#### CENTERS FOR MEDICARE & MEDICAID SERVICES

ID: O6SQ

Facility ID: 00121

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

MEDICARE/MEDICAID PROVIDER     (L1)	VNERSHIP	3. NAME AND AD (L3) SPRING VAI (L4) 800 MEMOR (L5) SPRING VAI 7. PROVIDER/SUI 01 Hospital 02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	LLEY CARE C RIAL DRIVE LLEY, MN	ENTER	(L6) 55975  02 (L7)  13 PTIP 22 CLIA  14 CORF  15 ASC  16 HOSPICE	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  FISCAL YEAR ENDING DATE: (L35)  09/30	
11LTC PERIOD OF CERTIFICATION From (a): To (b):  12.Total Facility Beds 13.Total Certified Beds	50 (L18) 50 (L17)	Complianc1. A B. Not in Con		am	And/Or Approved Waivers Of Th 2. Technical Personnel3. 24 Hour RN4. 7-Day RN (Rural SNF5. Life Safety Code  * Code: A	6. Scope of Services Limit 7. Medical Director	
14. LTC CERTIFIED BED BREAKDOW  18 SNF	19 SNF (L39)	ICF (L42) E SHOW LTC CANCE	IID (L43) ELLATION DATE)	:	15. FACILITY MEETS 1861 (e) (1) or 1861 (j) (1):	(L15)	
17. SURVEYOR SIGNATURE  Sarah Strenke, HFE NE II		Date :	05/24/2017	7.10	18. STATE SURVEY AGENCY A	on Specialist 08/01/2017	
				(L19)		(.	(L20)
P.  19. DETERMINATION OF ELIGIBILIT  _X 1. Facility is Eligible to Pace.  2. Facility is not Eligible.	'Y articipate	20. COM	BY HCFA RE	GIONAL	21. 1. Statement of Finar 2. Ownership/Contro 3. Both of the Above	ATE AGENCY  ucial Solvency (HCFA-2572)  Il Interest Disclosure Stmt (HCFA-1513)	(L20)
19. DETERMINATION OF ELIGIBILIT  _X 1. Facility is Eligible to Pa	(L21)  23. LTC AGREEM BEGINNING  (L41)  27. ALTERNATIV	20. COM RIC  ENT 24  DATE  VE SANCTIONS 1 of Admissions:	IPLIANCE WITH	CGIONAL CIVIL	21. 1. Statement of Finar 2. Ownership/Contro	ATE AGENCY  cial Solvency (HCFA-2572) d Interest Disclosure Stmt (HCFA-1513)  (L30)  INVOLUNTARY  05-Fail to Meet Health/Safety  ont  06-Fail to Meet Agreement	
19. DETERMINATION OF ELIGIBILIT  _X1. Facility is Eligible to Pa2. Facility is not Eligible  22. ORIGINAL DATE  OF PARTICIPATION  03/01/1987  (L24)  25. LTC EXTENSION DATE:	23. LTC AGREEM BEGINNING (L41) 27. ALTERNATIV A. Suspension B. Rescind Sus	20. COM RIC  ENT 24  DATE  VE SANCTIONS 1 of Admissions:	4. LTC AGREEM ENDING DATE (L25)	CGIONAL CIVIL	21. 1. Statement of Finar 2. Ownership/Contro 3. Both of the Above  26. TERMINATION ACTION:  VOLUNTARY 00  01-Merger, Closure  02-Dissatisfaction W/ Reimbursement  03-Risk of Involuntary Termination	ATE AGENCY  cial Solvency (HCFA-2572) cl Interest Disclosure Stmt (HCFA-1513)  (L30)  INVOLUNTARY  05-Fail to Meet Health/Safety ent  OTHER  07-Provider Status Change	(L20)



#### 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

Minnesota Department of Health Licensing and Certification Program

Kumalu Fiske Downing

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

Minnesota Department of Health Licensing and Certification Program

Kumalu Fiske Downing

Health Regulation Division

Telephone: (651) 201-4112 Fax: (651) 215-9697 Email: Kamala.Fiske-Downing@state.mn.us

cc: Licensing and Certification File

### POST-CERTIFICATION REVISIT REPORT

				_	
PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION			DATE OF REVI	SIT
245442 v <sub>1</sub>	A. Building B. Wing			5/15/2017	٧,0
Σ+3++2 γ1			Y2	0, 10, 20 17	Y3
NAME OF FACILITY		STREET ADDRESS, CITY, STATE, ZIP CODE			
SPRING VALLEY CARE CENT	ER	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).

ITE Y4		<b>DATE</b> Y5	ITEM Y4		<b>DATE</b> Y5	ITEM Y4		DATE Y5
ID Prefix		Correction	ID Prefix F03		Correction	ID Prefix		Correction
Reg. #	483.10(f)(1)-(3)	Completed	Reg. # 483.	.45(d)(e)(1)-(2)	Completed	Reg. #		Completed
LSC		04/27/2017	LSC		04/25/2017	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
Reg. #		Completed	Reg. #		Completed	Reg. #		Completed
LSC			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
Reg. #		Completed	Reg. #		Completed	Reg.#		Completed
LSC			LSC		-	LSC _		_
REVIEWE STATE AC		REVIEWED BY (INITIALS) GPN/kfd	<b>DATE</b> 5/24/2017	SIGNATURE OF	SURVEYOR	37476	<b>DATE</b> 5/1	5/2017
REVIEWS CMS RO	ED BY	REVIEWED BY (INITIALS)	DATE	TITLE			DATE	
FOLLOWUP TO SURVEY COMPLETED ON 3/29/2017				OR ANY UNCORRE			A OU IT\/O	s 🗆 no

Correction

Completed

**ID Prefix** 

Reg. #

LSC

		POST-C	ERTIFIC	OITAC	N REVISIT F	REPOF	RT		
_	ER / SUPPLIER / CL ICATION NUMBER	· .	STRUCTION MAIN BUILDIN	IG 01			Y2	DATE OF RE 5/2/2017	VISIT Y3
	F FACILITY G VALLEY CARE C	ENTER			STREET ADDRESS, 0 800 MEMORIAL DRIV SPRING VALLEY, MN	E	ZIP CODE		
program correcte provisio	n, to show those de ed and the date suc	ficiencies previously ch corrective action v	reported on the vas accomplish	e CMS-2567 ed. Each de	edicaid and/or Clinica 7, Statement of Defic eficiency should be fu the CMS-2567 (prefix	iencies and ully identified	Plan of Correct dusing either th	ion, that have ne regulation	e been or LSC
ITE	M	DATE	ITEM		DATE	ITEM		DA	TE
Y	1	Y5	Y4		Y5	Y4		Y	5
ID Prefix		Correction	ID Prefix		Correction	ID Prefix		Cor	rection
Reg. #	NFPA 101	Completed	Reg. #		Completed	Reg. #		Con	npleted
LSC	K0351	04/28/2017	LSC			LSC			

**ID** Prefix

Reg. #

LSC

Correction

Completed

Correction

Completed

**ID Prefix** 

Reg. #

LSC



#### 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

Minnesota Department of Health

Kamala Fiske Downing

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

				STAT	E FORM: RE	VISIT	REPORT				
	ER / SUPPLIER CATION NUME		MULTIPLE CON A. Building B. Wing	ISTRUCTIO	N				Y2	DATE OF 5/15/2017	7
NAME OF	F FACILITY VALLEY CAR					800 M	ET ADDRESS, C EMORIAL DRIVI IG VALLEY, MN	E			Y3
correctiv	e action was ation prefix co	accompli	shed. Each de	ficiency sho	se deficiencies p ould be fully ider Survey Report (p	ntified u	sing either the	regulation or L	SC provisio	n number a	and the
ITE	M		DATE	ITEM	]		DATE	ITEM		ļ	DATE
Y4			Y5	Y4			Y5	Y4			Y5
ID Prefix	21535		Correction	ID Prefix	21830		Correction	ID Prefix		C	Sorrection
Reg. #	MN Rule4658. Subp.1 ABCD	1315	Completed	Reg. #	MN St. Statute 1- Subd. 10	44.651	Completed	Reg. #		C	ompleted
LSC			04/25/2017	LSC			04/27/2017	LSC			
ID Prefix	-		Correction	ID Prefix	_		Correction	ID Prefix		C	Correction
Reg. #			Completed	Reg. #			Completed	Reg. #		С	ompleted
LSC			<del>-</del> -	LSC			-	LSC			
ID Prefix			Correction	ID Prefix			Correction	ID Prefix		C	orrection
Reg. #			Completed	Reg. #			Completed	Reg. #		С	ompleted
LSC				LSC			-	LSC			
ID Prefix			Correction	ID Prefix			Correction	ID Prefix		C	orrection
Reg. #			Completed	Reg. #			Completed	Reg. #		С	ompleted
LSC			_	LSC			_	LSC _			
ID Prefix			Correction	ID Prefix			Correction	ID Prefix		C	orrection
Reg. #			Completed	Reg. #			Completed	Reg. #		С	ompleted
LSC			_	LSC			-	LSC			
REVIEW			WED BY	DATE	SIGNATI	JRE OF	SURVEYOR			DATE	
STATE A	GENCY	(INITIA G	Ls) PN/kfd	5/24/20	17			37476		5/15	5/2017
REVIEWI CMS RO	ED BY	REVIEV	WED BY LS)	DATE	TITLE					DATE	
	FOLLOWUP TO SURVEY COMPLETED ON 3/29/2017				CK FOR ANY UN CORRECTED DEF					YES	□ NO

Page 1 of 1 EVENT ID: O6SQ12

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES

#### CENTERS FOR MEDICARE & MEDICAID SERVICES

ID: O6SQ

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

PART I -	TO BE COMPL	LETED BY T	HE STAT	TE SURVEY	AGENCY		Facility ID: 00121
MEDICARE/MEDICAID PROVIDER     NO.(L1) 245442     STATE VENDOR OR MEDICAID NO.     (L2) 046545300	3. NAME AND AD (L3) SPRING VAI (L4) 800 MEMOR (L5) SPRING VAI	LLEY CARE RIAL DRIVE		(L6)	55975	4. TYPE OF .  1. Initial 3. Terminati 5. Validation	2. Recertification ion 4. CHOW n 6. Complaint
5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9)	7. PROVIDER/SU 01 Hospital	PPLIER CATEG	ORY 09 ESRD	02 (L7) 13 PTIP	22 CLIA	7. On-Site V 8. Full Surve	/isit 9. Other ey After Complaint
6. DATE OF SURVEY <b>03/29/2017</b> (L34) 8. ACCREDITATION STATUS: (L10) 0 Unaccredited	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 D 15 ASC 16 HOSPICE		FISCAL YEAR	E ENDING DATE: (L35)
11. LTC PERIOD OF CERTIFICATION From (a): To (b):  12. Total Facility Beds 13. Total Certified Beds 50 (L18) 50 (L17)	X B. Not in Com	equirements e Based On:	gram	2. Tech 3. 24 H 4. 7-Da 5. Life	nnical Personnel	7. Med	oe of Services Limit lical Director ent Room Size
14. LTC CERTIFIED BED BREAKDOWN 18 SNF 18/19 SNF 19 SNF 50	ICF	IID		15. FACILITY I		(L15	j)
(L37) (L38) (L39) (L42) (L43)  6. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):							
17. SURVEYOR SIGNATURE	Date :			18. STATE SUF	RVEY AGENCY	APPROVAL	Date:
Sarah Strenke, HFE NE II	0-	4/21/2017	(L19)	Kamala Fisk	e-Downing, E	Enforcement S	Specialist 05/22/2017 (L20)
PART II - TO BE	COMPLETED B	BY HCFA RE	GIONAI	OFFICE OF	R SINGLE ST	TATE AGENO	CY
DETERMINATION OF ELIGIBILITY      1. Facility is Eligible to Participate     2. Facility is not Eligible  (L21)		IPLIANCE WITH ITS ACT:	H CIVIL	2. 0			PFA-2572) re Stmt (HCFA-1513)
22. ORIGINAL DATE 23. LTC AGREE	MENT 24	4. LTC AGREEN	MENT	26. TERMINA	TION ACTION:		(L30)
OF PARTICIPATION BEGINNING 03/01/1987	G DATE	ENDING DAT	ГЕ	VOLUNTARY 01-Merger, Clos	ure	05-1	VOLUNTARY Fail to Meet Health/Safety
(L24) (L41)		(L25)			on W/ Reimburse intary Termination	1	Fail to Meet Agreement
	IVE SANCTIONS n of Admissions:	(L44)		04-Other Reason	-	<u>01</u> 07-	<u>'HER</u> Provider Status Change -Active
(L27) B. Rescind S	uspension Date:						
		(L45)					
28. TERMINATION DATE: 29	9. INTERMEDIARY/	CARRIER NO.		30. REMARKS			
(L28)	03001		(L31)				
31. RO RECEIPT OF CMS-1539 32	2. DETERMINATION	OF APPROVAL	DATE				
(L32)			(L33)	DETERMIN	ATION APPR	ROVAL	



#### 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:

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

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

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

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

#### months after the survey date; and

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: <a href="http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc">http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc</a> 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: <a href="http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm">http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm</a>

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

Kumalu Fish Downing

Program Assurance Unit Health Regulation Division

Telephone: (651) 201-4112 Fax: (651) 215-9697

Email: Kamala.Fiske-Downing@state.mn.us

PRINTED: 05/22/2017 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E SURVEY PLETED
		245442	B. WING _	03/:	29/2017
	PROVIDER OR SUPPLIER  VALLEY CARE CENT	ER		STREET ADDRESS, CITY, STATE, ZIP CODE 800 MEMORIAL DRIVE SPRING VALLEY, MN 55975	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENT	-S	F 00	0	
	as your allegation of Department's acceptoriolled in ePOC, year the bottom of the	of correction (POC) will serve of compliance upon the otance. Because you are your signature is not required of first page of the CMS-2567 ic submission of the POC will ion of compliance.			
F 242 SS=D	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.  42 483.10(f)(1)-(3) SELF-DETERMINATION -		F 24	2	4/27/17
	schedules (includin health care and pro consistent with his	nas a right to choose activities, g sleeping and waking times), viders of health care services or her interests, assessments, d other applicable provisions			
		nas a right to make choices sor her life in the facility that e resident.			
	members of the collicommunity activitie facility. This REQUIREMEN	nas a right to interact with mmunity and participate in s both inside and outside the NT is not met as evidenced			
	review, the facility for bathing for 2 of	ion, interview and document ailed to determine preferences 3 residents (R8 and R10) as been operationalized.		PLAN OF CORRECTION 4/21/2017 F242 483.10 (f)(1)-(3) Self Determination –Right to Make Choices	
ABORATORY	Z DIRECTOR'S OR PROVID	ER/SUPPLIER REPRESENTATIVE'S SIGN	JATURE	TITLE	(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

**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.

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION		SURVEY PLETED
		245442	B. WING			03/2	29/2017
NAME OF I	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	, , ,	
ODDINO	VALLEY CARE CENT			8	00 MEMORIAL DRIVE		
SPRING	VALLEY CARE CENT	EH		S	PRING VALLEY, MN 55975		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	Х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 242	Continued From pa	ge 1	F 2	242			
		num Data Set (MDS) dated ne-person physical assist with			What corrective action(s) will be accomplished for those residents for have been affected by the deficient practice? All residents in the facilitative the right to make choices for themselves regarding their interest	lity s,	
	able to choose how shower. R8 stated s	p.m., R8 stated she was not often she took a bath or she had her bath/shower once day and would like one more			activities, sleeping and waking time bathing preferences, food choices plan of care. All residents have the interact with members inside and o of the facility and are able to make choices about all aspects of their life	and right to utside	
	to have two baths a she has one bath a be able to have two ever asked staff for R8 stated she did n	.m., R8 stated she would like week. R8 Stated right now week and it would be nice to a week, stated she has not more than one bath a week. ot remember being asked week she would like.			How will you identify other residents having the potential to be affected I same deficient practice and what corrective action will be taken? Al residents who reside in the facility I the right of self-determination. Rou assessment of residents choices we completed at admission, care	by the Inave Itine Itill be	
	(NA)-A stated the c upon admission wit often they would lik stated most resider shower a week. NA	3 p.m., nursing assistant harge nurse had a meeting h residents to decide how e a shower or bath. NA-A hts just had one bath orA stated if a resident an one a week it would be			conferences, changes in health cor or any time the resident voices a co The resident has the right to expres changes in preferences at any time accommodations will be made as r and appropriate. What measures will be put into play what systemic changes will be made ensure that the deficient practice do recur? Resident preferences inclu	oncern. ss any e and needed ce or le to oes not	
	nurse (LPN)-B state admission what a re bathing. LPN-B state accommodate more LPN-B stated R8 w Wednesday during	e than one more bath a week. as scheduled for a bath on the evening shift. LPN-B llow-up with R8 regarding her			side rail preferences, dental and vis facilitation, bath preferences, wake sleep times, dressing, activity, food therapy time preferences have bee to the care conference assessmen (Completed 4/12/2017) A policy re bathing choices will be implemente put into place that states bathing preferences must be addressed wi	sion and and n add t sheet. garding d and	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245442	B. WING			03/2	29/2017
	PROVIDER OR SUPPLIER  VALLEY CARE CENT	ER		80	TREET ADDRESS, CITY, STATE, ZIP CODE 00 MEMORIAL DRIVE PRING VALLEY, MN 55975	-	
(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 242	On 3/29/17, at 11:1 nurse (LPN)-B state and asked her if sh shower a week. We scheduled her an e mornings. LPN-B verification asked upon admission anywhere. LPN-B stated social there were any compreferences includiconferences. LPN-I notes for R8 and verdocumentation related frequency.  On 3/29/17, at 11:2 stated we currently preferences with reconferences. SS-A bring up bathing social during the care conferences. SS-A bring up bathing social status (BIMS) score R10's quarterly Min 3/3/17 indicated a EStatus (BIMS) score R10's care plan for indicated R10 required assistion Wednesday ever During interview with shower and sales and selection of the status	2 a.m., licensed practical ed she followed up with R8 e would like an extra bath or have gone ahead and extra bath on Saturday erified bathing preference was sion but was not documented tated bathing preferences are ng resident care conferences. I services should be asking if cerns with resident ng bathing during the care are reviewed care conference erified there was noted to preferences for bathing sident during care stated if a resident would hedule it would be discussed ference.  Immum Data Set (MDS), dated Brief Interview for Mental e of 13 (cognitively intact).  activities of daily living (ADL), ared one assistance with	F2	242	resident on admission and then year unless the resident requests otherw. This will be completed by 4/25/2011. How the facility plans to monitor its performance to make sure that sold are sustained? Develop a plan for ensuring that correction is achieved sustained. This plan must be implemented, and the corrective acceptance of correction is integrated into the consultance assurance system. Staff education provided at staff meetings schedule 4/25/2017 and 4/27/2017. Random will be completed weekly x 4 weeks ensure that resident preferences at being investigated and offered. Audicontinue at least monthly x 4 month ensure continued compliance. Find and progress will be reviewed with Quality Assurance/Quality Improved Committee.  Who is responsible for this plan of correction? The Director of Nursing designee will be responsible for compliance. Date of Correction: 4/27/2017	vise. 7. utions d and etion e plan puality n will be ed for n audits s to re dits will ns to dings the ment	

-	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	IPLE CONSTRUCTION IG		E SURVEY PLETED
		245442	B. WING _		03/	29/2017
	PROVIDER OR SUPPLIER	ER		STREET ADDRESS, CITY, STATE, ZIP CODE 800 MEMORIAL DRIVE SPRING VALLEY, MN 55975	•	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 242	daily, and in the fact according to her preashed how often shall be asked how often shall be asked how often shall be asked practical in 3:58 p.m. stated ba admission and follo conference. Care compared to a days of admission months.  Review of resident 6/22/16, 9/21/16, 3/5 bathing preferences meetings.  During an interview director of nursing (preferences for bath whether they want of confirmed at 9:29 a completed for R10 preferences of bath buring interview on social worker (SW) asked about bathing nursing assessment should be included.  The facility stated the policy that addresses	illity she was not bathed eferences and had not been evould like a bath.  The registered nurse (RN)-A and urse (LPN)-B on 3/28/17 at thing choices are asked on wed up at each care conferences completed within on and then every three care conference notes dated 8/17 and 3/15/17 identified note or choices discussed at the DON) and LPN-B stated hing asked on admission one or two a week. DON .m. no follow up assessment that would have asked the ing at time of an admission.  3/29/17, at 2:30 p.m. the -A indicated all residents were g frequency on their admission it, any documentation of such	F 24			
F 329 SS=D	FROM UNNECESS	DRUG REGIMEN IS FREE SARY DRUGS sary Drugs-General.	F 32	29		4/25/17

NAME OF PROVIDER OR SUPPLIER  SPRING VALLEY CARE CENTER  SPRING VALLEY CARE CENTER  SUMMAND STATEMENT OF DEFICIENCIES  (EACH OFFICIAL MIN 55975  FACILITY ON THE PRECEDENT OF THE PRECEDENCIES  (EACH OFFICIAL MIN 55975  FACILITY ON THE PRECEDENT OF THE PRECEDENCIES OF THE PRECEDENCY MIN TO PREFAT TAG  F 329  Continued From page 4  Each resident's drug regimen must be free from unnecessary drug. 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  (6) 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 REOULTEMENT is not met as evidenced by:  Based on interview and record review, the facility  PLAN OF CORRECTION 4/21/2017  F acting VALLEY, MN 55976  F acting VALLEY, MN 55976  PREFAT PROVIDERS STATE, ZIP CODE SPRING VALLEY, MN 55976  PREFAT PROVIDERS STATE, ZIP CODE SPRING VALLEY, MN 55976  PREFAT PROVIDERS STATE, ZIP CODE SPRING VALLEY, MN 55976  PROVIDERS STATE, ZIP CODE SPRING VALLEY, MN 55976  F acting VALLEY, MN 55976  PROVIDERS STATE, ZIP CODE SPRING VALLEY, MN 55		OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION  NG	(X3) DATE SI COMPLE	
SPRING VALLEY CARE CENTER  SPRING VALLEY CARE CENTER  SUMMARY STATEMENT OF DEFICIENCIES  GRAPH DEFICIENCY MUST BE PRECEDED BY FULL  REGULATORY ON LSC DENTIFYING INFORMATION)  F 329  Continued From page 4  Each resident's drug regimen must be free from unnecessary drug. 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 monitoring; 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  PLAN OF CORRECTION 4/21/2017			245442	B. WING	·····	0:	3/29/2017
FREDIT TAG  REGULATORY OR LSC IDENTIFYING INFORMATION)  FREDIT TAG  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  PLAN OF CORRECTION 4/21/2017			ER		800 MEMORIAL DRIVE	<u> </u>	
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  PLAN OF CORRECTION 4/21/2017	PRÉFIX	(EACH DEFICIENC)	/ MUST BE PRECEDED BY FULL	PREFIX	( (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE	N SHOULD BE	COMPLÉTION
	F 329	Each resident's dru unnecessary drugs drug when used  (1) In excessive do therapy); or  (2) For excessive de (3) Without adequal (4) Without adequal (5) In the presence which indicate the ed discontinued; or  (6) Any combination paragraphs (d)(1) the 483.45(e) Psychotr Based on a compre resident, the facility  (1) Residents who le drugs are not given medication is neces condition as diagnor clinical record;  (2) Residents who le gradual dose reduce interventions, unles an effort to disconti This REQUIREMEN	g regimen must be free from . An unnecessary drug is any se (including duplicate drug uration; or te monitoring; or te indications for its use; or of adverse consequences dose should be reduced or as of the reasons stated in arough (5) of this section.  opic Drugs. The ensure that mave not used psychotropic these drugs unless the sary to treat a specific these drugs unless the seary to treat a specific sed and documented in the sections, and behavioral as clinically contraindicated, in nue these drugs; NT is not met as evidenced	F3		4/04/0047	
	ORM CMS-2F		<u> </u>	1	Facility ID: 00121		neet Page 5 of 7

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP A. BUILDING	LE CONSTRUCTION		SURVEY PLETED
		245442	B. WING		03/2	29/2017
	PROVIDER OR SUPPLIER	ER		STREET ADDRESS, CITY, STATE, ZIP CODE BOO MEMORIAL DRIVE SPRING VALLEY, MN 55975		
(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 SHOUL CROSS-REFERENCED TO THE APPROFILIENCY)	D BE	(X5) COMPLETION DATE
F 329	Continued From parallel to ensure no interventions were administration of P medications for 1 or for unnecessary markets. R62's diagnosis for dated 11/23/16, included a stage one produced 1/26/17.  Order summary reproduced has orders for twice a day for buttas well as a PRN or hours as needed for Medication administrebruary 2017, indication 13 separate occurrences. Progress notes revertices a progress notes revertices and progress notes revertices.	age 5 n-pharmacological documented prior to RN (as needed) pain of 5 residents (R62) reviewed edications.  und on the Admission record licates restless legs syndrome essure ulcer of right buttock  port dated 3/29/17, indicates scheduled Tylenol 650 mg ock pain and restless leg pain order for 650 mg every six or pain in buttock and leg pain. estration record (MAR) dated icates R62 received PRN rate occasions. MAR dated ttes R62 received PRN Tylenol	F 329	DEFICIENCY)	found to at right to entions regimen ugs. 1 ed a prior to ts by the all lley at to be warm or ation. ace or de to does not pain	
	documented twice R62's care plan da have acute pain re present on admissi being relieved by re Tylenol. Staff to mo	ted 12/6/16, identifies R62 to lated to coccyx pressure ulcer lon. Interventions include pain epositioning, offloading and		stating that non-pharmacological intervention should be evaluated freffectiveness prior to administration medication for pain. The policy will updated by 4/25/2017 to include minterventions for non-pharmacological treatment of pain.  How the facility plans to monitor its performance to make sure that so are sustained? Develop a plan for	on of II be nore gical s lutions	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	IPLE CONSTRUCTION  NG		(X3) DATE SURVEY COMPLETED	
		245442	B. WING _		03/	29/2017	
	PROVIDER OR SUPPLIER  VALLEY CARE CENT	ER		STREET ADDRESS, CITY, STATE, ZIP CODE 800 MEMORIAL DRIVE SPRING VALLEY, MN 55975			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE	
F 329	quality, severity, and duration, aggravatir factors. Staff to mosymptoms of non-verity monitor/record/reportequests for pain treatments for pain treatments and partial practical nurse (LPI requests a PRN partial assesses the location the pain rating. Nurverify there is an apadminister the med will follow up for effection. Interview on 3/29/17 nursing (DON) state medications is that interventions are of each medication action provide any furth non-pharmacological attempted or documents and inistration of PI Requested policy readministration. Facting in the pain ration of PI Requested policy readministration. Facting in the pain ration of PI Requested policy readministration. Facting in the pain ration of PI Requested policy readministration. Facting in the pain ration of PI Requested policy readministration of PI Requested policy readm	atomical location, onset, and factors and relieving nitor/record/report any signs or erbal pain. Staff to ort any complaints of pain or eatment.  7, at 7:20 a.m. with licensed N)-A stated when a resident in medication the nurse on of the pain and assesses se will check the orders and opropriate PRN order and will ication accordingly as well as ectiveness of medication. Oharmacological interventions d and documented in the  7, at 8:18 a.m. with director of ed the expectation for PRN non-pharmacological fered and documented before Iministration. DON was unable er documentation that all interventions had been nented prior to the RN Tylenol for R62.  Elated to PRN medication illity provided policy titled, d 2/2011. Policy does not documentation of all interventions prior to	F 32	ensuring that correction is achie sustained. This plan must be implemented, and the corrective evaluated for its effectiveness. of correction is integrated into the assurance system. Staff educations provided at staff meetings scheed 4/25/2017. Random audits will completed weekly x 4 weeks to that resident who are receiving medications for pain have been non-pharmacological intervention. Audits will continue at least mor months to ensure continued corfindings and progress will be rewith the Quality Assurance/Qual Improvement Committee.  Who is responsible for this plan correction? The Director of Nur designee will be responsible for compliance.  Date of Correction: 4/25/2017	e action The plan the quality tion will be duled for the ensure torn offered this first. thly x 4 the pliance. viewed tity		

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PRINTED: 04/21/2017 FORM APPROVED OMB NO. 0938-0391

(X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA COMPLETED AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** A. BUILDING 01 - MAIN BUILDING 01 B. WING 245442 03/28/2017 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 800 MEMORIAL DRIVE SPRING VALLEY CARE CENTER SPRING VALLEY, MN 55975 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION ID (X5)(X4) ID (EACH CORRECTIVE ACTION SHOULD BE COMPLÉTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX **PREFIX** DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) K 000 INITIAL COMMENTS K 000 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

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.

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	
		245442	B. WING		03/	28/2017
	PROVIDER OR SUPPLIER  VALLEY CARE CENT	ER		STREET ADDRESS, CITY, STATE, ZIP CODE 800 MEMORIAL DRIVE SPRING VALLEY, MN 55975		
(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 SHIP) CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
K 000	DEFICIENCY MUS FOLLOWING INFO  1. A description of volto correct the deficition.  2. The actual, or proposed in the correct the deficition of volto correct the deficition.  3. The name and/oresponsible for correct a reoccurred (Spring Valley Livin basement. The build different times. The constructed in 1962 Type II(222) constructed to the (determined to be or Because the original are of the same type construction type at the facility was sure in 2014 the facility and the facility was sure in 2014 the facility. Northside of the build determined to be The separation between The building is fully fire alarm system we detection and space monitored for autornotification.	RRECTION FOR EACH TINCLUDE ALL OF THE DRMATION:  what has been, or will be, done ency.  oposed, completion date.  If title of the person rection and monitoring to ence of the deficiency.  g) is a 1-story building with no ding was constructed at (3) e original building was and was determined to be of fuction. In 1964, addition was (Westeran Trail) that was for Type II(222) construction. In all building and the (1) addition we of construction and meet the llowed for existing buildings, weyed as one building. The building is yee V (111) with a 1 hour in buildings.  sprinklered. The facility has a with full corridor smoke es open to the corridors that is matic fire department.	KO			

PRINTED: 04/21/2017 FORM APPROVED OMB NO. 0938-0391

(X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING 01 - MAIN BUILDING 01 245442 B. WING 03/28/2017 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 800 MEMORIAL DRIVE **SPRING VALLEY CARE CENTER** SPRING VALLEY, MN 55975 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES ID (X4) ID COMPLÉTION (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX **PREFIX** DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) K 000 Continued From page 2 K 000 The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by: K 351 NFPA 101 Sprinkler System - Installation 4/28/17 K 351 SS=D 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 Replace the sprinkler head in the Care 2012 EXISTING Center Freezer Storage area, Summit Fire protection has measured to insure the Nursing homes, and hospitals where required by construction type, are protected throughout by an correct size, and Spring Valley Living has approved automatic sprinkler system in requested a link style replacement head. This will be completed by 4-28-17 accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. All Sprinkler heads will be inspected and documented annually during, the annual In Type I and II construction, alternative protection measures are permitted to be substituted for sprinkler inspection. Person Responsible for this plan of sprinkler protection in specific areas where state correction: James Parsons, EVS Director or local regulations prohibit sprinklers. In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ' '	TIPLE CONSTRUC ING 01 - MAIN BI			(X3) DATE SURVEY COMPLETED	
		245442	B. WING			03/	28/2017	
	NAME OF PROVIDER OR SUPPLIER  SPRING VALLEY CARE CENTER			800 MEMORIA	ESS, CITY, STATE, ZIP CODE AL DRIVE LLEY, MN 55975			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	χ (EAC	ROVIDER'S PLAN OF CORREC SH CORRECTIVE ACTION SHO 3-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
K 351	sprinkler coverage required by NFPA Sprinkler Systems. 19.3.5.1, 19.3.5.2, 19.4.2, 19.3.5.10, 9 Findings Include:  On facility tour betwon March 28, 2017 interview revealed Observation during pendent sprinkler had color for the bulb so This deficient pract the residents, staff area.  This deficient pract	not exceed 6 square feet and covers the closet footprint as 13, Standard for Installation of 19.3.5.3, 19.3.5.4, 19.3.5.5, 9.7, 9.7.1.1(1)  ween 09:00 AM and 01:00 PM, based on observation and that the following include: In the inspection that the dry need in the freezer has lost the		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 <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 <a href="http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm">http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm</a>. 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

Kumalu Fiske Downing

Program Assurance Unit Health Regulation Division

Telephone: (651) 201-4112 Fax: (651) 215-9697

Email: Kamala.Fiske-Downing@state.mn.us

PRINTED: 05/22/2017 FORM APPROVED

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

NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
SPRING	VALLEY CARE CENTER		ORIAL DRIVE VALLEY, MN 55975			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY REGULATORY OR LSC IDENTIFYING INFORM.	/ FULL	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		2 000			
	*****ATTENTION*****					
	NH LICENSING CORRECTION ORD	DER				
	In accordance with Minnesota Statute, s 144A.10, this correction order has been pursuant to a survey. If, upon reinspect found that the deficiency or deficiencies herein are not corrected, a fine for each not corrected shall be assessed in according with a schedule of fines promulgated by the Minnesota Department of Health.	n issued tion, it is s cited n violation ordance				
	Determination of whether a violation has corrected requires compliance with all requirements of the rule provided at the number and MN Rule number indicated. When a rule contains several items, fail comply with any of the items will be contacted action of compliance. Lack of compliance re-inspection with any item of multi-part result in the assessment of a fine even that was violated during the initial inspectorrected.	e tag d below. lure to nsidered e upon t rule will if the item				
	You may request a hearing on any asset that may result from non-compliance with orders provided that a written request is the Department within 15 days of receip notice of assessment for non-compliance.	ith these s made to ot of a				
	INITIAL COMMENTS: You have agreed to participate in the element of State licensure orders consist the Minnesota Department of Health Informational Bulletin 14-01, available a http://www.health.state.mn.us/divs/fpc/pobul.htm The State licensing orders and delineated on the attached Minnesota	tent with at profinfo/inf				

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

04/19/17

**Electronically Signed** 

(X6) DATE

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TITLE

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00121	B. WING	<del></del>	03/2	9/2017
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
SPRING	VALLEY CARE CENT	FR	ORIAL DRIVI 'ALLEY, MN			
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2 000	Department of Hea you electronically. is necessary for Sta enter the word "cor text. You must then State licensure procompletion date, the corrected prior to e Minnesota Department provider and the folissued. Please indiccorrection that you and identify the dat Minnesota Department the State Licensing federal software. To assigned to Minnesota Department the State Licensing federal software. To assigned to Minnesota Department the State Licensing federal software. To assigned to Minnesota Department the State Licensing federal software. To assigned to Minnesota Department evideral software. To statute/rule out of computation or statute/ru	Ith orders being submitted to 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.  7, 28, & 29, 2017, surveyors staff, visited the above llowing correction orders are cate in your electronic plan of have reviewed these orders, e when they will be completed.  The order of Health is documenting and correction orders using any numbers have been so ta state statutes/rules for the state statutes/rules for the order of Deficiencies" column to Comply" portion of the nis column also includes the n violation of the state statute, "This Rule is not met as wing the surveyors findings Method of Correction and crection.  ARD THE HEADING OF THE	2 000			

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Minnesota Department of Health STATE FORM

O6SQ11 If continuation sheet 2 of 11

-	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	TE SURVEY MPLETED	
		00121	B. WING		3/29/2017
	PROVIDER OR SUPPLIER	800 MEM	DRESS, CITY, S DRIAL DRIVI ALLEY, MN		
(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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	Continued From pa	ge 2	2 000		
	PLAN OF CORREC	QUIREMENT TO SUBMIT A CTION FOR VIOLATIONS OF E STATUTES/RULES.			
21535	5 MN Rule4658.1315 Subp.1 ABCD Unnecessary Drug Usage; General		21535		4/25/17
	must be free from unnecessary drug is A. in excessive therapy; B. for excessive therapy; C. without adec D. in the prese which indicate the codiscontinued. In addition to the discontinued. In addition to the discontinued in the provisions in the Code of Federal Ref 483.25 (1) found in Operations Manual Long-Term Care Fade Department of Health Care Finance This standard is incavailable through the standard is incava	quate indications for its use; or nce of adverse consequences dose should be reduced or rug regimen review required in e nursing home must comply le Interpretive Guidelines for egulations, title 42, section Appendix P of the State, Guidance to Surveyors for acilities, published by the lith and Human Services, sing Administration, April 1992. Forporated by reference. It is ne Minitex interlibrary loan te Law Library. It is not			
	by: Based on interview failed to ensure nor interventions were	ent is not met as evidenced and record review, the facility n-pharmacological documented prior to RN (as needed) pain		PLAN OF CORRECTION 4/21/2017 F329 483.45 (d)(e)(1)-(2) Drug Regimen is Fre From Unnecessary Drugs	ee

Minnesota Department of Health

STATE FORM 6899 O6SQ11 If continuation sheet 3 of 11

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-	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
7.1.12 . 27.11	0. 0020	.5	A. BUILDING:			
			D WING	WWW.		
		00121	B. WING	<del></del>	03/2	9/2017
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
SDBING	VALLEY CARE CENT	ED 800 MEMO	ORIAL DRIV	E		
SFRING	VALLET CARL CENT	SPRING V	ALLEY, MN	55975		
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iAd			iAG	DEFICIENCY)		
21535	Continued From pa	ae 3	21535			
21000	-		21000			
		f 5 residents (R62) reviewed		What corrective action(s) will be		
	for unnecessary me	edications.		accomplished for those residents		
	Eindings include:			have been affected by the deficier		
	Findings include:			practice? All residents have the attempt non-pharmacologic intervention		
	R62's diagnosis for	and on the Admission record		prior to receiving medications for	5111101115	
		icates restless legs syndrome		discomfort. Each resident's drug	regimen	
		essure ulcer of right buttock		must be free from unnecessary dr		
	dated 1/26/17.	soure area. or right sattedit		out of 5 residents reviewed receive		
				non-pharmacological intervention	prior to	
	Order summary rep	oort dated 3/29/17, indicates		pain medication administration.		
		scheduled Tylenol 650 mg		How will you identify other residen	ts	
		ock pain and restless leg pain		having the potential to be affected	by the	
		rder for 650 mg every six		same deficient practice and what		
	hours as needed fo	r pain in buttock and leg pain.		corrective action will be taken? A		
	NA - dia atia a a a alasista	Lock's a second (NAAD) stated		residents who reside at Spring Val		
		tration record (MAR) dated		Living and have pain have the righ	it to be	
		cates R62 received PRN		provided with non-pharmacologic	vorm or	
		rate occasions. MAR dated tes R62 received PRN Tylenol		interventions (e.g., repositioning, v cold presses, etc.) prior to the	variii or	
	on 17 separate occ			administration of a prn pain medic	ation	
	on 17 separate occ	4310113.		What measures will be put into pla		
	Progress notes revi	lewed for the month of		what systemic changes will be ma		
		cates non-pharmacological		ensure that the deficient practice of		
		documented one time out of		recur? Spring Valley Living has a		
	13 opportunities. Pr	rogress notes reviewed for the		medication policy (Updated 2011)	in place	
	month of March 20	17, indicates		stating that non-pharmacological	-	
		al interventions were		intervention should be evaluated for		
	documented twice	out of 17 opportunities.		effectiveness prior to administration		
				medication for pain. The policy wi		
		ted 12/6/16, identifies R62 to		updated by 4/25/2017 to include m		
		ated to coccyx pressure ulcer		interventions for non-pharmacolog	licai	
		on. Interventions include pain epositioning, offloading and		treatment of pain.		
	Tylenol. Staff to mo			How the facility plans to monitor its performance to make sure that so		
		inely and as needed including		are sustained? Develop a plan for		
		atomical location, onset,		ensuring that correction is achieve		
		ng factors and relieving		sustained. This plan must be	a and	
		nitor/record/report any signs or		implemented, and the corrective a	ction	
	symptoms of non-v			evaluated for its effectiveness. Th		

Minnesota Department of Health

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	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00121	B. WING		03/2	9/2017
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS CITY S	STATE, ZIP CODE		
			ORIAL DRIV	,		
SPRING	VALLEY CARE CENT	FK	ALLEY, MN			
(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
21535	Continued From pa	ge 4	21535			
	Interview on 3/29/1 practical nurse (LPI requests a PRN pa assesses the locati the pain rating. Nur verify there is an apadminister the med will follow up for eff LPN-A stated non-pshould be attempte resident chart.	7, at 7:20 a.m. with licensed N)-A stated when a resident in medication the nurse on of the pain and assesses se will check the orders and propriate PRN order and will ication accordingly as well as ectiveness of medication. The sharmacological interventions d and documented in the				
	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.			Who is responsible for this plan of correction? The Director of Nursi designee will be responsible for compliance.  Date of Correction: 4/25/2017		
	administration. Fac "PRN Orders" dated identify offering or o	al interventions prior to				
	administrator, directions consulting pharmactions and proceed medication usage.	THOD OF CORRECTION: The tor of nursing (DON) and exist could review and revise ures for proper monitoring of The DON or designee, could views on a regular basis to				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00121	B. WING		03/2	29/2017
	PROVIDER OR SUPPLIER VALLEY CARE CENT	ED 800 MEMO	DRESS, CITY, S ORIAL DRIVI /ALLEY, MN	—		
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21535	•	ge 5 R CORRECTION: Twenty-one	21535			
21830	Residents of HC Farsubul. 10. Participy notification of family  (a) Residents shall in the planning of the includes the opportunity to request care conferences, a family member or oboth. In the event the present, a family member or oboth. In the event the present, a family member or oboth. In the event the present, a family member or conferences.  (b) If a resident where the efforts as required the either a family member writing by the resident and emergency that admitted to the facilify member to phanning, unless the tobelieve the resident directive to the conference of the conference of the planning of the planning of the phanning of the phanning, the facility efforts, consistent where the possible of the planning, the facility efforts, consistent of the planning of the planning of the planning, the facility efforts, consistent of the planning of t	pation in planning treatment;	21830			4/27/17

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Minnesota Department of Health STATE FORM

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00121	B. WING		03/2	9/2017
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21830	executed an advance sident's health car this paragraph, "rea (1) examining the resident; (2) examining the resident in the poss (3) inquiring of ar family member conwhether the resident directive and wheth physician to whom care; and (4) inquiring of the resident normally gwhether the resident directive. If a facilit designated emerge member to participa accordance with this liable to resident for the notification of the mergency contact family member was patient's privacy rig (c) In making reafamily member or directive and the medical reconstitution of the facility shall attembers or a design examining the personal the medical reconstitution of the facility shall attembers or a design examining the personal the medical reconstitution, the facility afamily memergency contact admission, the facilistic social service agentagency that the resident facility has been the f	ce directive relative to the e decisions. For purposes of asonable efforts" include: e personal effects of the ession of the facility; by emergency contact or tacted under this section at has executed an advance er the resident has a the resident normally goes for e physician to whom the pes for care, if known, at has executed an advance by notifies a family member or not contact or allows a family ate in treatment planning in s paragraph, the facility is not a damages on the grounds that the family member or or the participation of the simproper or violated the	21830			

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Minnesota Department of Health STATE FORM

INTERPRETATION OF CORRECTION  NUMBERS  PRINTY VALUEY CARE CENTER  SPRING VALLEY MN 55975  21830  CONTINUE CENTER CARE CORE CARE CENTER  CARE CARE CARE CARE CARE CARE CARE CARE	winnesc	<u>ita Department of He</u>	eaith				
NAME OF PROVIDER OR SUPPLIER  SPRING VALLEY CARE CENTER  SOM MEMORIAL DRIVE SPRING VALLEY CARE CENTER  SOM MEMORIAL DRIVE SPRING VALLEY, MN 55975				(X2) MULTIPL	E CONSTRUCTION		
NAME OF PROVIDER OR SUPPLIER  SPRING VALLEY CARE CENTER  SUMMARY STATEMENT OF DEFICIENCIES  PRED EACH DEPOCENCY MUST SEE PRECEDED BY RILLN  SPRING VALLEY, MN 55975  SUMMARY STATEMENT OF DEFICIENCIES  PRED EACH DEPOCENCY MUST SEE PRECEDED BY RILLN  PREF TAG  COUNTY SOCIAL SERVICE AGENCY MUST SEE PRECEDED BY RILLN  TO COUNTY SOCIAL SERVICE AGENCY MUST SEE PRECEDED BY RILLN  TO COUNTY SOCIAL SERVICE AGENCY MUST SEE PRECEDED BY RILLN  TO COUNTY SOCIAL SERVICE AGENCY MUST SEE PRECEDED BY RILLN  TO COUNTY SOCIAL SERVICE AGENCY MUST SEE PRECEDED BY RILLN  TO COUNTY SOCIAL SERVICE AGENCY MUST SEE PRECEDED BY RILLN  TO COUNTY SOCIAL SERVICE AGENCY MUST SEE PRECEDED BY RILLN  TO COUNTY SOCIAL SERVICE AGENCY MUST SEE PRECEDED BY RILLN  TO COUNTY SOCIAL SERVICE AGENCY  TO COUNTY SOCIAL SERVICE AGENCY MUST SEE SEE SEE SEE SEE SEE SEE SEE SEE S	AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:	·	COMPLETED	
NAME OF PROVIDER OR SUPPLIER  SPRING VALLEY CARE CENTER  SUMMARY STATEMENT OF DEFICIENCIES  PRED EACH DEPOCENCY MUST SEE PRECEDED BY RILLN  SPRING VALLEY, MN 55975  SUMMARY STATEMENT OF DEFICIENCIES  PRED EACH DEPOCENCY MUST SEE PRECEDED BY RILLN  PREF TAG  COUNTY SOCIAL SERVICE AGENCY MUST SEE PRECEDED BY RILLN  TO COUNTY SOCIAL SERVICE AGENCY MUST SEE PRECEDED BY RILLN  TO COUNTY SOCIAL SERVICE AGENCY MUST SEE PRECEDED BY RILLN  TO COUNTY SOCIAL SERVICE AGENCY MUST SEE PRECEDED BY RILLN  TO COUNTY SOCIAL SERVICE AGENCY MUST SEE PRECEDED BY RILLN  TO COUNTY SOCIAL SERVICE AGENCY MUST SEE PRECEDED BY RILLN  TO COUNTY SOCIAL SERVICE AGENCY MUST SEE PRECEDED BY RILLN  TO COUNTY SOCIAL SERVICE AGENCY MUST SEE PRECEDED BY RILLN  TO COUNTY SOCIAL SERVICE AGENCY  TO COUNTY SOCIAL SERVICE AGENCY MUST SEE SEE SEE SEE SEE SEE SEE SEE SEE S							
STRING VALLEY CARE CENTER  SOM MEMORIAL DRIVE SPRING VALLEY, MN 5975  DIPPETEX TAG (EACH DEFICIENCY MIST BE PRECEDED BY PULL REGULATORY OR LSC IDENTIFYING INFORMATION)  PRECED TAG (EACH DEFICIENCY MIST)  CONTINUED From page 7  county social service agency and local law enforcement agency shall assist the facility in identifying an 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 falled 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 was not able to have two a week, 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 had her bath/shower once a week on baths a week. 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 had her beful she will be not be a deficient practice and what corrective action will be laken? All residents before the facility have the right of a deficient practice and what corrective action will be laken? All residents clone will be completed admission, care			00121	B. WING		03/2	9/2017
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Minnesota Department of Health

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STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		00121	B. WING		03/29/2017		
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE	03/2	9/2017	
		800 MFM	ORIAL DRIV				
SPRING	VALLEY CARE CENT	SPRING V	ALLEY, MN	55975			
(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 CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROFILIENCY)	D BE	(X5) COMPLETE DATE	
21830	Continued From pa	ige 8	21830				
21830	On 3/28/17, at 12:3 (NA)-A stated the cupon admission wit often they would lik stated most resider shower a week. NA requested more that accommodated.  On 3/28/17, at 12:4 nurse (LPN)-B state admission what a rebathing. LPN-B state accommodate more LPN-B stated R8 w Wednesday during stated she would for bathing preferences.  On 3/29/17, at 11:1 nurse (LPN)-B stated and asked her if sh shower a week. We scheduled her an emornings. LPN-B vasked upon admission anywhere. LPN-B stollowed up on durit LPN-B stated social there were any conpreferences includiconferences. LPN-I notes for R8 and vedocumentation relative process.	33 p.m., nursing assistant charge nurse had a meeting th residents to decide how are a shower or bath. NA-A ants just had one bath or an one a week it would be as first day of esident's preference is for ated we ask first day of esident's preference is for ated we absolutely than one more bath a week. The evening shift. LPN-B collow-up with R8 regarding her second and she followed up with R8 the would like an extra bath or the evening shift. It would like an extra bath or the have gone ahead and the extra bath on Saturday erified bathing preference was son but was not documented stated bathing preferences are ng resident care conferences. It services should be asking if	21830	or any time the resident voices a commodations will be made as and appropriate.  What measures will be put into play what systemic changes will be made ensure that the deficient practice of recur? Resident preferences inclusive rail preferences, dental and vifacilitation, bath preferences, wake sleep times, dressing, activity, food therapy time preference assessment (Completed 4/12/2017). A policy rebathing choices will be implemented by the preferences must be addressed we resident on admission and then ye unless the resident requests other. This will be completed by 4/25/2014. How the facility plans to monitor its performance to make sure that so are sustained? Develop a plan for ensuring that correction is achieve sustained. This plan must be implemented, and the corrective a evaluated for its effectiveness. The of correction is integrated into the assurance system. Staff education provided at staff meetings schedul 4/25/2017 and 4/27/2017. Random will be completed weekly x 4 week ensure that resident preferences a investigated and offered. Audits with continue at least monthly x 4 montensure continued compliance. Fin and progress will be reviewed with	ess any e and needed ace or de to does not uding ision e and d and en add en add en add en add ith early wise. 17. s lutions d and ction ne plan quality n will be led for m audits is to are being ill iths to ndings		
		do not discuss bathing		ensure continued compliance. Fin	ndings the		

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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						
		00121	B. WING		03/2	9/2017					
NAME OF	PROVIDER OR SUPPLIER		DDRESS, 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 CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE COMPLETE						
21830	conferences. SS-A bring up bathing so during the care con R10's quarterly Min 3/3/17 indicated a E Status (BIMS) score R10's care plan for indicated R10 requibathing.  R10's nursing assis R10 required assist on Wednesday ever During interview wit R10 stated at home daily, and in the fact according to her preasked how often should be admission and follo conference. Care c 30 days of admission and follo conference. Care c 30 days of admission ths.  Review of resident 6/22/16, 9/21/16, 3/bathing preferences meetings.  During an interview director of nursing (preferences for bat whether they want of the state of	stated if a resident would hedule it would be discussed ference. imum Data Set (MDS), dated Brief Interview for Mental e of 13 (cognitively intact). activities of daily living (ADL), ared one assistance with stant care plan sheet indicated cance of one staff for bathing	21830	Who is responsible for this plan of correction? The Director of Nursir designee will be responsible for compliance.  Date of Correction: 4/27/2017							

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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				
		00121	B. WING	<del></del>	03/2	9/2017			
NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE  800 MEMORIAL DRIVE  SPRING VALLEY CARE CENTER  SPRING VALLEY, MN 55975									
(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			
21830	preferences of bath During interview on social worker (SW) asked about bathin nursing assessmen should be included The facility stated th policy that addresse frequency.  SUGGESTED MET The administrator con the need for self	sing at time of an admission.  3/29/17, at 2:30 p.m. the  -A indicated all residents were g frequency on their admission at, any documentation of such	21830						

6899

Minnesota Department of Health STATE FORM