff to coro of her incontinent bunaware of any character of the sapplying staff to coro of her hospital results of the sapplying staff to coro of her incontinent bunaware of any character of the sapplying staff to coro of her incontinent bunaware of any character of the sapplying staff to coro of her incontinent bunaware of any character of the sapplying staff to coro of her incontinent bunaware of any character of the sapplying staff to coro of her incontinent bunaware of any character of the sapplying staff to coro of her incontinent bunaware of any character of the sapplying staff to coro of her incontinent bunaware of any character of the sapplying staff to coro of her incontinent bunaware of any character of the sapplying staff to coro of her incontinent bunaware of any character of the sapplying staff to coro of her incontinent bunaware of any character of the sapplying staff to coro of her incontinent bunaw	with all of her cares except for . NA-B stated R32 had an atheter when she returned and stated R32's catheter had ved. NA-B stated R32 was of bowel and bladder and wore stated staff were to check and two hours for incontinence. Sed to use the bedpan for before the sores on her reloped and stated she felt it R32 to use the bedpan es. NA-B stated there have on R32's check and change sores started, other than for cream after incontinence. Tam. NA-A stated felt that the en declining in the last few and R32 was always incontinent the er and required routine, every all change. NA-A stated prior to me, she had constant stooling in esent R32 had soft incontinent R32 was compliant with enplete checking and changing rief. NA-A stated she was anges in R32's plan of care eturn. Tam. registered nurse (RN)-A cause of R32's peri-rectal rinary and bowel incontinence and not been any changes made and changing routine at that stated R32 had been uent buttocks pain and felt it	F 315			

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			COMPLETED		
		245281	B. WING				R 06/2017
	PROVIDER OR SUPPLIER CARE AND REHAB L	LC		600 FI	ET ADDRESS, CITY, STATE, ZIP CODE IFTH STREET SOUTHEAST, BOX 129 NESVILLE, MN 56514	1 04/	30/2011
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 315	On 4/6/17, at 11:56 (DON) confirmed R assessment indicat incontinence. The I of R32's peri rectal result of incontinence DON confirmed the any changes in R32 plan since the peridocumented on 2/2 A policy and process	a.m. the director of nursing (32's most recent bowel ed an increased in bowel DON stated she felt the cause wounds was MASD, as a ce of bowel and bladder. The facility had not considered 2's incontinence management rectal wounds were first	F3	15			

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION A. Building			DATE OF REV	/ISIT
	B. Wing		Y2	4/6/2017	Y3
NAME OF FACILITY		STREET ADDRESS, CITY, STATE, ZIP CODE			
VALLEY CARE AND REHAB L	LC	600 FIFTH STREET SOUTHEAST, BOX 129			
		BARNESVILLE, MN 56514			

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

ITE Y4		DATE Y5	ITEM Y4	DATE Y5	ITEM Y4		DATE Y5
ID Prefix Reg. # LSC	F0282 483.21(b)(3)(ii)	Correction Completed 03/13/2017	ID Prefix F0314 Reg. #		ID Prefix Reg. # LSC	F0441 483.80(a)(1)(2)(4)(e)(f)	Correction Completed 03/13/2017
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 PrefixReg. #	Correction Completed	ID Prefix Reg. # LSC		Correction Completed
ID Prefix Reg. # LSC		Correction Completed	ID PrefixReg. #	Correction	ID Prefix Reg. # LSC		Correction Completed
ID Prefix Reg. # LSC		Correction	ID PrefixReg. #	Correction	ID Prefix Reg. # LSC		Correction Completed
REVIEWE STATE AC REVIEWE CMS RO	ED BY	REVIEWED BY (INITIALS) GA/mm REVIEWED BY (INITIALS)	DATE 04/25/2017 DATE	SIGNATURE OF SURVEYOR 31256 TITLE		DATE	06/2017
FOLLOWUP TO SURVEY COMPLETED ON 2/10/2017		CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? YES NO					



PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

NOTICE OF ASSESSMENT FOR NONCOMPLIANCE WITH CORRECTION ORDERS FOR NURSING HOMES

Electronically Delivered April 25, 2017

Mr. Mark Rustad, Administrator Valley Care and Rehabilitation, LLC 600 Fifth Street Southeast, Box 129 Barnesville, Minnesota 56514

Re: Project # S5281027 and H5281029

Dear Mr. Rustad:

On April 6, 2017, survey staff of the Minnesota Department of Health, Licensing and Certification Program completed a reinspection of your facility, to determine correction of orders found on the survey completed on February 10, 2017 with orders received by you electronically on April 25, 2017. In addition an investigation of complaint number H5281029 was conducted and found to be substantiated at MN Rule 4658.0085, MN Rule 4658.0520 and MN Rule 4658.0525.

State licensing orders issued pursuant to the last survey completed on February 10, 2017 and found corrected at the time of this April 6, 2017 revisit, are listed on the State Form: Revisit Report Form.

State licensing orders issued pursuant to the last survey completed on February 10, 2017, found not corrected at the time of this April 6, 2017 revisit and subject to penalty assessment are as follows:

20265 -- MN Rule 4658.0085 - Notification Of Chg In Resident Health Status - \$350.00 20830 -- MN Rule 4658.0520 Subp. 1 - Adequate and Proper Nursing Care; General - \$350.00

The details of the violations noted at the time of this revisit completed on April 6, 2017 (listed above) are on the attached Minnesota Department of Health Statement of Deficiencies-Licensing Orders Form. Brackets around the ID Prefix Tag in the left hand column, e.g., {2 ----} will identify the uncorrected tags. It is not necessary to develop a plan of correction, electronically acknowledge and date this form and submit to the Minnesota Department of Health.

Therefore, in accordance with Minnesota Statutes, section 144A.10, you will be assessed an amount of \$700.00 *per day beginning on the day you view this notice*.

The fines shall accumulate daily until notification from the nursing home is electronically submitted to the Department stating that the orders have been corrected.

When the Department receives the electronically submitted notification that the orders are corrected, a reinspection will be conducted to verify that acceptable corrections have been made. If it is determined that acceptable corrections have not been made, the daily accumulation of the fines shall resume and the amount of the fines which otherwise would have accrued during the period prior to resumption shall be added to the total assessment. The resumption of the fine can be challenged by requesting a hearing within 15 days of the receipt of the notice of the resumption of the fine.

If the accumulation of the fine is resumed, the fines will continue to accrue in the manner described above until an electronically submitted notification stating that the orders have been corrected is received and verified by the Department.

The costs of all reinspections required to verify whether acceptable corrections have been made will be added to the total amount of the assessment.

You may request a hearing of any of the above noted penalty assessments provided that a written request is made within 15 days of the receipt of this Notice. Any request for a hearing shall be sent to Mary Henderson, Minnesota Department of Health, Licensing and Certification Program, Health Regulation Division, P.O. Box 64900, St. Paul, Minnesota 55164-0900.

Once the penalty assessments have been verified as corrected the facility will receive a notice of the total amount of the penalty assessment including the costs of any reinspections.

In addition, at the time of this reinspection completed on April 6, 2017 an additional violation was cited as follows:

20910 -- MN Rule 4658.0525 Subp. 5 A B - Rehab Incontinence

The violation is delineated on the electronically delivered Minnesota Department of Health State form. Only the ID Prefix Tag in the left hand column without brackets will identify these licensing orders. It is not necessary to develop a plan of correction, however, you will need to acknowledge when all orders will be corrected, and electronically submit. 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 Gail Anderson at:

Gail Anderson, Unit Supervisor
Fergus Falls Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
1505 Pebble Lake Road, Suite 300
Fergus Falls, Minnesota 56537-3858
Email: gail.anderson@state.mn.us

Phone: (218) 332-5140 Fax: (218) 332-5196 Valley Care and Rehabilitation LLC April 25, 2017 Page 3

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

Feel free to contact me if you have questions related to this eNotice.

Sincerely,

Mark Meeth

Mark Meath, Enforcement Specialist Program Assurance Unit Licensing and Certification Program Health Regulation Division Minnesota Department of Health

Email: mark.meath@state.mn.us Telephone: (651) 201-4118

Fax: (651) 215-9697

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
			A. BUILDING.		F	2	
		00968	B. WING			6/2017	
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE			
VALLEY	CARE AND REHAB L	1 (-	I STREET SO /ILLE, MN 5	OUTHEAST, BOX 129 6514			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE	
{2 000}	Initial Comments		{2 000}				
	****ATTE	NTION*****					
	NH LICENSING	CORRECTION ORDER					
	144A.10, this corre- pursuant to a surve found that the defic herein are not corre- not corrected shall	Minnesota Statute, section ction order has been issued by. If, upon reinspection, it is iency or deficiencies cited ected, a fine for each violation be assessed in accordance iines promulgated by rule of artment 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.						
	that may result fron orders provided tha the Department wit	hearing on any assessments non-compliance with these at a written request is made to hin 15 days of receipt of a ent for non-compliance.					
	4/6/17. During this of that the following cowere NOT correcte will remain in effect next onsite visit. Also	visit was completed on consite visit it was determined corrections orders 0265, 0830 d. These uncorrected orders and will be reviewed at the so uncorrected orders will be ole penalty assessment/s.					

Minnesota Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Electronically Signed 05/04/17

STATE FORM 6899 NQV412 If continuation sheet 1 of 33

TITLE

(X6) DATE

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00000			R	
		00968	b. WING		04/0	6/2017
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
VALLEY	CARE AND REHAB L	1 (-	ISTREET SO /ILLE, MN 5	OUTHEAST, BOX 129 6514		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE
{2 000}	Continued From pa	ge 1	{2 000}			
	completed. The cor Correction orders w Licensing 4658.008 licensing order issu Minnesota Departm the State Licensing federal software. Ta	complaint H5281029 was implaint was substantiated. Were reissued at State 35, 4658.0520, and new state ed 4658.0525 The ent of Health is documenting ag numbers have been sota state statutes/rules for				
	The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction.					
	FOURTH COLUMN "PROVIDER'S PLA APPLIES TO FEDE	RD THE HEADING OF THE N WHICH STATES, N OF CORRECTION." THIS ERAL DEFICIENCIES ONLY. R ON EACH PAGE.				
	PLAN OF CORREC	QUIREMENT TO SUBMIT A OTION FOR VIOLATIONS OF E STATUTES/RULES.				
{2 265}	MN Rule 4658.0089 Resident Health Sta	5 Notification of Chg in atus	{2 265}			5/8/17
	A nursing home mu	st develop and implement				

Minnesota Department of Health

STATE FORM NQV412 If continuation sheet 2 of 33

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
					R	
		00968	B. WING		04/0	6/2017
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE OUTHEAST, BOX 129		
VALLEY	CARE AND REHAB L	1 (-	/ILLE, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
{2 265}	physicians, physicial practitioners, and if legal representative member of a reside accident, or death. nursing services, an attending physician development of the have criteria which appropriate notifical. A. an accident results in injury and physician interventi. B. a significant physician interventi. B. a significant physical, mental, of example, a deterior psychosocial status conditions or clinical conditions or clinical example, a need to of treatment due to begin a new form of the sident from the need to deterior the sident from the sident	aff decisions to consult an assistants, and nurse known, notify the resident's or an interested family ent's acute illness, serious. At a minimum, the director of and the medical director or an must be involved in the se policies. The policies must address at least the tion times for: involving the resident which has the potential for requiring on; change in the resident's or psychosocial status, for reation in health, mental, or in either life-threatening all complications; ter treatment significantly, for adverse consequences, or to for treatment; to transfer or discharge the	{2 265}	corrected		
	Based on interview	and document review, the				

Minnesota Department of Health STATE FORM

NQV412 If continuation sheet 3 of 33

STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		00968			F 04/0	{ 6/2017	
NAME OF			I.		<u> U4/U</u>	0/2017	
	PROVIDER OR SUPPLIER CARE AND REHAB L	600 FIFTH		STATE, ZIP CODE DUTHEAST, BOX 129			
VALLET		BARNES	/ILLE, MN 5				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROINT DEFICIENCY)	D BE	(X5) COMPLETE DATE	
{2 265}	Continued From pa	ge 3	{2 265}				
	facility failed to ensure a primary physician was notified of a change of condition for 1 of 1 resident (R32) who utilized an indwelling urinary catheter to assist with wound healing.						
	Findings includes:						
	Review of R32's progress notes from 2/20/17, to 3/31/17, revealed the following:						
	-On 2/20/17, R32 had complained of butt pain and knee pain. The note further revealed R32's buttocks was red and bleeding in areas and a cream was applied. The note indicated R32 had been encouraged to get off her buttocks more often.						
	red rash, bleeding i and A&D ointment v indicated R32 had o difficulty with transf to off load more oftenumber of open are wounds. The note of	erfly wound around the anus, in some areas was observed was applied. The note complained of pain, had ers and should be encouraged en. The note lacked the eas and measurements of the did not indicate non ain interventions for R32's					
	bowel and bladder, and irritated. The naround her rectal a rated her pain at ar	ated R32 was incontinent of and her rectal area was red ote revealed R32 had pain rea that was constant and had a 8 on a numeric scale. The received Tylenol for the pain					
	completed with R32 reported constant p	interview had been 2, which revealed she had ain in her rectum and ated the pain at an 8 and					

Minnesota Department of Health

STATE FORM NQV412 If continuation sheet 4 of 33

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
			A. BOILDING.		F	3
		00968	B. WING			6/2017
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
VALLEY	CARE AND REHAB L	1 ()	I STREET SO /ILLE, MN 5	OUTHEAST, BOX 129 6514		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
{2 265}	stated the Tylenol withe pain away. A la complained of pain moving, pain in che note revealed R32 was constant and of the note further increquested somethin revealed the DON physician and obtain milligrams (mg) even of per day. A later in the medication and time she has had revealed a new cus wheelchair. -On 2/27/17, R32 with bladder. The note in had diffuse red street bleeding. The note encourage R32 not periods, turn and reuse printer identified the on rounds the next. -On 2/28/17, R32 with bladder and had correctum was red and of printer indicated biflucan had been then every other day bladder and the skill her rectum. The note complained of pain complained of pain	would help but it did not take ater note revealed R32 had in her buttock with sitting and est, ribs and abdomen. The had rated the pain at a 10, did not get relief from Tylenol. dicated R32 and her family had ng more for pain. A later note had contacted R32's primary ined an order for Tramadol 50 ery 4 hours with a maximum of ote revealed R32 had received I had stated this was the first elief from the pain. The note shion had been placed in R32's was incontinent of bowel and ndicated R32's peri-rectal area eaking, was intact and had no indicated staff were to the sit in wheelchair for prolonged eposition every 2 hours and and zinc-oxide. The notes en physician would be notified morning. The was incontinent of bowel and omplained of rectal pain, her distributed and received a dose of complaints of overall pain. A fed Diflucan had been started. Ordered every day for 4 days,				

Minnesota Department of Health

STATE FORM 6899 NQV412 If continuation sheet 5 of 33

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					3) DATE SURVEY COMPLETED	
		00968	B. WING			R 06/2017
	PROVIDER OR SUPPLIER CARE AND REHAB L	600 FIFTH		STATE, ZIP CODE OUTHEAST, BOX 129 66514		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
{2 265}	corticosteroid used used for buttocks p On 3/2/17, R32 wa bladder and had an area, and had complegs and buttocks. interview had been revealed R32 reporbuttocks area, rated note further revealed hydrocortisone creations of the characteristic later note revealed and wet. To other characteristic later note revealed and bladder and hapain. On 3/3/17, revealed bowel and bladder and irritated. On 3/9/17, revealed crease of her buttoched in and barrier creation and barrier creation. On 3/11/17, R32 of buttocks and received Tramadol for pain. On 3/12/17, R32's and barrier cream in con 3/13/17, R32 of over pain.	to treat hemorrhoids) were ain. as incontinent of bowel and open wound on her buttock blained of pain in her back. A further note indicated a pain completed with R32, which ted constant pain in her da 7 on a numeric scale. The ed barrier cream, am were used at that time. buttocks area was noted to be he note did not identify any s of R32's peri-rectal area. A R32 was incontinent of bowel do complained of buttocks. d R32 was incontinent of and her peri-rectal area was d R32 had open skin on the cks, was red, open and indicated R32 complained of eam was applied. complained of pain in her red barrier cream and	{2 265}			

Minnesota Department of Health

STATE FORM 6899 NQV412 If continuation sheet 6 of 33

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					SURVEY LETED	
		00968	B. WING		04/0	? 06/ 2017
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
VALLEY	CARE AND REHAB L	1 (=	STREET SO VILLE, MN 5	OUTHEAST, BOX 129 6514		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
{2 265}	R32's peri-rectal wowith worsening pair Tramadol and Tyler Diflucan. R32's recophysician had been wounds, and worse Further, R7's clinical documentation she hospital on 3/15/17. Review of R32's hos 3/20/17, revealed a catheter to prevent Review of R32's prorevealed R32 had cand had no relief from pain medication). Turinary output from further revealed R3 removed and not re R32 had voided foll and expressed relies The note indicated monitored for wetnes whether R32's physicatheter removal or notified of the removal or notified of the removal or notified from the hocatheter had recent R32 was always incand wore a brief da On 4/5/17, at 1:14 pc and the catheter had recent R32 was always incand wore a brief da On 4/5/17, at 1:14 pc and the catheter had recent R32 was always incand wore a brief da On 4/5/17, at 1:14 pc and the catheter had recent R32 was always incand wore a brief da On 4/5/17, at 1:14 pc and the catheter had recent R32 was always incand wore a brief da On 4/5/17, at 1:14 pc and the catheter had recent R32 was always incand wore a brief da On 4/5/17, at 1:14 pc and the catheter had recent R32 was always incand wore a brief da On 4/5/17, at 1:14 pc and the catheter had recent R32 was always incand wore a brief da On 4/5/17, at 1:14 pc and the catheter had recent R32 was always incand wore a brief da On 4/5/17, at 1:14 pc and the catheter had recent R32 was always incand wore a brief da On 4/5/17, at 1:14 pc and the catheter had recent R32 was always incand wore a brief da On 4/5/17, at 1:14 pc and the catheter had recent R32 was always incand wore a brief da On 4/5/17, at 1:14 pc and the catheter had recent R32 was always incand wore a brief da On 4/5/17, at 1:14 pc and the catheter had recent R32 was always incand wore a brief da On 4/5/17, at 1:14 pc and the catheter had recent R32 was always incand wore a brief da On 4/5/17, at 1:14 pc and the catheter had recent R32 was always incand wore a brief da On 4/5/17, at 1:14 pc and the catheter had recent R32 was always incand wore a brief da On 4/5/17,	bunds continued to worsen, a despite the use of as needed and and a scheduled dose of ord lacked documentation the notified of the worsening uning pain reports for R7. All record lacked had been admitted to the spital discharge orders dated in order to continue with Foley further perineal ulcers. Ogress note dated 3/31/17, complained of abdominal pain om Tramadol (non-narcotic he note revealed R32 had no her urinary catheter. The note 2's catheter had been eplaced. The note indicated owing the catheter removal, of from the abdominal pain. R32's briefs would be ess. The note did not identify sician had ordered R32's if R32's physician had been val. a.m. nursing assistant (NA)-B assistance with all of her ting and drinking. NA-B stated ing catheter when she ospital and stated R32's ally been removed. NA-B stated continent of bowel and bladder	{2 265}			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00968	B. WING			R 06/ 2017
	PROVIDER OR SUPPLIER CARE AND REHAB L	I C 600 FIFTH		TATE, ZIP CODE DUTHEAST, BOX 129 6514		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
{2 265}	catheter placed durheal the peri-rectal been discharged to and she came to viswas gone. FM-B state the time of the vithe catheter had be that time, she had a with the director of person, regarding hereceived no responto have concerns a as recently as this processed with the Econfirmed R32's Foremoved on 3/31/1 facility nurse. She cophysician had not go been notified of R3 until 4/4/17. The DO practice would be to order for the cathet. On 4/14/17, during p.m., R32's primary expect the facility to remove the indw R32 needed incontinealing the peri-received visits and satisfactions.	ing her hospitalization to help sores. FM-B stated R32 had the facility with the catheter sit one day and the catheter ated the facility nurse on duty sit, was unsure of when or why sen removed. FM-B stated at attempted to make contact nursing (DON) by email and in her concerns, though had se. FM-B stated she continued bout R32's skin and indicated boast weekend, during a visit, same position for over 3 a.m. R32's clinical record was pondon. At that time she pley catheter had been 7, by herself and another confirmed R32's primary viven an order to nor had he 2's Foley catheter removal DN stated the facility's usual onotify and obtain physicians	{2 265}			
	Physician Notification Condition Guideline	ed facility policy titled, on of Resident Change of es, directed the facility to notify physician and responsible				

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	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X3 A. BUILDING:			X3) DATE SURVEY COMPLETED	
			A. BUILDING:		F		
		00968	B. WING)6/2017	
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE			
VALLEY	CARE AND REHAB L	1 (=	I STREET SO /ILLE, MN 5	OUTHEAST, BOX 129 6514			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPERTION OF T	D BE	(X5) COMPLETE DATE	
{2 265}	Continued From page 8		{2 265}				
	party of changes in	condition.					
{2 830}	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General		{2 830}			5/8/17	
	Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed.						
	This MN Requirement is not met as evidenced by: Uncorrected based on the following findings. The original licensing order issued on 2/10/17 will remain in effect. Penalty assessment issued.			corrected			
	review, the facility fassess and monitor incontinence for 1 of for skin conditions at the facility failed to worsening pain for reviewed for pain. Tresulted in actual harmonic assessment of the facility failed to worsening pain for reviewed for pain.	on, interview and document ailed to comprehensively r skin breakdown related to of 3 residents (R32) reviewed and incontinence. In addition, comprehensively reassess 1 of 3 residents (R32) These deficient practices arm for R32 who experienced reakdown and increasing pain skin breakdown.					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED		
			A. BUILDING:			D	
		00968	B. WING			R 06/2017	
NAME OF	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, S	TATE, ZIP CODE			
VALLEY	CADE AND DEHAR I	600 FIFT	H STREET SC	OUTHEAST, BOX 129			
VALLEY (ARE AND REHARTIC			VILLE, MN 56	5514			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	IOULD BE	(X5) COMPLETE DATE	
{2 830}	Continued From pa	ge 9	{2 830}				
	developed multiple caused severe pair any incontinence car comprehensively as peri-rectal sores defurther sores from chealing. R32 was not reassessed for wor severity/frequency facility did provide pasome relief, R32 has described often as indwelling urinary continence.	nt of bowel and bladder and peri-rectal sores which much of the time and with are. The facility had not seessed R32's skin when the eveloped in order to prevent developing and promote ot comprehensively sening pain to manage of pain for R32. Although the pain analgesics that provided ad ongoing pain that she severe. In addition, R32's atheter was discontinued tion, despite being ordered to sores.					
	3/3/17, identified Rimpairment and had congestive heart far gastroenteritis and R32 required extens of daily living (ADL' personal hygiene. If frequently incontine of bowel (which was previous MDS comon a toileting prograincontinence. The firequent pain, rated scale of 0-10 (0 indicating the worst received as needed non-pharmacologic received scheduled further identified Riskin damage (MAS)	simum Data Set (MDS) dated 32 had moderate cognitive diagnoses which included ilure, non-infective colitis. The MDS identified sive assistance with activities s) including toileting and The MDS identified R32 was ent of urine, always incontinent is increase in frequency from pleted 12/1/16) and was not am for urinary or bowel MDS identified R32 had a five (5) on a numerical icating no pain and 10 in pain imaginable) had in the (PRN) medication and interventions and had not all interventions. The MDS 32 had moisture associated D) and received a topical is revealed R32 had not had					

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	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00968	B. WING		F 04/0	R 6/ 2017
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE	1 04/0	0/2017
	CARE AND REHAB L	I C 600 FIFTH	, ,	OUTHEAST, BOX 129		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
{2 830}	any physician presc physician visits with Review of R32's car revealed R32 requi toileting by one staf and required check repositioning every directed staff to pro and to complete pe episode. R32's car peri-rectal skin ulce moisture and incon plan did not identify sustained). R32's comonitor and docum and complete week plan identified the t Balsam Peru Casto reposition every 2 h relieving devices in Review of the untitl the current nursing R32 required assist incontinent brief, we every 2 hours, and The form identified incontinent of stool barrier cream to so During observation was seated in a wh Nursing assistant (I with cares and proc room. At that time a full mechanical lif wheelchair with the R32 if she was sore	cribed order changes or ain the last 14 days. re plan revised 3/28/17, red extensive assistance with f, was incontinent of bowel ing, changing and 2 hours. The care plan wide the bedpan as needed ri cares after each incontinent e plan identified R32 had a er near the anus related to tinence. (However, the care of the multiple skin wounds R32 are plan directed staff to ent the wound characteristics, say measurements. R32's care reatment included use of or oil three times a day, nours, and the use of pressure wheelchair and in bed. ed facility form identified as aide care sheet, identified tance of one staff, utilized a last to be checked and changed had a foley catheter in place. R32 was frequently, and to contact nurse for	{2 830}			

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AND BLAN OF CORRECTION INTERPRETATION NUMBER.			` ,	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			7. BOILDING.		F	3
		00968	B. WING			6/2017
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	ORESS, CITY, S	STATE, ZIP CODE		
VALLEY	CARE AND REHAB L	1 (-	I STREET SO ILLE, MN 5	OUTHEAST, BOX 129 6514		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
{2 830}	the mechanical lift. down on the bed, R moaned as she way NA-B and NA-A renunderneath R32. Not reassurance they was incontinent of and groaned again, remove R32's slack was incontinent of and a moderate ambowel. At that time, incontinent of bowe characteristics of the NA-A then proceed R32's peri-rectal artime, a deep gutture R32. NA-B patted Fher they would be a throughout the peri-R32's bowel were coff her skin. R32's buttocks had peri-rectal area, two o'clock position and and 3 o'clock position and a plastic cup to all for moaned during the had obtained the oid was to help heal the proceeded to apply her slacks and assi	As NA-B and NA-A laid R32 k32 groaned again. R32 s turned side to side while moved the lift sling from A-A and NA-B offered R32 yould be done soon. R32 was her left side, facing the wall. NA-B and NA-A proceeded to ks and incontinent brief. R32 a moderate amount of urine hount of formed, soft, sticky NA-A stated R32 was always and bladder and the he bowel were typical for R32. He to wipe the stool away from the ea with a wet wipe. At that all groan had emanated from R32's shoulder and reassured done shortly. R32 groaned rectal cleansing. NA-A stated often sticky and hard to wipe four open areas on her on the left side at the 8 d two on the right side at the 2 on. NA-A stated before R32 in March, she had had more which would bleed. NA-A had a lot of pain from the then applied an ointment in a sur of R32's open areas. R32 application. NA-A stated she ntment from the nurse and it to open areas. NA-A and NA-B a clean brief to R32, pulled up sted to her to a right side lying tessed relief the cares were	{2 830}			

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AND DUAN OF CODDECTION IDENTIFICATION NUMBER.			E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED	
					F	
		00968			04/0	6/2017
	PROVIDER OR SUPPLIER	600 FIFTH	, ,	STATE, ZIP CODE DUTHEAST, BOX 129		
VALLEY	CARE AND REHAB L	1 ('	/ILLE, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
{2 830}	Continued From pa	ge 12	{2 830}			
	Review of R32's Skin Observation Tool form dated 2/21/17, revealed R32 had an irritation in the crease of her buttocks.					
	dated 3/10/17, reve area which measur cm. However, a cor	cin Observation Tool form aled R32 had a red rectal ed 6 centimeters (cm) by 6 mprehensive assessment of a was not conducted despite eri-rectal sores.				
	dated 3/20/17, rever pressure ulcers (par presenting as a shared-pink wound becomesent as an intact definition) on the rigoressure ulcers on buttocks pressure ulcers on buttocks pressure ulcers in depth. The lemeasured .5 cm by 2 cm by 2 cm with .1 to the lack of a compressure ulcers on buttocks pressure ulce	cin Observation Tool form aled R32 had two stage 2 rtial thickness loss of dermis allow open ulcer with a d, without slough. May also t or open/ruptured blister. In the left buttock and two stage 2 the left buttock. The right ulcers measured .3 cm by .3 pth and .5 cm by .5 cm with .1 ft buttocks pressure ulcers .5 cm and .1 cm in depth and 1 cm in depth. (However, due aprehensive skin assessment, hable to be determined related ture).				
	form dated 3/23/17 pressure areas on which had worsend (mm) by 22 mm by treatment included Peru-Castrol Oil Oil times a day for moi reposition every 2 ha Foley urinary cath	eekly Wound Observation tool, identified R32 had a stage 2 her buttocks near the anus ed and measured 22 millimeter 1 mm. The form indicated the an application of Balsam ntment to R32's buttocks three sture associated open areas, lours, wheelchair cushion and neter. arterly Pain Assessment				

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AND DUAN OF CODDECTION IDENTIFICATION NUMBER:					OATE SURVEY OMPLETED	
		00968	B. WING		04/0	? 9 6/2017
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
VALLEY	CARE AND REHAB L	1 (=		OUTHEAST, BOX 129		
		BARNES	/ILLE, MN 5	6514		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
{2 830}	Continued From pa	ge 13	{2 830}			
{2 830}	signed 2/21/17, idel pain in the rectal are activities, which she scale. R32 reported exacerbated the pare R32 experienced in incontinent of bowe assessment revealed in place such as, Tybarrier cream. The had relief from the from repositioning. No further comprehe assessments were On 4/5/17, at 10:35 needed assistance eating and drinking indwelling urinary cafrom the hospital are recently been remo always incontinent of a brief daily. NA-B change R32 every the NA-B stated R32 not R32 required a full approximately Decepast R32 had utilized movements and stated rage to use the base the sores. NA-B stated recently be a peri-rectal area stared.	ntified R32 reported burning ea which limited day to day a rated a 6 on a numeric pain bowel movements in. The assessment indicated termittent rectal pain when I movements. The ed various interventions were plenol, rest, repositioning and assessment indicated R32 Tylenol and somewhat relief ensive wound and pain found in R32's clinical record. a.m. NA-B stated R32 with all of her cares except for NA-B stated R32 had an atheter when she returned and stated R32's catheter had exed. NA-B stated R32 was of bowel and bladder and wore stated staff were to check and two hours for incontinence. In longer used the toilet since mechanical lift, since ember. NA-B stated in the end a bedpan for bowel atted she felt it was too painful bedpan presently because of ted R32's sores around her ted at the end of February	{2 830}			
	R32 had several me before she went to NA-B stated she fel	een bleeding. She indicated ore areas that had been open the hospital in mid-March. It the open sores on R32's e very painful for her and she				
	was aware R32 had	d often complained of pain with ated there have been no				

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STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
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		00968	B. WING		04/0	6/2017
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
VALLEY	CARE AND REHAB L	1 (-	I STREET SO /ILLE, MN 5	OUTHEAST, BOX 129		
(VA) ID	SLIMMADV STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	- NI	(VE)
(X4) ID PREFIX TAG	(EACH DEFICIENCY	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROL DEFICIENCY)	D BE	(X5) COMPLETE DATE
{2 830}	Continued From pa	ge 14	{2 830}			
	since the sores star ointment or cream a On 4/5/17, at 1:02 p	o.m. with family member				
	(FM)-A and R32, FI family had concerns adequate care to R member had spoke concerns. R32 state the staff too much be to lay in bed. R32 spainful for her and oburning sensation version (sever) on a numer had a difficult time of was having pain, he aware the sores on her. R32 stated she in her body such as stated she received was effective some	M-A stated in the past the swith the facility providing 32, though felt another family on with staff regarding their ed she did not like to bother by asking for things and liked tated her bottom was very described the pain as a which she rated an 8-10 ic pain scale. R32 stated she explaining to staff where she bwever, she felt staff was her bottom were painful for e had ongoing pain elsewhere is her back, and joints and it of the time. R32 stated she her types of pain interventions				
	(non-pharmacologic she still had significated it was better sin hospital. R32 stated changes in her care hospital.	cal). R32 stated that although eant pain from the sores, she ce her return from the d she was unaware of any e since her return from the				
	p.m. FM-B indicated sores on her bottom nurse had explained were a common restated she felt R32 developed a serious confused and disort had voiced her confused sort sort sort sort sort sort sort sort	interview on 4/5/17, at 1:14 d she was aware R32 had in February and stated the d to her at that time that sores sult of incontinence. FM-B continued to decline, is cough, and had become iented. FM-B stated she again cerns to facility staff and was ipdated with any changes.				

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AND DIAN OF CODDECTION IDENTIFICATION NUMBER		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
			A. BUILDING:			
		00968	B. WING		04/0	⊰ 96/2017
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
VALLEY	CARE AND REHAB L	1 (=	I STREET SO /ILLE, MN 5	OUTHEAST, BOX 129 6514		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
{2 830}	Continued From pa	age 15	{2 830}			
	On 4/6/17, at 9:08 a required extensive except for eating. Now with checking and every two hours and both bowel and blacomplained of pain felt it was due to the NA-C stated R32 happroximately two been open and blee R32 used to use the become too painful it. NA-C stated since hospital, there have on 4/6/17, at 10:33 always incontinent required routine, exchange. NA-A stated allowing staff to conform the foliated prior to R32's constant stooling in had soft incontinent developed sores and mid-February and I times. NA-A stated all peri-rectal hygie sores. NA-A stated since R32's return R32 continued to his tated she was unaplan of care since hindicated a couple indicated a couple ind	a.m. NA- C stated R32 assistance all of her cares, IA-C stated R32 was assisted changing her incontinent brief d was always incontinent of dder. NA-C stated R32 with all peri-rectal cares and e sores on her peri-rectal area. ad the peri-rectal sores for months and the sores had eding at times. NA-C stated e bedpan, however it had for her so they no longer used e R32 had returned from the e been no changes in her care. 9 a.m. NA-A stated R32 was of bowel and bladder and very two hour check and ed R32 was compliant with mplete checking and changing orief. NA-A stated R32 used to eximately three to four months since R32's health has red a full mechanical lift. NA-A s hospitalization, she had her brief, and at present R32 t stools. NA-A stated R32 cound her peri-rectal area had been open and bleeding at R32 complained of pain with he, and felt it was due to the felt the sores had improved from the hospital, though felt ave pain with cares. NA-A aware of any changes in R32's her hospital return. NA-A of the NAs had considered heive pain medication prior to				

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AND BLAN OF CORRECTION \ IDENTIFICATION NUMBER:		, ,	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED	
			A. BUILDING:			_
		00968	B. WING		04/0	₹ 16/2017
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
VALLEY	CARE AND REHAB L	1 (=	I STREET SO /ILLE, MN 5	OUTHEAST, BOX 129 6514		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
{2 830}	morning cares wou had not discussed: On 4/6/17, at 11:08 (LPN)-A stated R32 started out as red le barrier cream. LPN pinpoint open areas to her hospitalization unsure of how mantime. She felt R32's improving since he LPN-A stated in the the hospital in Marcincrease in bowel in stated R32 currentl Tramadol (non-opic pain and every 4 he stated the schedule started on 3/21/17, She stated prior to R32 had only PRN stated she felt R32 pain from the perischeduled Tramadol On 4/6/17, at 11:25 stated she was awaredness prior to he however was not at her peri-rectal area aware the area was stated she was resweekly wound assecompleted a compifor R32's peri-rectar return on 3/21/17, (wounds were first restated R32 had 4 on the stated R32 had 4 on the	age 16 Ild help R32 with her pain, but this with the nurse at present. Is a.m. licensed practical nurse 2's peri-rectal wounds had esions that were treated with a 1-A stated R32 had small is in the peri-rectal region prior on in March, though was any areas were open at that is peri rectal sores have been in return from the hospital. It weeks before R32 went to ch, R32 had experienced an incontinence. LPN-A further by received scheduled bid analgesic) twice daily for ours as needed (PRN.) LPN-A and dosing for Tramadol was following her hospitalization. being hospitalized on 3/14/17, Tramadol and Tylenol. LPN-A continued to have frequent rectal sores, though felt the following paid and peri-rectal rectal sores, though felt the following hospitalization on 3/14/17, ware R32 had peri-rectal rectal sores in as RN-A stated she had been as reddened and sore. RN-A ponsible for the facility's essments and had not rehensive wound assessment all wounds until her hospital (30 days after R32's peri-rectal noted). At that time RN-A pen areas in her peri-rectal tiside and 2 on the right side of	{2 830}			

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AND BLAN OF CORRECTION (IDENTIFICATION NUMBER:		` '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
			A. BUILDING:			,
		00968	B. WING		04/0	[{] 6/2017
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
VALLEY	CARE AND REHAB L	1 (=	ISTREET SO /ILLE, MN 5	OUTHEAST, BOX 129 6514		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
{2 830}	of correction from to improve the facility' monitoring. RN-A schance to complete assessment for R3 she was hospitalized recent assessment peri-rectal wounds hospital return. RN R32's peri-rectal wobowel incontinence any changes made changing routine at R32 had been compain and felt it was sores. RN-A stated medications schediwere effective. During observation director of nursing R32's room to compuiet, lying in bed to with a blanket. The from over R32 and her left side. R32 at turned. RN-A process around R32's open areas on the measured approximately 0.3 composition of the second approx	stated part of the facility's plan he recent survey was to a swound assessments and tated she had not had a a comprehensive wound 2's peri -rectal wounds before and indicated the most as he had completed for R32's was on 3/23/17, after R32's land stated she felt the cause of bounds was both urinary and and stated there had not been at to R32's checking and at that time. RN-A further stated plaining of frequent buttocks it was due to the peri-rectal R32 now had oral pain uled and prn, which she felt on 4/6/17, at 1:42 p.m. the (DON) and RN-A entered aplete wound care. R32 was allted on her left side, covered DON removed the blanket assisted R32 to turn fully on bruptly groaned when she was beeded to visualize the open as rectum and stated R32 had 2 left side of her rectum which mately 1.7 cm by 1.2 cm by 0.3 dopen area measured cm by 0.4 cm and had no ted the previous 2 open areas and the side were now only red, she elt those areas had healed. Led to apply an ointment to all 4 R32 continued to groan while cares and applied the	{2 830}			

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AND DUAN OF CODDECTION DEPARTMENT AT AN AREA		(X2) MULTIPLE CONSTRUCTION (X: A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		00968	B. WING		F 04/0	? 6/ 2017
NAME OF	PROVIDER OR SUPPLIER		I.	STATE, ZIP CODE	1 01/0	0/2011
VALLEY	CARE AND REHAB L	1 (=	I STREET SO /ILLE, MN 5	OUTHEAST, BOX 129 6514		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETE DATE
{2 830}	Continued From pa	ge 18	{2 830}			
	3/31/17, revealed the -On 2/20/17, R32 he pain and knee pain R32's buttocks was and a cream was a	ogress notes from 2/20/17, to ne following: ad complained of buttocks . The note further revealed a red and bleeding in areas pplied. The note indicated R32 ed to get off her buttocks				
	red rash, bleeding i and A&D ointment v indicated R32 had o difficulty with transfe to off load more often number of open are wounds. The note of	erfly wound around the anus, in some areas was observed was applied. The note complained of pain, had ers and should be encouraged en. The note lacked the eas and measurements of the did not indicate non in interventions for R32's				
	bowel and bladder, and irritated. The no around her rectal a rated her pain at an	ated R32 was incontinent of and her rectal area was red be revealed R32 had pain rea that was constant and had a 8 on a numeric scale. The received Tylenol for the pain				
	completed with R32 reported constant p surrounding skin, ra stated the Tylenol w the pain away. A la complained of pain moving, pain in che note revealed R32	interview had been 2, which revealed she had ain in her rectum and ated the pain at an 8 and yould help but it did not take ter note revealed R32 had in her buttock with sitting and est, ribs and abdomen. The had rated the pain at a 10, lid not get relief from Tylenol.				

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STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				X3) DATE SURVEY COMPLETED	
		00000	B. WING		F		
		00968	b. WING		04/0	6/2017	
NAME OF	PROVIDER OR SUPPLIER		, ,	STATE, ZIP CODE			
VALLEY	CARE AND REHAB L	1 ('	ISTREETS! ILLE, MN 5	OUTHEAST, BOX 129 6514			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE	
{2 830}	Continued From pa	ge 19	{2 830}				
	requested somethir revealed the DON has physician and obtain milligrams (mg) even for the medication and time she has had revealed a new cus wheelchair.	dicated R32 and her family had any more for pain. A later note had contacted R32's primary ned an order for Tramadol 50 ery 4 hours with a maximum of the revealed R32 had received had stated this was the first elief from the pain. The note hion had been placed in R32's					
	bladder. The note in had diffuse red stre bleeding. The note encourage R32 not periods, turn and re use prn Tramadol a	ras incontinent of bowel and indicated R32's peri-rectal area aking, was intact and had no indicated staff were to sit in wheelchair for prolonged eposition every 2 hours and and zinc-oxide. The notes e physician would be notified morning.					
	bladder and had co rectum was red and of prn Tramadol for further note indicate Diflucan (anti-funga	ras incontinent of bowel and mplained of rectal pain, her dirritated and received a dose complaints of overall pain. A ed Diflucan had been started. It) had been ordered every day ery other day thereafter.					
	bladder and the skil her rectum. The no complained of pain received Tramadol	to treat hemorrhoids) were					
	bladder and had an	is incontinent of bowel and open wound on her buttock blained of pain in her back					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE COMP	SURVEY LETED
		00968	B. WING		04/0	R 9 6/2017
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE	•	
VALLEY	CARE AND REHAB L	I (=	STREET SO	OUTHEAST, BOX 129 6514		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
	interview had been revealed R32 repor buttocks area, rated note further reveale	A further note indicated a pain completed with R32, which ted constant pain in her d a 7 on a numeric scale. The d barrier cream, am were used at that time.				
	red, raw and wet. T other characteristics later note revealed	outtocks area was noted to be he note did not identify any s of R32's peri-rectal area. A R32 was incontinent of bowel d complained of buttocks				
		d R32 was incontinent of and her peri-rectal area was				
	crease of her buttoo	d R32 had open skin on the cks, was red, open and indicated R32 complained of am was applied.				
		omplained of pain in her ed barrier cream and				
	-On 3/12/17, R32's and barrier cream h	buttocks remained excoriated ad been applied.				
	-On 3/13/17, R32 re over pain.	eceived pain medication for all				
	R32's peri-rectal wo with worsening pain Tramadol and Tylen Diflucan. R32's reco physician had been	nical progress notes indicated bunds continued to worsen, a despite the use of as needed not and a scheduled dose of ord lacked documentation the notified of the worsening ning pain reports for R7.				

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	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
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NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
VALLEY	CARE AND REHAB L	1 (-	I STREET SO /ILLE, MN 5	OUTHEAST, BOX 129 6514		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
{2 830}	hospital on 3/15/17 -R32's medical records are record	al record lacked had been admitted to the had been admitted to the definition of the hospital. However, a note on the hospital. However, a note on the yand had been assisted to dentry for 3/21/17, indicated ician had been updated on the relation, and open areas to definition and open areas to describe a policy of the primary peri-rectal area, the note unds were showing the note further revealed R32's so to remain in place as her to heal. The property of the primary perison of the property of the primary perison of the property of the primary perison of the property of the property of the primary of the property of the primary o	{2 830}			
		w up of "skin ulcer" and tinue current therapy as				

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED	
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		00968	B. WING		04/0	6/2017
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
VALLEY	CARE AND REHAB L	1 (-	I STREET SO /ILLE, MN 5	OUTHEAST, BOX 129 6514		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
{2 830}	Continued From pa	ge 22	{2 830}			
	ordered.					
	completed with R32 daily, almost consta a 7 out of 10 on a r scheduled and PRI -On 3/31/17, R32 if pain and had no rerevealed R32 had r urinary catheter. The catheter had been The note indicated catheter removal, a abdominal pain. The would be monitored identify whether R3	interview had been 2 and revealed R32 reported ant pain of her buttocks, rated numeric scale and indicated N medications were effective. Inad complained of abdominal lief from Tramadol. The note no urinary output from her ne note further revealed R32's removed and not replaced. R32 had voided following the and expressed relief from the e note indicated R32's briefs of for wetness. The note did not 2's physician had ordered oval or if R32's physician had removal.				
		spitalization records from identified the following:				
	diagnoses which in of dehydration, care fibrillation. A hospit R32 presented to the multiple open wour inner buttocks. The was referred to a w	admitted to the hospital with cluded: lack of water as cause diomyopathy and atrial al note dated 3/14/17, revealed he hospital lethargic, with lads and significant pain to note further revealed R32 round specialist and was nous Tramadol (non-opioid				
	completed an asse area which reveale area measured 1.5	seled the hospital wound nurse ssment of R32's peri-rectal d the following: left peri-rectal cm by 1.5 cm by 0.7 cm and ple small scattered wounds,				

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	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00069	5 11/11/6		F 04/0	
		00968			04/0	6/2017
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE DUTHEAST, BOX 129		
VALLEY	CARE AND REHAB L	1 (-	ILLE, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETE DATE
{2 830}	of serosanguinous R32's peri-rectal uld from incontinence. Foley urinary cather Peru and castrol oil blood flow and prev Mepilex (dressing utrauma to the woun border foam dressin note revealed R32 pain of her buttocks Fentanyl (opioid an manage R32's pain -On 3/16/17, reveal discussed with R32 upon due to R32's plife. A further note reimprovement of pain rolluded Hospice set to the facility with the further perineal ulceincontinence. -On 3/20/17, R32 whospital and returned returned to the facility with the further perineal ulceincontinence. -On 3/20/17, R32 whospital and returned returned to the facility with the further perineal ulceincontinence. -On 3/20/17, R32 whospital and returned returned to the facility with the further perineal ulceincontinence. -On 3/20/17, R32 whospital and returned returned to the facility with the further perineal ulceincontinence. -On 3/20/17, R32 whospital and returned returned to the facility with the further perineal ulceincontinence. -On 3/20/17, R32 whospital and returned returned to the facility with the further perineal ulceincontinence. -On 3/20/17, R32 whospital and returned returned to the facility with the further perineal ulceincontinence. -On 3/20/17, R32 whospital and returned returned to the facility with the further perineal ulceincontinence.	wound bases, small amount drainage. The note indicated cers were caused by moisture The note revealed R32 had a ter placed, Venelex (Balsam topical, used to increase cent bacteria,) ointment and a used to minimize pain and d and surrounding skin,) ng for prevention. A further continued to have significant s, and intravenous (IV) algesic) was required to	{2 830}			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			A. BUILDING.		F	2
		00968	B. WING			6/2017
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
VALLEY	CARE AND REHAB L	1 (-	I STREET SO /ILLE, MN 5	OUTHEAST, BOX 129 6514		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
{2 830}	peri-rectal area at they were more like she felt the cause of was moisture, as a and bladder. She completed identified R32's per confirmed the tool I characteristics of the expected R32's per weekly and stated shoursing staff on improvement of the DON confirmed considered any characteristics of the poly confirmed considered any characteristics of the expected R32's per weekly and stated shoursing staff on improvement plans were first document stated she felt R32 to the peri-rectal work had managed R32'. Further, the DON shad been notified of 2/26/17, and Trama administered as ne felt R32 was responded to a scheduled pain regiment. The staff to offer non-phinterventions in additional confirmed R32 documentation of non interventions atternistated she was away was given to R32 his she was away was given to R32 hi	y open areas R32 had in her hat time, and stated she felt skin tears. The DON stated of R32's peri rectal wounds result of incontinence of bowel onfirmed a Skin Observation d on 3/10/17, which had also i-rectal wounds. The DON acked measurements and any ne wounds. She stated she rectal wound to be monitored she had been working with her proving pain management and as, monitoring and treatment. If the facility had not an any ne wounds in R32's incontinence since the peri-rectal wounds ted on 2/20/17. The DON had experienced pain related bunds and she felt the facility is pain appropriately. Itated R32's primary physician of an increase in R32's pain on adol had been ordered to be eded. The DON indicated she nisible to ask for pain she felt she needed them. The ility had not considered a iment to aid in R32's pain DON stated she would expect narmacological pain lition to pain medication to R32 is medical record lacked on-pharmacological pited for R32's pain. The DON are the pain medication that ad not always been effective.				

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STATEMENT OF DEFICIENCIES (X1)

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			A. BUILDING.		F	,
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NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
VALLEY	CARE AND REHAB L	1 (:	I STREET SO /ILLE, MN 5	OUTHEAST, BOX 129 6514		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
	facility nurse. She of physician had not go been notified of R3: until 4/4/17. The D0	3/31/17, by herself and another confirmed R32's primary liven an order to nor had he 2's Foley catheter removal DN stated the facility's usual onotify and obtain physicians				
	order for the cathet On 4/6/17, at 12:19 was left for R32's p					
	interview, R32's pricould not recall who R32's peri-rectal wo stated he would have complete a compreidentify a potential continually monitor	p.m. during a telephone mary physician indicated he ether he had been notified of bunds. R32's primary physician we expected the facilty to hensive assessment to cause, interventions and to any changes in condition -rectal sores, pain and				
		edication Administration February 2017, to March following:				
	order dated 11/18/1 mouth every 4 hour exceed 4000 mg in revealed an order of mg by mouth every pain, with a max of MAR identified the effective.	February MAR revealed an 6, for Tylenol 1000 mg by 15 as needed for pain, not to 24 hours. The MAR further lated 2/26/17, for Tramadol 50 4 hours as needed for severe 6 tablets in 24 hours. The medications were not always				
		larch MAR revealed R32 had rpain rated from a 7 to a 9				

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING:	(X3) DATE SURVEY COMPLETED
00968 B. WING	R 04/06/2017
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE	·
VALLEY CARE AND REHAB LLC 600 FIFTH STREET SOUTHEAST, BOX 129 BARNESVILLE, MN 56514	
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCE	AN OF CORRECTION (X5) VE ACTION SHOULD BE ED TO THE APPROPRIATE ICIENCY) (X5) COMPLETE DATE
(severe pain) on four times with varying results. The MAR revealed R32 had received Tramadol PRN for pain rated from 5-6 (moderate pain) until 3/10 then 8-10 (severe pain) PRN 23 times with varying effectiveness. Review of R32's Treatment Administration Records (TAR) from February 2017, to April 6th, 2017, revealed the following; -R32's February TAR revealed an order dated 2/27/17, for Barrier cream to peri-rectal area for moisture associated skin damage (MASD.) encourage resident to be off buttocks, turn and reposition every 2 hours. The TAR revealed an order dated 12/29/16, to complete skin/wound note and pain note every day shift Thursday for skin and pain. -R32's March TAR revealed an order dated 2/28/17, to ensure R32 was toileted every 2 hours while awake every day and evening related to dermatitis. The TAR revealed R32 continued to receive barrier cream to peri-rectal area for MASD, encourage resident to be off buttocks, turn and reposition every 2 hours. -R32's April TAR revealed an order dated 3/16/17, to complete skin and wound note every day shift for skin and pain. The TAR identified 3 of the 4 assessments were not completed. The TAR revealed an order to continue to turn and reposition R32 off of buttocks every 2 hours every shift for moisture associated open areas. Review of a physician progress note dated 2/21/17, revealed R32 was seen for a routine visit. The note revealed R32 had progressive weakness, weight gain and deconditioning. The note indicated R32 was to be seen again in 2	

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	SURVEY	
			A. BUILDING:			
		00968	B. WING		04/0	1 06/2017
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
VALLEY	CARE AND REHAB L	1 (-	I STREET SO /ILLE, MN 5	OUTHEAST, BOX 129 6514		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
{2 830}	Continued From pa	ge 27	{2 830}			
	weeks or sooner. T	The note did not identify R32's lad assessed R32's peri-rectal				
	3/4/17, identified the properly identify an at risk for impaired procedure identified assessment and m with any new skin is physician would be kept appraised of a	policy and procedure revised e facility's purpose was to a dassess residents that were skin integrity. The policy and an ongoing wound onitoring would be completed ssues and the primary notified of the condition and any changes.				
2 910	requested on 4/6/17	7, and not provided. 5 Subp. 5 A.B Rehab -	2 910			5/8/17
	Subp. 5. Incontined have a continuous produced management to recomprehensive results home must ensure A. a resident without an indwelling unless the resident that catheterization B. a resident where the receives appropriate prevent urinary traces.	nce. A nursing home must program of bowel and bladder duce incontinence and the f catheters. Based on the ident assessment, a nursing that: ho enters a nursing home ag catheter is not catheterized is clinical condition indicates was necessary; and no is incontinent of bladder the treatment and services to infections and to restore as the infection as possible.				
	This MN Requireme	ent is not met as evidenced				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPI A. BUILDING	LE CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		00968	B. WING		04/0	R 06/2017
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY,	STATE, ZIP CODE	-	
VALLEY	CARE AND REHAB L	1 (=	I STREET S /ILLE, MN 5	OUTHEAST, BOX 129 56514		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 910	by: Based on observation review, the facility for re-assess bowel incomposition and	on, interview and document ailed to comprehensively continence following onset of d skin breakdown (MASD) for 2) reviewed with a change in . arterly Minimum Data Set 6, identified R32 had impairment and had a cluded non-infective colitis. The MDS identified sive assistance with toileting incontinent of bowel. arterly MDS dated 3/3/17, moderate cognitive impairment is of non-infective colitis. The MDS identified equire extensive assistance nal hygiene and R32 was now of bowel. re plan revised 3/28/17, red extensive assistance with and was incontinent of bowel d physical limitations. R32's acility staff to check R32 every with toileting as needed, mmode and to provide peri	2 910	corrected		

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ,	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		00968	B. WING			R 06/2017
NAME OF	PROVIDER OR SUPPLIER		DRESS. CITY. S	STATE, ZIP CODE	1 0 1/0	0,2011
VALLEY	CARE AND REHAB L	I C 600 FIFTH	STREET SO	OUTHEAST, BOX 129		
VALLET	OANE AND HENAD E	BARNES	/ILLE, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHO) CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
2 910	Continued From pa	ge 29	2 910			
2 910	The form identified incontinent of stool, barrier cream to so Review of R32's Bla Evaluation dated 2/incontinent of bowe assessment indicat onset of bowel inco the past six months 2-5 years. The asse of R32's bowel mov revealed R32's peri No further Bladder/forms were found in the change in frequicausing MASD. During observation was seated in a whom the stool of the stool of the change in frequicausing MASD.	R32 was frequently and to contact nurse for re on bottom. adder/Bowel Continence 19/17, revealed R32 was	2910			
	with cares and procoroom. At that time a full mechanical lift wheelchair with the R32 if she was sore NA-B and NA-A asset the mechanical lift. down on the bed, RNA-A proceeded to incontinent brief. R3 moderate amount of amount of formed, so NA-A stated R32 was and bladder and the were typical for R32 wipe the stool away with a wet wipe. At	eeded to wheel R32 assistance beeded to wheel R32 to her NA-B entered R32's room with at the lift, R32 groaned. NA-A asked and R32 responded she was sisted R32 over to the bed with As NA-B and NA-A laid R32 as groaned again. NA-B and remove R32's slacks and R32 was incontinent of a furine and a moderate soft, sticky bowel. At that time, as always incontinent of bowel as characteristics of the bowel as NA-A then proceeded to a from R32's peri-rectal area that time, a deep guttural and from R32. NA-B patted				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					DATE SURVEY COMPLETED	
		00968	B. WING		04/0	R 06/ 2017
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE	<u>, </u>	0.2011
VALLEY	CARE AND REHAB L	I (=	I STREET SO	OUTHEAST, BOX 129		
(VA) ID	CHMMA DV CTA	TEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF CORRECTI	ON	(VE)
(X4) ID PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 910	Continued From pa	ge 30	2 910			
	done shortly. R32 g peri-rectal cleansing were often sticky ar R32's buttocks had peri-rectal area, two o'clock position and and 3 o'clock positio	reassured her they would be roaned throughout the g. NA-A stated R32's bowel and hard to wipe off her skin. If four open areas on her on the left side at the 8 two on the right side at the 2 on. NA-A stated before R32				
	went to the hospital than 4 open areas was tated she felt R32 open areas. NA-A ta plastic cup to all formouned during the had obtained the oil was to help heal the proceeded to apply her slacks and assisposition. R32 expredone and stated she	in March, she had had more which would bleed. NA-A had a lot of pain from the then applied an ointment from our of R32's open areas. R32 application. NA-A stated she at the open areas. NA-A and NA-B a clean brief to R32, pulled up sted to her to a right side lying ssed relief the cares were e wanted to sleep.				
	needed assistance eating and drinking. indwelling urinary car from the hospital arrecently been remo always incontinent of a brief daily. NA-B change R32 every thange R32 every thange R32 every thange R32 us bowel movements a peri-rectal area dew was too painful for I because of the sore been no changes to program since the s	a.m. NA-B stated R32 with all of her cares except for NA-B stated R32 had an atheter when she returned and stated R32's catheter had wed. NA-B stated R32 was of bowel and bladder and wore stated staff were to check and wo hours for incontinence. sed to use the bedpan for pefore the sores on her eloped and stated she felt it R32 to use the bedpan as. NA-B stated there have a R32's check and change sores started, other than r cream after incontinence.				

6899

Minnesota Department of Health

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				DATE SURVEY COMPLETED	
			D WING		F		
		00968	B. WING		04/0	6/2017	
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE			
VALLEY	CARE AND REHAB L	I (=	I STREET SO /ILLE, MN 5	OUTHEAST, BOX 129 6514			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE	
2 910	R32's health had be months. NA-A state of bowel and bladde two hour check and R32's hospitalizatio her brief, and at prestools. NA-A stated allowing staff to conformed the incontinent bunaware of any chasince her hospital results of R32's checking at time. RN-A further scomplaining of frequency was it was due to the On 4/6/17, at 11:56 (DON) confirmed R assessment indicate incontinence. The E of R32's peri rectal result of incontinence the any changes in R32 plan since the peridocumented on 2/2 A policy and proced assessment and mand not provided.	a.m. NA-A stated felt that een declining in the last few d R32 was always incontinent er and required routine, every change. NA-A stated prior to n, she had constant stooling in esent R32 had soft incontinent R32 was compliant with inplete checking and changing rief. NA-A stated she was anges in R32's plan of care eturn. a.m. registered nurse (RN)-A stated of R32's peri-rectal rinary and bowel incontinence d not been any changes made and changing routine at that stated R32 had been uent buttocks pain and felt it in peri-rectal sores. a.m. the director of nursing 32's most recent bowel ed an increased in bowel DON stated she felt the cause wounds was MASD, as a coof bowel and bladder. The facility had not considered 2's incontinence management rectal wounds were first 0/17. Jure for incontinence anagement was requested,	2 910				
		HOD OF CORRECTION: The DON) or designee could					

6899

Minnesota Department of Health

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			71. BOILDING.		F	.
		00968	B. WING			6/2017
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
VALLEY	CARE AND REHAB L	1 (-	I STREET SO ILLE, MN 5	OUTHEAST, BOX 129 6514		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 910	Continued From pa	ge 32	2 910			
	comprehesnively as	uce bowel incontinence, and				
	TIME PERIOD FOR (21) days.	R CORRECTION: Twenty-one				

Minnesota Department of Health

			STAT	E FORM: REV	/ISIT R	EPORT				
	ER / SUPPLIER / CLIA / CATION NUMBER	MULTIPLE CON A. Building B. Wing	ISTRUCTIC	N				Y2	DATE 4/6/20	OF REVISIT
NAME O	F FACILITY CARE AND REHAB LI					ADDRESS, C		, ZIP CODE		13
VALLET						VILLE, MN 56				
correctiv	ort is completed by a S re action was accomplisation prefix code previorm).	shed. Each de	ficiency sho	ould be fully identi	ified usir	ng either the	regulation	or LSC provisio	n numb	er and the
ITE	М	DATE	ITEM	I		DATE	ITEM			DATE
Y4		Y5	Y4			Y5	Y4			Y5
ID Prefix	20565	Correction	ID Prefix	20900	(Correction	ID Prefix	21390		Correction
Reg. #	MN Rule 4658.0405 Subp. 3	Completed	Reg. #	MN Rule 4658.052 Subp. 3	25 (Completed	Reg. #	MN Rule 4658.08 Subp. 4 A-I	300	Completed
LSC	-	03/13/2017	LSC		C	03/13/2017	LSC			04/06/2017
ID Prefix	21426	Correction	ID Prefix		(Correction	ID Prefix			Correction
Reg. #	MN St. Statute 144A.04 Subd. 3	Completed	Reg. #		(Completed	Reg. #			Completed
LSC		04/06/2017	LSC				LSC			_
ID Prefix		Correction	ID Prefix		(Correction	ID Prefix			Correction
Reg. #		Completed	Reg. #		(Completed	Reg. #			Completed
LSC		=	LSC				LSC			_
ID Prefix		Correction	ID Prefix		(Correction	ID Prefix			Correction
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LSC		_	LSC				LSC			
ID Prefix		Correction	ID Prefix		(Correction	ID Prefix			Correction
Reg. #		Completed	Reg. #		(Completed	Reg. #			Completed
LSC		_	LSC	_			LSC			_

REVIEWED BY (INITIALS)

DATE

TITLE

DATE

FOLLOWUP TO SURVEY COMPLETED ON 2/10/2017

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

SIGNATURE OF SURVEYOR

31256

DATE

04/06/2017

Χ

REVIEWED BY

(INITIALS) GA/mm

DATE

04/25/2017

REVIEWED BY

STATE AGENCY

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

ID: NQV4

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

<u>. </u>	PART I -	TO BE COMPI	LETED BY T	THE STAT	TE SURVEY AGEN	ICY		Fac	cility ID: 00968
MEDICARE/MEDICAID PROVID (L1)		3. NAME AND ADDRESS OF FACILITY (L3) VALLEY CARE AND REHAB LLC (L4) 600 FIFTH STREET SOUTHEAST, BO (L5) BARNESVILLE, MN			BOX 129 (L6) 56514	4. TYPE (1. Initial 3. Termin 5. Valida 7. On-Sit	nation tion	2 (L8) 2. Recertification 4. CHOW 6. Complaint 9. Other	
5. EFFECTIVE DATE CHANGE OF $(L9) \textbf{11/01/2015}$	OWNERSHIP	7. PROVIDER/SU 01 Hospital	JPPLIER CATEG 05 HHA	ORY 09 ESRD	02 (L7) 13 PTIP 22 C	LIA		urvey After C	
6. DATE OF SURVEY 02/19 8. ACCREDITATION STATUS: 0 Unaccredited 1 TJC 2 AOA 3 Other	0/2017 (L34) (L10)	02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	06 PRTF 07 X-Ray 08 OPT/SP	10 NF 11 ICF/IID 12 RHC	14 CORF 15 ASC 16 HOSPICE		FISCAL YE.	AR ENDING	G DATE: (L35)
11LTC PERIOD OF CERTIFICATIO From (a): To (b): 12.Total Facility Beds 13.Total Certified Beds	35 (L18) 35 (L17)	Compliance	equirements e Based On:		And/Or Approved Wa 2. Technical P 3. 24 Hour RN 4. 7-Day RN (5. Life Safety	ersonnel I Rural SNI	6. S 7. M 8. P	Requirement cope of Serv ledical Direc atient Room S	ices Limit
13. Total Certified Beds	35 (E17)		and/or Applied V	_	* Code: B*		(L12)		
14. LTC CERTIFIED BED BREAKDO 18 SNF 18/19 SNF 35	OWN 19 SNF	ICF	IID		15. FACILITY MEETS 1861 (e) (1) or 1861 ((I	L15)	
(L37) (L38)	(L39)	(L42)	(L43)						
16. STATE SURVEY AGENCY REM	IARKS (IF APPLICA	ABLE SHOW LTC CA	ANCELLATION I	DATE):					
17. SURVEYOR SIGNATURE		Date :			18. STATE SURVEY A	GENCY A	APPROVAL		Date:
Tammy Williams, HFE	NEII		04/14/2017	(L19)	Mark Mes	th,	Enforceme	nt Specialis	o4/17/2017
PA	RT II - TO BE	COMPLETED I	BY HCFA RE	EGIONAI	OFFICE OR SIN	GLE ST	TATE AGE	NCY	
19. DETERMINATION OF ELIGIBIDE _X 1. Facility is Eligible to 1 2. Facility is not Eligible	Participate		IPLIANCE WITH	H CIVIL	21. 1. Statemer 2. Ownersh 3. Both of t	ip/Control	Interest Disclo		CFA-1513)
22. ORIGINAL DATE	23. LTC AGREEN	MENT 24	4. LTC AGREEN	MENT	26. TERMINATION A	CTION:		(L3	30)
OF PARTICIPATION 07/01/1985	BEGINNING	DATE	ENDING DA	ГЕ	VOLUNTARY 01-Merger, Closure	00		INVOLUNT 05-Fail to Me	ARY eet Health/Safety
(L24)	(L41)		(L25)		02-Dissatisfaction W/ R			06-Fail to Me	eet Agreement
25. LTC EXTENSION DATE: (L27)	•	n of Admissions:	(L44)		03-Risk of Involuntary T 04-Other Reason for Wit			OTHER 07-Provider S 00-Active	Status Change
	D. Rescilla St	uspension Date:	(L45)						
28. TERMINATION DATE:	29	. INTERMEDIARY	CARRIER NO.		30. REMARKS				
		06201							
	(L28)			(L31)					
31. RO RECEIPT OF CMS-1539	32	. DETERMINATION	I OF APPROVAL	DATE					

(L33)

DETERMINATION APPROVAL

(L32)



PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered March 2, 2017

Mr. Mark Rustad, Administrator Valley Care And Rehabilitation LLC 600 Fifth Street Southeast, Box 129 Barnesville, Minnesota 56514

RE: Project Number S5281

Dear Mr. Rustad:

On February 10, 2017, 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 isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G), as evidenced by the attached CMS-2567, whereby significant corrections are required. A copy of the Statement of Deficiencies (CMS-2567 and/or Form A) is enclosed.

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

<u>No Opportunity to Correct</u> - the facility will have remedies imposed immediately after a determination of noncompliance has been made;

<u>Remedies</u> - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS);

Appeal Rights - the facility rights to appeal imposed remedies;

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

<u>Potential Consequences</u> - the consequences of not attaining substantial compliance 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:

Gail Anderson, Unit Supervisor
Fergus Falls Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Email: gail.anderson@state.mn.us

Phone: (218) 332-5140 Fax: (218) 332-5196

NO OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of September 1, 2016, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when they have deficiencies of actual harm or above cited. The current survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G. Your facility meets the criterion and remedies will be imposed immediately. Therefore, this Department is imposing the following remedy:

• State Monitoring effective March 7, 2017. (42 CFR 488.422)

This Department recommended the enforcement remedy listed below to the CMS Region V Office for imposition:

• Civil money penalty for the deficiency cited at F314. (42 CFR 488.430 through 488.444)

In addition, Sections 1819(h)(2)(D) and (E) and 1919(h)(2)(C) and (D) of the Act and 42 CFR 488.417(b) require that, regardless of any other remedies that may be imposed, denial of payment for new admissions must be imposed when the facility is not in substantial compliance 3 months after the last day of the survey identifying noncompliance. Thus, the CMS Region V Office concurs, is imposing the following remedy and has authorized this Department to notify you of the imposition:

• Mandatory denial of payment for new Medicare and Medicaid admissions, effective May 10, 2017 (42 CFR 488.417 (b))

The CMS Region V Office will notify your fiscal intermediary that the denial of payment for new admissions is effective May 10, 2017. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective May 10, 2017. You should notify all Medicare/Medicaid residents admitted on or after this date of the restriction.

Furthermore, Federal law, as specified in the Act at Sections 1819(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to a denial of payment. Therefore, Valley Care and Rehabilitation LLC is prohibited from offering or conducting a Nurse Assistant Training/Competency Evaluation Programs or Competency Evaluation Programs for two years effective May 10, 2017. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions. If this prohibition is not rescinded, under Public Law 105-15 (H.R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

The CMS Region V Office will notify you of their determination regarding our recommendations, Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) prohibition.

APPEAL RIGHTS

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40, et seq. You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at https://dab.efile.hhs.gov no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

Tamika.Brown@cms.hhs.gov

Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted as of October 1, 2014, unless you do not have access to a computer or internet service. In those circumstances you may call the Civil Remedies Division to request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a written request for a waiver along with your written request for a hearing. A written request for a hearing must be filed no later than sixty (60) days after receiving this letter, by mailing to the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
(202) 565-9462

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Tamika Brown, Principal Program Representative by phone at (312) 353-1502 or by e-mail at Tamika.Brown@cms.hhs.gov.

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

• 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 ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for their respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a revisit of your facility will be conducted to verify that substantial compliance with the regulations has been attained. The revisit 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 we will recommend that the remedies imposed be discontinued effective the date of the on-site verification. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

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 May 10, 2017 (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 August 10, 2017 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

Feel free to contact me if you have questions related to this eNotice.

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist Program Assurance Unit Licensing and Certification Program Health Regulation Division Minnesota Department of Health

Email: mark.meath@state.mn.us Telephone: (651) 201-4118

Fax: (651) 215-9697

PRINTED: 04/14/2017 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245281	B. WING		·····	02/	10/2017
	PROVIDER OR SUPPLIER CARE AND REHAB L	LC		60	REET ADDRESS, CITY, STATE, ZIP CODE 0 FIFTH STREET SOUTHEAST, BOX 129 ARNESVILLE, MN 56514		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 000	INITIAL COMMENT	rs	F 0	000			
	signature is not req page of the CMS-2	led in ePOC and therefore a uired at the bottom of the first 567 form. Electronic POC will be used as bliance.					
F 157	revisit of your facilit validate that substa		F 1	57			3/13/17
SS=D	(g)(14) Notification	,					
	consult with the res	mediately inform the resident; ident's physician; and notify, or her authority, the resident hen there is-					
		olving the resident which has the potential for requiring on;					
	mental, or psychosodeterioration in hea	ange in the resident's physical, ocial status (that is, a lth, mental, or psychosocial threatening conditions or ns);					
	a need to disconting treatment due to ac	treatment significantly (that is, ue an existing form of diverse consequences, or to orm of treatment); or					
	(D) A decision to tra	ansfer or discharge the					
A BODATODY	/ DIRECTOR'S OR PROVID	ER/SUPPLIER REPRESENTATIVE'S SIGN	JATURE		TITI F		(X6) DATE

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.

Electronically Signed

03/13/2017

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TPLE CONSTRUCTION NG		E SURVEY PLETED
		245281	B. WING		02/	10/2017
	PROVIDER OR SUPPLIER CARE AND REHAB L	LC	STREET ADDRESS, CITY, STATE, ZIP CO 600 FIFTH STREET SOUTHEAST, BO BARNESVILLE, MN 56514		ODE	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOOT CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 157	§483.15(c)(1)(ii). (ii) When making not (14)(i) of this section all pertinent informatics available and prophysician. (iii) The facility must resident and the resident (B) A change in roo as specified in §483. (B) A change in roo as specified in §483. (iv) The facility must update the address phone number of the This REQUIREMENT by: Based on observation review, the facility for a significant change resident (R32) whe pressure ulcer development and the required extensive daily living (ADLs). R32's admission M 12/1/16, identified Frequired extensive daily living (ADLs). R32 was at risk for	otification under paragraph (g) n, the facility must ensure that ation specified in §483.15(c)(2) wided upon request to the t also promptly notify the sident representative, if any, and or roommate assignment 3.10(e)(6); or ident rights under Federal or cions as specified in paragraph	F 1:	1. R32 has been seen by her physician with documentation of 2. All residents were reviewed in status. All residents are revidaily shift reports. Any resident have a status change; his/her or reported to their primary physic determination of further assess treatment. 3. Policies & procedures were and updated as needed. All numbave been re-educated on the report any changes noted in restatus. Licensed staff were furt	of the visit. for change ewed at who may condition is cian for a ment or reviewed rsing staff need to sident	

	ND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING		PLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		245281	B. WING		02/	10/2017	
	PROVIDER OR SUPPLIER CARE AND REHAB L	LC		STREET ADDRESS, CITY, STATE, ZIP COD 600 FIFTH STREET SOUTHEAST, BOX BARNESVILLE, MN 56514	E		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE	
F 157	R32 had diagnoses and peripheral eder R32's Care Area As 12/1/16, identified F pressure ulcers and CAA identified R32 chair for pressure r On 2/6/17, at 5:35 p (DON) stated R32 pressure ulcer on h On 2/8/17, at 7:12 a lying on her back in her torso and lower remained on her ba assistant (NA)-C er with morning cares that covered R32, be directly on a pillow, and a second pillow, and a second pillow, and a second pillow calves. R32's left h centimeter (cm) siz the heel, which had dark brown/black in center of the area we (non-viable yellow, tissue; usually mois mucinous in texture the base of the work.	device in her chair. Iders dated 11/17/16, identified is which included osteoporosis ma. Idesessment (CAA) dated required assessment. The required a cushion for her relief. Identified in the director of nursing had a current unstageable	F 15	educated on the need to verify changes in resident status and facility protocols for provider not a. The DON will monitor & revishift reports and required follow staff & providers as needed. The audits will be done daily for 90 until 100% compliance is achievable audit outcomes will be submitted QAA Committee for comment 5. Date of Completion: March	d follow otification. iew all daily w-up with hese daily days or eved. The ed to the &/or review.		
		ire scab. p.m. director of nursing was at risk for development of					

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONS	(X3) DATE SURVEY COMPLETED		
		245281	B. WING			02/	10/2017
	PROVIDER OR SUPPLIER CARE AND REHAB L	LC		600 FIFT	ADDRESS, CITY, STATE, ZIP CODE TH STREET SOUTHEAST, BOX 129 ESVILLE, MN 56514		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 157	record at that time and R32's previous preside indicated the facility pressure ulcer had tie up shoes. DON current pressure ulcerord lacked documonitoring, and indiffacility needed to in On 2/8/17, at 1:14 pure wheelchair in her reshoes on both feet. The surveyor in the pressure ulcer after shoe from R32's left current pressure ulcurent pressure ulcurrent pres	DN reviewed R32's clinical and stated the record indicated source ulcer had resolved. She had felt the previous been caused by R32's brown stated R32 did not have a cer. DON confirmed R32's mentation of weekly skin icated this was an area the	F 1	57			

	ATEMENT OF DEFICIENCIES D PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED		
		245281	B. WING		02/	10/2017		
	PROVIDER OR SUPPLIER CARE AND REHAB L	LC		STREET ADDRESS, CITY, STATE, ZIP COD 600 FIFTH STREET SOUTHEAST, BOX BARNESVILLE, MN 56514	E	10/2011		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	OULD BE	(X5) COMPLETION DATE		
F 157	R32 had a current of On 2/9/17, at 12:00 interview, R32's phi had developed a prinad seen the pressive He indicated he had current pressure ulder R32's progress not skin/wound docume 1/18/17 to 2/09/17, -1/8/2017, identified to left heel had closs side of both knees stomach. However, status of left heel progression of concern -1/26/2017, skin/wour concern -2/2/2017, skin/wour concern -2/9/17, ski	the survey team on 2/6/17 that unstageable pressure ulcer. I p.m. during a telephone ysician (MD)-A confirmed R32 ressure ulcer in December, sure ulcer last on 1/3/17, and e ulcer was healing at that time. It do not been notified of R32's cer. es which included all entation was reviewed from and revealed: I unstageable pressure ulcer sed. mall red dots on the front and and has redness at skin fold of the note did not address ressure ulcer. Ind note listed no areas of the und note listed no areas of the note listed no areas	F 15	7				
		ty policy, Prevention and						

-	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED
		245281	B. WING _		02/10/2017
	PROVIDER OR SUPPLIER CARE AND REHAB L	LC		STREET ADDRESS, CITY, STATE, ZIP CODE 600 FIFTH STREET SOUTHEAST, BOX 129 BARNESVILLE, MN 56514	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETION
F 157	pressure ulcer the find Braden Scale Asservature and the sevaluation of skin ribased on risk factor. Review of the facility dated 11/1/15, reversive for pressure ulcomples and the sevaluation of the word surrounding tissues changes, signs infering the electronic recomples and the sevaluation of the word surrounding tissues changes, signs infering the electronic recomples and the services provides outlined by the comples of the services provided by the comples of the services provided by the comples of the services provided by the comples of the services of the ser	sident developed a new racility would initiate a TTT, a sesment and complete an sk factors and reevaluate rs. By policy, Skin Assessment aled all residents identified at cers would be assessed by new alterations in skin also identified on residents ys the licensed nurse would toe skin assessment and note kin condition and document an bund, the status of and treatments, any ction and document findings cord. BYICES BY QUALIFIED ARE PLAN ive Care Plans led or arranged by the facility, omprehensive care plan,	F 15	57	s
	facility failed to imp	ssure ulcers. In addition, the lement skin monitoring related resident (R37) who currently		development have been reviewed a their plans of care updated as need assure appropriate turning, position	led to

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION G		E SURVEY PLETED
		245281	B. WING		02/	10/2017
	PROVIDER OR SUPPLIER CARE AND REHAB L	LC		STREET ADDRESS, CITY, STATE, ZIP CODE 600 FIFTH STREET SOUTHEAST, BOX 12: BARNESVILLE, MN 56514	E	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 282	received anticoagu Findings include: R20's care plan da at risk for altered si facility staff to assis (2) hours. R20's undated, nur indicated R20 requevery two hours. During continuous 7:10 a.m. to 10:12 - At 7:10 a.m. R20 with a seat cushion gown, with the TV of - At 7:47 a.m. R20 wheelchair in her re independent chang observed to offer Frepositioning or car - At 8:19 a.m. R20 wheelchair in her re time, nursing assis room, draped a hor that time NA-E ente blanket over R20's R20 to the dining re	lant therapy. ted 1/24/16, identified R20 was kin integrity and directed at R20 to reposition every two sing assistant care guide, ired turning and repositioning observation on 2/8/17, from am. revealed the following: was seated in a wheelchair in her room, wore a hospital on. remained seated in a com. R20 had not made any les in position, no staff were 120 assistance with res. remained seated in the com in a hospital gown. At that tant (NA)-D entered R20's usecoat over R20's chest. At lered R20's room, draped a lap and proceeded to wheel com. NA-D and NA-E were not	F 283	offloading activities are outlined. document turning, repositioning & offloading activities on each resic the individual resident care sheet All residents with noted bruising a residents that are at risk for bruis secondary to diagnosis, accident medication regimens have had a full body audit, identifying existing and the bruises' characteristics. O plans were updated with directed modalities or interventions for bru monitoring. Hereafter, all residen have full body audits on a schedu day. Resident skin conditions will additionally be monitored as need throughout the day during routine cares. 3. DON or designee will review a bath audits for compliance. The I designee will also review all daily notes for 90 days or until 100% compliance is achieved & mainta staff providing direct cares to res have been educated on the moni protocols to assure any bruise or integument involvement is immed reported & recorded. Additionally nursing staff were educated on u documentation criteria for turning repositioning and off-loading for r at risk for skin issues. 4. The DON or designee will revie	lent with s. and those ing s or n initial y bruises Care lise is will aled bath ded ADL I weekly DON or progress ined. All dents toring other diately all se and residents ew/audit	
	wheelchair in the d	remained seated in the		all care sheet documentation dail days; then, 2X a week for 30 day 100% compliance is achieved to compliance. Additionally, the DO designee will do unannounced, observational audits on select res	s or until assure N or	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		LE CONSTRUCTION		E SURVEY PLETED
		245281	B. WING			02/·	10/2017
_	PROVIDER OR SUPPLIER CARE AND REHAB L	LC		6	TREET ADDRESS, CITY, STATE, ZIP CODE 00 FIFTH STREET SOUTHEAST, BOX 129 BARNESVILLE, MN 56514		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 282	any independent children and immediately was observed to an and immediately was observed to be trivia. R20 a.m. R20 wheelchair in the reno independent chawere observed to ore positioning. - At 9:40 a.m. R20 wheelchair in the reno independent chawere observed to ore positioning. - At 9:57 a.m. NA-Cup in the wheelchair in the repositioned. R20 wheelchair in her repositioned. R20 wheelchair in her replaced clean beddin - At 10:13 a.m. NA-	remained seated in the ning room. R20 was not any independent changes in remained seated in the ning room. At that time N)-A approached R20 and lminister medications to R20 alked away. The mained seated in the ning room and was wheeled to be an activity aid to listen to ained seated in the wheelchair ral of 2 hours and 10 minutes. The resident lobby. R20 had made anges in position. No staff fer R20 assistance with the was notified R20 had been or without repositioning since the NA-C stated R20 needed ositioning every 2 hours and the R20 had last been was then wheeled to her room to remained seated in the soom while NA-C and NA-E	F 2	282	daily to assure consistency in documentation for 7 days. All audi outcomes shall be presented to the Committee for review &/or commer 5. Date of correction: March 13, 20	e QAA nt.	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ,	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		245281	B. WING			02/ ⁻	10/2017
NAME OF PROVIDER OR SUPPLIER VALLEY CARE AND REHAB LLC				6	STREET ADDRESS, CITY, STATE, ZIP CODE 100 FIFTH STREET SOUTHEAST, BOX 129 BARNESVILLE, MN 56514		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 282	wheelchair to her band assisted R20 to removed R20's dry revealed R20's skir upper thighs were below and 3 minutes. During interview on stated R20 was to every two hours. Nother last time R20 was to every two hours. Nother last time R20 was to every two hours. Nother last time R20 was to every two hours. Nother last time R20 was received timely toiled buring interview on stated R20 had not and changed for interview of stated R20 had not and changed for interview of stated R20 had not and changed for interview of stated R20 had not and changed for interview of stated R20 had not and changed for interview of stated R20 had not and changed for interview of stated R20 had not and changed for interview of stated R20 had not and changed for interview of stated R20 had not and changed for interview of stated R20 had not and changed for interview of practical nurse (LP risk for developing reported staff were every two hours and confirmed three how wheelchair without During interview of director of nursing risk for development bowel and bladder The DON reported	ed. NA-E removed the lift sling or roll towards NA-C. NA-C incontinent brief which non the buttocks and back of bright red in color, skin intact. In observed seated position 0:13 a.m. a total of 3 hours 1 2/8/17, at 9:57 a.m. NA-C be repositioned and toileted lA-C stated she was unsure of ras repositioned and her usual lack of repositioning was to clock. NA-C stated that was sed to ensure residents eting and repositioning. 1 2/8/17, at 10:01 a.m. NA-E been repositioned or checked continence since 7:00 a.m. but able to independently 1 2/8/17, at 1:1 p.m. licensed N)-A confirmed R20 was at pressure ulcers. LPN-A expected to reposition R20 d as needed. LPN-A urs was too long to sit in the	F 2	282			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION IG	(X3) DAT CON	(X3) DATE SURVEY COMPLETED		
		245281	B. WING _		02	10/2017	
NAME OF PROVIDER OR SUPPLIER VALLEY CARE AND REHAB LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 600 FIFTH STREET SOUTHEAST, BOX 129 BARNESVILLE, MN 56514				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 282	guides after the corconsidered the care resident's care plan expected R20 would incontinence care preduce risk of future stated there was not ensure timely cares stated she was unsensuring residents. DON confirmed times	mprehensive assessments and e guides as an extension of the e. The DON stated she d have been repositioned and provided every two hours to e skin breakdown. The DON of formal system in place to a were completed. The DON ure how the staff were received timely care. The ely resident cares were not the DON stated the point of ed resident care	F 28				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245281	B. WING		02	/10/2017
NAME OF PROVIDER OR SUPPLIER VALLEY CARE AND REHAB LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 600 FIFTH STREET SOUTHEAST, BOX 129 BARNESVILLE, MN 56514			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CORREC X (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 282	Continued From pa	ge 10	F 2	82		
	was on anticoagula monitor/document/i anticoagulant thera directed staff to cor and report abnorma On 2/07/17, at 12:0 wheelchair in her ro (FM)-A present. Irre green bruises, appr diameter, were obs and several purple sizes were observe FM-A stated R37 hapast, and obtained	red 12/10/16, identified R37 nt therapy, directed staff to report adverse reactions to py which included bruising and applete daily skin inspections alities to nurse. O p.m. R37 was seated in her form with a family member regular shaped yellow/light roximately 1.5 inch in erved on both lower cheeks colored bruises in various d on the tops of both hands. and fallen in the facility in the the bruises. She indicated and did not remember falling.				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDII	(X3) DATE SURVEY COMPLETED				
		245281	B. WING _		02/10/2017		
NAME OF PROVIDER OR SUPPLIER VALLEY CARE AND REHAB LLC				STREET ADDRESS, CITY, STATE, ZIP COL 600 FIFTH STREET SOUTHEAST, BOX BARNESVILLE, MN 56514	DDE .		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE COMPLÉTION		
F 282	Continued From pa	nge 11	F 28	32			
	Review of R37's pr 2/5/17 revealed:	ogress notes from 12/19/16 to					
	head on the side ta	I a fall from bed and hit her ble and was bleeding from her nd was sent to the emergency I.					
	and had a laceration which was closed with the back top of her 40 centimeter (cm) elbow area which n	urned from emergency room in to her left eyebrow area with glue. R37 had bruising to left shoulder which measured x 50 cm, a bruise to her left measured 90 cm x 80 cm, and upper thigh area which x 150 cm.					
		ided bruises to her left bulder and elbow from nted fall.					
	administration reco and January 2017 of treatments and mo included to monitor minutes two times monitoring. However documentation of n	s monthly treatment rds (TAR) for December 2016 revealed R37 had various nitoring in place which for ear wax, elevate feet 20 a day, and respiratory er, the TARs lacked nonitoring for bruising and tions to anticoagulant therapy.					
		ntation of monitoring of R37's in the clinical record.					
	(DON) stated R37 the emergency roo	9 p.m. director of nurses fell on 12/19/16, was sent to m and returned with significant rmed progress notes and lack					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245281	B. WING		02 /	10/2017	
NAME OF PROVIDER OR SUPPLIER VALLEY CARE AND REHAB LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 600 FIFTH STREET SOUTHEAST, BOX 129 BARNESVILLE, MN 56514			
(X4) ID PREFIX TAG			ID PROVIDER'S PLAN OF CORRECTI PREFIX (EACH CORRECTIVE ACTION SHOUL TAG CROSS-REFERENCED TO THE APPRO DEFICIENCY)		BE	(X5) COMPLETION DATE	
F 282 F 309 SS=D	the measurements error. She stated th bruise was identified clinical weekly mon She stated she exp set up the bruise meturned from the edocument weekly a had not been done. Orders to be followed be completed by nutre Review of the facility dated 11/1/15, identified the total days the license head to toe skin as alterations in skin devaluation in the elementary of the facility's Care Findicated the resident appropriate care recresidents highest lead to the total days the license head to toe skin as alterations in skin devaluation in the elementary of the facility's Care Findicated the residents highest lead appropriate care recresidents highest lead appropriate care recresidents highest lead applies to all care a residents. Each residents. Each residents. Each residents. Each residents attain or practicable physical well-being, consisted	7's bruises and stated she felt of the bruises were likely an e usual facility practice when a d was for the nurse to set up itoring in the resident TAR. ected the nurse should have onitoring in the TAR when R37 mergency room and nd confirmed the monitoring She stated she expected ed, weekly skin inspections to urses and bruises monitored. Ty policy, Skin Assessment tified on residents designated sed nurse would complete a sessment and note any ondition and document an ectronic record. Plan Policy dated 9/14/15, ent care plan would ensure the quired to maintain or attain the evel of functioning possible. PROVIDE CARE/SERVICES ELL BEING e undamental principle that and services provided to facility sident must receive and the enth encessary care and maintain the highest I, mental, and psychosocial ent with the resident's sessment and plan of care.	F2			3/13/17	

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		A. BUILDING			(X3) DATE SURVEY COMPLETED	
245	281 B. WII	NG		02/1	0/2017	
NAME OF PROVIDER OR SUPPLIER VALLEY CARE AND REHAB LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 600 FIFTH STREET SOUTHEAST, BOX 129 BARNESVILLE, MN 56514		1 32/10/2011	
(X4) ID SUMMARY STATEMENT OF DEFICI PREFIX (EACH DEFICIENCY MUST BE PRECED TAG REGULATORY OR LSC IDENTIFYING INI	ED BY FULL PRI	D EFIX AG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE	
Continued From page 13 Quality of care is a fundamental prapplies to all treatment and care pracility residents. Based on the conassessment of a resident, the facility that residents receive treatment an accordance with professional stand practice, the comprehensive persocare plan, and the residents' choice but not limited to the following: (k) Pain Management. The facility must ensure that pain reprovided to residents who require sconsistent with professional standathe comprehensive person-centered and the residents' goals and preferment of practice, the comprehensive personservices, consistent with profession of practice, the comprehensive percare plan, and the residents' goals preferences. This REQUIREMENT is not met a by: Based on observation, interview a review, the facility failed to monitor of 3 residents (R37) reviewed for no related skin conditions. Findings include: R37's quarterly Minimum Data Set 1/12/17, identified R37 had moderating impairment, and required extensive with all activities of daily living (ADI	inciple that rovided to apprehensive ty must ensure d care in dards of an-centered es, including ananagement is such services, and care plan, rences. The that rive such and standards son-centered and servidenced and document bruising for 1 on-pressure (MDS) dated ate cognitive assistance	F 309	1.R37 has been assessed and car interventions for bruising incorporat the plan of care. Additionally, her exbruises are being monitored for hea 2.All residents with noted bruising a those residents that are at risk for b secondary to diagnosis, accidents of medication regimens have had an infull body audit, identifying existing b and the bruises' characteristics. Caplans were updated with directed modalities or interventions for bruismonitoring. Hereafter, all residents	ed into kisting aling. Ind bruising or nitial ruises re		

` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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	PROVIDER OR SUPPLIER CARE AND REHAB L	LC		600 F	ET ADDRESS, CITY, STATE, ZIP CODE IFTH STREET SOUTHEAST, BOX 129 NESVILLE, MN 56514	,	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPROFICIENCY)) BE	(X5) COMPLETION DATE
F 309	conditions/bruises. R37's care plan dat was on anticoagula monitor/document/tanticoagulant thera directed staff to cor and report abnormal revealed R37 receir Coumadin (medica have every shift monanticoagulant thera Con 2/07/17, at 12:0 wheelchair in her rouse (FM)-A present. Irregreen bruises, approximater, were obstand several purple sizes were observe FM-A stated R37 hapast, and obtained R37 was forgetful at Review of R37's progressive of R37's progressive and nose a room for evaluation complete the pack top of her was closed with back top of her	ted 12/10/16, identified R37 ant therapy, directed staff to report adverse reactions to py which included bruising and implete daily skin inspections alities to nurse. Immary report dated 1/6/17, wed a routine daily dose of tion to thin blood) and was to onitoring for bruising related to py. In p.m. R37 was seated in her com with a family member regular shaped yellow/light roximately 1.5 inch in rerved on both lower cheeks colored bruises in various and fallen in the facility in the the bruises. She indicated and did not remember falling. In a fall from bed and hit her ble and was bleeding from her nd was sent to the emergency	F3	da acc th cas de nc cc st ha pr ini re nu do re at 4. all da ob da ob da ob	ay. Resident skin conditions will ditionally be monitored as neederoughout the day during routine at the second strees. DON or designee will review all atth audits for compliance. The Dosignee will also review all daily potes for 90 days or until 100% ompliance is achieved & maintain aff providing direct cares to reside the second street on the monitor otocols to assure any bruise or of the second street degree at the second of the monitor otocols to assure any bruise or of the second street degree at the second of the second o	weekly ON or orogress ned. All lents oring other ately all e and sidents w/audit for 7 or until ssure or dents it e QAA ent.	

` ,		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	RIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED	
		245281	B. WING		02/	10/2017
	PROVIDER OR SUPPLIER CARE AND REHAB L	LC		STREET ADDRESS, CITY, STATE, ZIP CODE 600 FIFTH STREET SOUTHEAST, BOX 12: BARNESVILLE, MN 56514)	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT ((EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 309	a bruise to her left to measured 230 cm stated 230 cm stated 230 cm stated 230 cm stated and previously documents. Administration Reco 2016 and January 2 various treatments included to monitor minutes two times a monitoring. However documentation of mother adverse react. No further documents bruising was found. On 2/10/17, at 12:1 (DON) stated R37 fthe emergency roof bruises. DON confit of monitoring of R3 the measurements error. She stated the bruise was identified clinical weekly mon She stated she exposet up the bruise more returned from the edocument weekly a had not been done, orders to be followed be completed by numerical stated.	neasured 90 cm x 80 cm, and upper thigh area which x 150 cm. ded bruises to her left bulder and elbow from need fall. s monthly Treatment bords (TAR) for December 2017, revealed R37 had and monitoring in place which for ear wax, elevate feet 20 a day, and respiratory	F 3	09		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245281	B. WING		02/10/2017	,
	ROVIDER OR SUPPLIER	LC		STREET ADDRESS, CITY, STATE, ZIP CODE 600 FIFTH STREET SOUTHEAST, BOX 129 BARNESVILLE, MN 56514		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		TION
	bath days the licens head to toe skin as alterations in skin c evaluation in the el 483.25(b)(1) TREA	ified on residents designated sed nurse would complete a sessment and note any ondition and document an ectronic record. TMENT/SVCS TO	F 309		3/13/17	7
SS=G	facility must ensure (i) A resident receiv professional standar pressure ulcers and ulcers unless the indemonstrates that the composition of the composition of the control of the contro	. Based on the essment of a resident, the		1.R32 comprehensive assessment completed. R32 and R20 care plans been assessed and care plan interventions for pressure ulcer previncorporated into the plan of care. 2. All residents will have baseline comprehensive assessment completupon admission. Thereafter, all resimil have comprehensive assessment completed annually and with change condition to include, but not limited to	ention ted dents nt	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	DENTIFICATION NITIMBED:		JLTIPLE CONSTRUCTION DING		(X3) DATE SURVEY COMPLETED	
		245281	B. WING			02 /1	0/2017	
	PROVIDER OR SUPPLIER CARE AND REHAB L	LC		60	REET ADDRESS, CITY, STATE, ZIP CODE 00 FIFTH STREET SOUTHEAST, BOX 129 ARNESVILLE, MN 56514			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 314	Findings include: R32's admission M 12/1/16, identified I required extensive daily living (ADLs). R32 was at risk for had no current pres pressure reducing R32's admission of R32 had diagnoses and peripheral ede R32's Care Area As 12/1/16, identified I pressure ulcers and CAA identified R32 chair for pressure r R32's care plan da had limited physica osteomyelitis of ver history of falls, was assistance from sta locomotion, and an directed staff to ens footwear (laced, no or mobilizing in who relieving cushion in indicated R32 had impairment related fragile skin and util cushion in wheelch directed staff R32 r inspections to iden and any changes in	inimum Data Set (MDS) dated R32 had intact cognition and assistance with all activities of The MDS further identified developing pressure ulcers, soure ulcers and utilized a device in her chair. Inderest dated 11/17/16, identified is which included osteoporosis ma. Indesessment (CAA) dated R32 was at risk for developing direquired assessment. The required a cushion for her	F3	314	formation of new pressure ulcer as in the RAI Manual. 3. All residents have had physical assessments completed, tissue tole and Braden assessments completed and/or reviewed, and their plans of updated as needed to assure approturning, positioning or offloading activities each resident with the individual recare sheets. Care plans were updated with direct modalities or interventions for skin/monitoring. Hereafter, all residents have full body audits on a schedule day. Resident skin conditions will additionally be monitored as needed throughout the day during routine Acares. 4. DON or designee will review all valued throughout the day during routine Acares. 4. DON or designee will review all daily protes for 90 days or until 100% compliance is achieved & maintain staff providing direct cares to reside have been educated on the monito protocols to assure any bruise or or integument involvement is immediate reported & recorded. Additionally, an ursing staff were educated on used documentation criteria for turning, repositioning and off-loading for resat risk for skin issues. MDS Coord was educated on requirements for completion of a comprehensive assessment based on RAI Manual. 6. The DON or designee will review all care sheet documentation daily all care sheet documentation daily.	skin erance ed care opriate tivities rring, on sident eted wound will ed bath d.DL veekly DN or rogress ed. All ents ring ther ately all and sidents inator		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP A. BUILDING	PLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		245281	B. WING	 	02/	10/2017	
	PROVIDER OR SUPPLIER CARE AND REHAB L	LC		STREET ADDRESS, CITY, STATE, ZIP CO 600 FIFTH STREET SOUTHEAST, BO BARNESVILLE, MN 56514	DDE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION OF CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 314	identify R32's curredirection for the use to keep pressure of Review of the untitl facility, identified as guide, listed various which included ass transferring, dressis shoes at night. The direction for pressure of the Prevalon book R32's Tissue Tolera used to determine a schedule) dated 11 current skin integrith history of pressure hour repositioning were found in R32's development of pressure assessment for pressure found in R32's Braden Scale assessment for pressure for the	Int pressure ulcer, and lacked to of Prevalon boots or pillows of for R32's heel. The defacility form provided by the state heroist the nursing assistant care is directions for R32's cares istance with toileting, and directed the use of the care guide did not include are relief for R32's heels or use of the care for R32's heels or use of the care guide did not include appropriate repositiong appropriate repositiong /21/16, identified R32 had no y concerns, did not have a ulcers and could tolerate a 2 the corogram. No further TTT forms is clinical record, despite the same ulcers.	F 314	days; then, 2X a week for 30 100% compliance is achieve compliance. The DON or deaudit to ensure comprehensiassessments are completed residents at admission, annusignificant change and/or the development of any new pre Additionally, the DON or desunannounced, observational select residents daily to assuconsistency in documentation All audit outcomes shall be puthe QAA Committee for revisionment. 7. Date of correction: March	d to assure signee will ve for all lally, with essure ulcer. ignee will do audits on lare in for 7 days. oresented to ew &/or		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			TE SURVEY MPLETED
		245281	B. WING		02	/10/2017
	PROVIDER OR SUPPLIER CARE AND REHAB L	LC		STREET ADDRESS, CITY, STATE, ZIF 600 FIFTH STREET SOUTHEAST, BARNESVILLE, MN 56514	CODE	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIVE CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 314	The form listed R32 review, had 3 centil the middle of her so pulling away in a bl soft.	2 had 12/20/16, labs for meter (cm) blackened area in ble of the left foot, edges were ster form, and center was	F3	14		
	(DON) stated R32 I pressure ulcer on her back in her torso and lower remained on her bassistant (NA)-C er with morning cares linens, and both R3 on a pillow, covered second pillow was a The heels/feet were relieve pressure. At (cm) sized open are observed, and an adark brown/black in center of the area of the area of the area of the area of the word in the base of the word throughout the word surrounded the ent to lift each foot/leg compression hose reapply both socks place R32's heels/falternating between lower extremities. Fire word in the same of the socks place R32's heels/falternating between lower extremities.	c.m. the director of nursing had a current unstageable er left heel. a.m. R32 had her eyes closed, bed with bed linens covering extremities. At 7:54 a.m. R32 ack in bed and nursing hered the room to assist R32. NA-C pulled down R32' bed 2's heels/feet rested directly din white cloth socks and a observed under R32's calves. In ont elevated off the pillow to approximately 2.5 centimeter a on the back of the heel was approximately 1.5 cm sized regular shaped scab in the with a yellow colored slough tan, gray, green or brown at, can be soft, stringy and a slough may be adherent to and or present in clumps and bed) area which ire scab. NA-C assisted R32 to remove the socks, apply to both lower extremities and to her feet. NA-C continued to eet directly on to the pillow, assisting to dress R32's R32's heels rested directly on to the pillow, or assisting to dress R32's R32's heels rested directly on to the pillow, or assisting to dress R32's R32's heels rested directly on to the pillow, or assisting to dress R32's R32's heels rested directly on to the pillow, or assisting to dress R32's R32's heels rested directly on to the pillow, or assisting to dress R32's R32's heels rested directly on to the pillow, or assisting to dress R32's R32's heels rested directly on to the pillow, or assisting to dress R32's R32's heels rested directly on to the pillow.				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
		245281	B. WING _		02	/10/2017
	PROVIDER OR SUPPLIER	LC		STREET ADDRESS, CITY, STATE, ZIP CO 600 FIFTH STREET SOUTHEAST, BC BARNESVILLE, MN 56514	DDE	10/2011
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 314	transfer into the seproceeded to assist On 2/8/17, at 9:03 abeen unaware R32 on the pillow and harested R32's heel of cares. She indicate tried the boots (Preunderstood R32 did On 2/8/17, at 9:16 ashould be off the behanging off the pillobed or pillow. On 2/8/17, 9:24 a.m (LPN)-A stated R32 of pressure ulcers a R32 had a current	at to sit on the edge of the bed, at of a wheelchair and the R32 into the bathroom. a.m. NA-C stated she had the sheels were resting directly and been unaware she had directly on the pillow during and she thought the facility had evalon) with R32 once, and	F 31	4		
	stated R32 had a p the past which had not have a current	n. registered nurse (RN)-A ressure ulcer at her left heel in resolved, and stated she did pressure ulcer. She stated she risk for pressure ulcers at this				
	seated in a wheeld wore brown tie up s rested on the foot p At 12:36 p.m., R32 in the dining room, both feet.	a.m. R32 was observed hair in the dining room. R32 shoes on both feet, which hedals of the wheelchair. was seated in her wheelchair with the same brown shoes on was seated in her wheelchair in				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION			SURVEY PLETED
		245281	B. WING		_	02 /1	10/2017
	PROVIDER OR SUPPLIER CARE AND REHAB L	LC		STREET ADDRESS, CITY, STA 600 FIFTH STREET SOUTH BARNESVILLE, MN 565	EAST, BOX 129		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	X (EACH CORRECTIVE CROSS-REFERENCED		BE	(X5) COMPLETION DATE
F 314	the dining room, paseveral other reside the same brown tie On 2/8/17, at 12:59 risk for developmer reviewed R32's clin stated the record in pressure ulcer had indicated the facility pressure ulcer had tie up shoes. DON current ulcer. She comprehensive skin been completed on development of R3. DON confirmed R3 documentation of windicated this was a improve on. She indicated this was a improve on. She indicated the previous told facility staff her shoe and felt the proposition from the should have compressure ulcer. On 2/8/17, at 1:14 pwheelchair in her reshoes on both feet. the surveyor in the pressure ulcer after shoe from R32's left current pressure ulcer shoe from R32's left current pressure ulcer shoe from R32's left current pressure ulcer shoe from R32's left current pressure ulc	rticipating in an activity with ents. R32 continued to wear up shoes on both feet. p.m. DON stated R32 was at at of pressure ulcers. DON ical record at that time and dicated R32's previous resolved/closed. She had felt the previous been caused by R32's brown stated R32 did not have a confirmed the most current in assessment for R32 had 12/6/17, prior to the 2's previous pressure ulcer.	F3	14			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245281	B. WING _		02/	/10/2017
	PROVIDER OR SUPPLIER CARE AND REHAB L	LC		STREET ADDRESS, CITY, STATE, ZIP CODE 600 FIFTH STREET SOUTHEAST, BOX 12 BARNESVILLE, MN 56514	-	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 314	On 2/9/17, at 9:03 a worn her brown she she developed and stated she understo healed, she could windicated she wore On 2/9/17, at 9:05 a place pillows under she needed staff as and she did not renher shoes. On 2/9/17, at 9:15 a currently had an opindicated she had rabout the open are she felt R32 had no been admitted to the On 2/9/17, at 9:40 a interview, the DON way to accurately different pressure ulcurrent pressure ulcurre	a.m. NA-A stated R32 had not bees for about a month after open area on her foot. NA-A bood since R32's open area had wear the brown shoes and them routinely. a.m. R32 stated staff routinely her heels at night. She stated sistance to apply her shoes nember the last time she wore a.m. NA-D confirmed R32 en area on her left heel and notified the nurses and DON a in the past. She indicated of worn shoes since she had be facility. a.m. during a follow up stated she felt there was no etermine when R32's current curred. She confirmed R32's cer and indicated she felt the cer had reopened soon after	F 31	4		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CL IDENTIFICATION NUMBER		. ,	(X2) MULTIPLE CONSTRUCTION A. BUILDING		
	245281	B. WING _		02/10/2017	
NAME OF PROVIDER OR SUPE			STREET ADDRESS, CITY, STATE, ZIP C 600 FIFTH STREET SOUTHEAST, E BARNESVILLE, MN 56514	CODE	
PREFIX (EACH DEFIC	Y STATEMENT OF DEFICIENCIES IENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE COMPLÉTION	
weekly skin insabnormalities to confirmed R32 after admission had caused the R32 had stopp discussed alter the facility was somewhere elsonce R32's shoutting gas ontreliable historia her brown shour R32 required a DON stated R32 the past June 3 time to assess she was aware on 2/9/17, at 9 had R32 removers after the developed and resumed wear stated she had pressure since in the facility. SR32 had a currof the pressure notified the phyulcer. DON did regarding notified the phyulcer.	expected all the nurses to complete spections, assess and report to the physician for treatment. Do had developed a pressure ulcern, at that time she felt the shoes expressure ulcer. She indicated ed wearing the shoes and staff homative shoes for R32, however, concerned about causing a blist see on her foot. DON stated she for each of the stated R32 was a ran and DON confirmed R32 wore estably at present, and confirmed essistance with applying her shoes a fail and a polyment of the pressure ulcer sing of the pressure ulcer. 1:40 a.m. DON stated the facility we the brown tie up shoes for 2 to five the brown tie up shoes for 2 to five the pressure ulcer. 1:40 a.m. DON stated the facility we the brown tie up shoes for 2 to five the pressure ulcer. 1:40 a.m. DON stated the facility we the brown tie up shoes for 2 to five the pressure ulcer. 1:40 a.m. DON stated the facility we the brown tie up shoes for 2 to five the pressure ulcer. 1:40 a.m. DON stated the facility we the brown tie up shoes for 2 to five the pressure ulcer. 1:40 a.m. DON stated the facility we the brown tie up shoes for 2 to five the pressure ulcer. 1:40 a.m. DON stated the facility we the brown tie up shoes for 2 to five the pressure ulcer. 1:40 a.m. DON stated the facility we the brown tie up shoes for 2 to five the pressure ulcer. 1:40 a.m. DON stated the facility we the brown tie up shoes for 2 to five the pressure ulcer. 1:40 a.m. DON stated the facility we the brown tie up shoes for 2 to five the pressure ulcer. 1:40 a.m. DON stated the facility we the brown tie up shoes for 2 to five the pressure ulcer.	ad er elt not d ss. e d ce	4		

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245281	B. WING _		02	/10/2017
	PROVIDER OR SUPPLIER CARE AND REHAB L	LC		STREET ADDRESS, CITY, STATE, ZIP CO 600 FIFTH STREET SOUTHEAST, BO BARNESVILLE, MN 56514	DDE	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 314	of erythema. He st about development started her on antib indicated he was un pressure ulcer, had on 1/3/17, and he fo	age 24 ated he had been concerned of osteomyelitis and had biotics at that time. MD-A nsure of the cause of R32's I seen the pressure ulcer last elt the pressure ulcer was and understood it continued	F 31	4		
	interview in the faci previous pressure usuperficial. He indicand inflamed, and hopen area because osteomyelitis and non 1/3/17, he had fulcer was healing. R32's left heel, he face	a.m. during a follow up lity, MD-A stated R32's ulcer had been open and cated the area had been red he had ordered a culture of the a R32 had a history of hultiple infections. He stated felt R32's previous pressure MD-A stated during exam of felt R32's current pressure and indicated he felt at that healed.				
	following: -12//23/16, identifie left heel, culture of antibiotic started, a patient positioned a pressure off of left lindicated to follow and sooner as need -1/3/17, left heel loo to continue treatmet.	oked better, and directed staff ent.				
		ealed for December 2016, staff skin/wound note weekly, every				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245281	B. WING		02	/10/2017
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO 600 FIFTH STREET SOUTHEAST, BO BARNESVILLE, MN 56514	DDE	
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F 314	Thursday and Prev pressure off of hee done every evening 12/31/16. However for use of Prevalor relief for left heel done every evening 12/31/16. However for use of Prevalor relief for left heel done every evening 1/31/17. However, use of Prevalon both for left heel during R32's progress not skin/wound docum 11/18/16 to 2/09/17 -12/16/2016, identif R32's left heel with like a scab. The not was provided regal provider was updated and wrote new ord included a wound of changes. The note follow up next wee -12/23/2016, identition her left heel mediameter, and a blaarea which measure	valon boots or pillows to keep el which was documented as g and night shift 12/23/16 thru r, R32's TAR lacked direction a boots, pillows or pressure uring the day. anuary TAR staff skin/wound note weekly, every valon boots or pillows to keep el which was documented as g and night shift 1/1/17 thru R32's TAR lacked direction for tots, pillows or pressure relief the day. tes which included all entation was reviewed from 7 and revealed: fied a nickel size black area on the surrounding area raised of also indicated education rding offloading of heels, ted and they would continue to fied R32's provider was there ers for left sole ulcer which culture, and medication indicated provider would	F 3	14		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245281	B. WING			02/10/2017	
NAME OF PROVIDER OR SUPPLIER VALLEY CARE AND REHAB LLC				60	TREET ADDRESS, CITY, STATE, ZIP CODE 00 FIFTH STREET SOUTHEAST, BOX 129 ARNESVILLE, MN 56514		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 314	Continued From pa	ge 26	F 3	14			
	ulcer which measur	ied R32 had an open left heel red 1.5 cm X .5 cm, was dark e and was improved.					
		ied area on heel was not vas applied as ordered and did tus of the ulcer					
	-1/2/2017, identified as ordered.	d left heel treatment continued					
	-1/3/2017, identified left heel scab had sloughed off, leaving a clean smooth surface and area measured 0.5 cm X .25 cm.						
		d left heel was dry, scabbed 4 mm and was improving					
	-1/8/2017, identified to left heel had clos	d unstageable pressure ulcer ed.					
	side of both knees	mall red dots on the front and and had redness at skin fold of the note did not address kin/ pressure ulcer.					
	-1/19/17, listed no a	areas of concern.					
	-1/26/2017, listed h	ad no areas of concern.					
	-2/2/2017, listed no	areas of concern.					
	-2/9/17, listed no a	reas of concern.					
	Treatment of Skin E	ry policy, Prevention and Breakdown, dated 11/1/15, sident developed a new					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION ING		(X3) DATE SURVEY COMPLETED	
		245281	B. WING		02	2/10/2017	
	PROVIDER OR SUPPLIER CARE AND REHAB L	LC		STREET ADDRESS, CITY, STATE, ZIP CODE 600 FIFTH STREET SOUTHEAST, BOX BARNESVILLE, MN 56514			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		OULD BE	(X5) COMPLETION DATE	
F 314	Braden Scale Asse evaluation of skin ribased on risk facto Review of the facilit dated 11/1/15, reverisk for pressure uldweekly to identify a integrity. The policy designated bath dacompele a head to any alterations in skevaluation of the wasurrounding tissues	acility would initiate a TTT, a ssment and complete an sk factors and reevaluate rs. by policy, Skin Assessment aled all residents identified at cers would be assessed by new alterations in skin also identified on residents ys the licensed nurse would toe skin assessment and note kin condition and document and bund, the status of a and treatments, any ction and document findings	F3	314			
	R20 had diagnoses hypertension (HTN) pulmonary disease R20 was severely dextensive to total as daily living (ADL). Twas totally dependent bed mobility, transfidentified R20 was skin was intact, was	am and had a pressure					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		((X3) DATE SURVEY COMPLETED	
		245281	B. WING			02/1	0/2017
	PROVIDER OR SUPPLIER CARE AND REHAB L	LC		STREET ADDRESS, CITY, STATE, ZIP CO 600 FIFTH STREET SOUTHEAST, BC BARNESVILLE, MN 56514		<u> </u>	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		SHOULD E		(X5) COMPLETION DATE
F 314	dependent on staff including reposition was at risk for pres weakness, limited r Further, the CAA id offered repositionin R20's care plan dat at risk for altered sk facility staff to assis (2) hours. R20's undated, nur indicated R20 requirevery two hours. R20's Braden Scale Pressure ulcer date at risk for pressure ulcer date at risk for pressure. During continuous of 7:10 a.m. R20 with a seat cushion gown, with the TV of the At 7:47 a.m. R20 wheelchair in her roundependent chang observed to offer R repositioning or car - At 8:19 a.m. R20 wheelchair in her rotime, nursing assists	/20/16, indicated R20 was for activities of daily living, ing. The CAA identified R20 sure ulcers related to mobility, and dementia. entified R20 needed to be g every two hours. red 1/24/16, identified R20 was kin integrity and directed at R20 to reposition every two sing assistant care guide, ired turning and repositioning e/Skin Risk Assessment for ed 12/5/16, indicated R20 was ulcer development. rebservation on 2/8/17, from am. revealed the following: was seated in a wheelchair in her room, wore a hospital on. remained seated in a oom. R20 had not made any es in position, no staff were 20 assistance with	F3	314			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245281	B. WING		02	/10/2017	
	PROVIDER OR SUPPLIER CARE AND REHAB L	LC		STREET ADDRESS, CITY, STATE, ZIP C 600 FIFTH STREET SOUTHEAST, B BARNESVILLE, MN 56514	CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE	
F 314	that time NA-E enter blanket over R20's R20 to the dining roobserved to offer R repositioning. - At 8:40 a.m. R20 wheelchair in the dindependently. R20 any independent chair in the dobserved to make a position. - At 9:07 a.m. R20 wheelchair in the dobserved to make a position. - At 9:07 a.m. R20 wheelchair in the doproached R20 amedications to R20 amedications to R20 away. - At 9:20 a.m. R20 wheelchair in the dother resident lobby a trivia. R20 had remat that time for a to repositioning. - At 9:40 a.m. R20 wheelchair in the resident chair in the dapproached R20 a.m. R20 wheelchair in the dapproach	ered R20's room, draped a lap and proceeded to wheel com. NA-D and NA-E were not a lace assistance with lace assistance with lace assistance with lace assistance with lace as a	F3	14			

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	IPLE CONSTRUCTION NG		COMPLETED	
		245281	B. WING _		02	/10/2017	
	PROVIDER OR SUPPLIER CARE AND REHAB L	LC		STREET ADDRESS, CITY, STATE, ZIP CODE 600 FIFTH STREET SOUTHEAST, BOX BARNESVILLE, MN 56514			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 314	repositioned. R20 v by NA-C. - At 10:08 a.m. R2 wheelchair in her replaced clean bedding. - At 10:13 a.m. NA-transfer with a full replaced clean bedding. - At 10:13 a.m. NA-transfer with a full replaced clean bedding. - At 10:13 a.m. NA-transfer with a full replaced removed R20 to removed R20's dry revealed R20's skir upper thighs were to remove thighs were to replace to remove the stated R20 was to replace to keep transfer and replaced timely to received timely to receive the method staff us received timely to reposition. During interview on stated R20 had not and changed for inconfirmed R20 was pressure ulcers. Life the results of the reposition.	ovas then wheeled to her room oremained seated in the oom while NA-C and NA-E	F 3:				

	OF DEFICIENCIES OF CORRECTION	ECTION I DENTIFICATION NUMBER:		RIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED		
		245281	B. WING	B. WING		02/10/2017	
	PROVIDER OR SUPPLIER CARE AND REHAB L	LC		STREET ADDRESS, CITY, STATE, ZIP CODE 600 FIFTH STREET SOUTHEAST, BOX 129 BARNESVILLE, MN 56514	-		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE	
F 314	too long to sit in the repositioning. During interview on confirmed R20 was pressure ulcers due incontinence, and in she added the spectoursing assistance comprehensive assistance reguides as an explan. The DON state devery two skin breakdown. The formal system in play were completed. The unsure how the state received timely care resident cares were DON stated the points.	ge 31 e wheelchair without 2/9/17, at 8:37 a.m. the DON at risk for development of to bowel and bladder mobility. The DON reported effic interventions on the care guides after the essments and considered the extension of the resident's care ted she expected R20 would ened and incontinence care hours to reduce risk of future to PON stated there was no ace to ensure timely cares the DON stated she was ff were ensuring residents en The DON confirmed timely to not being monitored. The ent of care system captured mentation, but not in actual	F3	14			
F 441 SS=F	Treatment of Skin E indicated staff would measures such as repositioning sched developing a pressidentified to be at ris 483.80(a)(1)(2)(4)(e) PREVENT SPREAL (a) Infection preventage of the facility must es	titled, Prevention and Breakdown dated 9/6/16, d implement preventative effective turning and ules to help reduce the risk of the ulcer with residents sk for impaired skin integrity. E)(f) INFECTION CONTROL, D, LINENS tion and control program. tablish an infection prevention in (IPCP) that must include, at	F 4	41		3/13/17	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	FIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED	
		245281	B. WING		02	/10/2017
	PROVIDER OR SUPPLIER CARE AND REHAB L	LC		STREET ADDRESS, CITY, STATE, ZIP CO 600 FIFTH STREET SOUTHEAST, BO BARNESVILLE, MN 56514	DDE	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 441	investigating, and communicable disevolunteers, visitors, providing services that arrangement based conducted according accepted national simplementation is F (2) Written standard for the program, whimited to: (i) A system of survice possible communicable communicable diservented; (ii) When and to whom communicable diservented; (iii) Standard and transfer to be followed to provide the program of the progr	owing elements: eventing, identifying, reporting, controlling infections and cases for all residents, staff, and other individuals under a contractual dupon the facility assessmenting to §483.70(e) and following standards (facility assessment Phase 2); ds, policies, and procedures nich must include, but are not reillance designed to identify stable diseases or infections read to other persons in the reason possible incidents of ease or infections should be reasonable infections; isolation should be used for a	F4	41		

, ,		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION ((X3) DATE SURVEY COMPLETED	
		245281	B. WING			02/1	0/2017
	PROVIDER OR SUPPLIER CARE AND REHAB L	LC		60	TREET ADDRESS, CITY, STATE, ZIP CODE 00 FIFTH STREET SOUTHEAST, BOX 129 ARNESVILLE, MN 56514		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	3E	(X5) COMPLETION DATE
F 441	must prohibit emploisease or infected contact with reside contact will transm (vi) The hand hygically staff involved in the facility's actions taken by the sactions of infection (f) Annual review of its program, as necess. This REQUIREME by: Based on interview facility failed to imprint the saction control prosurveillance of all including those not prevent potential special sactions. Findings include: During interview with sactions of the saction control log 12/16/16, was completely sactions the sactions of the	ces under which the facility oyees with a communicable I skin lesions from direct nts or their food, if direct it the disease; and ene procedures to be followed direct resident contact. cording incidents identified IPCP and the corrective e facility. anel must handle, store, port linens so as to prevent the test of the facility will conduct an its IPCP and update their	F4	411	1. Policies & procedures were revie and updated to establish and identify location of resident in facility with infection, symptoms, diagnosis and/cultures performed, treatment moda and resolution of infection. 2. All residents have had a preliminar review to determine if there are any & symptoms of potential infections. 3. All residents who have objective of subjective symptoms of potential infections shall be tracked & trended utilizing current protocols. These prohave been updated to include the additional potential infections. 4. The DON or designee will review residents at daily shift reports and	or ditties, ary signs or d	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245281	B. WING			02/-	10/2017
	PROVIDER OR SUPPLIER CARE AND REHAB L	LC		60	TREET ADDRESS, CITY, STATE, ZIP CODE 00 FIFTH STREET SOUTHEAST, BOX 129 ARNESVILLE, MN 56514	•	
(X4) ID PREFIX TAG				Х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 441	end date, culture reisolation required. I documentation of in antibiotics in the far. Review of the mon 12/15 through 12/1 various resident infections, broinfections and all in specific antibiotic under the logs symptoms of infections of infections and infections of infections of infections of infections and the logs symptoms of infections in the logs symptoms of infections in the logs symptoms of infections of infections not the log logical	edication ordered, medication esults (if obtained), and However, the log lacked infections not treated with cility. thly infection control logs from 6 revealed the facility tracked fections which included urinary enchitis, pneumonia, eye infections listed identified the ised to treat the infection. Iacked documentation of itions or viral illness not treated	F 4	141	review/audit all progress notes dail new symptoms. All audit outcome be reported to the QAA Committee comment &/or review. 5. Management/charge personnel attempt to have the ill employee individual what symptoms are present to war illness call-in and document same absence report for tracking. 6. The DON or designee shall track trend resident infections and emploreported illnesses as they occur. The ongoing and be reviewed quarter. Quarterly the DON or designee track and trend, compile data, with analysis to determine if there are commonalities to staff illnesses and resident symptoms of infection. A charge personnel who take absending the educated on the need to ascertain symptoms r/t illness or absences. 8. All staff will receive education or Infection Control policy and procedupon hire, annually at staff in-service as needed for any new updates fro CDC. 9. Date of Correction: March 13, 2	es shall for will dicate rant an on an c and oyee his will erly. shall an d/or ll ce calls ures ce, and m	

	ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			FIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED		
		245281	B. WING		02/10/2017		
	PROVIDER OR SUPPLIER CARE AND REHAB L	LC	•	STREET ADDRESS, CITY, STATE, ZIP CODE 600 FIFTH STREET SOUTHEAST, BOX 129 BARNESVILLE, MN 56514			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF CORF ((EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE COMPLETION		
F 441	Continued From pa be completed utilizi definitions of syster	ng the criteria of the	F 4	41			

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Printed: 02/10/2017 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

(X2) MULTIPLE CONSTRUCTION
A. BUILDING 01 - MAIN BUILDING 01

(X3) DATE SURVEY COMPLETED

245281

B. WING _

02/07/2017

NAME OF PROVIDER OR SUPPLIER

VALLEY CARE AND REHAB LLC

STREET ADDRESS, CITY, STATE, ZIP CODE

600 FIFTH STREET SOUTHEAST. BOX 129 BARNESVILLE, MN 56514

BARNESVILLE, MN 56514								
(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	K 000						
	n e							
	FIRE SAFETY							
	A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety. At the time of this survey Valley Care & Rehab LLC 01 Main Building was found in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of the Health Care Facilities Code, (NFPA 99).		e					
	Valley Care & Rehab is a 1-story building with no basement. The building was constructed at 3 different times. The original building was constructed in 1963 and was determined to be of Type II(000) construction. In 1980, a Sun Room addition was added to the south of the Dining Room/Day Room that was determined to be of Type V(000) construction. In 1994 an addition to the main entrance, to the west was constructed and was determined to be of Type II(111) construction. The building is divided into 4 smoke zones by two 30-minute fire barriers, one two hour fire barrier and is fully sprinkled per NFPA 13.		×	- ×				
	The facility has a capacity of 35 beds and a census of 34 at the time of the survey		g = w	-				
	Because of the lack of 2-hr fire separation between the Sun Room addition and the original building, the entire building is downgraded to Type V(000) and was surveyed as 1 building.	2	8	4				
	The requirement at 42 CFR, Subpart 483.70(a) is							
LABORATO	RY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SI	GNATURE	TITLE	(X6) DATE				

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.

Printed: 02/10/2017 FORM APPROVED OMB NO. 0938-0391

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NUM	LIERICHA I.		G 01 - MAIN BUILDING 01	(X3) DATE SURVEY COMPLETED	
		245281		B. WING		02/07/2017	
	ROVIDER OR SUPPLIER CARE AND REHAB				ETATE, ZIP CODE ET SOUTHEAST. BOX 129		
VALLET	CARE AND REHAB	LLC			IN 56514		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCE (EACH DEFICIENCY MUST BE PRECEDED BY FULL F OR LSC IDENTIFYING INFORMATION)		REGULATORY	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE ACTION SHOU (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE COMPLETION	
K 000	Continued From pa	age 1		K 000	**		
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s		2	3	2	* #		
					a.		



PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered March 2, 2017

Mr. Mark Rustad, Administrator Valley Care And Rehabilitation LLC 600 Fifth Street Southeast, Box 129 Barnesville, Minnesota 56514

Re: Enclosed State Nursing Home Licensing Orders - Project Number

Dear Mr. Rustad:

The above facility was surveyed on February 6, 2017 through February 10, 2017 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health, Health Regulation Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

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

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

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction

Valley Care And Rehabilitation LLC March 2, 2017 Page 4

order. This column also includes the findings that are in violation of the state statute after the statement, "This Rule is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

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

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

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact Gail Anderson at: (218) 332-5140 or email: gail.anderson@state.mn.us.

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.

Feel free to contact me if you have questions related to this eNotice.

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist Program Assurance Unit Licensing and Certification Program Health Regulation Division Minnesota Department of Health

Email: mark.meath@state.mn.us Telephone: (651) 201-4118

Fax: (651) 215-9697

PRINTED: 04/14/2017 FORM APPROVED

(X6) DATE

Minnesota Department of Health

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00968	B. WING	·····	02/1	0/2017
	PROVIDER OR SUPPLIER CARE AND REHAB L	I C 600 FIFTH		STATE, ZIP CODE OUTHEAST, BOX 129 6514		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 000	Initial Comments		2 000			
	****ATTE	NTION*****				
	NH LICENSING	CORRECTION ORDER				
	144A.10, this correct pursuant to a surver found that the deficient herein are not corrected shall with a schedule of the Minnesota Department of which a schedule of the Minnesota Department of which with a schedule of the Minnesota Department of which will be supported by the schedule of the Minnesota Department of the Minnesota Department of the schedule of the	nether a violation has been				
	number and MN Ru When a rule contain comply with any of lack of compliance. re-inspection with a result in the assess	compliance with all rule provided at the tag alle number indicated below. In several items, failure to the items will be considered Lack of compliance upon my item of multi-part rule will ment of a fine even if the item uring the initial inspection was				
	that may result from orders provided tha the Department witl	hearing on any assessments non-compliance with these tawritten request is made to nin 15 days of receipt of a nt for non-compliance.				
	receipt of State lice the Minnesota Depa Informational Bullet http://www.health.si	participate in the electronic nsure orders consistent with artment of Health in 14-01, available at tate.mn.us/divs/fpc/profinfo/infe licensing orders are				

Minnesota Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

03/13/17 **Electronically Signed**

TITLE

STATE FORM 6899 NQV411 If continuation sheet 1 of 38

STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00968	B. WING	·····	02/1	0/2017
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
VALLEY	CARE AND REHAB L	1 (=	I STREET SO ILLE, MN 5	OUTHEAST, BOX 129 6514		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 000	you electronically. is necessary for State enter the word "corrected. You must then State licensure proceompletion date, the corrected prior to el Minnesota Departm." On February 6th, 7 surveyors of this Deabove provider and orders are issued. electronic plan of correviewed these ordethey will be completed. Minnesota Departmente State Licensing federal software. The assigned to Minnesota Departmente State Licensing federal software. The assigned to Minnesota Departmente State Licensing federal software. The assigned to Minnesota Departmente State Licensing federal software. The assigned to Minnesota Departmente State Licensing federal software. The assigned tag in column entitled "ID statute/rule out of commany Statemente and replaces the "Torrection order. The findings which are in after the statement, evidence by." Follow	Although no plan of correction ate Statutes/Rules, please rected" in the box available for indicate in the electronic cess, under the heading e date your orders will be lectronically submitting to the nent of Health. Ath, 8th, 9th and 10th 2017, epartment's staff, visited the the following correction Please indicate in your correction that you have ers, and identify the date when ted. The Health is documenting Correction Orders using ag numbers have been lota state statutes/rules for umber appears in the far left of Prefix Tag." The state ompliance is listed in the ent of Deficiencies" column to Comply" portion of the nis column also includes the nis violation of the state statute in the surveyors findings Method of Correction and	2 000			
2 265	·	5 Notification of Chg in	2 265			3/13/17

Minnesota Department of Health

STATE FORM 6899 NQV411 If continuation sheet 2 of 38

STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00968	B. WING		02/1	0/2017
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE	•	
VALLEY	CARE AND REHAB L	1 ('	I STREET SO ILLE, MN 5	OUTHEAST, BOX 129 6514		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETE DATE
2 265	policies to guide staphysicians, physicians, physicians practitioners, and if legal representative member of a reside accident, or death. nursing services, an attending physician development of the have criteria which appropriate notifica. A. an accident results in injury and physician interventi B. a significant physician interventi B. a significant physical, mental, o example, a deterior psychosocial status conditions or clinical conditions or clinical conditions or clinical example, a need to of treatment due to begin a new form of the sident from the need to deside the conditions of the sident from the need to deside the conditions of the sident from the need to deside the conditions of the sident from the need to deside the conditions of the sident from the need to deside the conditions of the sident from the need to deside the conditions of the sident from the need to deside the sident from the si	ast develop and implement aff decisions to consult an assistants, and nurse known, notify the resident's or an interested family ent's acute illness, serious. At a minimum, the director of and the medical director or an must be involved in the se policies. The policies must address at least the tion times for: involving the resident which has the potential for requiring on; change in the resident's resychosocial status, for ation in health, mental, or in either life-threatening al complications; ter treatment significantly, for discontinue an existing form adverse consequences, or to f treatment; o transfer or discharge the	2 265			
	by: Based on observati review, the facility for a significant change	on, interview and record ailed to notify the physician of of condition for 1 of 1		corrected		

Minnesota Department of Health

STATE FORM 6899 NQV411 If continuation sheet 3 of 38

AND DIAN OF CORRECTION IN IDENTIFICATION NUMBER:		` ′	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED	
			7 11 20 12 2 11 10 1			
		00968	B. WING		02/1	0/2017
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
VALLEY	CARE AND REHAB L	1 (=	I STREET SO /ILLE, MN 5	OUTHEAST, BOX 129 6514		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 265	Continued From pa	age 3	2 265			
	pressure ulcer deve	eloped in the facility.				
	Findings include:					
	12/1/16, identified I required extensive daily living (ADLs). R32 was at risk for	inimum Data Set (MDS) dated R32 had intact cognition and assistance with all activities of The MDS further identified developing pressure ulcers, ssure ulcers and utilized a device in her chair.				
		rders dated 11/17/16, identified s which included osteoporosis ma.				
	12/1/16, identified for pressure ulcers and	ssessment (CAA) dated R32 was at risk for developing d required assessment. The required a cushion for her relief.				
		p.m. the director of nursing had a current unstageable ner left heel.				
	lying on her back in her torso and lower remained on her bat assistant (NA)-C er with morning cares that covered R32, but directly on a pillow, and a second pillow calves. R32's left house centimeter (cm) siz the heel, which had dark brown/black in	a.m. R32 had her eyes closed, a bed with bed linens covering rextremities. At 7:54 a.m., R32 ack in bed and nursing attered the room to assist R32. NA-C removed the bed linens both R32's heels/feet rested covered in white cloth socks was observed under R32's eel had an approximate 2.5 and approximate 1.5 cm sized regular shaped scab in the with a yellow colored slough				

Minnesota Department of Health

STATE FORM 6899 NQV411 If continuation sheet 4 of 38

PRINTED: 04/14/2017 FORM APPROVED

Minnesota Department of Health
STATEMENT OF DEFICIENCIES (X1)

	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00968	B. WING		02/1	0/2017
NAME OF	PROVIDER OR SUPPLIER		DRESS, CITY, S	STATE, ZIP CODE		, _ , _ ,
VALLEY	CARE AND REHAB L	1 (:	I STREET SO	OUTHEAST, BOX 129 6514		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 265	(non-viable yellow, tissue; usually mois mucinous in texture the base of the wou throughout the wousurrounded the ent On 2/8/17, at 12:59 (DON) stated R32 pressure ulcers. Do record at that time R32's previous presindicated the facility pressure ulcer had tie up shoes. DON current pressure ulcer had tie up shoes. DON current pressure ulcer diacked docu monitoring, and indifficulty needed to in On 2/8/17, at 1:14 pwheelchair in her roshoes on both feet. the surveyor in the pressure ulcer after shoe from R32's lecurrent pressure ulcer after shoe from R32's lecurrent pressure ulcer occurrent	tan, gray, green or brown st, can be soft, stringy and st. Slough may be adherent to and or present in clumps and bed) area which ire scab. p.m. director of nursing was at risk for development of DN reviewed R32's clinical and stated the record indicated soure ulcer had resolved. She whad felt the previous been caused by R32's brown stated R32 did not have a cer. DON confirmed R32's mentation of weekly skin icated this was an area the	2 265			

Minnesota Department of Health

STATE FORM 6899 If continuation sheet 5 of 38 NQV411

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		00968	B. WING		02/1	0/2017
VALLEY CARE AND REHABILIC 600 FIFTH				STATE, ZIP CODE DUTHEAST, BOX 129 6514		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 265	record. She also ind nurses to complete assess and report a for treatment. She in R32 had a current pof the pressure ulconotified the physicia ulcer. DON did not regarding notifying R32 had a current to On 2/9/17, at 12:00 interview, R32's phyhad developed a prhad seen the pressure He indicated he had current pressure ulconotic progress not skin/wound docume 1/18/17 to 2/09/17, -1/8/2017, identified to left heel had closside of both knees stomach. However, status of left heel producern -1/26/2017, skin/wound concern -1/26/2017, skin/wound -1/26/2017, skin/wound concern -1/26/2017, s	dicated she expected all the weekly skin inspections, abnormalities to the physician indicated she was not aware pressure ulcer and the status or until 2/8/17, and had not an of the current pressure offer any other information the survey team on 2/6/17 that unstageable pressure ulcer. p.m. during a telephone ysician (MD)-A confirmed R32 essure ulcer in December, ure ulcer last on 1/3/17, and ulcer was healing at that time. It not been notified of R32's cer. es which included all entation was reviewed from and revealed: d unstageable pressure ulcer red. mall red dots on the front and and has redness at skin fold of the note did not address				

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	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00968	B. WING		02/1	0/2017
NAME OF I	PROVIDER OR SUPPLIER		DRESS. CITY. S	STATE, ZIP CODE	02/1	0/2017
	CARE AND REHAB L	600 FIFTH	STREET S	OUTHEAST, BOX 129		
			/ILLE, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 265	Continued From pa	ge 6	2 265			
	-2/9/17, skin/wound concern	I note listed no areas of				
	Treatment of Skin E revealed when a re pressure ulcer the t Braden Scale Asse	ty policy, Prevention and Breakdown, dated 11/1/15, sident developed a new facility would initiate a TTT, a ssment and complete an isk factors and reevaluate rs.				
	dated 11/1/15, reversk for pressure uld weekly to identify a integrity. The policy designated bath da compele a head to any alterations in slevaluation of the wasurrounding tissues	s and treatments, any action and document findings				
	The director of nursimplement policies notifying the physic conditions, includin development of pre The quality assessing the property of the	essure ulcers. ment and assurance erform random audits to				
	TIME PERIOD FOR days.	R CORRECTION: Twenty (21)				

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STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00968	B. WING		02/1	0/2017
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
VALLEY	CARE AND REHAB L	I (:		OUTHEAST, BOX 129		
040 15	CLIMMA DV CTA		ILLE, MN 5		DNI .	()(5)
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF	D BE	(X5) COMPLETE DATE
2 565	Continued From pa	ge 7	2 565			
2 565	MN Rule 4658.0405 Plan of Care; Use	5 Subp. 3 Comprehensive	2 565			3/13/17
		omprehensive plan of care personnel involved in the .				
	by: Based on observati review the facility fa interventions for rou resident (R20) who development of pre facility failed to impl	ent is not met as evidenced on, interview and document iled to implement care plan utine repositioning for 1 of 1 was identified at risk for ssure ulcers. In addition, the ement skin monitoring related resident (R37) who currently ant therapy.		corrected		
	Findings include:					
	at risk for altered sk	ed 1/24/16, identified R20 was kin integrity and directed t R20 to reposition every two				
		sing assistant care guide, red turning and repositioning				
		observation on 2/8/17, from am. revealed the following:				
		was seated in a wheelchair in her room, wore a hospital on.				

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TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) 2 565 Continued From page 8 - At 7:47 a.m. R20 remained seated in a wheelchair in her room. R20 had not made any independent changes in position, no staff were observed to offer R20 assistance with repositioning or cares. - At 8:19 a.m. R20 remained seated in the wheelchair in her room in a hospital gown. At that time, nursing assistant (NA)-D entered R20's room, draped a housecoat over R20's chest. At		NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		SURVEY PLETED
VALLEY CARE AND REHAB LLC 600 FIFTH STREET SOUTHEAST, BOX 129 BARNESVILLE, MN 56514 (X4) ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 2 565 Continued From page 8 - At 7:47 a.m. R20 remained seated in a wheelchair in her room. R20 had not made any independent changes in position, no staff were observed to offer R20 assistance with repositioning or cares. - At 8:19 a.m. R20 remained seated in the wheelchair in her room in a hospital gown. At that time, nursing assistant (NA)-D entered R20's room, draped a housecoat over R20's chest. At			00968	B. WING		02/	10/2017
(X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 2 565 Continued From page 8 - At 7:47 a.m. R20 remained seated in a wheelchair in her room. R20 had not made any independent changes in position, no staff were observed to offer R20 assistance with repositioning or cares. - At 8:19 a.m. R20 remained seated in the wheelchair in her room in a hospital gown. At that time, nursing assistant (NA)-D entered R20's room, draped a housecoat over R20's chest. At	NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 2 565 Continued From page 8 - At 7:47 a.m. R20 remained seated in a wheelchair in her room. R20 had not made any independent changes in position, no staff were observed to offer R20 assistance with repositioning or cares. - At 8:19 a.m. R20 remained seated in the wheelchair in her room in a hospital gown. At that time, nursing assistant (NA)-D entered R20's room, draped a housecoat over R20's chest. At	VALLEY	CARE AND REHAB L	1 (:				
- At 7:47 a.m. R20 remained seated in a wheelchair in her room. R20 had not made any independent changes in position, no staff were observed to offer R20 assistance with repositioning or cares. - At 8:19 a.m. R20 remained seated in the wheelchair in her room in a hospital gown. At that time, nursing assistant (NA)-D entered R20's room, draped a housecoat over R20's chest. At	PRÉFIX	(EACH DEFICIENCY	/ MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF	HOULD BE	COMPLETE
that time NA-E entered R20's room, draped a blanket over R20's lap and proceeded to wheel R20 to the dining room. NA-D and NA-E were not observed to offer R20 assistance with repositioning. - At 8:40 a.m. R20 remained seated in the wheelchair in the dining room and ate independently. R20 was not observed to make any independent changes in position. - At 8:57 a.m. R20 remained seated in the wheelchair in the dining room. R20 was not observed to make any independent changes in position. - At 9:07 a.m. R20 remained seated in the wheelchair in the dining room. At that time registered nurse (RN)-A approached R20 and was observed to administer medications to R20 and immediately walked away. - At 9:20 a.m. R20 had remained seated in the wheelchair in the dining room and was wheeled to the resident lobby by an activity aid to listen to trivia. R20 had remained seated in the wheelchair at that time for a total of 2 hours and 10 minutes. - At 9:40 a.m. R20 had remained seated in the wheelchair in the resident lobby. R20 had made	2 565	- At 7:47 a.m. R20 wheelchair in her ro independent chang observed to offer R repositioning or car - At 8:19 a.m. R20 wheelchair in her ro time, nursing assist room, draped a houthat time NA-E enter blanket over R20's R20 to the dining ro observed to offer R repositioning. - At 8:40 a.m. R20 wheelchair in the di independently. R20 any independent chair in the di observed to make a position. - At 9:07 a.m. R20 wheelchair in the di registered nurse (R was observed to ac and immediately was observed to ac and immediately was wheelchair in the di the resident lobby by trivia. R20 had rem at that time for a total chair in the di registered nurse (R was observed to ac and immediately was observed to accomplish the resident lobby by the resident lobby b	remained seated in a com. R20 had not made any es in position, no staff were 20 assistance with es. remained seated in the com in a hospital gown. At that tant (NA)-D entered R20's usecoat over R20's chest. At ered R20's room, draped a lap and proceeded to wheel com. NA-D and NA-E were not 20 assistance with remained seated in the ming room and ate was not observed to make manges in position. remained seated in the ming room. R20 was not cany independent changes in position and independent changes in the ming room. At that time in the ming room and was not cany independent changes in the ming room and was wheeled to calked away. The mained seated in the ming room and was wheeled to calked away. The mained seated in the ming room and was wheeled to calked away. The mained seated in the ming room and was wheeled to calked away and to listen to calked seated in the wheelchair tall of 2 hours and 10 minutes.	2 565			

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NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE SOF IFTH STREET SOUTHEAST, BOX 129 BARNESVILLE, IM SOS144 PRIPER TAQ SUBMARKY STATEMENT OF DEFICIENCIES PREFIX TAQ SUBMARKY STATEMENT OF DEFICIENCIES EACH DEFIDIOR WIST BE PRECEDED BY YOUL FREGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAQ 2 565 Continued From page 9 no independent changes in position. No staff were observed to offer R20 assistance with repositioning. - At 9:57 a.m. NA-C was notified R20 had been up in the wheelchair without repositioning every 2 hours and was unsure of when R20 had last been repositioned. R20 was then wheeled to her room by NA-C. - At 10:08 a.m. R20 remained seated in the wheelchair in her room while NA-C and NA-E placed clean bedding on R20's bed. - At 10:13 a.m. NA-C and NA-E assisted R20 to transfer with a full mechanical lift from the wheelchair to her bed. NA-E removed the lift sling and assisted R20 to roll towards NA-C. NA-C removed R20's dry incontinent brief which revealed R20's skin on the buttocks and back of upper thighs were bright red in color, skin intact. -R20 remained in an observed seated position from 7:10 a.m. to 10:13 a.m. a total of 3 hours and 3 minutes. During interview on 2/8/17, at 9:57 a.m. NA-C stated R20 was to be repositioned and toileted every two hours. NA-C stated she was unsure of the last time R20 was repositioned and her usual practice to keep track of repositioning, was to keep an eye on the clock. NA-C Stated that was the method staff used to ensure residents received timely tolleting and repositioning. During interview on 2/8/17, at 10:01 a.m. NA-E	AND DIANIOE CORRECTION IN INDENTIFICATION NI IMPER-		` '	E CONSTRUCTION	(X3) DATE COMP	SURVEY	
SUMMARY STATEMENT OF DEFICIENCIES PREVIOUS PREVIO			00968	B. WING		02/1	0/2017
PROVIDER'S PLAN OF CORRECTION PREFIX TABLE PROVIDER'S PLAN OF CORRECTION PREFIX TAG	NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
PRIEFIX TAG RESOLATORY OR LSC IDENTIFYING INFORMATION) 2 565 Continued From page 9 no independent changes in position. No staff were observed to offer R20 assistance with repositioning. - At 9:57 a.m. NA-C was notified R20 had been up in the wheelchair without repositioning since 7:10 a.m. At that time NA-C stated R20 needed assistance with repositioned satistance with repositioned and NA-C. - At 10:08 a.m. R20 remained seated in the wheelchair in her room while NA-C and NA-E placed clean bedding on R20's bed. - At 10:13 a.m. NA-C and NA-E assisted R20 to transfer with a full mechanical lift from the wheelchair to her bed. NA-E removed the lift sling and assisted R20 roll to roll towards NA-C. NA-C removed R20's skin on the buttocks and back of upper thighs were bright red in color, skin intact. -R20 remained in an observed seated position from 7:10 a.m. to 10:13 a.m. a total of 3 hours and 3 minutes. During interview on 2/8/17, at 9:57 a.m. NA-C stated R20 was to be repositioned and her usual practice to keep track of repositioning was to keep an eye on the clock. NA-C stated that was the method staff used to ensure residents received timely toleting and repositioning. During interview on 2/8/17, at 10:01 a.m. NA-E.	VALLEY	CARE AND REHAB L	1 (=				
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stated R20 had not been repositioned or checked	2 565	no independent chawere observed to or repositioning. - At 9:57 a.m. NA-Cup in the wheelchair 7:10 a.m. At that tim assistance with repositioned. R20 wby NA-C. - At 10:08 a.m. R20 wheelchair in her repositioned clean beddir - At 10:13 a.m. NA-transfer with a full numbeelchair to her be and assisted R20 to removed R20's dry revealed R20's skin upper thighs were be received timely to least time R20 was to be every two hours. Note the method staff us received timely toiled.	anges in position. No staff ffer R20 assistance with was notified R20 had been r without repositioning since he NA-C stated R20 needed ositioning every 2 hours and n R20 had last been was then wheeled to her room on the needed of the needed of the needed os the needed of the needed				

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NAME OF PROVIDER OR SUPPLIER VALLEY CARE AND REHAB LLC SOFITH STREET SOUTHEAST, BOX 129 BANNESVILLE, MN 56514 CV4, ID CV4, ID CV5, ID CV6,	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				(X3) DATE COMP	SURVEY LETED	
NAME OF PROVIDER OR SUPPLIER VALLEY CARE AND REHAB LLC SOO FIFTH STREET SOUTHEAST, BOX 129 BARNESVILLE, MN 56514 PREFIX (EACH DEVELOPED BY THE STREET SOUTHEAST, BOX 129 EACH DEVELOPED BY THE STREET SOUTHEAST, BOX 129 EACH DEVELOPED BY THE STREET SOUTHEAST, BOX 129 EACH DEVELOPED BY THE STREET SOUTHEAST, BOX 129 BARNESVILLE, MN 56514 PREFIX (EACH DEVELOPED BY THE STREET SOUTHEAST, BOX 129 EACH DEVELOP BY THE STREET COURSE. LPAN 15 EACH DEVELOP BY THE STREET COU			00968	B. WING		02/1	0/2017
CALLET CARE AND REPASE LLC CALLET CARE AND REPASE LACTOR CALLET CARE AND ACCORPRECTION	NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE	•	
PRÉFIX TAG REGOULATORY OR LSC IDENTIFYING INFORMATION) 2 566 Continued From page 10 NA-E stated was not able to independently reposition. During interview on 2/8/17, at 1:1 p.m. licensed practical nurse (LPN)-A confirmed R20 was at risk for developing pressure ulcers. LPN-A confirmed R20 was at risk for developing pressure ulcers. LPN-A reported staff were expected to reposition R20 every two hours and as needed. LPN-A confirmed R20 was at risk for developing pressure ulcers. LPN-A confirmed three hours was too long to sit in the wheelchair without repositioning. During interview on 2/9/17, at 8:37 a.m. the director of nursing (DON) confirmed R20 was at risk for development of pressure ulcers due to bowel and bladder incontinence, and immobility. The DON reported she added the specific interventions on the nursing assistance care guides after the comprehensive assessments and considered the care guides as an extension of the resident's care plan. The DON stated she expected R20 would have been repositioned and incontinence care provided every two hours to reduce risk of future skin breakdown. The DON stated there was no formal system in place to ensure timely cares were completed. The DON stated she was unsure how the staff were ensuring residents received timely care. The DON confirmed timely resident cares were not being monitored. The DON stated the point of care system captured resident care were not being monitored. The DON stated the point of care system captured resident care were not being monitored. The DON stated the point of care system captured resident care were not being monitored. The DON stated the point of care system captured resident care were not being monitored. The DON stated the point of care system captured resident care were not only the provident captured resident care document/report adverse reactions to anticoagulant therapy, directed staff to monitor/document/report adverse reactions to anticoagulant therapy which included bruising and	VALLEY	CARE AND REHAB L	I (=				
NA-E stated was not able to independently reposition. During interview on 2/8/17, at 1:1 p.m. licensed practical nurse (LPN)-A confirmed R20 was at risk for developing pressure ulcers. LPN-A reported staff were expected to reposition R20 every two hours and as needed. LPN-A confirmed three hours was too long to sit in the wheelchair without repositioning. During interview on 2/9/17, at 8:37 a.m. the director of nursing (DON) confirmed R20 was at risk for development of pressure ulcers due to bowel and bladder incontinence, and immobility. The DON reported she added the specific interventions on the nursing assistance care guides after the comprehensive assessments and considered the care guides as an extension of the resident's care plan. The DON stated she expected R20 would have been repositioned and incontinence care provided every two hours to reduce risk of future skin breakdown. The DON stated there was no formal system in place to ensure timely cares were completed. The DON stated she was unsure how the staff were ensuring residents received timely care. The DON confirmed timely resident cares were not being monitored. The DON stated the point of care system captured resident care documentation, but not in actual time. R37's care plan dated 12/10/16, identified R37 was on anticoagulant therapy, directed staff to monitor/document/report adverse reactions to anticoagulant therapy which included bruising and directed staff to complete daily skin inspections	PREFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO	LD BE	COMPLETE
On 2/07/17, at 12:00 p.m. R37 was seated in her	2 565	NA-E stated was not reposition. During interview on practical nurse (LPI risk for developing preported staff were every two hours and confirmed three how wheelchair without of the Don reported interventions on the guides after the conconsidered the care resident's care plan expected R20 would incontinence care preduce risk of future stated there was not ensure timely cares stated she was unsensuring residents in Don confirmed timbeing monitored. To care system capture documentation, but R37's care plan dat was on anticoagular theral directed staff to contant report abnormal	2/8/17, at 1:1 p.m. licensed N)-A confirmed R20 was at pressure ulcers. LPN-A expected to reposition R20 das needed. LPN-A ars was too long to sit in the repositioning. 2/9/17, at 8:37 a.m. the DON) confirmed R20 was at at of pressure ulcers due to incontinence, and immobility. She added the specific enursing assistance care inprehensive assessments and a guides as an extension of the incorposition and i				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLI A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00968	B. WING		02/1	10/2017
	PROVIDER OR SUPPLIER CARE AND REHAB L	600 FIFTH		OUTHEAST, BOX 129 6514		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
2 565	wheelchair in her ro (FM)-A present. Irregreen bruises, apprediameter, were observed and several purples sizes were observed FM-A stated R37 has past, and obtained R37 was forgetful at Review of R37's progressive and side to the side	com with a family member egular shaped yellow/light coximately 1.5 inch in erved on both lower cheeks colored bruises in various d on the tops of both hands. and fallen in the facility in the the bruises. She indicated and did not remember falling. Degress notes from 12/19/16 to a fall from bed and hit her ble and was bleeding from her had was sent to the emergency of the form of the result of the shoulder which measured in the fall of the saured 90 cm x 80 cm, and supper thigh area which is 150 cm. Deduction of the fall of th	2 565			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		00968	B. WING		02/1	0/2017
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
VALLEY	CARE AND REHAB L	1 (-	I STREET SO /ILLE, MN 5	OUTHEAST, BOX 129 6514		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 565	Continued From page 12		2 565			
	bruising was found	ntation of monitoring of R37's in the clinical record. 9 p.m. director of nurses				
	(DON) stated R37 the emergency root bruises. DON confi of monitoring of R3 the measurements	fell on 12/19/16, was sent to m and returned with significant rmed progress notes and lack 7's bruises and stated she felt of the bruises were likely an				
	error. She stated the usual facility practice when a bruise was identified was for the nurse to set up clinical weekly monitoring in the resident TAR. She stated she expected the nurse should have set up the bruise monitoring in the TAR when R37 returned from the emergency room and document weekly and confirmed the monitoring had not been done. She stated she expected orders to be followed, weekly skin inspections to be completed by nurses and bruises monitored.					
	dated 11/1/15, iden bath days the licens head to toe skin as	ty policy, Skin Assessment tified on residents designated sed nurse would complete a sessment and note any ondition and document an lectronic record.				
	indicated the reside appropriate care re	Plan Policy dated 9/14/15, ent care plan would ensure the quired to maintain or attain the evel of functioning possible.				
	The director of nurs implement policies ensuring staff imple	THOD FOR CORRECTION: sing (DON) or designee could and procedures related to ement resident care plans. ment and assurance				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
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VALLEY	CARE AND REHAB L	1 (=	I STREET SO /ILLE, MN 5	OUTHEAST, BOX 129 6514		
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2 565	Continued From pa	ge 13	2 565			
	committee could pe ensure compliance	erform random audits to				
	TIME PERIOD FOR days.	R CORRECTION: Twenty (21)				
2 830	MN Rule 4658.0520 Proper Nursing Car	O Subp. 1 Adequate and re; General	2 830			3/13/17
	receive nursing carcustodial care, and individual needs an the comprehensive plan of care as des 4658.0405. A nursi of bed as much as written order from the	general. A resident must e and treatment, personal and supervision based on d preferences as identified in resident assessment and scribed in parts 4658.0400 and ing home resident must be out possible unless there is a he attending physician that the in in bed or the resident				
	by: Based on observati review, the facility fa	ent is not met as evidenced on, interview and document ailed to monitor bruising for 1) reviewed for non-pressure ons.		corrected		
	Findings include:					
	1/12/17, identified F impairment, and rewith all activities of	imum Data Set (MDS) dated R37 had moderate cognitive quired extensive assistance daily living (ADL). The MDS R7 had no current skin				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
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VALLEY	CARE AND REHAB L	I (:	I STREET SO /ILLE, MN 5	OUTHEAST, BOX 129 6514		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 830	conditions/bruises. R37's care plan dat was on anticoagular monitor/document/anticoagulant thera directed staff to cor and report abnormal Review of order surrevealed R37 receive Coumadin (medica have every shift monanticoagulant thera On 2/07/17, at 12:0 wheelchair in her row (FM)-A present. Irregreen bruises, approximater, were obsund several purple sizes were observe FM-A stated R37 hapast, and obtained R37 was forgetful at Review of R37's progressive and several purple sizes were observe FM-A stated R37 hapast, and obtained R37 was forgetful at Review of R37's progressive and nose a room for evaluation -12/19/16, R37 returned and had a laceratio which was closed with back top of her	red 12/10/16, identified R37 nt therapy, directed staff to report adverse reactions to py which included bruising and implete daily skin inspections alities to nurse. Immary report dated 1/6/17, wed a routine daily dose of tion to thin blood) and was to initoring for bruising related to py. O p.m. R37 was seated in her room with a family member regular shaped yellow/light eximately 1.5 inch in erved on both lower cheeks colored bruises in various d on the tops of both hands. and fallen in the facility in the the bruises. She indicated and did not remember falling. Digress notes from 12/19/16 to a fall from bed and hit her ble and was bleeding from her and was sent to the emergency	2 830	DELINITY (

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		00968	B. WING		02/1	0/2017
NAME OF	PROVIDER OR SUPPLIER		DRESS, CITY, S	STATE, ZIP CODE	1 02/1	0/2011
VALLEY	CARE AND REHAB L	1 (:	I STREET SO /ILLE, MN 5	OUTHEAST, BOX 129 6514		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROL DEFICIENCY)	.D BE	(X5) COMPLETE DATE
2 830	Continued From pa	ge 15	2 830			
	a bruise to her left umeasured 230 cm	upper thigh area which x 150 cm.				
	-1/2/17, R37 had faded bruises to her left cheekbone, left shoulder and elbow from previously documented fall.					
	Administration Rec 2016 and January 2 various treatments included to monitor minutes two times a monitoring. However documentation of m	s monthly Treatment ords (TAR) for December 2017, revealed R37 had and monitoring in place which for ear wax, elevate feet 20 a day, and respiratory er, the TARs lacked nonitoring for bruising and tions to anticoagulant therapy.				
		ntation of monitoring of R37's in the clinical record.				
	(DON) stated R37 fthe emergency roof bruises. DON confiction of monitoring of R3 the measurements error. She stated the bruise was identified clinical weekly mone She stated she exposet up the bruise mone returned from the edocument weekly a had not been done orders to be followed be completed by number of the state	9 p.m. director of nurses fell on 12/19/16, was sent to m and returned with significant rmed progress notes and lack 7's bruises and stated she felt of the bruises were likely an e usual facility practice when a d was for the nurse to set up itoring in the resident TAR. ected the nurse should have onitoring in the TAR when R37 mergency room and and confirmed the monitoring. She stated she expected ed, weekly skin inspections to urses and bruises monitored.				
	dated 11/1/15, iden	ty policy, Skin Assessment tified on residents designated sed nurse would complete a				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		00968	B. WING		02/1	10/2017
	PROVIDER OR SUPPLIER CARE AND REHAB L	600 FIFTH		STATE, ZIP CODE DUTHEAST, BOX 129 6514		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 830	head to toe skin as alterations in skin cevaluation in the electric SUGGESTED MET The director of nurs	sessment and note any ondition and document an ectronic record. THOD FOR CORRECTION: sing (DON) or designee could	2 830			
	ensuring staff ident skin conditions, nor resolved. In addition implement policies ensuring staff and thoroughly reviews root cause and app ensure staff implement reduce injury and further quality assessing	and procedures related to ify and monitor bruising and in-pressure related until on, the DON or designee could and procedures related to the interdisciplinary team falls and accidents to identify ropriate interventions, and nent identified interventions to urther falls/accidents. ment and assurance erform random audits to				
	days.	R CORRECTION: Twenty (21)				
2 900	Subp. 3. Pressure comprehensive res of nursing services development of a n provides that:	sores. Based on the ident assessment, the director must coordinate the ursing care plan which	2 900			3/13/17
	without pressure so pressure sores unle condition demonstr	o enters the nursing home ores does not develop ess the individual's clinical ates, and a physician they were unavoidable; and				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		00968	B. WING		02/1	0/2017
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
VALLEY	CARE AND REHAB L	1 (-	ISTREET SO VILLE, MN 5	OUTHEAST, BOX 129 6514		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETE DATE
2 900	Continued From pa	ge 17	2 900			
	receives necessar	who has pressure sores by treatment and services to be revent infection, and prevent by eloping.				
	This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to comprehensively assess, accurately monitor and implement interventions for 1 of 1 resident (R32) with a reoccurring unstageable pressure ulcer to the heel. In addition, the facility failed to implement interventions to prevent development of pressure ulcers for 1 of 1 resident (R20) who was at risk for development of pressure ulcers. This deficient practice resulted in actual harm for R32 with the development of a recurring pressure ulcer.			corrected		
	12/1/16, identified Frequired extensive daily living (ADLs). R32 was at risk for had no current prespressure reducing of R32's admission or	ders dated 11/17/16, identified				
	R32's Care Area As 12/1/16, identified F pressure ulcers and	ssessment (CAA) dated R32 was at risk for developing d required assessment. The required a cushion for her				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		00968	B. WING		02/	10/2017
NAME OF	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, S	TATE, ZIP CODE		
VALLEY	CARE AND REHAB L	I (=	H STREET SC VILLE, MN 50	OUTHEAST, BOX 129 6514		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETE DATE
2 900	'	ge 18 ed 12/18/16, identified R32	2 900			
	had limited physical osteomyelitis of ver history of falls, was assistance from stal locomotion, and amdirected staff to ens footwear (laced, no or mobilizing in whe relieving cushion in indicated R32 had timpairment related fragile skin and utilicushion in wheelched directed staff R32 minspections to identiand any changes in to the nurse. Howevidentify R32's curredirection for the use to keep pressure of Review of the untitle	I mobility, related to tebra, weakness, had a weight bearing and required off for toileting, transfers, abulation. R32's care plan sure R32 wore appropriate skid shoes) when ambulating elchair, and use of a pressure the wheelchair. The care plan he potential/actual skin to contact dermatitis and zed a pressure relieving air. The care plan further equired weekly skin ify redness and open areas R32's skin were be reported ver, R32's care plan did not not pressure ulcer, and lacked to of Prevalon boots or pillows				
	guide, listed various which included assi transferring, dressir shoes at night. The	s directions for R32's cares stance with toileting, ng and directed the use of e care guide did not include re relief for R32's heels or use				
	used to determine a schedule) dated 11/ current skin integrit history of pressure hour repositioning p	ance Test (TTT) form (tool appropriate repositiong /21/16, identified R32 had no y concerns, did not have a ulcers and could tolerate a 2 program. No further TTT forms is clinical record, despite ssure ulcers.				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00968	B. WING		02/1	0/2017
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
VALLEY	CARE AND REHAB L	1 (=	STREET SO	OUTHEAST, BOX 129		
(V4) ID	SLIMMARY STA	TEMENT OF DEFICIENCIES	ID ID	PROVIDER'S PLAN OF CORRECT	ION	(VE)
(X4) ID PREFIX TAG	(EACH DEFICIENCY	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 900	Continued From pa	ge 19	2 900			
	11/29/16, 12/2/16, a had very moist skin friction and shear, water majority of her time risk for developmer. Review of R32's Sk dated 11/21/16, ide of purple spots on the bleeding from smalextremities, and ide Review of the untitle facility, dated 12/23 various resident natheform listed R32 review, had 3 centires the middle of her so	e Assessment (risk ssure ulcers) forms dated and 12/6/16, identified R32, had potential problem for walked occasionally, spent the in her chair or bed and was at at of pressure ulcers. Sin Observation Tool form ntified R32 had purpura (rash he skin caused by internal I blood vessels) on upper entified no other open areas. Bed form provided by the 1/16, revealed the form listed mes and reason to be seen. I had 12/20/16, labs for meter (cm) blackened area in ole of the left foot, edges were ster form, and center was				
	(DON) stated R32 h pressure ulcer on h On 2/8/17, at 7:12 a lying on her back in her torso and lower remained on her ba assistant (NA)-C er with morning cares linens, and both R3 on a pillow, covered second pillow was of The heels/feet were	o.m. the director of nursing had a current unstageable er left heel. a.m. R32 had her eyes closed, bed with bed linens covering extremities. At 7:54 a.m. R32 ack in bed and nursing hered the room to assist R32. NA-C pulled down R32' bed 2's heels/feet rested directly d in white cloth socks and a observed under R32's calves. In the content of the pillow to happroximately 2.5 centimeter				

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00069	B. WING		00/1	0/2017
		00968			02/1	0/2017
NAME OF F	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
VALLEY	CARE AND REHAB L	I (:	ILLE, MN 5	OUTHEAST, BOX 129 6514		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROFIDEFICIENCY)	D BE	(X5) COMPLETE DATE
2 900	observed, and an a dark brown/black in center of the area w (non-viable yellow, tissue; usually mois mucinous in texture the base of the wou throughout the wou surrounded the entito lift each foot/leg tompression hose treapply both socks place R32's heels/fe alternating between lower extremities. Fithe pillow during mon NA-C assisted R32 transfer into the sea proceeded to assist On 2/8/17, at 9:03 a been unaware R32's heel docares. She indicated tried the boots (Predunderstood R32 did on 2/8/17, at 9:16 a should be off the behanging off the pillobed or pillow. On 2/8/17, 9:24 a.m (LPN)-A stated R32 of pressure ulcers a R32 had a current part of the pillog of the pi	ea on the back of the heel was pproximately 1.5 cm sized regular shaped scab in the with a yellow colored slough tan, gray, green or brown at, can be soft, stringy and a Slough may be adherent to and or present in clumps and bed) area which re scab. NA-C assisted R32 to remove the socks, apply to both lower extremities and to her feet. NA-C continued to be the directly on to the pillow, a assisting to dress R32's R32's heels rested directly on borning cares. At 8:00 a.m., to sit on the edge of the bed, at of a wheelchair and at R32 into the bathroom. a.m. NA-C stated she had sheels were resting directly and been unaware she had irectly on the pillow during dishe thought the facility had walon) with R32 once, and	2 900			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		00968	B. WING		02/	10/2017
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE		
		600 FIFTI	H STREET SO	UTHEAST, BOX 129		
VALLEY	CARE AND REHAB L	I (=	VILLE, MN 56			
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CO	RRECTION	(X5)
PRÉFIX TAG		' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)		COMPLETE DATE
2 900	Continued From pa	ge 21	2 900			
	stated R32 had a po the past which had not have a current p	n. registered nurse (RN)-A ressure ulcer at her left heel in resolved, and stated she did pressure ulcer. She stated she risk for pressure ulcers at this				
	seated in a wheelch wore brown tie up s rested on the foot p At 12:36 p.m., R32 in the dining room, both feet. At 3:08 p.m., R32 w the dining room, pa several other reside	a.m. R32 was observed nair in the dining room. R32 shoes on both feet, which edals of the wheelchair. was seated in her wheelchair with the same brown shoes on as seated in her wheelchair in rticipating in an activity with ents. R32 continued to wear up shoes on both feet.				
	risk for developmer reviewed R32's clin stated the record in pressure ulcer had indicated the facility pressure ulcer had tie up shoes. DON current ulcer. She comprehensive skir been completed on development of R32 DON confirmed R32 documentation of windicated this was a improve on. She incaware of the previotold facility staff her shoe and felt the previores.	p.m. DON stated R32 was at at of pressure ulcers. DON ical record at that time and dicated R32's previous resolved/closed. She had felt the previous been caused by R32's brown stated R32 did not have a confirmed the most current assessment for R32 had 12/6/17, prior to the 2's previous pressure ulcer. 2's record lacked reekly skin monitoring, and an area the facility needed to dicated the facility had become us pressure ulcer when R32 foot was uncomfortable in the essure ulcer had been caused shoe. DON stated the facility				

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NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 600 FIFTH STREET SOUTHEAST, BOX 129 BARNESVILLE, MN 56514 CAN IDEA PROVIDERS PLAN OF CORRECTION SHOULD BE PRECEDED BY FULL AREGULATORY OR LSC DENTIFYING INFORMATION) PREPRINT TAG PROVIDERS PLAN OF CORRECTION SHOULD BE CROSS REFERENCES OF TAG PROPOPRIATE DEFICIENCY) 2 900 Continued From page 22 2 900 Should have comprehensively assessed R32's pressure ulcer. On 2/B/17, at 1:14 p.m. R32 was seated in her wheelchair in her room and wore the brown tie up shoes on both feet. The DON was present with the surveyor in the room and visualized R32's pressure ulcer after DON removed the brown shoe from R32's left too. DON stated R32's current pressure ulcer measured .05 cm wide by 1.0 cm long, with white/back scab and skin surrounding the area was pink in color. She stated she would expect staff to complete a comprehensive reassessment for R32 at the time the reoccurring pressure ulcer had developed. On 2/9/17, at 9:03 a.m. NA-A stated R32 had not worn her brown shoes for about a month after she developed an open area on her foot. NA-A stated she understood since R32's open area had healed, she could wear the brown shoes and indicated she wore them routinely. On 2/9/17, at 9:05 a.m. R32 stated staff routinely place pillows under her heels at night. She stated she needed staff assistance to apply her shoes and she did not remember the last time she wore her shoes.	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
NAME OF PROVIDER OR SUPPLIER VALLEY CARE AND REHAB LLC (A) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL MY TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL MY TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL MY TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL MY TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL MY TAG (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) 2 900 Continued From page 22 2 900 should have comprehensively assessed R32's pressure ulcer my heelchair in her room and wore the brown tie up shoes on both feet. The DON was present with the surveyor in the room and visualized R32's pressure ulcer after DON removed the brown shoe from R32's left foot. DON stated R32's current pressure ulcer measured .05 cm wide by 1.0 cm long, with white/back scab and skin surrounding the area was pink in color. She stated she would expect staff to complete a comprehensive reassessment for R32 at the time the reoccurring pressure ulcer had developed. On 2/9/17, at 9:03 a.m. NA-A stated R32 had not worn her brown shoes for about a month after she developed an open area on her foot. NA-A stated she understood since R32's open area had healed, she could wear the brown shoes and indicated she wore them routinely. On 2/9/17, at 9:05 a.m. R32 stated staff routinely place pillows under her heels at night. She stated she needed staff assistance to apply her shoes and she did not remember the last time she wore			00968	B. WING		02/1	0/2017
XA, ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY 2 900 Continued From page 22 2 900 Should have comprehensively assessed R32's pressure ulcer. On 2/8/17, at 1:14 p.m. R32 was seated in her wheelchair in her room and wore the brown tie up shoes on both feet. The DON was present with the surveyor in the room and visualized R32's pressure ulcer after DON removed the brown shoe from R32's left foot. DON stated R32's current pressure ulcer measured .05 cm wide by 1.0 cm long, with white/back scab and skin surrounding the area was pink in color. She stated she would expect staff to complete a comprehensive reassessment for R32 at the time the reoccurring pressure ulcer had developed. On 2/9/17, at 9:03 a.m. NA-A stated R32 had not worn her brown shoes for about a month after she developed an open area on her foot. NA-A stated she understood since R32's open area had healed, she could wear the brown shoes and indicated she wore them routinely. On 2/9/17, at 9:05 a.m. R32 stated staff routinely place pillows under her heels at night. She stated she needed staff assistance to apply her shoes and she did not remember the last time she wore	NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 2 900 Continued From page 22 should have comprehensively assessed R32's pressure ulcer. On 2/8/17, at 1:14 p.m. R32 was seated in her wheelchair in her room and wore the brown tie up shoes on both feet. The DON was present with the surveyor in the room and visualized R32's pressure ulcer after DON removed the brown shoe from R32's left foot. DON stated R32's current pressure ulcer measured .05 cm wide by 1.0 cm long, with white/back scab and skin surrounding the area was pink in color. She stated she would expect staff to complete a comprehensive reassessment for R32 at the time the reoccurring pressure ulcer had developed. On 2/9/17, at 9:03 a.m. NA-A stated R32 had not worn her brown shoes for about a month after she developed an open area on her foot. NA-A stated she understood since R32's open area had healed, she could wear the brown shoes and indicated she wore them routinely. On 2/9/17, at 9:05 a.m. R32 stated staff routinely place pillows under her heels at night. She stated she needed staff assistance to apply her shoes and she did not remember the last time she wore	VALLEY	CARE AND REHAB L	1 (-				
should have comprehensively assessed R32's pressure ulcer. On 2/8/17, at 1:14 p.m. R32 was seated in her wheelchair in her room and wore the brown tie up shoes on both feet. The DON was present with the surveyor in the room and visualized R32's pressure ulcer after DON removed the brown shoe from R32's left foot. DON stated R32's current pressure ulcer measured .05 cm wide by 1.0 cm long, with white/back scab and skin surrounding the area was pink in color. She stated she would expect staff to complete a comprehensive reassessment for R32 at the time the reoccurring pressure ulcer had developed. On 2/9/17, at 9:03 a.m. NA-A stated R32 had not worn her brown shoes for about a month after she developed an open area on her foot. NA-A stated she understood since R32's open area had healed, she could wear the brown shoes and indicated she wore them routinely. On 2/9/17, at 9:05 a.m. R32 stated staff routinely place pillows under her heels at night. She stated she needed staff assistance to apply her shoes and she did not remember the last time she wore	PREFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO	.D BE	COMPLETE
On 2/9/17, at 9:15 a.m. NA-D confirmed R32 currently had an open area on her left heel and indicated she had notified the nurses and DON about the open area in the past. She indicated she felt R32 had not worn shoes since she had been admitted to the facility. On 2/9/17, at 9:40 a.m. during a follow up interview, the DON stated she felt there was no way to accurately determine when R32's current	2 900	should have compressure ulcer. On 2/8/17, at 1:14 p wheelchair in her roshoes on both feet, the surveyor in the pressure ulcer after shoe from R32's left current pressure ulcarent pressure ul	ehensively assessed R32's o.m. R32 was seated in her from and wore the brown tie up The DON was present with froom and visualized R32's DON removed the brown it foot. DON stated R32's or measured .05 cm wide by hite/back scab and skin froe was pink in color. She expect staff to complete a ssessment for R32 at the time from and visualized R32 had not froes for about a month after fropen area on her foot. NA-A frood since R32's open area had froe was the brown shoes and from R32 stated staff routinely from	2 900			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		00968	B. WING		02/1	10/2017
NAME OF	PROVIDER OR SUPPLIER		DRESS CITY S	TATE, ZIP CODE	1 0=/-	. 0, 20 11
		600 FIFTH		OUTHEAST, BOX 129		
VALLEY	CARE AND REHAB L	1 (=	/ILLE, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE	(X5) COMPLETE DATE
2 900	Continued From pa	ge 23	2 900			
		cer and indicated she felt the cer had reopened soon after				
	facility practice was weekly skin check if document the resul resident clinical rec R32's care plan and care guide and stat designated wound nursing assistants it nurses and nurses indicated she experimental statement of the confirmed R32 had after admission, at had caused the pre R32 had stopped with discussed alternative the facility was concomewhere else or once R32's shoes we putting gas onto a formal result of the confirmed R32 had stopped with the facility was concomewhere else or once R32's shoes we putting gas onto a formal result in the facility was concomewhere else or once R32's shoes we putting gas onto a formal result in the facility was concomewhere else or once R32's shoes we putting gas onto a formal result in the resu	a.m. DON added the usual for the nurses to complete a for all residents, and to ts of the skin check in the ord. The DON confirmed discurrent nursing assistant ed the facility did not have a nurse but she expected to report any changes to the to assess the area. She also cted all the nurses to complete ions, assess and report exphysician for treatment. DON developed a pressure ulcer that time she felt the shoes ssure ulcer. She indicated rearing the shoes and staff had be shoes for R32, however, cerned about causing a blister the foot. DON stated she felt were worn again, it was like ire. She stated R32 was a not all DON stated she are the possible of the stated R32 was a not all DON stated she said to the possible of the po				
	her brown shoes da R32 required assist DON stated R32 ha the past June 2016	ad DON confirmed R32 wore ally at present, and confirmed cance with applying her shoes. ad not seen a podiatrist since, she stated she had not had 's current pressure ulcer since he pressure ulcer.				
	had R32 remove th weeks after the pre developed and afte resumed wearing th	a.m. DON stated the facility e brown tie up shoes for 2 vious pressure ulcer r the 2 weeks, R32 had ne shoes. Further, the DON visualized R32's left heel				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00968	B. WING		02/1	0/2017
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
VALLEY	CARE AND REHAB L	1 (=	I STREET SO /ILLE, MN 5	OUTHEAST, BOX 129 6514		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 900	pressure since 12/2 in the facility. She in R32 had a current of the pressure ulce notified the physicia ulcer. DON did not regarding notifying R32 had a current of the pressure ulcer. DON did not regarding notifying R32 had a current of the pressure ulcer, and developed a prarea had been dent of erythema. He stabout development started her on antibindicated he was urpressure ulcer, had on 1/3/17, and he for healing at that time to heal. On 2/10/17, at 8:50 interview in the faci previous pressure usuperficial. He indicand inflamed, and hopen area because osteomyelitis and non 1/3/17, he had fulcer was healing. R32's left heel, he fulcer was healing. R32's left heel, he fulcer was healing. R32's pholowing:	23/16, when the physician was adicated she was not aware pressure ulcer and the status of until 2/8/17, and had not an of the current pressure offer any other information the survey team on 2/6/17 unstageable pressure ulcer. p.m. during a telephone ysician (MD)-A confirmed R32 essure ulcer in December, the uded, and had a small amount ated he had been concerned of osteomyelitis and had initics at that time. MD-A insure of the cause of R32's seen the pressure ulcer was and understood it continued a.m. during a follow up lity, MD-A stated R32's ulcer had been open and stated the area had been red he had ordered a culture of the R32 had a history of multiple infections. He stated felt R32's previous pressure MD-A stated during exam of elt R32's current pressure and indicated he felt at that	2 900			

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	E SURVEY IPLETED
00968 B. WING 02	/10/2017
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE	
VALLEY CARE AND REHAB LLC 600 FIFTH STREET SOUTHEAST, BOX 129 BARNESVILLE, MN 56514	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 900 Continued From page 25 antibiotic started, and directed staff to keep patient positioned and use boot/pillows to keep pressure off of left heel. Further, the orders indicated to follow up with physician in 1 week and sooner as needed. -1/3/17, left heel looked better, and directed staff to continue treatment. Review of R32's Treatment Administration Records (TAR) revealed for December 2016, staff documentation of skin/wound note weekly, every Thursday and Prevalon boots or pillows to keep pressure off of heel which was documented as done every evening and night shift 12/23/16 thru 12/31/16. However, R32's TAR lacked direction for use of Prevalon boots, pillows or pressure relief for left heel during the day. Review of R32's January TAR staff documentation of skin/wound note weekly, every Thursday and Prevalon boots or pillows to keep pressure off of heel which was documented as done every evening and night shift 11/17 thru 1/31/17. However, R32's TAR lacked direction for use of Prevalon boots, pillows or pressure relief for left heel during the day. R32's progress notes which included all skin/wound documentation was reviewed from 11/18/16 to 2/09/17 and revealed: -12/16/2016, identified a nickel size black area on R32's left heel with the surrounding area raised like a scab. The note also indicated education was provided regarding offloading of heels, provider was updated and they would continue to monitor.	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED	
		00968	B. WING		02/1	0/2017
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
VALLEY	CARE AND REHAB L	1 (-	I STREET SO /ILLE, MN 5	OUTHEAST, BOX 129 6514		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 900	Continued From pa	ge 26	2 900			
	included a wound c	ers for left sole ulcer which ulture, and medication indicated provider would for foot.				
	on her left heel mea diameter, and a bla area which measur	ied resident had an open area asuring 5 millimeters (mm) in ck area surrounding the open ed 2.5 cm in diameter. The s wound was cultured and				
	ulcer which measur	ried R32 had an open left heel red 1.5 cm X .5 cm, was dark e and was improved.				
		ied area on heel was not was applied as ordered and did tus of the ulcer				
	-1/2/2017, identified as ordered.	d left heel treatment continued				
		d left heel scab had sloughed smooth surface and area (.25 cm.				
		d left heel was dry, scabbed I 4 mm and was improving				
	-1/8/2017, identified to left heel had clos	d unstageable pressure ulcer ed.				
	side of both knees	mall red dots on the front and and had redness at skin fold of the note did not address kin/ pressure ulcer.				
	-1/19/17, listed no a	areas of concern.				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
			7.1. 20.23			
		00968	B. WING		02/1	0/2017
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
VALLEY	CARE AND REHAB L	1 (-	I STREET SO /ILLE, MN 5	OUTHEAST, BOX 129 6514		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 900	Continued From pa	ge 27	2 900			
	-1/26/2017, listed had no areas of concern.					
	-2/2/2017, listed no areas of concern.					
	-2/9/17, listed no areas of concern.					
	Treatment of Skin E revealed when a re pressure ulcer the f Braden Scale Asse	by policy, Prevention and Breakdown, dated 11/1/15, sident developed a new facility would initiate a TTT, a sement and complete an ask factors and reevaluate rs.				
	dated 11/1/15, reverisk for pressure uld weekly to identify an integrity. The policy designated bath dacompele a head to any alterations in skevaluation of the wasurrounding tissues	and treatments, any ction and document findings				
	R20 had diagnoses hypertension (HTN) pulmonary disease R20 was severely dextensive to total as daily living (ADL). Twas totally dependent bed mobility, transferidentified R20 was skin was intact, was	S dated 12/8/16, indicated which included dementia, and chronic obstructive (COPD). The MDS identified cognitively impaired, required esistance for all activities of the MDS also indicated R20 ent on two staff assistance for ers. Further, the MDS at risk for pressure ulcers, so on a turning and am and had a pressure				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING: _	E CONSTRUCTION		E SURVEY PLETED
	00968	B. WING		02/	10/2017
NAME OF PROVIDER OR SUPPLIER VALLEY CARE AND REHAB LL	C 600 FIFTH		TATE, ZIP CODE BUTHEAST, BOX 129 8514		
PREFIX (EACH DEFICIENCY I	EMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETE DATE
dependent on staff for including repositioning was at risk for pressive weakness, limited must further, the CAA ide offered repositioning. R20's care plan date at risk for altered ski facility staff to assist (2) hours. R20's undated, nursi indicated R20 require every two hours. R20's Braden Scale/Pressure ulcer dated at risk for pressure ulcer dated at risk for at risk for at risk for pressure ulcer dated at risk for at r	ne wheelchair. 20/16, indicated R20 was or activities of daily living, ng. The CAA identified R20 ure ulcers related to nobility, and dementia. entified R20 needed to be givery two hours. 2d 1/24/16, identified R20 was in integrity and directed R20 to reposition every two ing assistant care guide, ed turning and repositioning 2/Skin Risk Assessment for d 12/5/16, indicated R20 was ulcer development. 2/Servation on 2/8/17, fromm. revealed the following: 2/as seated in a wheelchair in her room, wore a hospital n. 2/20 had not made any is in position, no staff were 20 assistance with	2 900			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED	
		00968	B. WING		02/1	0/2017
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
VALLEY	CARE AND REHAB L	1 (=	I STREET SO /ILLE, MN 5	OUTHEAST, BOX 129 6514		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 900	that time NA-E enter blanket over R20's R20 to the dining roobserved to offer R repositioning. - At 8:40 a.m. R20 make a wheelchair in the dinidependently. R20 any independent character in the dineserved to make a position. - At 8:57 a.m. R20 make a position. - At 9:07 a.m. R20 make a position.	ered R20's room, draped a lap and proceeded to wheel from. NA-D and NA-E were not 20 assistance with remained seated in the ming room and ate was not observed to make langes in position. The mained seated in the ming room. R20 was not any independent changes in remained seated in the ming room. At that time RN-A and was observed to administer and immediately walked that remained seated in the ming room and was wheeled to be an activity aid to listen to an activity and 10 minutes. The and remained seated in the resident lobby. R20 had made anges in position. No staff fifer R20 assistance with	2 900	DEFICIENCY)		
	7:10 a.m. At that tin assistance with rep was unsure of wher	r without repositioning since ne NA-C stated R20 needed ositioning every 2 hours and n R20 had last been was then wheeled to her room				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	E CONSTRUCTION		SURVEY PLETED	
		00968	B. WING		02/	10/2017
	PROVIDER OR SUPPLIER CARE AND REHAB L	600 FIFTI		TATE, ZIP CODE DUTHEAST, BOX 129 6514		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
2 900	by NA-C. - At 10:08 a.m. R2 wheelchair in her replaced clean bedding the placed clean bedding a.m. NA-transfer with a full replaced clean bedding and assisted R20 to removed R20's dry revealed R20's skir upper thighs were be replaced R20's skir upper thighs were be replaced R20 remained in a from 7:10 a.m. to 1 and 3 minutes. During interview on stated R20 was to be every two hours. Note the last time R20 was preactice to keep trakeep an eye on the the method staff us received timely toiled. During interview on stated R20 had not and changed for incomplete the position. During interview on confirmed R20 was pressure ulcers. Life expected to reposition as needed. LPN-A	0 remained seated in the pom while NA-C and NA-E				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED	
		00968	B. WING		02/1	0/2017
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE	•	
VALLEY	CARE AND REHAB L	I (=	I STREET SO /ILLE, MN 5	OUTHEAST, BOX 129 6514		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 900	Continued From pa	ge 31	2 900			
	confirmed R20 was pressure ulcers due incontinence, and in she added the spectoursing assistance comprehensive assistance comprehensive assistance comprehensive assistance comprehensive assistance comprehensive assistance comprehensive assistance guides as an explan. The DON stathave been reposition provided every two skin breakdown. The formal system in play were completed. The unsure how the state received timely care resident cares were DON stated the points.	2/9/17, at 8:37 a.m. the DON at risk for development of to bowel and bladder amobility. The DON reported offici interventions on the care guides after the essments and considered the extension of the resident's care ted she expected R20 would and incontinence care thours to reduce risk of future to PON stated there was not ace to ensure timely cares are DON stated she was fif were ensuring residents at the DON confirmed timely anot being monitored. The not of care system captured mentation, but not in actual				
	Treatment of Skin E indicated staff would measures such as repositioning sched developing a pressi	titled, Prevention and Breakdown dated 9/6/16, d implement preventative effective turning and ules to help reduce the risk of ure ulcer with residents sk for impaired skin integrity.				
	The director of nursimplement policies ensuring staff compassessment on all plactors and approprioutinely monitor all until resolved.	HOD FOR CORRECTION: sing (DON) or designee could and procedures related to blete a comprehensive pressure ulcers, identify causal riate interventions, and pressure ulcers for healing ment and assurance				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED	
		00968	B. WING		02/1	0/2017
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
VALLEY	CARE AND REHAB L	I (=	I STREET SO /ILLE, MN 5	OUTHEAST, BOX 129 6514		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
2 900	Continued From pa	ge 32	2 900			
	committee could pe ensure compliance.	erform random audits to				
	TIME PERIOD FOR days.	R CORRECTION: Twenty (21)				
21390	MN Rule 4658.0800	Subp. 4 A-I Infection Control	21390			3/13/17
	control program muprocedures which pare A. surveillance collection to identify residents; B. a system for control of outbreaks C. isolation and reduce risk of trans D. in-service exprevention and con E. a resident he immunization progrationed in part 465 procedures of resid the prevention and F. the development of the prevention and F. the development of the products, including defined in part 4656 G. a system for products which affed disinfectants, antised incontinence products. In methods for incontinence products which affed disinfectants which affed disinfectants antised incontinence products.	ealth program including an am, a tuberculosis program as 8.0810, and policies and ent care practices to assist in treatment of infections; ment and implementation of dicies and infection control a tuberculosis program as 8.0815; reviewing antibiotic use; review and evaluation of ct infection control, such as eptics, gloves, and				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED	
		00968	B. WING		02/1	0/2017
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
VALLEY	CARE AND REHAB L	1 (=	ISTREET SO ILLE, MN 5	OUTHEAST, BOX 129 6514		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
21390	This MN Requirem by: Based on interview facility failed to impinfection control prosurveillance of all sincluding those not prevent potential sp. This deficient practall 34 resident. Findings include: During interview wir (DON) on 2/9/17, a infection control log 12/16/16, was com log flow sheets ider diagnosis, signs & ordered or not), meend date, culture reisolation required. It documentation of in antibiotics in the fact Review of the montal 12/15 through 12/1 various resident infections, broinfections and all in specific antibiotic undewever, the logs I symptoms of infect with antibiotics in the fact of the control of the c	ent is not met as evidenced and document review, the lement a comprehensive ogram which included signs/symptoms of infections treated with an antibiotic to oread of infection in the facility. ice had the potential to affect th the director of nursing t 10:59 a.m. a review of the g for 12/31/15, through pleted. The infection control ntified the date, room, symptoms, culture/lab order (if edication ordered, medication esults (if obtained), and However, the log lacked infections not treated with cility. thly infection control logs from 6 revealed the facility tracked ections which included urinary inchitis, pneumonia, eye fections listed identified the sed to treat the infection. acked documentation of ions or viral illness not treated	21390	corrected		

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION (X3 A. BUILDING:			DATE SURVEY COMPLETED		
		00968	B. WING		02/1	0/2017		
NAME OF F	NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE							
VALLEY	VALLEY CARE AND REHAB LLC 600 FIFTH STREET SOUTHEAST, BOX 129 BARNESVILLE, MN 56514							
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES (MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE		
21390	Continued From pa	ge 34	21390					
21390	the procedure for the include: Any time an antibior resident, the reside were added to the I and when the symple indicated the facility viral illness or symple not treated with antifacility did not include treated with medical The facility policy tithe Healthcare Acquires identified the purposor forms for the surveil and cluster infection and an assessment be completed utilized definitions of system SUGGESTED MET director of nursing (review policies and components of the program. Facility stromponents of surveilling and components of survei	tic was prescribed to a nt and the medication utilized ist, and then the symptoms began were added. She of did not routinely monitor for stoms of infections which were ibiotics and confirmed the de infections that were not ation on the monthly logs. Ited, Outcome Surveillance for d Infections revised 10/28/16, se to provide guidelines and illiance of healthcare acquired as occurring within the facility, to for presenting symptoms willing the criteria of the infections. THOD OF CORRECTION: The (DON) and/or designee could procedures related to the infection control monitoring aff could be educated on the cycliance of infections. The and/or designee could develop	21390					
	compliance.	n to ensure ongoing						
	TIME PERIOD FOR (21) days.	R CORRECTION: Twenty one-						
21426	MN St. Statute 144. Prevention And Cor	A.04 Subd. 3 Tuberculosis ntrol	21426			3/10/17		
		e provider must establish and nensive tuberculosis						

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				ATE SURVEY OMPLETED	
		00968	B. WING		02/1	0/2017	
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE			
VALLEY	CARE AND REHAB L	1 (-	I STREET SO /ILLE, MN 5	OUTHEAST, BOX 129 6514			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROL DEFICIENCY)	D BE	(X5) COMPLETE DATE	
21426	infection control pro- current tuberculosis issued by the Unite Control and Preven Tuberculosis Elimin Morbidity and Morta This program must infection control pla unpaid employees, residents, and volus Health shall provide regarding implement	ogram according to the most infection control guidelines distates Centers for Disease attion (CDC), Division of the pattern attion, as published in CDC's ality Weekly Report (MMWR). Include a tuberculosis and that covers all paid and contractors, students, interest. The Department of the technical assistance and the guidelines.	21426				
	by: Based on interview facility failed to ens baseline screening residents (R40, R3; were completed an were followed for 2 according to the Ce Prevention (CDC) a of Health (MDH) gu Findings include: R40 was admitted t first step TST was a p.m. with results re hours after the test	and document review, the ure a facility tuberculosis (TB) was completed for 2 of 5 (2), tuberculin skin test (TST) d documentation guidelines of 5 residents (R40, R3) enters for Disease Control and and the Minnesota Department didelines. To the facility on 2/3/17. R40's administered 2/4/17, at 2:12 ad on 2/5/17, at 7:15 p.m. (29 was administered.) R40's a had been completed on		corrected			

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STATEMENT OF DEFICIENCIES (X1)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				DATE SURVEY COMPLETED	
			A. BUILDING:				
		00968	B. WING		02/1	0/2017	
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE			
VALLEY	CARE AND REHAB L	LC 600 FIFTH BARNES\	OUTHEAST, BOX 129 6514				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE	
21426	2/6/17. The TST to appropriate amoun reaction of the skin results were not do the measurement of documented. R40's administration reco in the box with staff reading. No further of the skin testing with the skin testing w	est was not given the tof time to reveal an accurate test. In addition, R40's TST cumented as negative nor was of induration or lack of it selectronic medication and (EMAR) had a check mark initials and the time of the documentation of the results was found in the clinical record. 11/18/16. Review of R32's ked a base line TB symptom and 8/22/16. Review of R3's ealed R3's first TST had not until 9/8/16, seventeen days by the chart documentation also exact number of induration on of the reading for both the	21426				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				ATE SURVEY OMPLETED	
		00968	B. WING		02/1	0/2017	
NAME OF I	NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE						
VALLEY	VALLEY CARE AND REHAB LLC 600 FIFTH STREET SOUTHEAST, BOX 129 BARNESVILLE, MN 56514						
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE	
21426	Continued From page 37		21426				
	information.						
	revised 10/26/16, d all residents shall b with a TST. #3. All the two step proces screenings and into	eled Tuberculosis Control Plan irected #1. Upon admission, e screened for tuberculosis initial skin testing will utilize ess. #5. The results of all erventions shall be residents electronic medical					
	The infection control designee could reviprocedures to ensuincluded. Appropriate regarding requiremental conducted and the committee meeting	THOD OF CORRECTION: of coordinator/nurse or ew the TB policies and re required information is ate staff could be educated ents. Audits could be could be results reviewed at the quality s. R CORRECTION: Twenty-one					

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