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: O6SQ
Facility ID: 00121

1. MEDICARE/MEDICAID PROVIDER NO. (L1) **245442**

2. STATE VENDOR OR MEDICAID NO. (L2) **046545300**

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

4. TYPE OF ACTION: **7** (L8)

1. Initial 2. Recertification
3. Termination 4. CHOW
5. Validation 6. Complaint
7. On-Site Visit 9. Other
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9)

6. DATE OF SURVEY **05/24/2017** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

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

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

12. Total Facility Beds **50** (L18)

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

10. THE FACILITY IS CERTIFIED AS:

X A. In Compliance With Program Requirements Compliance Based On:
___ 1. Acceptable POC

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

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

* Code: **A** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	50			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Sarah Strenke, HFE NE II 05/24/2017 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Joanne Simon, Certification Specialist 08/01/2017 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE (L41)

24. LTC AGREEMENT ENDING DATE (L25)

25. LTC EXTENSION DATE: (L27)

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

26. TERMINATION ACTION: (L30)

VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal

INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE: (L28)

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

30. REMARKS

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE **05/22/2017** (L33)

DETERMINATION APPROVAL

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

CMS Certification Number (CCN): 245442

May 24, 2017

Ms. Gladys Peterson, Administrator
Spring Valley Care Center
800 Memorial Drive
Spring Valley, MN 55975

Dear Ms. Peterson:

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 April 28, 2017 the above facility is certified for:

50 Skilled Nursing Facility/Nursing Facility Beds

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

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

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

Please contact me if you have any questions.

Sincerely,

Kamala Fiske-Downing

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

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered

May 24, 2017

Ms. Gladys Peterson , Administrator
Spring Valley Care Center
800 Memorial Drive
Spring Valley, MN 55975

RE: Project Number S5442028

Dear Ms. Peterson:

On April 11, 2017, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on March 29, 2017. This survey found the most serious deficiencies to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D) whereby corrections were required.

On May 15, 2017, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on May 2, 2017 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on March 29, 2017. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of April 28, 2017. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on March 29, 2017, effective April 28, 2017 and therefore remedies outlined in our letter to you dated April 11, 2017, will not be imposed.

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

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

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

cc: Licensing and Certification File

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION A. Building B. Wing	DATE OF REVISIT
245442 Y1	Y2	5/15/2017 Y3

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

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0242 Reg. # 483.10(f)(1)-(3) LSC	Correction Completed 04/27/2017	ID Prefix F0329 Reg. # 483.45(d)(e)(1)-(2) LSC	Correction Completed 04/25/2017	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 Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS) GPN/kfd	DATE 5/24/2017	SIGNATURE OF SURVEYOR 37476	DATE 5/15/2017
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	
3/29/2017	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
245442 (Y1)	A. Building 01 - MAIN BUILDING 01 B. Wing (Y2)	5/2/2017 (Y3)

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

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix Reg. # NFPA 101 LSC K0351	Correction Completed 04/28/2017	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 Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS) TL/kfd	DATE 5/24/2017	SIGNATURE OF SURVEYOR 37008	DATE 5/2/2017
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	
3/28/2017	☐ 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

Electronically delivered

May 24, 2017

Ms. Gladys Peterson, Administrator
Spring Valley Care Center
800 Memorial Drive
Spring Valley, MN 55975

Re: Reinspection Results - Project Number S5442028

Dear Ms. Peterson:

On May 15, 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 March 29, 2017, with orders received by you on April 14, 2017. At this time these correction orders were found corrected and are listed on the accompanying Revisit Report Form submitted to you electronically.

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

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing

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

cc: Licensing and Certification File

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION A. Building B. Wing	DATE OF REVISIT
00121 Y1	Y2	5/15/2017 Y3

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

This report is completed by a State surveyor to show those deficiencies previously reported 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 State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix 21535 Reg. # MN Rule4658.1315 Subp.1 ABCD LSC	Correction Completed 04/25/2017	ID Prefix 21830 Reg. # MN St. Statute 144.651 Subd. 10 LSC	Correction Completed 04/27/2017	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 Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS) GPN/kfd	DATE 5/24/2017	SIGNATURE OF SURVEYOR 37476	DATE 5/15/2017
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON 3/29/2017	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

 EVENT ID: O6SQ12

STATE FORM: REVISIT REPORT (11/06)

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: O6SQ
Facility ID: 00121

1. MEDICARE/MEDICAID PROVIDER NO.(L1) **245442**

2. STATE VENDOR OR MEDICAID NO. (L2) **046545300**

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

4. TYPE OF ACTION: **2** (L8)

1. Initial **2. Recertification**
3. Termination **4. CHOW**
5. Validation **6. Complaint**
7. On-Site Visit **9. Other**
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9)

6. DATE OF SURVEY **03/29/2017** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

12.Total Facility Beds **50** (L18)

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

10.THE FACILITY IS CERTIFIED AS:

A. In Compliance With Program Requirements Compliance Based On:
____1. Acceptable POC

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	50			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Sarah Strenke, HFE NE II 04/21/2017 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 05/22/2017 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30)

VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal

INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered

April 11, 2017

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

RE: Project Number S5442028

Dear Ms. Solberg:

On March 29, 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 constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level D), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

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

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

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

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

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

months after the survey date; and

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

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

DEPARTMENT CONTACT

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

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

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by May 8, 2017, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

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.

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by June 29, 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 September 29, 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
Telephone: (651) 430-3012
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245442	A. BUILDING ______ B. WING ______	03/29/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 242 SS=D	483.10(f)(1)-(3) SELF-DETERMINATION - RIGHT TO MAKE CHOICES (f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. (f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. (f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to determine preferences for bathing for 2 of 3 residents (R8 and R10) as the system had not been operationalized.	F 242	PLAN OF CORRECTION 4/21/2017 F242 483.10 (f)(1)-(3) Self Determination –Right to Make Choices	4/27/17

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE
(X6) DATE: 04/19/2017

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

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F 242	Continued From page 1 Findings include: R8's quarterly Minimum Data Set (MDS) dated 3/10/17, required one-person physical assist with bathing. On 3/27/17, at 2:11 p.m., R8 stated she was not able to choose how often she took a bath or shower. R8 stated she had her bath/shower once a week on Wednesday and would like one more each week. On 3/28/17 12:29 p.m., R8 stated she would like to have two baths a week. R8 Stated right now she has one bath a week and it would be nice to be able to have two a week, stated she has not ever asked staff for more than one bath a week. R8 stated she did not remember being asked how many baths a week she would like. On 3/28/17, at 12:33 p.m., nursing assistant (NA)-A stated the charge nurse had a meeting upon admission with residents to decide how often they would like a shower or bath. NA-A stated most residents just had one bath or shower a week. NA-A stated if a resident requested more than one a week it would be accommodated. On 3/28/17, at 12:45 p.m., licensed practical nurse (LPN)-B stated we ask first day of admission what a resident's preference is for bathing. LPN-B stated we absolutely accommodate more than one more bath a week. LPN-B stated R8 was scheduled for a bath on Wednesday during the evening shift. LPN-B stated she would follow-up with R8 regarding her bathing preferences.	F 242	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? All residents in the facility have the right to make choices for themselves regarding their interests, activities, sleeping and waking times, bathing preferences, food choices and plan of care. All residents have the right to interact with members inside and outside of the facility and are able to make choices about all aspects of their life. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? All residents who reside in the facility have the right of self-determination. Routine assessment of residents choices will be completed at admission, care conferences, changes in health conditions or any time the resident voices a concern. The resident has the right to express any changes in preferences at any time and accommodations will be made as needed and appropriate. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? Resident preferences including side rail preferences, dental and vision facilitation, bath preferences, wake and sleep times, dressing, activity, food and therapy time preferences have been add to the care conference assessment sheet. (Completed 4/12/2017) A policy regarding bathing choices will be implemented and put into place that states bathing preferences must be addressed with	

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F 242	Continued From page 2 On 3/29/17, at 11:12 a.m., licensed practical nurse (LPN)-B stated she followed up with R8 and asked her if she would like an extra bath or shower a week. We have gone ahead and scheduled her an extra bath on Saturday mornings. LPN-B verified bathing preference was asked upon admission but was not documented anywhere. LPN-B stated bathing preferences are followed up on during resident care conferences. LPN-B stated social services should be asking if there were any concerns with resident preferences including bathing during the care conferences. LPN-B reviewed care conference notes for R8 and verified there was no documentation related to preferences for bathing frequency. On 3/29/17, at 11:20 a.m., social services (SS)-A stated we currently do not discuss bathing preferences with resident during care conferences. SS-A stated if a resident would bring up bathing schedule it would be discussed during the care conference. R10's quarterly Minimum Data Set (MDS), dated 3/3/17 indicated a Brief Interview for Mental Status (BIMS) score of 13 (cognitively intact). R10's care plan for activities of daily living (ADL), indicated R10 required one assistance with bathing. R10's nursing assistant care plan sheet indicated R10 required assistance of one staff for bathing on Wednesday evenings. During interview with R10 on 3/27/17 at 1:44 p.m. R10 stated at home she would take a shower	F 242	resident on admission and then yearly unless the resident requests otherwise. This will be completed by 4/25/2017. How the facility plans to monitor its performance to make sure that solutions are sustained? Develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system. Staff education will be provided at staff meetings scheduled for 4/25/2017 and 4/27/2017. Random audits will be completed weekly x 4 weeks to ensure that resident preferences are being investigated and offered. Audits will continue at least monthly x 4 months to ensure continued compliance. Findings and progress will be reviewed with the Quality Assurance/Quality Improvement Committee. Who is responsible for this plan of correction? The Director of Nursing or designee will be responsible for compliance. Date of Correction: 4/27/2017	

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F 242	Continued From page 3 daily, and in the facility she was not bathed according to her preferences and had not been asked how often she would like a bath. During interview with registered nurse (RN)-A and licensed practical nurse (LPN)-B on 3/28/17 at 3:58 p.m. stated bathing choices are asked on admission and followed up at each care conference. Care conferences completed within 30 days of admission and then every three months. Review of resident care conference notes dated 6/22/16, 9/21/16, 3/8/17 and 3/15/17 identified no bathing preferences or choices discussed at the meetings. During an interview on 3/29/17 at 8:41 a.m. the director of nursing (DON) and LPN-B stated preferences for bathing asked on admission whether they want one or two a week. DON confirmed at 9:29 a.m. no follow up assessment completed for R10 that would have asked the preferences of bathing at time of an admission. During interview on 3/29/17, at 2:30 p.m. the social worker (SW)-A indicated all residents were asked about bathing frequency on their admission nursing assessment, any documentation of such should be included on this form. The facility stated they did not have a specific policy that addressed choices for bathing frequency.	F 242		
F 329 SS=D	483.45(d)(e)(1)-(2) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS 483.45(d) Unnecessary Drugs-General.	F 329		4/25/17

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F 329	Continued From page 4 Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used-- (1) In excessive dose (including duplicate drug therapy); or (2) For excessive duration; or (3) Without adequate monitoring; or (4) Without adequate indications for its use; or (5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or (6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. 483.45(e) Psychotropic Drugs. Based on a comprehensive assessment of a resident, the facility must ensure that-- (1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; (2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility	F 329	PLAN OF CORRECTION 4/21/2017	

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F 329	Continued From page 5 failed to ensure non-pharmacological interventions were documented prior to administration of PRN (as needed) pain medications for 1 of 5 residents (R62) reviewed for unnecessary medications. Findings include: R62's diagnosis found on the Admission record dated 11/23/16, indicates restless legs syndrome and a stage one pressure ulcer of right buttock dated 1/26/17. Order summary report dated 3/29/17, indicates R62 has orders for scheduled Tylenol 650 mg twice a day for buttock pain and restless leg pain as well as a PRN order for 650 mg every six hours as needed for pain in buttock and leg pain. Medication administration record (MAR) dated February 2017, indicates R62 received PRN Tylenol on 13 separate occasions. MAR dated March 2017, indicates R62 received PRN Tylenol on 17 separate occasions. Progress notes reviewed for the month of February 2017, indicates non-pharmacological interventions were documented one time out of 13 opportunities. Progress notes reviewed for the month of March 2017, indicates non-pharmacological interventions were documented twice out of 17 opportunities. R62's care plan dated 12/6/16, identifies R62 to have acute pain related to coccyx pressure ulcer present on admission. Interventions include pain being relieved by repositioning, offloading and Tylenol. Staff to monitor/record pain characteristics routinely and as needed including	F 329	F329 483.45 (d)(e)(1)-(2) Drug Regimen is Free From Unnecessary Drugs What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? All residents have the right to attempt non-pharmacologic interventions prior to receiving medications for discomfort. Each resident's drug regimen must be free from unnecessary drugs. 1 out of 5 residents reviewed received a non-pharmacological intervention prior to pain medication administration. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? All residents who reside at Spring Valley Living and have pain have the right to be provided with non-pharmacologic interventions (e.g., repositioning, warm or cold presses, etc.) prior to the administration of a prn pain medication. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? Spring Valley Living has a pain medication policy (Updated 2011) in place stating that non-pharmacological intervention should be evaluated for effectiveness prior to administration of medication for pain. The policy will be updated by 4/25/2017 to include more interventions for non-pharmacological treatment of pain. How the facility plans to monitor its performance to make sure that solutions are sustained? Develop a plan for	

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F 329	Continued From page 6 quality, severity, anatomical location, onset, duration, aggravating factors and relieving factors. Staff to monitor/record/report any signs or symptoms of non-verbal pain. Staff to monitor/record/report any complaints of pain or requests for pain treatment. Interview on 3/29/17, at 7:20 a.m. with licensed practical nurse (LPN)-A stated when a resident requests a PRN pain medication the nurse assesses the location of the pain and assesses the pain rating. Nurse will check the orders and verify there is an appropriate PRN order and will administer the medication accordingly as well as will follow up for effectiveness of medication. LPN-A stated non-pharmacological interventions should be attempted and documented in the resident chart. Interview on 3/29/17, at 8:18 a.m. with director of nursing (DON) stated the expectation for PRN medications is that non-pharmacological interventions are offered and documented before each medication administration. DON was unable to provide any further documentation that non-pharmacological interventions had been attempted or documented prior to the administration of PRN Tylenol for R62. Requested policy related to PRN medication administration. Facility provided policy titled, "PRN Orders" dated 2/2011. Policy does not identify offering or documentation of non-pharmacological interventions prior to administration of medication.	F 329	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. Staff education will be provided at staff meetings scheduled for 4/25/2017. Random audits will be completed weekly x 4 weeks to ensure that resident who are receiving prn medications for pain have been offered non-pharmacological interventions first. Audits will continue at least monthly x 4 months to ensure continued compliance. Findings and progress will be reviewed with the Quality Assurance/Quality Improvement Committee. Who is responsible for this plan of correction? The Director of Nursing or designee will be responsible for compliance. Date of Correction: 4/25/2017	

F5442035

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245442	A. BUILDING **01 - MAIN BUILDING 01** B. WING ______	**03/28/2017**

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K 000	INITIAL COMMENTS THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ON-SITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety - State Fire Marshal Division. At the time of this survey, (Spring Valley Living) was found not 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. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: Health Care Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St Paul, MN 55101-5145, or By email to: Marian.Whitney@state.mn.us and	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		04/19/2017

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

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K 000	Continued From page 1 Angela.Kappenman@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. (Spring Valley Living) is a 1-story building with no basement. The building was constructed at (3) different times. The original building was constructed in 1962 and was determined to be of Type II(222) construction. In 1964, addition was constructed to the (Westeran Trail) that was determined to be of Type II(222) construction. Because the original building and the (1) addition are of the same type of construction and meet the construction type allowed for existing buildings, the facility was surveyed as one building. In 2014 the facility added a new Wing to the Northside of the building. The building is determined to be Type V (111) with a 1 hour separation between buildings. The building is fully sprinklered. The facility has a fire alarm system with full corridor smoke detection and spaces open to the corridors that is monitored for automatic fire department notification. The facility has a capacity of 50 beds and had a census of 49 at the time of the survey.	K 000		

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K 000	Continued From page 2 The requirement at 42 CFR, Subpart 483.70(a) is **NOT MET** as evidenced by:	K 000		
K 351 SS=D	NFPA 101 Sprinkler System - Installation Spinkler System - Installation 2012 EXISTING Nursing homes, and hospitals where required by construction type, are protected throughout by an approved automatic sprinkler system in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. In Type I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where state or local regulations prohibit sprinklers. In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area of the closet does not exceed 6 square feet and sprinkler coverage covers the closet footprint as required by NFPA 13, Standard for Installation of Sprinkler Systems. 19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1) This **STANDARD** is not met as evidenced by: Spinkler System - Installation 2012 EXISTING Nursing homes, and hospitals where required by construction type, are protected throughout by an approved automatic sprinkler system in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. In Type I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where state or local regulations prohibit sprinklers. In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area	K 351	Replace the sprinkler head in the Care Center Freezer Storage area, Summit Fire protection has measured to insure the correct size, and Spring Valley Living has requested a link style replacement head. This will be completed by 4-28-17 All Sprinkler heads will be inspected and documented annually during, the annual sprinkler inspection. Person Responsible for this plan of correction: James Parsons, EVS Director	4/28/17

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K 351	Continued From page 3 of the closet does not exceed 6 square feet and sprinkler coverage covers the closet footprint as required by NFPA 13, Standard for Installation of Sprinkler Systems. 19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1) Findings Include: On facility tour between 09:00 AM and 01:00 PM on March 28, 2017, based on observation and interview revealed that the following include: Observation during the inspection that the dry pendent sprinkler head in the freezer has lost the color for the bulb style head. This deficient practice could affect the safety of all the residents, staff and visitors within the kitchen area. This deficient practice was confirmed by the Facility Maintenance Director at the time of discovery.	K 351		

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically submitted

April 11, 2017

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

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5442028

Dear Ms. Solberg:

The above facility was surveyed on March 27, 2017 through March 29, 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 only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the deficiency within the established time frame is required. The “suggested method of correction” is for your information and assistance only.

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

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

statement, "This Rule is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.

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

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should contact Gary Nederhoff, Unit Supervisor at (507) 206-2731.

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

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

Please feel free to call me with any questions.

Sincerely,

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

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00121	A. BUILDING: ______ B. WING ______	03/29/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm The State licensing orders are delineated on the attached Minnesota	2 000		

Minnesota Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		04/19/17

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2 000	Continued From page 1 Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. On dates, March 27, 28, & 29, 2017, surveyors of this Department's staff, visited the above provider and the following correction orders are issued. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed. Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.	2 000		

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2 000	Continued From page 2 THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000		
21535	MN Rule4658.1315 Subp.1 ABCD Unnecessary Drug Usage; General Subpart 1. General. A resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used: A. in excessive dose, including duplicate drug therapy; B. for excessive duration; C. without adequate indications for its use; or D. in the presence of adverse consequences which indicate the dose should be reduced or discontinued. In addition to the drug regimen review required in part 4658.1310, the nursing home must comply with provisions in the Interpretive Guidelines for Code of Federal Regulations, title 42, section 483.25 (1) found in Appendix P of the State Operations Manual, Guidance to Surveyors for Long-Term Care Facilities, published by the Department of Health and Human Services, Health Care Financing Administration, April 1992. This standard is incorporated by reference. It is available through the Minitex interlibrary loan system and the State Law Library. It is not subject to frequent change. This MN Requirement is not met as evidenced by: Based on interview and record review, the facility failed to ensure non-pharmacological interventions were documented prior to administration of PRN (as needed) pain	21535	PLAN OF CORRECTION 4/21/2017 F329 483.45 (d)(e)(1)-(2) Drug Regimen is Free From Unnecessary Drugs	4/25/17

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21535	Continued From page 3 medications for 1 of 5 residents (R62) reviewed for unnecessary medications. Findings include: R62's diagnosis found on the Admission record dated 11/23/16, indicates restless legs syndrome and a stage one pressure ulcer of right buttock dated 1/26/17. Order summary report dated 3/29/17, indicates R62 has orders for scheduled Tylenol 650 mg twice a day for buttock pain and restless leg pain as well as a PRN order for 650 mg every six hours as needed for pain in buttock and leg pain. Medication administration record (MAR) dated February 2017, indicates R62 received PRN Tylenol on 13 separate occasions. MAR dated March 2017, indicates R62 received PRN Tylenol on 17 separate occasions. Progress notes reviewed for the month of February 2017, indicates non-pharmacological interventions were documented one time out of 13 opportunities. Progress notes reviewed for the month of March 2017, indicates non-pharmacological interventions were documented twice out of 17 opportunities. R62's care plan dated 12/6/16, identifies R62 to have acute pain related to coccyx pressure ulcer present on admission. Interventions include pain being relieved by repositioning, offloading and Tylenol. Staff to monitor/record pain characteristics routinely and as needed including quality, severity, anatomical location, onset, duration, aggravating factors and relieving factors. Staff to monitor/record/report any signs or symptoms of non-verbal pain. Staff to	21535	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? All residents have the right to attempt non-pharmacologic interventions prior to receiving medications for discomfort. Each resident’s drug regimen must be free from unnecessary drugs. 1 out of 5 residents reviewed received a non-pharmacological intervention prior to pain medication administration. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? All residents who reside at Spring Valley Living and have pain have the right to be provided with non-pharmacologic interventions (e.g., repositioning, warm or cold presses, etc.) prior to the administration of a prn pain medication. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? Spring Valley Living has a pain medication policy (Updated 2011) in place stating that non-pharmacological intervention should be evaluated for effectiveness prior to administration of medication for pain. The policy will be updated by 4/25/2017 to include more interventions for non-pharmacological treatment of pain. How the facility plans to monitor its performance to make sure that solutions are sustained? Develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan	

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21535	Continued From page 4 monitor/record/report any complaints of pain or requests for pain treatment. Interview on 3/29/17, at 7:20 a.m. with licensed practical nurse (LPN)-A stated when a resident requests a PRN pain medication the nurse assesses the location of the pain and assesses the pain rating. Nurse will check the orders and verify there is an appropriate PRN order and will administer the medication accordingly as well as will follow up for effectiveness of medication. LPN-A stated non-pharmacological interventions should be attempted and documented in the resident chart. Interview on 3/29/17, at 8:18 a.m. with director of nursing (DON) stated the expectation for PRN medications is that non-pharmacological interventions are offered and documented before each medication administration. DON was unable to provide any further documentation that non-pharmacological interventions had been attempted or documented prior to the administration of PRN Tylenol for R62. Requested policy related to PRN medication administration. Facility provided policy titled, "PRN Orders" dated 2/2011. Policy does not identify offering or documentation of non-pharmacological interventions prior to administration of medication. SUGGESTED METHOD OF CORRECTION: The administrator, director of nursing (DON) and consulting pharmacist could review and revise policies and procedures for proper monitoring of medication usage. The DON or designee, could audit medication reviews on a regular basis to ensure compliance.	21535	of correction is integrated into the quality assurance system. Staff education will be provided at staff meetings scheduled for 4/25/2017. Random audits will be completed weekly x 4 weeks to ensure that resident who are receiving prn medications for pain have been offered non-pharmacological interventions first. Audits will continue at least monthly x 4 months to ensure continued compliance. Findings and progress will be reviewed with the Quality Assurance/Quality Improvement Committee. Who is responsible for this plan of correction? The Director of Nursing or designee will be responsible for compliance. Date of Correction: 4/25/2017	

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21535	Continued From page 5 TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21535		
21830	MN St. Statute 144.651 Subd. 10 Patients & Residents of HC Fac.Bill of Rights Subd. 10. Participation in planning treatment; notification of family members. (a) Residents shall have the right to participate in the planning of their health care. This right includes the opportunity to discuss treatment and alternatives with individual caregivers, the opportunity to request and participate in formal care conferences, and the right to include a family member or other chosen representative or both. In the event that the resident cannot be present, a family member or other representative chosen by the resident may be included in such conferences. (b) If a resident who enters a facility is unconscious or comatose or is unable to communicate, the facility shall make reasonable efforts as required under paragraph (c) to notify either a family member or a person designated in writing by the resident as the person to contact in an emergency that the resident has been admitted to the facility. The facility shall allow the family member to participate in treatment planning, unless the facility knows or has reason to believe the resident has an effective advance directive to the contrary or knows the resident has specified in writing that they do not want a family member included in treatment planning. After notifying a family member but prior to allowing a family member to participate in treatment planning, the facility must make reasonable efforts, consistent with reasonable medical practice, to determine if the resident has	21830		4/27/17

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21830	Continued From page 6 executed an advance directive relative to the esident's health care decisions. For purposes of this paragraph, "reasonable efforts" include: (1) examining the personal effects of the resident; (2) examining the medical records of the resident in the possession of the facility; (3) inquiring of any emergency contact or family member contacted under this section whether the resident has executed an advance directive and whether the resident has a physician to whom the resident normally goes for care; and (4) inquiring of the physician to whom the resident normally goes for care, if known, whether the resident has executed an advance directive. If a facility notifies a family member or designated emergency contact or allows a family member to participate in treatment planning in accordance with this paragraph, the facility is not liable to resident for damages on the grounds that the notification of the family member or emergency contact or the participation of the family member was improper or violated the patient's privacy rights. (c) In making reasonable efforts to notify a family member or designated emergency contact, the facility shall attempt to identify family members or a designated emergency contact by examining the personal effects of the resident and the medical records of the resident in the possession of the facility. If the facility is unable to notify a family member or designated emergency contact within 24 hours after the admission, the facility shall notify the county social service agency or local law enforcement agency that the resident has been admitted and the facility has been unable to notify a family member or designated emergency contact. The	21830		

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21830	Continued From page 7 county social service agency and local law enforcement agency shall assist the facility in identifying and notifying a family member or designated emergency contact. A county social service agency or local law enforcement agency that assists a facility in implementing this subdivision is not liable to the resident for damages on the grounds that the notification of the family member or emergency contact or the participation of the family member was improper or violated the patient's privacy rights. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to determine preferences for bathing for 2 of 3 residents (R8 and R10) as the system had not been operationalized. Findings include: R8's quarterly Minimum Data Set (MDS) dated 3/10/17, required one-person physical assist with bathing. On 3/27/17, at 2:11 p.m., R8 stated she was not able to choose how often she took a bath or shower. R8 stated she had her bath/shower once a week on Wednesday and would like one more each week. On 3/28/17 12:29 p.m., R8 stated she would like to have two baths a week. R8 Stated right now she has one bath a week and it would be nice to be able to have two a week, stated she has not ever asked staff for more than one bath a week. R8 stated she did not remember being asked how many baths a week she would like.	21830	PLAN OF CORRECTION 4/21/2017 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? All residents in the facility have the right to make choices for themselves regarding their interests, activities, sleeping and waking times, bathing preferences, food choices and plan of care. All residents have the right to interact with members inside and outside of the facility and are able to make choices about all aspects of their life. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? All residents who reside in the facility have the right of self-determination. Routine assessment of residents choices will be completed at admission, care conferences, changes in health conditions	

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21830	Continued From page 8 On 3/28/17, at 12:33 p.m., nursing assistant (NA)-A stated the charge nurse had a meeting upon admission with residents to decide how often they would like a shower or bath. NA-A stated most residents just had one bath or shower a week. NA-A stated if a resident requested more than one a week it would be accommodated. On 3/28/17, at 12:45 p.m., licensed practical nurse (LPN)-B stated we ask first day of admission what a resident's preference is for bathing. LPN-B stated we absolutely accommodate more than one more bath a week. LPN-B stated R8 was scheduled for a bath on Wednesday during the evening shift. LPN-B stated she would follow-up with R8 regarding her bathing preferences. On 3/29/17, at 11:12 a.m., licensed practical nurse (LPN)-B stated she followed up with R8 and asked her if she would like an extra bath or shower a week. We have gone ahead and scheduled her an extra bath on Saturday mornings. LPN-B verified bathing preference was asked upon admission but was not documented anywhere. LPN-B stated bathing preferences are followed up on during resident care conferences. LPN-B stated social services should be asking if there were any concerns with resident preferences including bathing during the care conferences. LPN-B reviewed care conference notes for R8 and verified there was no documentation related to preferences for bathing frequency. On 3/29/17, at 11:20 a.m., social services (SS)-A stated we currently do not discuss bathing preferences with resident during care	21830	or any time the resident voices a concern. The resident has the right to express any changes in preferences at any time and accommodations will be made as needed and appropriate. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? Resident preferences including side rail preferences, dental and vision facilitation, bath preferences, wake and sleep times, dressing, activity, food and therapy time preferences have been add to the care conference assessment sheet. (Completed 4/12/2017) A policy regarding bathing choices will be implemented and put into place that states bathing preferences must be addressed with resident on admission and then yearly unless the resident requests otherwise. This will be completed by 4/25/2017. How the facility plans to monitor its performance to make sure that solutions are sustained? Develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system. Staff education will be provided at staff meetings scheduled for 4/25/2017 and 4/27/2017. Random audits will be completed weekly x 4 weeks to ensure that resident preferences are being investigated and offered. Audits will continue at least monthly x 4 months to ensure continued compliance. Findings and progress will be reviewed with the Quality Assurance/Quality Improvement Committee.	

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21830	Continued From page 9 conferences. SS-A stated if a resident would bring up bathing schedule it would be discussed during the care conference. R10's quarterly Minimum Data Set (MDS), dated 3/3/17 indicated a Brief Interview for Mental Status (BIMS) score of 13 (cognitively intact). R10's care plan for activities of daily living (ADL), indicated R10 required one assistance with bathing. R10's nursing assistant care plan sheet indicated R10 required assistance of one staff for bathing on Wednesday evenings. During interview with R10 on 3/27/17 at 1:44 p.m. R10 stated at home she would take a shower daily, and in the facility she was not bathed according to her preferences and had not been asked how often she would like a bath. During interview with registered nurse (RN)-A and licensed practical nurse (LPN)-B on 3/28/17 at 3:58 p.m. stated bathing choices are asked on admission and followed up at each care conference. Care conferences completed within 30 days of admission and then every three months. Review of resident care conference notes dated 6/22/16, 9/21/16, 3/8/17 and 3/15/17 identified no bathing preferences or choices discussed at the meetings. During an interview on 3/29/17 at 8:41 a.m. the director of nursing (DON) and LPN-B stated preferences for bathing asked on admission whether they want one or two a week. DON confirmed at 9:29 a.m. no follow up assessment completed for R10 that would have asked the	21830	Who is responsible for this plan of correction? The Director of Nursing or designee will be responsible for compliance. Date of Correction: 4/27/2017	

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21830	Continued From page 10 preferences of bathing at time of an admission. During interview on 3/29/17, at 2:30 p.m. the social worker (SW)-A indicated all residents were asked about bathing frequency on their admission nursing assessment, any documentation of such should be included on this form. The facility stated they did not have a specific policy that addressed choices for bathing frequency. SUGGESTED METHOD OF CORRECTION: The administrator could in-service all employees on the need for self choice in residents choices. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21830		