CENTERS FOR MEDICARE & MEDICAID SERVICES

ND HUMAN SERVICES	CENTERS FOR
MEDICARE/MEDICAID CERTIFICATIO	ON AND TRANSMITTAL
PART I. TO BE COMPLETED BY THE S	TATE SURVEY AGENCY

ID: ONVZ

PART I - TO BE COMPLETED BY THE STAT					TE SURVE	EY AGENCY	Fac	ility ID: 00286	
1. MEDICARE/MEDICA (L1) 245566 2.STATE VENDOR OR M (L2) 844240100			3. NAME AND AI (L3) VALLEY VI (L4) 510 EAST C (L5) HOUSTON,	IEW HEALTHO EDAR STREET	CARE & R		(L6) 55943	 TYPE OF ACTION: Initial Termination Validation 	2 (L8) 2. Recertification 4. CHOW 6. Complaint 9. Outplan
5. EFFECTIVE DATE CF (L9)	IANGE OF OWNERSF	ΗP	 PROVIDER/SU 01 Hospital 	PPLIER CATEGO 05 HHA	RY 09 ESRD	<u>02</u> 13 PTIP	(L7) 22 CLIA	7. On-Site Visit 8. Full Survey After Con	9. Other uplaint
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16. STATE SURVEY AG	×	APPLICABL		ELLATION DATE):				
17. SURVEYOR SIGNAT	TURE		Date :			18. STATI	E SURVEY AGENCY A	APPROVAL	Date:
Jennifer Kolsr	ud Brown, Uni	t Superv	visor (09/15/2021	(L19)	Melissa	Poepping, Enfo	prcement Specialist	09/15/2021(L20)
	PART I	I - TO BI	E COMPLETED	BY HCFA RE	EGIONAI	OFFICE	OR SINGLE ST	ATE AGENCY	
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Electronically delivered September 15, 2021 CMS Certification Number (CCN): 245566

Administrator Valley View Healthcare & Rehab 510 East Cedar Street Houston, MN 55943

Dear Administrator:

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 September 10, 2021 the above facility is certified for:

45 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 45 skilled nursing facility beds.

You should advise our office of any changes in staffing, services, or organization, which might affect your certification status. If, at the time of your next survey, we find your facility to not be in substantial compliance your Medicare and/or Medicaid provider agreement may be subject to non-renewal or termination.

Please contact me if you have any questions.

Sincerely,

Mighing

Melissa Poepping, Health Program Representative Senior Program Assurance | Licensing and Certification Minnesota Department of Health P.O. Box 64970 Saint Paul, Minnesota 55164-0970 Phone: 651-201-4117 Email: melissa.poepping@state.mn.us



Electronically delivered September 15, 2021

Administrator Valley View Healthcare & Rehab 510 East Cedar Street Houston, MN 55943

RE: CCN: 245566 Cycle Start Date: July 9, 2021

Dear Administrator:

On August 30, 2021, we notified you a remedy was imposed. On September 10, 2021 the Minnesota Department of Health and Public Safety completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of September 10, 2021.

As authorized by CMS the remedy of:

• Mandatory denial of payment for new Medicare and Medicaid admissions effective October 9, 2021 did not go into effect. (42 CFR 488.417 (b))

In our letter of July 29, 2021, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from October 9, 2021 due to denial of payment for new admissions. Since your facility attained substantial compliance on September 10, 2021, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded. However, this does not apply to or affect any previously imposed NATCEP loss.

The CMS Region V Office may notify you of their determination regarding any imposed remedies.

Feel free to contact me if you have questions.

Sincerely,

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Melissa Poepping, Health Program Representative Senior Program Assurance | Licensing and Certification Minnesota Department of Health P.O. Box 64970 Saint Paul, Minnesota 55164-0970 Phone: 651-201-4117 Email: melissa.poepping@state.mn.us



Electronically delivered

September 15, 2021

Administrator Valley View Healthcare & Rehab 510 East Cedar Street Houston, MN 55943

Re: Reinspection Results Event ID: ONVZ13

Dear Administrator:

On September 10, 2021 survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on July 9, 2021. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

Mi This

Melissa Poepping, Health Program Representative Senior Program Assurance | Licensing and Certification Minnesota Department of Health P.O. Box 64970 Saint Paul, Minnesota 55164-0970 Phone: 651-201-4117 Email: melissa.poepping@state.mn.us

DEPARTMENT OF HEALTH AND HUMAN SERVICES	CENTERS FOR MEDICARE & MEDI	CAID SERVICES
MEDICARE/MEDICAID CERTIFICATION AN	D TRANSMITTAL	ID: ONVZ
PART I - TO BE COMPLETED BY THE STATE	SURVEY AGENCY	Facility ID: 00286

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Electronically delivered

August 30, 2021

Administrator Valley View Healthcare & Rehab 510 East Cedar Street Houston, MN 55943

RE: CCN: 245566 Cycle Start Date: July 9, 2021

Dear Administrator:

On July 29, 2021, we informed you that we may impose enforcement remedies.

On August 24, 2021, the Minnesota Departments of Health and Public Safety completed a revisit and it has been determined that your facility is not in substantial compliance. The most serious deficiencies in your facility were found to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D), as evidenced by the electronically attached CMS-2567, whereby corrections are required.

REMEDIES

As a result of the survey findings and in accordance with survey and certification memo 16-31-NH, this Department recommended the enforcement remedy(ies) listed below to the CMS Region V Office for imposition. The CMS Region V Office concurs and is imposing the following remedy and has authorized this Department to notify you of the imposition:

• Mandatory Denial of Payment for new Mediare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective October 9, 2021

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective October 9, 2021. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective October 9, 2021.

You should notify all Medicare/Medicaid residents admitted on, or after, this date of the restriction. The remedy must remain in effect until your facility has been determined to be in substantial compliance or your provider agreement is terminated. Please note that the denial of payment for new admissions includes Medicare/Medicaid beneficiaries enrolled in managed care plans. It is your obligation to inform managed care plans contracting with your facility of this denial of Valley View Healthcare & Rehab August 30, 2021 Page 2 payment for new admissions.

This Department is also recommending that CMS impose a civil money penalty. You will receive a formal notice from the CMS RO only if CMS agrees with our recommendation.

• Civil money penalty. (42 CFR 488.430 through 488.444)

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than \$11,160; has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

If you have not achieved substantial compliance by October 9, 2021, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, Valley View Healthcare & Rehab will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from October 9, 2021. You will receive further information regarding this from the State agency. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions. However, under Public Law 105-15, you may contact the State agency and request a waiver of this prohibition if certain criteria are met.

ELECTRONIC PLAN OF CORRECTION (ePOC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved. The failure to submit an acceptable ePOC can lead to termination of your Medicare and Medicaid participation (42 CFR 488.456(b)).

To be acceptable, a provider's ePOC must include the following:

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.
- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.

Valley View Healthcare & Rehab August 30, 2021 Page 3

- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

DEPARTMENT CONTACT

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

Jennifer Kolsrud Brown, RN, Unit Supervisor Rochester District Office Licensing and Certification Program Health Regulation Division Minnesota Department of Health 18 Wood Lake Drive Southeast Rochester, Minnesota 55904-5506 Email: jennifer.kolsrud@state.mn.us Office: (507) 206-2727 Mobile: (507) 461-9125

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a Post Certification Revisit (PCR), of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

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.

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

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by January 9, 2022 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is Valley View Healthcare & Rehab August 30, 2021 Page 4

mandated by the Social Security Act at § 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR § 488.412 and § 488.456.

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.

APPEAL RIGHTS

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

Tamika.Brown@cms.hhs.gov

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

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

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

INFORMAL DISPUTE RESOLUTION (IDR) / INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

Valley View Healthcare & Rehab August 30, 2021 Page 5

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: <u>https://mdhprovidercontent.web.health.state.mn.us/ltc_idr.cfm</u>

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: <u>https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html</u>

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

Feel free to contact me if you have questions.

Sincerely,

Mitig

Melissa Poepping, Health Program Representative Senior Program Assurance | Licensing and Certification Minnesota Department of Health P.O. Box 64970 Saint Paul, Minnesota 55164-0970 Phone: 651-201-4117 Email: melissa.poepping@state.mn.us

DEPART	MENT OF HEALTH	AND HUMAN SERVICES			1		APPROVED
CENTER	RS FOR MEDICARE	& MEDICAID SERVICES			0	MB NO.	0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	`́СОМ	E SURVEY IPLETED
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					10 EAST CEDAR STREET		
VALLEY	VIEW HEALTHCARE	& REHAB		Н	IOUSTON, MN 55943		
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	was conducted to for issued related to a exited on 7/9/2021.	8/24/2021, an offsite revisit ollow up on deficiencies standard recertification survey Your facility was NOT IN CFR Part 483, Requirements Facilities.					
	The following tag w	vas recited: (F698).					
	as your allegation of Department's accept enrolled in ePOC, y	f correction (POC) will serve of compliance upon the ptance. Because you are your signature is not required a first page of the CMS-2567					
{F 698} SS=D	an on-site revisit of conducted to valida with the regulations	acceptable electronic POC, your facility may be ate that substantial compliance has been attained.	{F 6	98}			9/1/21
	require dialysis reco with professional st	sure that residents who eive such services, consistent andards of practice, the son-centered care plan, and					
LABORATORY	DIRECTOR'S OR PROVID	ER/SUPPLIER REPRESENTATIVE'S SIGN	NATURE		TITLE		(X6) DATE
Electron	ically Signed						09/02/2021

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

PRINTED: 09/09/2021

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
				IG		R
		245566	B. WING			24/2021
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
VALLEY	VIEW HEALTHCARE	& REHAB		510 EAST CEDAR STREET HOUSTON, MN 55943		
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	Based on intervier facility failed to ensi- was consistently m 1 residents (R25) m addition, the facility comprehensive dia frequency and time pre-and post-dialys for nursing docume coordination of card Findings include: According to R25's (EHR) facesheet, F	lysis care plan to reflect e periods for completing sis assessments, or standards entation to include clarity on e with the dialysis center. electronic health record R25 had the following ence on renal dialysis with end		On August 25, 2021, written communication was given to fla and TMAS to read and sign to acknowledge. The communicat document stated the following: communicate with the dialysis day that R25 goes to dialysis. A communication book was dever in July to be sent with R25, and not been utilized. There are ne the MAR that need to be signe completed each dialysis day. T communication book will go ou with the condition he leaves in, he returns the TMA/nurse will r book and document in progres what was communicated.	tion We must unit every A eloped back d this had w orders in d off and The it with R25 and when read the	
	intervention dated of any unusual rednes greater than 100.5 contact dialysis uni intervention failed t nursing assessmen On 07/08/21 an inter care plan directing	EHR care plan, an 07/08/21, "check my port for ss, swelling temperature F or 38 C or other problems, t immediately." The o include a frequency for this nt. ervention was added to R25's nurses how to contact the had questions about R25's		It was also added to MAR that on the day and evening shift an evaluate port and document th completed. Dialysis unit was called and no 8/24/2021 that R25 was diagno pneumonia, they were also not this day that R25 is considering dialysis, and that VV social wo inform them of specific date.	re to at this was tified on osed with tified on g ending	
	port or where to se medical emergency this activity would be administration reco	nd him in the case of a y. This intervention indicated be listed on R25's treatment ord (TAR) for all three shifts to venings and nights.		Dialysis notified on 8/24/21 by worker to confirm the ending d dialysis.	ate of	
	According to R25's	physician orders, dated		Resident (R25) has ended dial 8/30/2021 and has returned to		

Facility ID: 00286

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION		SURVEY PLETED
245566				R 08/24/2021		
	PROVIDER OR SUPPLIER	& REHAB		STREET ADDRESS, CITY, STATE, ZIP CODE 510 EAST CEDAR STREET HOUSTON, MN 55943		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPRON DEFICIENCY)	D BE	(X5) COMPLETIC DATE
{F 698}	(central venous acc day between 6:30 a On 07/08/2021 an a added the R25's ca on what to do if the port, and this also w for documentation f Two previous interv remained on R25's have a Central Ven upper right chest for dialysis team" and a on the TAR twice a 10:30 a.m. and also 10:30 p.m. The sec 3/23/2021 indicated the port for signs an every shift and report team. This was to b According to R25's record (MAR) for 08 physician's order for not completed two left the building (dia MAR indicated the completed within the A request was mad facility did not provi	rses to check R25's port cess site for dialysis) once a a.m. and 10:30 a.m. additional intervention was are plan providing information re was bleeding from R25's was listed as being on the TAR for all three shifts. rentions, both dated 3/23/21 care plan. One indicated "I ous Catheter port on my or dialysis, report changes to showed this was to be marked day between 6:30 a.m. and between 7:00 p.m. and cond intervention also dated d the nurses should assess and symptoms of infection port changes to the dialysis be marked on the TAR. medication administration B/1/2021 thru 08/16/2021, the or monitoring the port daily was times because he had already alysis days) and five times the assessment was not be ordered time frame. e for R25's TAR, but the	{F 698	 home with family and hospice. Valley View at this time had no represent the receiving dialysis. If Valley View were to experience resident receiving dialysis treatment following would be implemented immediately upon admission. 1.Memorandum of Understanding the dialysis team. This would be presidents paper chart and scanne Matrix. 2.The care plan would be correct updated and would be accurate to the dialysis team sets forth. 3.The dialysis team phone number posted at the nurse's station, and resident's chart. 4.There would be an accurate or how, and when to check the port site. What to document when inspect the dialy View. At this time it wo communication book that would be transferred back and forth. 6.DON or designee would audit communication book weekly to er that it is being utilized. This audit brought forth to the QA/QAPI tear 	another ent the from placed in d in to and o what er will be in the ler on or fistula pecting. sis unit uld be a e	

Facility ID: 00286

TATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION		E SURVEY PLETED	
	245566		B. WING _			R 08/24/2021	
NAME OF PROVIDER OR SUPPLIER VALLEY VIEW HEALTHCARE & REHAB				STREET ADDRESS, CITY, STATE, ZIP CODE 510 EAST CEDAR STREET HOUSTON, MN 55943			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETIC DATE	
{F 698}	developed symptor starting 8/16/2021 a diagnosed with pne- indicating the dialys change in condition According to an inter nursing (DON) on 0 DON stated an exp and document on F during the day shift stated this was to b and TAR. DON state expectations for nu assessments in the 08/23/2021 she had would be asking the DON said it was im dialysis unit, the fac communicate abou also said the facility with him to all dialys it to be adequate co dialysis care team of provider's notes on they made rounds a facility had initiated communication boo dialysis so the facilit could share information only one note, we h condition." Alternation expectation for nurs in condition to the of document that com- confirmed that no sidocumented when	ns of a respiratory infection and on 8/17/2021 was sumonia. No documentation sis unit was advised of R25's n. erview with the director of 08/24/2021, at 10:36 a.m. ectation for nurses to monitor R25's dialysis port twice daily, and the evening shift. DON we documented in the MAR red she also had not had rses to document a progress notes, but as of d changed her mind and e nurses to do a daily note. portant for all entities, the cility and the resident to t changes in condition. DON v sent a copy of R25's MAR sis appointments and believed ommunication since the could access the medical R25 if they saw him when at the facility. DON said the	{F 69	 8} 7.DON or designee would audi weekly x 3 weeks then monthly results would be brought forth to QAPI quarterly meetings. 8.There would be education gives to all nursing the care plan that the resident to have the safe quality of life the deserve. Education would also all the above information. 	v and to the QA/ ven by the staff on would need ney would		

If continuation sheet Page 4 of 6

CENTE	RS FOR MEDICARE	AND HUMAN SERVICES & MEDICAID SERVICES				FORM	0: 09/09/2021 APPROVED 0: 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION		TE SURVEY MPLETED R
		245566	B. WING			08	/24/2021
NAME OF	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
VALLEY	VIEW HEALTHCARE	& REHAB			10 EAST CEDAR STREET IOUSTON, MN 55943		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
{F 698}	decided to stop dial for end-of-life care unsure of any spec R25's EHR progress and 08/16/21 did nd about stopping dial planning or a referr Notes provided fror interdisciplinary tea to show any discus pneumonia or decise During a phone inter registered nurse (R unit stated an expe the unit whenever a of condition. RN-A own medical notes notes from outside do so unless they h in condition. RN-A check R25's vital si should send inform outside the patient's skin condition. RN-A would not be adequ R25's current condi further stated that v information about a dialysis nurse know that may be further as significant chang Following a dialysis most likely to devel few hours and state	lysis and to return to his home with hospice, but DON was ific date. as notes between 8/01/2021 ot include any information ysis treatment, discharge al to hospice care.	{F 6	98}			

Facility ID: 00286

If continuation sheet Page 5 of 6

		I AND HUMAN SERVICES E & MEDICAID SERVICES				FORM	09/09/2021 APPROVED 0938-0391
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	COM	E SURVEY PLETED
		245566	B. WING				₹ 24/2021
NAME OF	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
VALLEY	VIEW HEALTHCARE	& REHAB			10 EAST CEDAR STREET IOUSTON, MN 55943		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
{F 698}	and to monitor for a hours. Symptoms of noted could be nau cramping, change i pressure. RN-A sta R25 had been diag in the month and di communication fror infection. RN-A stat should have been r team. According to the fa phone interview 8/2 communication bet contracted care en stating "if we have communicate to the Administrator said to facility nurses shou is relevant that mig receives at dialysis documentation sho saying, "I would ho	adverse events for several of problems that might be usea, vomiting, muscle in cognition or a swing in blood ated he was not aware that prosed with pneumonia earlier id not recall any m the facility regarding an ted this was information that reported to the dialysis care cility Administrator during a 24/21, 2:41 p.m. tween the facility and tities needed to go both ways, relevant issues we would em and vice versa." The that in the case of dialysis, ald communicate anything that the affect the care the resident a. Administrator also said that buld be as timely as possible, pe they would document right nat other persons who provide	{F 69	98}			

Facility ID: 00286

If continuation sheet Page 6 of 6

DEPARTMENT OF HEALTH AND HUMA	CENTERS FOR MEDICARE & MEDICAID SERVI					
	ND TRANSMITTAL E SURVEY AGENCY		ONVZ ility ID: 00286			
1. MEDICARE/MEDICAID PROVIDER NO. (L1) 245566	3. NAME AND ADDRESS OF FACILITY (L3) VALLEY VIEW HEALTHCARE & RI	EHAB	 TYPE OF ACTION: Initial 	<u>2 (</u> L8) 2. Recertification		
2.STATE VENDOR OR MEDICAID NO. (L2) 844240100	(L4) 510 EAST CEDAR STREET (L5) HOUSTON, MN	(L6) 55943	3. Termination	 Kecertification CHOW Complaint 		

 5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9) 6. DATE OF SURVEY 07/09/2021 (L34) 		(L5) HOUSTON, MN				5. Validation 6. Complaint			
	7. PROVIDER/SU	JPPLIER CATEG	JORY	<u>02</u> (L7)		7. On-Site Visit 9. Other			
6 DATE OF SURVEY 07/09/2021 (1.34)	01 Hospital	05 HHA	09 ESRD		CLIA	8. Full Survey After Complaint			
0. DATE OF SURVEY 01109/2021 (EST	02 SNF/NF/Dual	06 PRTF	10 NF	14 CORF					
8. ACCREDITATION STATUS:(L10)	03 SNF/NF/Distinct	07 X-Ray	11 ICF/IID	15 ASC		FISCAL YEAR ENDING DATE: (L35)			
0 Unaccredited 1 TJC 2 AOA 3 Other	04 SNF	08 OPT/SP	12 RHC	16 HOSPICE		09/30			
11LTC PERIOD OF CERTIFICATION	10.THE FACILITY	Y IS CERTIFIED	AS:						
From (a):	A. In Complia	ance With		And/Or Approved Wa	aivers Of Th	e Following Requirements:			
To (b):		equirements		2. Technical I	Personnel	6. Scope of Services Limit			
	Complianc	e Based On:		3. 24 Hour R1	N	7. Medical Director			
12.Total Facility Beds 45 (L18)	1. A	cceptable POC		4. 7-Day RN	(Rural SNF)	8. Patient Room Size			
13. Total Certified Beds45(L17)	X B. Not in Cor	nnliance with Pro	aram	5. Life Safety	/ Code	9. Beds/Room			
13. Iolai Certified Beus		and/or Applied V	0	* Code: B *	(L12)			
14. LTC CERTIFIED BED BREAKDOWN	·			15. FACILITY MEET	S				
18 SNF 18/19 SNF 19 SN	IF ICF	IID		1861 (e) (1) or 1861	(j) (1):	(L15)			
45									
(L37) (L38) (L39) (L42)	(L43)							
16. STATE SURVEY AGENCY REMARKS (IF APPL	ICABLE SHOW LTC CA	ANCELLATION	DATE):						
17. SURVEYOR SIGNATURE	Date :			18. STATE SURVEY	AGENCY A	PPROVAL Date:			
Kathy Hahn, HFE NE II	(08/13/2021	(L19)	Melissa Poeppi	ing, Enfo	prcement Specialist 08/27/2021			
E	E COMPLETED I		. ,		•	(L20)			
i	E COMPLETED I 20. COM		EGIONAL	21. 1. Stateme	IGLE STA	(L20)			
PART II - TO B	E COMPLETED I 20. COM	BY HCFA RF 19LIANCE WITH	EGIONAL	21. 1. Stateme 2. Owners	IGLE STA	(L20) ATE AGENCY al Solvency (HCFA-2572)			
PART II - TO B	E COMPLETED I 20. COM RIGI	BY HCFA RF 19LIANCE WITH	EGIONAL	21. 1. Stateme 2. Owners	GLE STA	(L20) ATE AGENCY al Solvency (HCFA-2572)			
PART II - TO E 19. DETERMINATION OF ELIGIBILITY 1. Facility is Eligible to Participate 2. Facility is not Eligible	E COMPLETED I 20. COM RIGI	BY HCFA RF 19LIANCE WITH	EGIONAL H CIVIL	21. 1. Stateme 2. Owners	GLE STA ent of Financia hip/Control I the Above :	(L20) ATE AGENCY al Solvency (HCFA-2572)			
PART II - TO B 19. DETERMINATION OF ELIGIBILITY 1. Facility is Eligible to Participate 2. Facility is not Eligible (L2 22. ORIGINAL DATE 23. LTC AGR	E COMPLETED I 20. COM RIGI	BY HCFA RE IPLIANCE WITH HTS ACT:	EGIONAL H CIVIL MENT	21. 1. Stateme 2. Ownersi 3. Both of	GLE STA ent of Financia hip/Control I the Above :	(L20) ATE AGENCY al Solvency (HCFA-2572) nterest Disclosure Stmt (HCFA-1513)			
PART II - TO B 19. DETERMINATION OF ELIGIBILITY 1. Facility is Eligible to Participate 2. Facility is not Eligible (L2 22. ORIGINAL DATE 23. LTC AGR	E COMPLETED I 20. COM RIGI) EEMENT 2	BY HCFA RE APLIANCE WITH HTS ACT: 4. LTC AGREEM	EGIONAL H CIVIL MENT	21. 1. Stateme 2. Ownersi 3. Both of 26. TERMINATION	ACTION:	(L20) ATE AGENCY al Solvency (HCFA-2572) nterest Disclosure Stmt (HCFA-1513) (L30)			
PART II - TO B 19. DETERMINATION OF ELIGIBILITY 1. Facility is Eligible to Participate 2. Facility is not Eligible (L2 22. ORIGINAL DATE 23. LTC AGR OF PARTICIPATION BEGINN	E COMPLETED I 20. COM RIGI) EEMENT 2	BY HCFA RE APLIANCE WITH HTS ACT: 4. LTC AGREEM	EGIONAL H CIVIL MENT	21. 1. Stateme 2. OWNERS 3. Both of 26. TERMINATION . <u>VOLUNTARY</u>	AGLE ST4 ent of Financi. hip/Control I the Above : ACTION: <u>00</u>	(L20) ATE AGENCY al Solvency (HCFA-2572) nterest Disclosure Stmt (HCFA-1513) (L30) <u>INVOLUNTARY</u> 05-Fail to Meet Health/Safety			
PART II - TO E 19. DETERMINATION OF ELIGIBILITY 1. Facility is Eligible to Participate 2. Facility is not Eligible (L2 22. ORIGINAL DATE Q5 PARTICIPATION BEGINN 07/01/1991 (L24)	E COMPLETED I 20. COM RIGI) EEMENT 2	BY HCFA RE APLIANCE WITH HTS ACT: 4. LTC AGREEN ENDING DA	EGIONAL H CIVIL MENT	21. 1. Stateme 2. OWNERS 3. Both of 26. TERMINATION. <u>VOLUNTARY</u> 01-Merger, Closure	IGLE STA ent of Financia hip/Control I 'the Above : ACTION: <u>00</u> Reimbursem	(L20) ATE AGENCY al Solvency (HCFA-2572) nterest Disclosure Stmt (HCFA-1513) (L30) <u>INVOLUNTARY</u> 05-Fail to Meet Health/Safety			
PART II - TO B 19. DETERMINATION OF ELIGIBILITY 1. Facility is Eligible to Participate 2. Facility is not Eligible (L2 22. ORIGINAL DATE 23. LTC AGR OF PARTICIPATION BEGINN 07/01/1991 (L24) (L24) 25. LTC EXTENSION DATE: 27. ALTERN	E COMPLETED I 20. COM RIGH) EEMENT 2. ING DATE	BY HCFA RE APLIANCE WITH HTS ACT: 4. LTC AGREEN ENDING DA	EGIONAL H CIVIL MENT	21. 1. Stateme 2. OWNERS 3. Both of 26. TERMINATION. <u>VOLUNTARY</u> 01-Merger, Closure 02-Dissatisfaction W/1	ACTION: 00 00 00 00 00 00 00 00 00 0	(L20) ATE AGENCY al Solvency (HCFA-2572) nterest Disclosure Stmt (HCFA-1513) (L30) <u>INVOLUNTARY</u> 05-Fail to Meet Health/Safety ent 06-Fail to Meet Agreement			
PART II - TO B 19. DETERMINATION OF ELIGIBILITY	E COMPLETED I 20. COM RIGI) EEMENT 2. ING DATE ATIVE SANCTIONS	BY HCFA RE APLIANCE WITH HTS ACT: 4. LTC AGREEN ENDING DA	EGIONAL H CIVIL MENT	20. TERMINATION 26. TERMINATION VOLUNTARY 01-Merger, Closure 02-Dissatisfaction W/1 03-Risk of Involuntary	ACTION: 00 00 00 00 00 00 00 00 00 0	(L20) ATE AGENCY al Solvency (HCFA-2572) nterest Disclosure Stmt (HCFA-1513) (L30) <u>INVOLUNTARY</u> 05-Fail to Meet Health/Safety ent 06-Fail to Meet Agreement <u>OTHER</u>			
PART II - TO B 19. DETERMINATION OF ELIGIBILITY	E COMPLETED I 20. COM RIGI) EEMENT 2. ING DATE ATIVE SANCTIONS sion of Admissions:	BY HCFA RF APLIANCE WITH HTS ACT: 4. LTC AGREEN ENDING DA (L25)	EGIONAL H CIVIL MENT	20. TERMINATION 26. TERMINATION VOLUNTARY 01-Merger, Closure 02-Dissatisfaction W/1 03-Risk of Involuntary	ACTION: 00 00 00 00 00 00 00 00 00 0	(L20) ATE AGENCY al Solvency (HCFA-2572) nterest Disclosure Stmt (HCFA-1513) (L30) <u>INVOLUNTARY</u> 05-Fail to Meet Health/Safety ent 06-Fail to Meet Agreement <u>OTHER</u> 07-Provider Status Change			
PART II - TO B 19. DETERMINATION OF ELIGIBILITY	E COMPLETED I 20. COM RIGI) EEMENT 2. ING DATE ATIVE SANCTIONS sion of Admissions:	BY HCFA RE APLIANCE WITH HTS ACT: 4. LTC AGREEN ENDING DA (L25) (L44) (L45)	EGIONAL H CIVIL MENT	20. TERMINATION 26. TERMINATION VOLUNTARY 01-Merger, Closure 02-Dissatisfaction W/1 03-Risk of Involuntary	ACTION: 00 00 00 00 00 00 00 00 00 0	(L20) ATE AGENCY al Solvency (HCFA-2572) nterest Disclosure Stmt (HCFA-1513) (L30) <u>INVOLUNTARY</u> 05-Fail to Meet Health/Safety ent 06-Fail to Meet Agreement <u>OTHER</u> 07-Provider Status Change			
PART II - TO B 19. DETERMINATION OF ELIGIBILITY	E COMPLETED I 20. COM RIGI) EEMENT 2. ING DATE ATIVE SANCTIONS sion of Admissions: d Suspension Date:	BY HCFA RE APLIANCE WITH HTS ACT: 4. LTC AGREEN ENDING DA (L25) (L44) (L45)	EGIONAL H CIVIL MENT	20FFICE OR SIN 21. 1. Stateme 2. Ownersi 3. Both of 26. TERMINATION <u>VOLUNTARY</u> 01-Merger, Closure 02-Dissatisfaction W/1 03-Risk of Involuntary 04-Other Reason for Wi	ACTION: 00 00 00 00 00 00 00 00 00 0	(L20) ATE AGENCY al Solvency (HCFA-2572) nterest Disclosure Stmt (HCFA-1513) (L30) (L30) <u>INVOLUNTARY</u> 05-Fail to Meet Health/Safety ent 06-Fail to Meet Agreement <u>OTHER</u> 07-Provider Status Change			
PART II - TO E 19. DETERMINATION OF ELIGIBILITY	E COMPLETED I 20. CON RIGH 20. CON RIGH 20. CON RIGH 20. TON Sion of Admissions: d Suspension Date: 29. INTERMEDIARY.	BY HCFA RE APLIANCE WITH HTS ACT: 4. LTC AGREEN ENDING DA (L25) (L44) (L45)	EGIONAL H CIVIL MENT	20FFICE OR SIN 21. 1. Stateme 2. Ownersi 3. Both of 26. TERMINATION <u>VOLUNTARY</u> 01-Merger, Closure 02-Dissatisfaction W/1 03-Risk of Involuntary 04-Other Reason for Wi	ACTION: 00 00 00 00 00 00 00 00 00 0	(L20) ATE AGENCY al Solvency (HCFA-2572) nterest Disclosure Stmt (HCFA-1513) (L30) (L30) <u>INVOLUNTARY</u> 05-Fail to Meet Health/Safety ent 06-Fail to Meet Agreement <u>OTHER</u> 07-Provider Status Change			

(L33)

DETERMINATION APPROVAL

(L32)



Electronically delivered July 29, 2021

Administrator Valley View Healthcare & Rehab 510 East Cedar Street Houston, MN 55943

Re: State Nursing Home Licensing Orders Event ID: ONVZ11

Dear Administrator:

The above facility was surveyed on July 6, 2021 through July 9, 2021 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. 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 or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 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 and/or statute 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 order 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 https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04 8.html. The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered 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 or rule after the statement, "This MN Requirement is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

Valley View Healthcare & Rehab July 29, 2021 Page 2 PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.

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

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

Jennifer Kolsrud Brown, RN, Unit Supervisor Rochester District Office Licensing and Certification Program Health Regulation Division Minnesota Department of Health 18 Wood Lake Drive Southeast Rochester, Minnesota 55904-5506 Email: jennifer.kolsrud@state.mn.us Office: (507) 206-2727 Mobile: (507) 461-9125

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,

Joanne Simon, Enforcement Specialist Minnesota Department of Health Licensing and Certification Program Program Assurance Unit Health Regulation Division Telephone: 651-201-4161 Fax: 651-215-9697 Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

		AND HUMAN SERVICES			0		APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ·		E CONSTRUCTION	(X3) DAT COM	E SURVEY PLETED
		245566	B. WING				C 09/2021
NAME OF F	PROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE	-	
VALLEY	VIEW HEALTHCARE	& REHAB			0 EAST CEDAR STREET OUSTON, MN 55943		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
E 000	Initial Comments		E 0	00			
	Preparedness Requ 7/09/2021, during a	Appendix Z Emergency uirements was conducted on recertification survey. The be in compliance with the ency Preparedness					
F 000	signature is not req page of the CMS-29 correction is require	ed in ePOC and therefore a uired at the bottom of the first 567 form. Although no plan of ed, it is required that the facility of the electronic documents. TS	F0	000			
	survey was conduct investigation was all was found to be NC requirements of 42	D21, a standard recertification ted at your facility. A complaint lso conducted. Your facility DT in compliance with the CFR 483, Subpart B, ong Term Care Facilities.					
	SUBSTANTIATED (MN00062490),H55 (MN00074068),H55 H5566013C (MN00 (MN00067177), NC						
	AND The following comp UNSUBSTANTIATI	laints were found to be ED:					
	H5566012C (MN00	062109)					
LABORATOR'	Y DIRECTOR'S OR PROVID	DER/SUPPLIER REPRESENTATIVE'S SIG	NATURE		TITLE		(X6) DATE
	ically Signed						08/04/2021

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.

DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 08/13/2021

TATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIF	PLE CONSTRUCTION (X3) DA	TE SURVEY		
	F CORRECTION	IDENTIFICATION NUMBER:			MPLETED		
		045500			С		
		245566	B. WING	STREET ADDRESS, CITY, STATE, ZIP CODE	/09/2021		
NAME OF F	PROVIDER OR SUPPLIER						
VALLEY	VIEW HEALTHCARE	& REHAB	510 EAST CEDAR STREET HOUSTON, MN 55943				
(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) COMPLETIO DATE		
F 000	Continued From pa	ge 1	F 000)			
	as your allegation of Departments accept enrolled in ePOC, y at the bottom of the form. Your electron be used as verificat	·					
F 658 SS=E	onsite revisit of you validate that substa regulations has bee Services Provided I	Meet Professional Standards	F 658	3	8/13/21		
	The services provid as outlined by the o must- (i) Meet professiona	prehensive Care Plans led or arranged by the facility, comprehensive care plan, al standards of quality. NT is not met as evidenced					
	Based on observat failed to ensure sta standards of practic for 6 of 12 residents and R286) observe Additionally, the fac properly assessing	tion and interview the facility ff followed professional ce of medication administration s (R19, R13, R288, R7, R289, d during medication pass. cility failed to ensure staff were appropriate placement of a G-tube) (a tube inserted		F658 Valley View Healthcare & Rehab's following policies titled Administering Medications and Enteral Tube Feeding vi Continuous Pump were reviewed on 08/03/2021.	a		
	through the abdom into the stomach) p	en delivering nutrition directly er policy before administration resident (R1) with a G-tube.		LPN-A was reorientated on medication administration and G-Tube feedings (including placement and flushing) on the following dates: 07/17/21, 07/18/21, 07/19/21. LPN-A has documented			

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	-	AND HUMAN SERVICES				FORM	08/13/202 APPROVE 0938-039
TATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245566	B. WING				C 09/2021
	PROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE	0//	JJ/2021
	VIEW HEALTHCARE	& REHAB		510	DEAST CEDAR STREET DUSTON, MN 55943		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETIC DATE
F 658	Continued From pa	ige 2	F 6	658			
	to the facility with a of left acetabulum (the "ball-and-socke use of anticoagular R7's Face Sheet in the facility with a pr weakness and cong On 7/6/21, at 4:45 p (LPN)-A was admir residents after they evening meal. LPN with 2 medicine cup administered one n second medicine cup administered one n second medicine cup administered one n second medicine cup administered warfa medication cups dia release 100 mg tab administered warfa medication cups dia resident name or m R19's Face Sheet i the facility with a pr (severe of complete on one side of the b weakness or loss o body) following cere of the brain that con inability to control v muscles) affecting R13's Face Sheet i the facility with a pr	principle diagnosis of fracture (break in the socket portion of the hip joint), long term current ints and glaucoma. dicated R7 was admitted to inciple diagnosis of muscle gestive heart failure. o.m., licensed practical nurse instering medications to arrived to the dining room for J-A entered the dining room os of medication and medicine cup to R7 and the up to R288 who were seated Review of medications dministered acetaminophen metoprolol succinate extended olet and R288 was rin 1 mg tablet, The d not have any identifiers for medications present. Indicated R19 was admitted to inciple diagnosis of hemiplegia e loss of strength or paralysis pody) and hemiparesis (partial of strength on one side of the ebral infarction (injury to parts introl movement, resulting in oluntary movement of group of left non-dominate side.			All licensed staff and TMAs will re education course on medication administration through Educare ar required to have it completed by 08/08/2021. Risk of re-occurrence will be minin the Director of Nursing or designe initiating the following: 1)All licensed staff and TMAs will educated on the facility policy Administering Medications prior to compliance date. Education include the individual administering the medication checks the label again EMAR 3 times to verify the right re right medication, right dosage, right and right route of administration b giving the medication. Education of policy was initiated on 08/03/21. Of staff who have not been schedule work prior to our compliance date educated prior to their next sched shift. All licensed staff will be educ the facility policy Enteral Tube Fee Continuous Pump prior to our com date. Education will include check appropriate placement of G tube a flushing of the G-tube. Education of policy was initiated on 08/03/2021 staff who have not been schedule work prior to our compliance date educated prior to their next schedus hift. All licensed staff will be educated policy was initiated on 08/03/2021 staff who have not been schedule work prior to our compliance date educated prior to their next schedus hift. 2)10 medication pass audits will b	nd are nized by e be our led that st the esident, nt time efore on the on-call d to will be uled cated on eding via npliance ing for and on the . On-call d to will be uled	
	non-traumatic intra- within the brain).	cerebral hemorrhage (bleeding			2)10 medication pass audits will b completed monthly x3 months to e Licensed Staff and TMAs are follo	ensure	

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	OF DEFICIENCIES	<u>& MEDICAID SERVICES</u> (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTI	PLE CONSTRUCTION	(X3) DAT	0938-039 E SURVEY	
AND PLAN (OF CORRECTION	DENTIFICATION NUMBER:		G		PLETED	
		245566	B. WING				
NAME OF	PROVIDER OR SUPPLIER	243300	<u> </u>	STREET ADDRESS, CITY, STATE, ZIP CODE	07/	09/2021	
	VIEW HEALTHCARE	& REHAB		510 EAST CEDAR STREET HOUSTON, MN 55943			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE	
F 658	During observation LPN-A arrived into medicine cups of m one medicine cup to them. LPN-A then next to R13 who wa walked away. Neiti resident identifier o Review of medicati R13 received Vitan tablet, and R19 red 2 tablets, atrovasta mg tablet, Metform metoprolol tartrate During interview on indicated she did se R7's medications at the to identify the medi when asked if settin separate residents of practice she stat have done that." During medication 5:30 p.m., LPN-A h administration reco computer screen. that included Novol give 8 units and wa tablet orally. LPN-/ set up the insulin d with another nurse preset on the insuli warfarin 4 mg in a placed metformin 1	on 7/6/21, at 5:05 p.m., the dining room with 2 nedication and administered o R19 and observed R19 take set down the medication cup as at the same table, and her medicine cup had a r medication name present. ons administered included hin C (Ascorbic Acid) 500 mg ceived Tylenol 500 mg tablets tin 40 mg tablet, Depakote 500 in 1000 mg tablet, and tablet 50 mg tablet.	F 65		be audited by are ing via bocedure. wed at that they A indings		

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		AND HUMAN SERVICES				FORM	08/13/2021 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ·		LE CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		245566	B. WING	i			C 09/2021
NAME OF P	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
VALLEY	VIEW HEALTHCARE	& REHAB			510 EAST CEDAR STREET HOUSTON, MN 55943		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
	indicated she know given it the last 2-3 medications to R28 medication cart. LF and viewed vancom times a day orally for Vancomycin medica medicine in cup and When questioned if medication and dos medications she ad she looked at the E did not verify the me from the cart with th R1 R1's Face Sheet pr diagnosis of esopha gastro-esophageal esophagitis without R1's quarterly Minin 3/30/21, indicated F received 51% or gre feeding. R1's Physician's Or check placement of liquid; 0.07 gram-1. per hour giving 120 until 8:00 a.m. and water every 4 hours During observation 6:05 p.m., LPN-A re 1.5 kcal/ml, 240 ml	he computer screen, LPN-A rs what he gets as she has nights. LPN-A administered 66 and returned to the PN-A opened R289's EMAR nycin 125 mg 1 capsule four or 10 days. LPN-A pulled the ation card 125 mg and placed d administered to R289. f she verified the correct sage to the EMAR on the dministered, LPN-A indicated EMAR prior to sitting down but edication, or dosage pulled he EMAR order.		658			

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		AND HUMAN SERVICES				FORM	08/13/2021 APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ´		E CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		245566	B. WING	i			C 09/2021
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
VALLEY	VIEW HEALTHCARE	& REHAB		-	10 EAST CEDAR STREET IOUSTON, MN 55943		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 658	Continued From parscreen was black a battery was dead or entered R1's room, the g-tube with 60 m filled a new infusion Nutren 1.5 kcal/ml. knows to flush with amount of Nutren to stated she just know tubing on the pump and set the pump to room. The administration record administration of the knows she is support and she has done t what to give and how A review of LPN-A medication administration of the knows she is support and she has done t what to give and how A review of LPN-A medication, dosage verification in EMAFA competency on E last satisfactorily con included checking p for breath sounds a stethoscope over stamount of air into e for air to enter the state of the st	age 5 and LPN-A confirmed the n the computer. LPN-A and using tap water flushed ml's of water. LPN-A then n bag with the 5 cartons of When questioned how she 60 ml's of water and the o give and at what rate, she ws. LPN-A then primed the o, connected to R1's g-tube o run at 75 ml/hour and left the stration pump hung on a pole hanging on the top. LPN-A ot check placement of the look at the medication rd (MAR) prior to e water or Nutren stating she osed to, but the computer died this many times and knows ow to do it. competencies included stration monitoring was with identification of resident, a, route, time, including order R was satisfactory completed. Interal Nutritional therapy was ompleted on 1/19/13 that position of the tube by listening at end of tubePlace tomach and instill a small enteral feeding tube and listen stomach.	1	358			
	medication adminis	stration and should be verified or to administration as this is					

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	08/13/2021 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED C	
		245566	B. WING				_ 09/2021
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
VALLEY	VIEW HEALTHCARE	& REHAB			10 EAST CEDAR STREET IOUSTON, MN 55943		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 658	part of the five right administration., and solutions and water also confirmed, me and administered fo but should be done DON indicated if a of should have been p retrieved to verify th with physician order A policy titled "Adm 4/2019 included: - The individual adm checks the label Th- right resident, right time and right meth before giving the m A policy titled, Enter Continuous Pump, - Verify that there is procedure. - Check the enteral order before admin information: - Resident nam - Type of formu - Date and time - Route of deliv - Access site - Method (pum - Rate of admin - Verify placement of placement has been	s of medication d includes tube feeding flushes of g-tubes. The DON dications should not be set up or 2 residents at the same time one person at a time. The computer battery was dead, it olugged in or a new cart ne tube feeding instructions rs prior to administration. inistering Medications" dated ninistering the medication fREE (3) times to verify the medication, right dosage, right od (route) of administration edication. ral Tube Feeding via dated 11/2018 included: a physician's order for this nutrition label against the istration checking the following me, ID and room number; ula; e formula was prepared /er p, gravity, syringe): and	F 6	558			
F 684 SS=D	Quality of Care		F 6	84			8/13/21

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TATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	PLE CONSTRUCTION		E SURVEY
	F CORRECTION	IDENTIFICATION NUMBER:	. ,	G		PLETED
						2
		245566	B. WING _		07/0	09/2021
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
VALLEY	VIEW HEALTHCARE	& REHAB		510 EAST CEDAR STREET HOUSTON, MN 55943		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETIO DATE
F 684	Continued From pa	nge 7	F 68	4		
	CFR(s): 483.25	5				
	applies to all treatm facility residents. Be assessment of a re- that residents recei- accordance with pr practice, the compre- care plan, and the pr This REQUIREMED by: Based on observar review, the facility f and monitor increase lower extremities for reviewed for edema Findings include: According to the fa (EHR) face sheet, I hypertension (high respiratory failure v inadequate respirate oxygen levels) and fluid in the lungs a related to cardiac, in	fundamental principle that nent and care provided to ased on the comprehensive sident, the facility must ensure we treatment and care in ofessional standards of rehensive person-centered		F684 R14 and R4 will have an assessin completed by RD by 08/05/2021 of current weight status. R14 and R4 have a fluid assessment complet RN by 08/04/2021. Both of these assessments will be communicat primary provider with documental such and any new interventions/of appropriate. All current residents in the facility their weights assessed by the CD designee and any resident flaggin significant change in weight per p be communicated with primary pr This will be completed by date of	on 4 will ed by an ed to the tion of orders as will have M or ng for oolicy will	
	Nutritional status: I related to advanced and moderate prote with a start date of approaches include	am at increased nutrition risk d age, adult failure to thrive, ein calorie malnutrition for R14, 11/21/20. Corresponding care ed providing a general diet with nal supplement three times		compliance. Valley View Healthcare & Rehab Weight Change was reviewed an updated on 08/04/2021. Risk of re-occurrence will be mini	d	

Facility ID: 00286

	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	IPLE CONSTRUCTION		0938-039 E SURVEY	
AND PLAN C	F CORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN	NG		PLETED	
		245566	B. WING			C 09/2021	
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COL		09/2021	
	VIEW HEALTHCARE	& REHAB		510 EAST CEDAR STREET HOUSTON, MN 55943			
(X4) ID PREFIX TAG	(EACH DEFICIENC)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	IOULD BE	(X5) COMPLETIO DATE	
F 684	Continued From pa	age 8	F 68	34			
	staff was to notify the significant weight of According to a physic progress note date extremity edema (fit tissues). According to a physic medical doctor (ME being seen for a row (11/3/20) for acute pulmonary edema tissue of the lungs) provision of medical function to remove indicated nursing s at that time. MD-A regular and lungs were pressing on will result in an independent of the low compression hose) by PA-C indicated nursing staff should changes or decomplements of the low and R14 was not were pressing on will result in an independent of the low compression hose after March of 2020 provided.	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 8 R14's weight at least weekly. Additionally, nursing staff was to notify the primary care provider of any significant weight changes. According to a physician assistant's (PA-C) progress note dated 11/17/20, R14 had no lower extremity edema (fluid accumulation in the		 1)All licensed staff will be educ facility policy Valley View Heal Rehab Weight Change Policy compliance date. On-call staff not been scheduled to work pic compliance date will be educat their next scheduled shift. RD educated on Valley View Heal Rehab Policy Weight Change procedure. 2)All residents with significant changes will be audited month months to ensure the policy is The audit will be ongoing until QA and a determination is ma are no longer necessary. 3)Audits will be brought to the committee quarterly to discuss and need for further auditing a additional staff training. 	thcare & prior to our who have ior to our ted prior to will be thcare & policy and weight ly x 3 followed. reviewed at de that they QA s findings		
		ition note written by a certified CDM) in the EHR dated					

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		HAND HUMAN SERVICES				FORM	08/13/2021 APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ´			(X3) DATI COM	E SURVEY IPLETED
		245566	B. WING	i			C 09/2021
NAME OF I	PROVIDER OR SUPPLIER	•		S	STREET ADDRESS, CITY, STATE, ZIP CODE	-	
VALLEY	VIEW HEALTHCARE	& REHAB			510 EAST CEDAR STREET HOUSTON, MN 55943		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
F 684	5/12/2021: "Diet order is gener does prefer to eat r reports appetite is g 50-100% of food or oz nutrition supplem nutrition. Resident of continue having sup 141# on 5/11/21. W admission. Weight 11/12/20, this does gain over the past of monitor weight and According to R14's weighed: 115 pound (lbs) on 121 lbs on 12/09/20 130.3 lbs on 1/13/2 133.2 lbs on 2/16/2 135.2 lbs on 3/9/21 135.4 lbs on 4/20/2 140.5 lbs on 6/22/2 145.1 lbs on 7/6/21 During an observat R14 was sitting in h her feet dependent visual swelling of bo stockings or tubi-gr On 7/07/21, 11:25 a recliner in room, leg swollen and tubi-gri On 7/08/21, 9:25 a. recliner napping wit	ral, cut up foods. Resident meals in her room. Resident good. Resident does consume n most meal trays. Offering 4 nent TID with meals for extra does like this and wishes to pplement. Recent weight was veight has increased since on admission was 115# on represent a 22.6% weight 6 months. Will continue to oral intake." EHR weight record, R14 11/12/20 0 11 11 11 11 11 11 11 11 11 11 11 11	F	584			

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		HAND HUMAN SERVICES E & MEDICAID SERVICES				FORM	08/13/2021 APPROVED 0938-0391
STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	ì í			(X3) DATE COM	E SURVEY PLETED
		245566	B. WING	i			C 09/2021
NAME OF	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
	VIEW HEALTHCARE			5	10 EAST CEDAR STREET		
VALLET		& RENAD		H	IOUSTON, MN 55943		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 684	Continued From pa	age 10	F€	684			
	registered nurse (R technique for check recliner with feet ele compression tube of had moved. The lo was ballooned up to of the portion that w RN-C stated, "well, put on right." RN-C quickly touching the without pressure. F compress the tissue for edema. RN-C al receiving diuretics a done daily and door administration reco During an interview of Nursing (DON) s weights from the CH responsible to mon unless there are sp sure weights do not as when someone in nurses should notic weights, but that the any significant char interdisciplinary tea was told that is not (weight increase) sh DON also said the f resident weights int unable to see what so cannot report a c	y 7/09/21, 1:08 PM the Director stated she receives a list of DM and the CDM is nitor the resident weights becific orders for nurses to be t go over a defined limit, such has edema. DON did say that ce if there are changes in the CDM should be bringing up nges in weight at the am meetings. DON state, "I my area to monitor and this should have been caught." nursing assistants enter the to the EHR, but they are a previous weight had been					

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TATEMENT	OF DEFICIENCIES F CORRECTION	KMEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL		· · ·	(X3) DATE SURVEY COMPLETED		
			A. BUILDI			С		
		245566	B. WING			•	/09/2021	
NAME OF PROVIDER OR SUPPLIER				EET ADDRESS, CITY, STATE, ZIP COI	JE			
VALLEY	VIEW HEALTHCARE	& REHAB			EAST CEDAR STREET JSTON, MN 55943			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETIO DATE	
F 684	Continued From pa	aae 11	F 6	84				
	with the registered was unable to find a had reviewed or as unsure when she s said she did not do with the RD. CDM of dietary supplement them with the nursi telling the nursing of change. During an interview stated any resident respiratory problem should have on-goi of their condition, a medical care provio significant or on-go condition. RN-B stat to assess weights, lung sounds on a re cardiopulmonary pr be done for R14. R in weight should be this could indicate a which might "lead to out of control." RN- significant weight c decrease of about a RN-B stated he wa documentation in the assessment or eva related to edema of 2021. RN-B was at	cussed R14's 22% weight gain dietician (RD). She sated she any documentation that the RD sessed R14, and she was hould report to the RD. She cument conversations she had did state that R14 liked her and had discussed continuing ng team, but did not recall department about the weight on 7/9/21, 2:07 p.m. RN-B with cardiovascular and/or is related to fluid overload ng assessment and evaluation nd nurses should report to the der if the person has a ing change in their weight or ated an expectation for nurses edema, vital signs, heart and egular basis for persons with roblems and said this should N-B also stated that increases e evaluated and reported as a problem with fluid overload o a lot of problems and spiral B gave a definition of hange of an increase or 5% in a three month period. s unable to find nursing ne nurses' notes of luation of R14's condition r weight gain since March ole to locate a list of edema ner evaluation or reporting.						

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		I AND HUMAN SERVICES				FORM	08/13/2021 APPROVED 0938-0391		
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		ì í		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED C				
		245566	B. WING				_ 09/2021		
NAME OF PROVIDER OR SUPPLIER				S	STREET ADDRESS, CITY, STATE, ZIP CODE				
VALLEY VIEW HEALTHCARE & REHAB			510 EAST CEDAR STREET HOUSTON, MN 55943						
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE		
F 684	brought it to their at residents were wea wondered if that ind stated she had initia improvement project said she thought sh prior to the survey, edema checks to th person was receivin had not provided an nurses, but had pos should come to her said she wrote the r checks for edema of done in the morning and then again whe determine effective also said it was exp a gentle but firm pre with enough force to tissue when doing a edema. Anything le Facility provided the described dated 5/1 as follows: "Nurses- when chat when giving Lasix [please chart amour TMAs-please ask y when charting. In pl tenderness, skin ch evaluated. Pitting: t pitting and non-pittin determine the exter can push on the ski	tention that quite a few ring tubi-grips and TMA licated a problem. DON	F	584					

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	T OF DEFICIENCIES	E & MEDICAID SERVICES	(X2) MU	TIPI	LE CONSTRUCTION		0938-039 E SURVEY	
IDENTIFICATION NUMBER:		` '		S	COMPLETED			
	0.47700					С		
		245566	B. WING			07/	09/2021	
NAME OF PROVIDER OR SUPPLIER					STREET ADDRESS, CITY, STATE, ZIP CODE			
VALLEY	VIEW HEALTHCARE	& REHAB			510 EAST CEDAR STREET HOUSTON, MN 55943			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROIN DEFICIENCY)	D BE	(X5) COMPLETIOI DATE	
F 684		age 13 ck to its original position. Then	F 6	684	ŀ			
	grade it on a scale swollen area with y an indentation in th non-pitting edema.	from 1-2. If you press a your finger and it doesn't cause he skin, it's considered If you need additional ssing edema please see me						
		monitoring edema or fluid ested, but not provided.						
	4/15/21, and includ diagnosis of acute diagnosis included	entified a re-admission date of ded primary readmission diastolic heart failure. Other chronic systolic heart failure, nentia with Lewy bodies, and egular heart beat).						
	assessment dated intact cognition. R assistance of two v received antipsych seven days and no	imum Data Set (MDS) 2/2/21, identified R4 to have 4 required extensive with transfers, and toileting, otic medication daily over past o diuretic. Weight was bunds with no weight gain or						
	indicated a signific in last 30 days or 1	DS assessment dated 4/11/21, ant weight gain of >5% or more 0% or greater over past 6 ras documented as 168						
	increased nutrition	ed 10/30/20, included R4 is at risk related to recent fluid overload and CHF with						

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		HAND HUMAN SERVICES E & MEDICAID SERVICES				FORM	08/13/2021 APPROVED 0938-0391
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		· /		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED C		
		245566	B. WING				09/2021
NAME OF	PROVIDER OR SUPPLIER	•		S⊺	TREET ADDRESS, CITY, STATE, ZIP CODE	-	
VALLEY	VIEW HEALTHCARE	& REHAB			10 EAST CEDAR STREET IOUSTON, MN 55943		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 684	history of moderate Goal included R4 w pound plus or minu dated 10/30/20, inc record intake of foo monitor and record notify primary care significant weight cl Provider orders dat (compression stock a.m., and off at bed 3/19/21 included we bath day and manu on Monday, Wedne instructions to not c automatic machine Review of R4's doc 1/8/2021 weighed 12 3/12/2021 weighed 12 3/12/2021 weighed 15 3/12/2021 weighed 16 3/12/2021 we	e calorie/protein malnutrition. vill maintain weight at 150 us 5 pounds. Interventions cluded staff will monitor and od and fluid daily, and staff will weights at least weekly and provider (PCP) and family of changes. ted 3/11/21, included Tubigrips kings used for swelling) on dtime. Order written on eigh weekly in bath chair on ual blood pressure and pulse esday and Friday with special obtain blood pressure with s. cumented weights indicated: 127.2 pounds. 140.2 pounds. 53 pounds. d 156.5 pounds.	F 6	;84			

If continuation sheet Page 15 of 38

		AND HUMAN SERVICES				FORM	08/13/2021 APPROVED 0938-0391		
		· /		LE CONSTRUCTION	(X3) DATI COM	E SURVEY PLETED			
		245566	B. WING	i			C 09/2021		
NAME OF I	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE				
VALLEY VIEW HEALTHCARE & REHAB			510 EAST CEDAR STREET HOUSTON, MN 55943						
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE		
F 684	 148/54, 184/78, 199 was added for blood A provider progress discussion on blood all over the place. If to decreased heart today of 131/55 but 145/64, 152/93 and in note as 140 pour A provider progress continue to review of recorded as 138/63 175/48 and today 14 156.7 pounds. A nurse progress da indicated nursing re and resident is to we edema, size E. No regarding edema put A provider progress a follow up of her bl blood pressures be 149/49, 151/62 and weight present. A progress note dat indicated R4 was has children and continue children throughout was two men in her now. A progress note dat indicated resident of 	9/81 and 160/74. Amlodipine d pressure. s note dated 2/11/21 included d pressure and how they are Metoprolol was decreased due rates with blood pressures t others included 185/46, 1 164/53. Weight was present	F	584					

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DEPARTMENT OF HEALT CENTERS FOR MEDICAR	H AND HUMAN SERVICES				FORM	08/13/2021 APPROVED 0938-0391				
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		` ´		E CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED				
	245566	B. WING				C 09/2021				
NAME OF PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE						
VALLEY VIEW HEALTHCARE & REHAB			510 EAST CEDAR STREET HOUSTON, MN 55943							
PREFIX (EACH DEFICIENC	ATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE				
indicated the resid hallucinations and VS: 168/99, HR 5 and temperature 9 recommended resive which was arrange Review of Weight was present on m run weekly from 1 Variance Report of indicated a 9.1% v 2/19/21 in 14 days was a 7.4% weigh A quality assurand February 2021 ind was 154, and 30 weight change. S for 15.8% change 137 for 12.4% wei significant weight Recommendation Resident does pre- history of mal calco Staff reports she e During interview of certified dietary m weights were com there is a significa- nursing is notified, weight gain was s was transferred to	v. ated 4/11/21 at 11:26 a.m. lent has been experiencing has not slept in over 24 hours. 5, pulse oximetry 84%, RR 24 07.1. On-call physician sident be transferred to ED, ed and completed. Variance Reports indicated R4 ultiple weight variance reports 1/22/20 through 4/12/21. The lated 1/12/21 through 4/12/21 veight gain from 2/5/21 to 5, and from 3/31/21 to 4/7/21 t gain in 7 days. Exe report dated 12/2020 through luded R4's most recent weight days ago was 140 with 10% ixty days ago weight was 133 and 90 days ago weight was ght gain. Findings included a gain over the past 30/90 days. s included diet order is general. fer small portions. R4 has rie and protein malnutrition.	F	584							

Facility ID: 00286

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MILLI T	IPLE CONSTRUCTION		<u>). 0938-039</u> TE SURVEY
	OF DEFICIENCIES	IDENTIFICATION NUMBER:		NG	· · ·	MPLETED
						С
		245566	B. WING		07	/09/2021
NAME OF	PROVIDER OR SUPPLIER	·	·	STREET ADDRESS, CITY, STATE, ZIP (CODE	
VALLEY	VIEW HEALTHCARE	& REHAB		510 EAST CEDAR STREET HOUSTON, MN 55943		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETIO DATE
F 684	comparison over the staff questions rega eating or may ask to CDM added the far gain. The CDM income any of the above not TMA-A and was un notified regarding F indicate she brough interdisciplinary me with the director of During interview on indicated she does the CDM but had b to monitor. The DC present to not except provider with a cert would be responsite symptoms like leg of this instance, the C communicated the or brought it up at I her a report. The D significant weight g questioned and rept someone. During interview on	ws weekly weights and does a he past 3 months then may ask arding edema, how they are to have them re-weighed. mily also questioned the weight dicated she did not document or the conversation with asure if registered dietician was R4's weight gain. The CDM did ht reports multiple times to the betings (IDT) and shared those nursing. A 7/9/21, 1:08 p.m., the DON receive a list of weights from een told that it is not her area DN indicated if orders are bed a certain weight or contact cain weight parameter, nursing ole or if resident is having edema. The DON indicated in		34		
	the time of the hosp exact date but assu the weight. TMA-A of the conversation	pitalization but was unsure the umed something was off with indicated that was the extent and the CDM did not question otoms of fluid overload.				

Facility ID: 00286

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CENTERS FOR MEDICARE & MEDICAID SERVICES		MB NO. 0938-0391
	IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
245566 B. WING		C 07/09/2021
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE	
VALLEY VIEW HEALTHCARE & REHAB	510 EAST CEDAR STREET HOUSTON, MN 55943	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETION
 F 684 Continued From page 18 F 68 monitor weights that are completed daily but weekly weights are generally the responsibility of dietary to monitor. RN-C further indicated if provider orders include weight parameters, nursing would be the one to contact the provider. During observation and interview on 7/09/21, at 3:30 p.m., R4 indicated the fluid pill has been working for her and she was told her heart isn't in that great of condition and she has heart failure. R4 did not recall being in the hospital, having edema or any breathing difficulty in the past 6 months. R4 was sitting in her wheelchair, on room air, with easy respirations and no pedal edema. Multiple attempts were made to contact R4's primary care provider (PCP) without return call. Did receive a call back from registered nurse (RN)-D on 7/9/21, at 2:39 p.m. who indicated the above weights should have been initially reported to PCP with the weight gain from January until February. Attempted to reach medical director 7/9/21, at 3:49 p.m., and received a return call from physician assistant, certified (PA-C) on 7/9/21, at 4:21 p.m PA-C indicated she does not have specific parameters but generally a 10 pound weight gain over 30 days would be significant. PA-C further indicated if any symptoms are associated with weight gain such as shortness of breath or edema, it should be brought to the attention of the PCP. PA-C indicated the above weights should have been discussed by the facility and the nurses made aware of the significant weight gain. PA-C further indicated someone should have to notified the PCP. 		

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TATEMENT	OF DEFICIENCIES	K MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION		TE SURVEY MPLETED
		245566	B. WING	<u></u>	C	
	PROVIDER OR SUPPLIER	243300		STREET ADDRESS, CITY, STATE, ZIP COD		/09/2021
		& REHAB				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APF DEFICIENCY)	OULD BE	(X5) COMPLETIO DATE
F 684	hospital indicated F	age 19 Imary" dated 4/15/21 from the R4 was hospitalized with acute re) Heart Failure 4/11/21	F 684	4		
F 688 SS=D	10/28/20 written by included: - All residents are to otherwise ordered by insure adequate nu- by lab within normal body weight range supervisor or regist - Any resident with more pounds in 1 v done to determine - Significant weight days or 7.5% in 90 - The attending phy weight change and on physician round - Care plan will be	a weight change of five (5) or veek will have a re-weight the accuracy of the change. change is defined as 5% in 30 days, or 10% in 180 days. /sician will be notified of the orders requested as indicated s or per fax. updated accordingly. Decrease in ROM/Mobility	F 68	8		8/13/21
	resident who enters range of motion do range of motion un	facility must ensure that a s the facility without limited es not experience reduction in less the resident's clinical rates that a reduction in range				
	motion receives ap services to increas	sident with limited range of propriate treatment and e range of motion and/or to rease in range of motion.				

Facility ID: 00286

If continuation sheet Page 20 of 38

	-	AND HUMAN SERVICES					APPROVEI 0938-039
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ·		E CONSTRUCTION (X	(X3) DATE SURVEY COMPLETED C 07/09/2021	
		245566	B. WING				
NAME OF I	PROVIDER OR SUPPLIER	•		S	TREET ADDRESS, CITY, STATE, ZIP CODE		
VALLEY	VIEW HEALTHCARE	& REHAB			10 EAST CEDAR STREET IOUSTON, MN 55943		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 688	Continued From pa	age 20	F 6	88			
	receives appropriat assistance to main the maximum pract reduction in mobility This REQUIREMEN by: Based on observat review, the facility f motion (ROM) serv provided according recommendations f reviewed for limited Findings include: R19's face sheet, in hemiplegia and her infarction affecting disorder, weakness R19's quarterly Min assessment dated understands, had n and required extens mobility, toileting ar assistance of one f MDS also indicated of range of motion extremities on one R19's plan of care of care deficit in trans related to left sided R19 is non-ambula R19 will be encoura with activities and v	for 1 of 2 resident (R19) d range of motion. Included diagnosis of miparesis following cerebral left side, major depressive and chronic pain. Mimum Data Set (MDS) 6/21/21, included R19 noderate cognitive impairment sive assist of two for bed nd transfers, and extensive or personal hygiene. The d R19 had functional limitations (ROM) in upper and lower			 F688 R19 completed reassessment by phy therapy on 7/28/21 for ROM exercises residents with contractures will be reassessed by physical therapies by of compliance. Valley View Healthcar and Rehab Policy Range of motion Exercises has been viewed and upda 8/3/2021 Risk of reoccurrence will be minimize the Director of Nursing or Nursing or designee initiating the following: All nursing staff will be educated of ROM exercises. All nursing staff will where to find instructions on each individual resident's plan of care. Onstaff who have not been scheduled to work prior to compliance date will be educated prior to their next scheduled shift. Nursing staff working with resident that have a ROM care plan will be randomly audited 2 times a week for weeks then 1 time a week for 4 week then random audits as needed to cor exercises are being completed and b completed correctly. 	es. All date re ated ed by n know -call o d ts ts 4 (s ncur	

Facility ID: 00286

OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA					
245566	DENTIFICATION NUMBER:	. ,	IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
	245566	B. WING _			C 7/09/2021	
ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODA			
VIEW HEALTHCARE	& REHAB		510 EAST CEDAR STREET HOUSTON, MN 55943			
(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHO	OULD BE	(X5) COMPLETIO DATE	
Continued From pa	age 21	F 68	38			
postural deviation, to realign posture and function, to enhance my range of motion and overcome limitations prohibited by a recline type of chair, and to prevent contractures and orthopedic deformities, and staff will follow physical and occupational therapy recommendations.			committee quarterly to discuss	finding and		
2:15 p.m., R19 was room. R19's left ha was able to open h upon request with f and less mobile tha they do not apply h	s sitting in Broda chair in his and was curled into a fist. R19 is fingers and wiggle them fourth digit remaining lowered an other fingers. R19 indicated eat or exercise either of his	ing in Broda chair in his was curled into a fist. R19 ngers and wiggle them h digit remaining lowered ther fingers. R19 indicated or exercise either of his				
R19 is in the dining right hand. Left ha curled into a fist. F move both arms ar remained down and	in the dining room feeding himself with his ind. Left hand was on arm of chair and nto a fist. R19 upon request was able to oth arms and all fingers except 4th digit ed down and less mobile than other digits.					
and signed by certi assistant (COTA)-A program to include minutes prior to see passive range of m upper extremity, ar free range as tolera is to decrease pain	fied occupational therapy A included R19 updated apply heat pack for 15 ssion, complete active and notion (AROM, PROM) to right and should do digits within pain ated 10 times and 2 sets. Goal a, increase range of motion and					
	SUMMARY STA (EACH DEFICIENCE REGULATORY OR L Postural deviation, function, to enhance overcome limitation of chair, and to pre- orthopedic deforming physical and occup recommendations. During observation 2:15 p.m., R19 was room. R19's left hat was able to open h upon request with f and less mobile that they do not apply h arms or fingers adde that here". During observation R19 is in the dining right hand. Left hat curled into a fist. F move both arms ar remained down and R19 indicated staff R19's Restorative and signed by certia assistant (COTA)-A program to include minutes prior to se passive range of m upper extremity, ar free range as tolera is to decrease pain increase activities of R19's Restorative and signed by certiants and the second	function, to enhance my range of motion and overcome limitations prohibited by a recline type of chair, and to prevent contractures and orthopedic deformities, and staff will follow physical and occupational therapy recommendations. During observation and interview on 7/06/21, at 2:15 p.m., R19 was sitting in Broda chair in his room. R19's left hand was curled into a fist. R19 was able to open his fingers and wiggle them upon request with fourth digit remaining lowered and less mobile than other fingers. R19 indicated they do not apply heat or exercise either of his arms or fingers adding "they don't do anything like	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX. TAG Continued From page 21 postural deviation, to realign posture and function, to enhance my range of motion and overcome limitations prohibited by a recline type of chair, and to prevent contractures and orthopedic deformities, and staff will follow physical and occupational therapy recommendations. F 68 During observation and interview on 7/06/21, at 2:15 p.m., R19 was sitting in Broda chair in his room. R19's left hand was curled into a fist. R19 was able to open his fingers and wiggle them upon request with fourth digit remaining lowered and less mobile than other fingers. R19 indicated they do not apply heat or exercise either of his arms or fingers adding "they don't do anything like that here". During observation on 7/07/21, at 12:25 p.m., R19 is in the dining room feeding himself with his right hand. Left hand was on arm of chair and curled into a fist. R19 upon request was able to move both arms and all fingers except 4th digit remained down and less mobile than other digits. R19 indicated staff do not exercise has hands. R19's Restorative Program sheet dated 9/11/20 and signed by certified occupational therapy assistant (COTA)-A included R19 updated program to include apply heat pack for 15 minutes prior to session, complete active and passive range of motion (AROM, PROM) to right upper extremity, and should do digits within pain free range as tolerated 10 times and 2 sets. Goal is to decrease pain, increase range of motion and increase activities of daily living participation. R19's Restorative Nursing document dated	VIEW HEALTHCARE & REHAB HOUSTON, MN 55943 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY WIDT BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREPX TAG PROVIDERS PLAN OF CORRECT (EACH CORRECTIVE ACTION SHG CROSS-REFERENCED TO THE APP DEFICIENCY) Continued From page 21 postural deviation, to realign posture and function, to enhance my range of motion and overcome limitations prohibited by a recline type of chair, and to prevent contractures and orthopedic deformities, and staff will follow physical and occupational therapy recommendations. F 688 During observation and interview on 7/06/21, at 2:15 p.m., R19 was sitting in Broda chair in his room. R19's left hand was curled into a fist. R19 was able to open his fingers and wiggle them upon request with fourth digit remaining lowered and less mobile than other fingers. R19 indicated they do not apply heat or exercise either of his right hand. Left hand was on arm of chair and curled into a fist. R19 upon request was able to move both arms and all fingers except 4th digit remained down and less mobile than other digits. R19 indicated staff do not exercise has hands. R19's Restorative Program sheet dated 9/11/20 and signed by certified occupational therapy assistant (COTA)-A included R19 updated program to include apply heat pack for 15 minutes prior to session, complete active and passive range of motion (AROM, PROM) to right upper extremity, and should do digits within pain free range as tolerated 10 times and 2 sets. Goal is to decrease pain, increase range of motion and increase activities of daily living participation.	VIEW HEALTHCARE & REHAB HOUSTON, MN 55943 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFX TAG PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) Continued From page 21 postural deviation, to realign posture and function, to enhance my range of motion and overcome limitations prohibited by a recline type of chair, and to prevent contractures and orthopedic deformities, and staff will follow physical and occupational therapy recommendations. F 688 During observation and interview on 7/06/21, at 2:15 p.m., R19 was sitting in Broda chair in his room. R19's left hand was curied into a fist. R19 was able to open his fingers and wiggle them upon request with fourth digit remaining lowered and less mobile than other fingers. R19 indicated they do not apply heat or exercise either of his arms or fingers adding "they don't do anything like that here". Not apply heat or exercise as hands. R19's Restorative Program sheet dated 9/11/20 and signed by certified occupational therapy assistant (COTA)-A included R19 updated program to include apply heat pack for 15 minutes prior to session, complete active and passive range of motion (AROM, PROM) to right upper extermity, and should do digits within pain free range as tolerated 10 times and 2 sets. Goal is to decrease pain, increase range of motion and increase activities of daily living participation. R19's Restorative Nursing document dated Name	

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		AND HUMAN SERVICES				FORM	08/13/2021 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ·		E CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		245566	B. WING				C 09/2021
NAME OF F	PROVIDER OR SUPPLIER	-		S	TREET ADDRESS, CITY, STATE, ZIP CODE	-	
VALLEY	VIEW HEALTHCARE	& REHAB			10 EAST CEDAR STREET IOUSTON, MN 55943		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
	Continued From participate of motion was complexed, unavailability information. deferrent refusal. During interview on COTA-B indicated I shoulder pain and in was cooperative with range of motion wa Heat would help loo be done with less d R19 did participate open and close his COTA-B indicated s issues with his left I hand being any differ with position or mov- indicated they can of the order includes a shoulder, arm and I During interview on assistant (NA)-A ind of the time and will exercises on the rig to work with him for included R19 does further indicated sh with his left hand. During interview on director of nursing (nge 22 pleted 29 times. Reasons t performing included not ble, could not assess, no ed due to condition and one 7/08/21, at 9:11 a.m., R19 was treated for his ncluded his entire arm. R19 th heat stating it felt good and is done as he could tolerate. osen the joints so ROM could liscomfort. COTA-B indicated in therapy and would actively right hand on demand. she did not remember any hand or the 4th digit on his left erent than his other fingers vement. COTA-B further only treat and evaluate what and for this one it was the right	TAG			RIATE	DATE
	indicated the procest few months with NA	Irsing". The DON further ss has changed over the past A performing versus a y had previously. The DON					

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		I AND HUMAN SERVICES				FORM	08/13/2021 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ·		LE CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		245566	B. WING				C 09/2021
NAME OF F	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
VALLEY	VIEW HEALTHCARE	& REHAB			510 EAST CEDAR STREET HOUSTON, MN 55943		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 688	further indicated the paper prior but she no records that go p the "Restorative Nu During observation 11:01 a.m., R19 wi heat on his right she no, and they do not further indicated he but cooperated with arm and opening an digit remained less towards his fist than left digits curled into During interview on indicated staff shou he refuses which sh agreed R19 would o own with some pror During interview on indicated R19 will s own, but most of th NA-B indicated R19 will move both his a NA-B was not awar hand or fingers. A policy titled "Rang undated included: - The purpose of th resident's joints and - Review the reside any special needs of - Be gentle with the procedure	 a process was documented on shredded them so there are past what is documented on irsing" record. and interview on 7/8/21. at hen asked if they offer to put oulder or arm and he stated do ROM with him either. R19 does not want heat applied, a moving both right and left and closing both fists. Left 4th mobile and more curled an other digits. R19 at rest has be a fist. 7/9/21, at 8:24 a.m., the DON and be documenting refused if the believes is happening but cooperate with ROM on his mpting by staff. 8/9/21 at 8:33 a.m., NA-B ometimes do ROM on his e time requires prompting. a generally cooperatives and arms and hands upon request. a of Motion Exercises" is procedure is to exercise the d muscles. nt's care plan to assess for 	Fδ	\$88			

Facility ID: 00286

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						. 0938-039		
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	· · ·	TE SURVEY IPLETED		
						С		
		245566	B. WING		07	/09/2021		
NAME OF F	PROVIDER OR SUPPLIER		·	STREET ADDRESS, CITY, STATE, ZIP CODE				
VALLEY	VIEW HEALTHCARE	E & REHAB	510 EAST CEDAR STREET HOUSTON, MN 55943					
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETIO DATE		
F 688	Continued From p	age 24	F 688	3				
	staff/charge nurse							
	exercised.	emity at the joint as it is being hrough its range of motion 3						
	times unless other - Move each joint g	wise instruction gently, smoothly and slowly						
	through its range of - Remember to store of pain.	of motion op an exercise before the point						
	•	nt/Restore Eating Skills (4)(5)	F 693	3		8/13/21		
	both percutaneous percutaneous end enteral fluids). Bas	stric and gastrostomy tubes, s endoscopic gastrostomy and oscopic jejunostomy, and sed on a resident's sessment, the facility must						
	eat enough alone enteral methods u condition demonst	sident who has been able to or with assistance is not fed by nless the resident's clinical rates that enteral feeding was and consented to by the						
	means receives th services to restore and to prevent cor including but not lin diarrhea, vomiting abnormalities, and This REQUIREME	sident who is fed by enteral e appropriate treatment and e, if possible, oral eating skills nplications of enteral feeding mited to aspiration pneumonia, dehydration, metabolic nasal-pharyngeal ulcers. ENT is not met as evidenced						
	by: Record on observe	ation, interview and document		F693				

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CENTER	RS FOR MEDICARE	& MEDICAID SERVICES			OMB NO.	<u>0938-039</u>	
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	TIPLE CONSTRUCTION	` ́сом	E SURVEY PLETED	
		245566	B. WING			C 09/2021	
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	07/0	09/2021	
			510 EAST CEDAR STREET				
VALLEY	VIEW HEALTHCARE	& REHAB		HOUSTON, MN 55943			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETIO DATE	
F 693	Continued From pa	age 25	F 6	02			
1 000	• - · · · · · · · · · · · · · · · · · ·	-	FO	95			
	review the facility failed to verify physician orders prior to enteral feeding (nutrition taken through a			Valley View Heath Care and Re	hah's		
	tube that goes directly to the stomach) and check			following policies titled Administ			
		strostomy tube (g-tube) per		Medications and Enteral Tube F			
	facility policy prior t	o administration for 1 of 1		continuous Pump were reviewe			
	resident (R1) obser	rved with a g-tube.		8/3/21.			
	Findings include:			LPN was reoriented on medicat			
		lo - l		administration and G-tube feedi			
		ncluded primary diagnosis of ction, gastro-esophageal reflux		(including placement and flushir July 17th,18th, and 19th. LPN h			
		agitis without bleeding.		documented competency of the			
		laglie Willout blocallig.		All licensed staff and TMAs will			
	R1's quarterly Minir	mum Data Set (MDS)		education course on medication			
		3/30/21, indicated R1 was		administration through Educare			
	cognitively intact, and received 51% or greater of			required to have completed by A	August 08,		
	calories from tube t	feeding.		2021.			
		rders dated 6/15/21, included		Risk of re-occurrence will be mi			
	•	f G-tube every shift, Nutren		the Director of Nursing or design	nee		
		ula) 1.5 calorie liquid; 0.07		initiating the following:			
		t 75 milliliters (ml's) per hour tal from 6:00 p.m. until 8:00		1) All licensed staff and TMAs w	ill he		
		be with 120 ml of water every		reeducated on the facility policy			
	4 hours.			Administering Medications and	Enteral		
				Tube Feeding prior to the comp			
	5	and interview on 7/6/21, at		date. Education includes that the			
		etrieved 5 cartons of Nutren		individual administering the med			
		's per carton from refrigerator medication cart. The computer		checks label against the EMAR verify the right medication, right			
		and LPN-A confirmed the		right time, and right route of me			
		n the computer. LPN-A		before administrating medicatio			
		, and using tap water flushed		Education on the policy was initi	ated on		
		ml's of water. LPN-A then		7/19/21. On call staff who have			
		h bag with the 5 cartons of		scheduled to work prior to comp			
		When questioned how she 60 ml's of water and the		date will be educated prior to the scheduled shift to work. All licer			
		o give and at what rate, she		will be educated facility policy E			
		ws. LPN-A then primed the		Tube Feeding via continuous pu			

Facility ID: 00286

						<u>OMB NO.</u>	
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDIN		ISTRUCTION		E SURVEY PLETED
							C
		245566	B. WING _				09/2021
NAME OF I	PROVIDER OR SUPPLIER	1		STREET	ADDRESS, CITY, STATE, ZIP CODE		
VALLEY	VIEW HEALTHCARE	& REHAB			ST CEDAR STREET TON, MN 55943		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETIO DATE
F 693	Continued From pa	age 26	F 69	13			
	tubing on the pump to room. The administ with a stethoscope indicated she did not administration reco administration reco administration of the knows she is support and she has done to what to give and how During interview on registered nurse (R placement for R1 is water into the g-tub abdomen next to tu gurgles. During interview on director of nursing process is followed medication adminis order and the produ- the five rights of me DON confirmed if a should have been p retrieved to verify th provider order prior A policy titled, Ente Continuous Pump, - Verify that there is procedure. - Check the enteral order before admini- information:	 a, connected to R1's g-tube b, connected to R1's g-tube b, or un at 75 ml/hour and left the b, and the stration pump hung on a pole hanging on the top. LPN-A b, check placement of the look at the medication rd (MAR) prior to e water or Nutren stating she b, but the computer died c, but the computer died d, 7/08/21, at 11:06 a.m., c, RN)-C indicated tube c, checked by inserting 15 ml of d, 7/09/21, at 8:20 a.m., the (DON), confirmed the same for tube feedings as for stration including checking the uct three times and following edication administration. The a computer battery was dead, it bugged in or a new cart the tube feeding product to the 		to c incl plac tub call wor edu shif 2)1 con tha the pro ran ens Tub anc unti is n nec traii	bur compliance date. Educatio ude checking for appropriate cement of G tune and flushing e Education was initiated on 8 staff who have not been sche k prior to our compliance date icated prior to their next scheo ft to work. 0 medication pass audits will the npleted monthly x 3 months to t licensed staff and TMAs are Administering Medication poli cedure. 3 licensed staff will be domly audited monthly x3 mon sure that they are following the be Feeding via continuous Pur d Procedure. Audits will be on il reviewed at QA and a determ nade that they are no longer cessary. All new licensed staff ned on upon hire. Audits will be bought to the QA nmittee quarterly to discuss fir a need for further auditing and ditional staff training	of the G /3/21. On duled to will be luled oe ensure following cy and hths to Enteral np Policy going nination will be	

If continuation sheet Page 27 of 38

TATEMEN	F OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			B NO. 0938-0 (3) DATE SURVEY COMPLETED	
					С	
		245566	B. WING		07/09/2021	
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
VALLEY	VIEW HEALTHCARE	& REHAB	510 EAST CEDAR STREET HOUSTON, MN 55943			
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)			
F 693 F 698 SS=D	- Date and time - Route of deliv - Access site - Method (pum - Rate of admi - Verify placement of placement has bee least 30 ml's of war amount. Dialysis	e formula was prepared ver ip, gravity, syringe): and	F 693 F 698		8/13/21	
	require dialysis reco with professional st comprehensive per the residents' goals This REQUIREMEN by: Based on observat review facility failed site was consistent 1 of 1 residents (R2 addition, the facility comprehensive dia and symptoms of c corresponding inter or how to coordinat Findings include: According to R25's (EHR) facesheet, F	sure that residents who eive such services, consistent candards of practice, the son-centered care plan, and a and preferences. NT is not met as evidenced tion, interview and document to ensure the dialysis access ly monitored and assessed for 25) receiving hemodialysis. In failed to provide a lysis care plan to reflect signs omplications with rventions and clarity on when the care with the dialysis center.		F698 R14 Care plan has been updated as 7/8/21 to reflect checking port for any unusual redness, swelling temperatu greater than 100.5 F or 38 C or other problems, contact dialysis unit immediately. If patient experiences excessive blee from upper right access port, the nur should apply direct pressure on acce site. Nursing home staff should call 9 immediately if bleeding time is more 1-2 min or if the nurse is unable to co bleeding from access port. Nurse Or	/ re eding se ss 011 than ontrol	

Facility ID: 00286

		& MEDICAID SERVICES			OMB NO.			
	F OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ·	TIPLE CONSTRUCTION	СОМ	E SURVEY PLETED		
		245566	B. WING			C		
	PROVIDER OR SUPPLIER	245500	D. WING		TREET ADDRESS, CITY, STATE, ZIP CODE			
	ROVIDER OR SUPPLIER			510 EAST CEDAR STREET	IE, ZIP CODE			
VALLEY	VIEW HEALTHCARE	& REHAB		HOUSTON, MN 55943				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF COF (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE DEFICIENCY DEFICIENCY		ACTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLETIO DATE				
F 698	Continued From pa	ae 28	F 6	98				
F 090	nurses were to "che access site for dialy redness warmth, ar Instructions: THIS I NURSE!!!!!!!!!!!!!!!!!! once a day between According to a phys nurses were to "not pressures that are Please continue to ordered, but you do pressures >150/90 any symptoms of ch headache. Please of symptoms. Otherwid don't need to notify 6:30 a.m. and 10:30 10:30 p.m. daily. Of provider to notify not dialysis. During an interview registered nurse (R communicated with change in status, b sure and needed to	eck PORT [a central venous ysis] on right chest. Check for nd signs of infection. Special S TO BE DONE BY THE ! [sic]" ordered to be done n 6:30 a.m. and 10:30 a.m. sician's order dated 4/16/21 tify provider of any blood >150/90. Special instructions: check blood pressures as o not need to notify of blood as long as he doesn't have hest pain, dyspnea or notify if he does have these ise is he is asymptomatic you ." ordered to be done between 0 a.m. and 7:00 p.m. and rder does not state which or direct nurses to notify	Fo	 For any general ques port: Contact dialysis hours (5am-430pm) a after hour urgent relat contact 507-284-2517 acute illness, resident emergency room at S 507-255-5992 or MCI emergency room. Order in computer no main provider if BP re than 150/90 if he wer of chest pain, dyspne Included in R14 chart Memorandum of Und Clinic Dialysis Service Risk of re-occurrence the following 1) All licensed staff ha on the importance of each shift. Licensed se educated on the Valle Dialysis residents. Lic been educated on we phone numbers are k reach dialysis unit if n 	unit during working at 608-392-5011, ted questions 1. In the event of an t should be sent to Gaint Mary's Hospital HS La Crosse, WI w reads to contact eadings are greater e to have symptoms a, or headache. T is now erstanding Mayo es. e will be reduced by ave been educated checking the port on staff have been ey View Policy of censed staff have ere the dialysis unit ept and how to			
	dialysis treatment, l other information. F R25's port, blood pr would go to dialysis "is drained and just after dialysis they w him rest, bringing h	whenever he went to his but did not routinely send any RN-A said the facility checked ressure and temp before he s, but when he came back he wants to rest." RN-A said yould put R25 in bed and let im a late supper. erview 7/08/21, 7:35 a.m.		communication book by resident to and fro appointment for any r communication betwee A license staff will doo any communication th dialysis team, includir concerning weight ch port concerns or gene	m each dialysis necessary een each team. cument each shift on ney had with the ng and not limited to anges, skin tone,			

		E & MEDICAID SERVICES				0938-039
	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION		E SURVEY PLETED
		245566	B. WING			C 09/2021
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CC		J9/2021
		& REHAB		510 EAST CEDAR STREET HOUSTON, MN 55943		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(X5) COMPLETIOI DATE
F 698	port every morning swelling, but they of about bleeding or of stated his blood-pri- twice daily because with swings in his b low. RN-C also said should be checked return from dialysis she would call if R2 related to his dialys information was not chart. RN-C said "I be in his admission the name of a continumber to dial, but who they should ta manager? That's h before." RN-C said had previously wor with symptoms of i room and said, "I g should do [here]". I care for R25 becau experience, but did training. According to an int RN-B stated R25's information directin dialysis port and w complications or th also said the care p to monitor for fluid specifically who to complications or sy	age 29 for redness, warmth and lid not need to be concerned other complications. RN-C also essure needed to be monitored e he had been having problems blood pressure, both high and d that R25's blood-pressure as soon as possible after his s. RN-C was unable to say who 25 was showing complications sis and confirmed that this of readily available in R25's can't say for 100% but it might n notes." RN-C did not know act person nor a direct phone said, "I guess I'm not sure lk to there, maybe the care ow it was where I worked I that at a facility where she ked they would send people nfection to the emergency uess that's probably what we RN-C said she knew how to use she had previous dialysis I not relate any facility acquired erview 7/08/21, 8:00 a.m. care plan should include ng nurses on how to monitor a hat to do if there were e dressing came off. RN-B blan should include directions or electrolyte imbalances and contact if R25 was to have any ymptoms indicating a problem. at this information was not	F 69		or charting intation of continue nen monthly of the audits required. All ete dialysis e staff will as there is a d Health Care scussed ts will be beetings and	

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	RS FOR MEDICARE	& MEDICAID SERVICES	(X2) MUL	TIPLE CONSTRUCTION		0. 0938-039 TE SURVEY
	DF CORRECTION	IDENTIFICATION NUMBER:	. ,			MPLETED
		245566	B. WING		07	C 7/09/2021
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COL		103/2021
VALLEY	VIEW HEALTHCARE	& REHAB		510 EAST CEDAR STREET HOUSTON, MN 55943		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	IOULD BE	(X5) COMPLETIO DATE
F 698	chart. RN-B located "Memorandum of U Dialysis Services" a chart, it was in a fo am going to put this care plan now." RN confirmed progress regular communicat According to an inter- stated that the nurse "most of the time, we they do." According to an inter- Director of Nursing could do an assess general, would be to through the nurse's licensed individuals expectation of doct and notification to a a significant chang assessment, accorr include as assess resident's weight, b how they were feel described possible infection, fluid imba- nausea, fatigue and DON said a dialysis every day before the treatment and them facility. DON also s checked every shift that actually." The send any abnorma	-	F 6	98		

Facility ID: 00286

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G		TE SURVEY MPLETED
		245566	B. WING		C 07/09/2021	
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COL		103/2021
VALLEY	VIEW HEALTHCARE	& REHAB		510 EAST CEDAR STREET HOUSTON, MN 55943		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	IOULD BE	(X5) COMPLETIO DATE
F 698	include the results DON was unable to provided to the num A document titled T Understanding May (MCDS) Patients W Long-Term Care Fa 12/24/20 with R25's received. The docu information for the	of any assessments done. o recall if education had been sing staff. The Memorandum of yo Clinic Dialysis Services /ho Are Residents in acilities/Nursing Homes dated s name at the top was iment includes all contact dialysis unit and indicates,	F 69	8		
	dialysis unit and the essential to develop of care for each par document includes "Please remember "lifeline". Special at vascular access so can experience infe or intravenous cath redness, swelling, t F or 38 C or other p dialysis unit immed further education re	e communication between the e long-term care facility is o an efficient and effective plan tient." In addition, the the following information, the patient's access is her/his tention should be paid to this that it does not clot. Patients ections of these fistulas, grafts eters. If there is any unusual emperature greater than 100.5 problems, contact the patient's iately. If you wish to receive egarding the dare of dialysis e contact the dialysis unit."				
	and communication was requested: A document was pr Disease, Care of a indicated staff carin renal disease "shal special needs of the indicated the reside	dialysis assessments, cares in with the dialysis care team rovided titled End-Stage Renal Resident with (no date) ing for residents with end-stage I be trained in the care and ese residents," and also it ent's comprehensive care plan ient's needs related to				

Facility ID: 00286

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TATEMEN	F OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		(X3) DA). 0938-039 TE SURVEY MPLETED
		245566	B. WING		07	C 7/ 09/2021
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD		/05/2021
VALLEY	VIEW HEALTHCARE	& REHAB		510 EAST CEDAR STREET HOUSTON, MN 55943		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETIO DATE
	A document titled H was provided and in "hemodialysis device medical personnel and demonstrated use of these device Central Dialysis Ca non-dialysis person the general medi the resident's medi follows: 1. location dressing (interventi report from dialysis given. 4. Observation A request was made competency testing care of a dialysis part A request for any d past three months provided. Pharmacy Srvcs/Pr CFR(s): 483.45(a)(§483.45 Pharmacy The facility must pr drugs and biologicat them under an agre §483.70(g). The fac personnel to admin permits, but only ur a licensed nurse. §483.45(a) Procedu pharmaceutical ser	demodialysis care (no date) indicated the purpose to be: ces may only be accessed by who have received training clinical competency regarding es." It describes the care of theters: "Do not allow anel to access the catheter ical nurse should document in cal record every shift as of catheter. 2. condition of ons if needed). 3. Any part of nurse post-dialysis being ons post-dialysis. le for evidence of education or g of nursing staff related to the atient, but none was provided. ialysis assessments for the were requested, but were not rocedures/Pharmacist/Records b)(1)-(3)	F 698			8/13/21

Facility ID: 00286

If continuation sheet Page 33 of 38

				TIP			0938-039
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ·				E SURVEY PLETED
						C	2
		245566	B. WING			07/0	09/2021
NAME OF F	PROVIDER OR SUPPLIER	·		S	STREET ADDRESS, CITY, STATE, ZIP CODE		
VALLEY	VIEW HEALTHCARE	& REHAB			510 EAST CEDAR STREET HOUSTON, MN 55943		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 755	Continued From pa	ige 33	F 7	755			
	biologicals) to meet	t the needs of each resident.					
		Consultation. The facility ain the services of a licensed					
		ides consultation on all ision of pharmacy services in					
		blishes a system of records of tion of all controlled drugs in enable an accurate					
	order and that an a is maintained and p This REQUIREMEN	rmines that drug records are in ccount of all controlled drugs periodically reconciled. NT is not met as evidenced					
		tion, interview and document ailed to ensure their system for			F755		
	medication reconcil timely identification	liation was adequate to ensure of loss or diversion of narcotic f 1 medication room			A 7/10/21 new systems are in place loose leaf papers and verification pl of EKIT and its tag verification. There is a Binder with pages that an numerically number and dated. Nur	rocess	
	Findings include:				staff are to verify five tag system at start of shift. This will be done by 2	each	
	was reviewed with emergency kit (E-k	On 7/7/21, at 10:12 a.m. the medication room was reviewed with registered nurse (RN)-A. The emergency kit (E-kit) was behind a locked door entry to medication room and a locked cupboard			members at the same time. Verifyir page number, date and time of tag from their shift and the shift prior to	ng checks	
	both opened with a	physical key. The E-kit nedications and controlled			Valley View Healthcare and Rehab E-Kit Medication and Reconciliation		
	substances. The E numbered lock tags	E-kit was secured with green s with an identifier number			reviewed and updated on 8/3/2021.		
		se leafed three ring binder the E-kit along with a			Risk of reoccurrence will be minimiz	zed by:	

Facility ID: 00286

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TATEMEN	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTII	PLE CONSTRUCTION	(X3) DAT	E SURVEY
ND PLAN C	F CORRECTION	IDENTIFICATION NUMBER:		G	`´CO№	IPLETED
		245566	B. WING			C 09/2021
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD		03/2021
VALLEY	VIEW HEALTHCARE	& REHAB		510 EAST CEDAR STREET HOUSTON, MN 55943		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APF DEFICIENCY)	OULD BE	(X5) COMPLETIO DATE
F 755	Continued From pa	ge 34	F 75	5		
	RN-A stated staff d identifiers at shift of green tag numbers binder next to the E would be no way of removed medicatio page from the three green numbered lo During interview on of nursing (DON) of for diversion with th system for the E-kit not say for sure the dates or verifying th changes. During interview on consultant pharmac potential for diversion	7/7/21, at 10:29 a.m. director onfirmed there was a potential the loose leaf binder verification the DON indicated she can the staff are looking at previous the numbers during shift 7/8/21, at 1:49 p.m. the cist indicated there could be a on using a loose leaf three ring		 Director of Nursing or design 1x week audits for 4 weeks to proper procedure is being follo nursing staff. Then biweekly fo then monthly until QA determin date. All staff were educated in 7/ next procedure and sign off on education. Any licensed staff w educated prior to their next sch shift to work. Results of audits will be brod quarterly QA meetings to deter procedure is working or if syste updating. 	ensure wed by r 1 month, nes an end 9/21 to the the vill be neduled ught to mine if	
	Requested a copy of reconciliation policy receive one. Free from Unnec P CFR(s): 483.45(c)(§483.45(c)(3) A psy that affects brain ac processes and beh	v and procedure, but did not sychotropic Meds/PRN Use 3)(e)(1)-(5)	F 75	8		8/13/21

Facility ID: 00286

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		I AND HUMAN SERVICES				FORM	08/13/2021 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ·		E CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		245566	B. WING				C 09/2021
NAME OF F	PROVIDER OR SUPPLIER		•	ST	TREET ADDRESS, CITY, STATE, ZIP CODE	-	
VALLEY	VIEW HEALTHCARE	& REHAB			10 EAST CEDAR STREET OUSTON, MN 55943		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 758	(iv) Hypnotic Based on a compre	ehensive assessment of a	F 7	'58			
	§483.45(e)(1) Resid psychotropic drugs unless the medicati	a must ensure that dents who have not used are not given these drugs ion is necessary to treat a s diagnosed and documented d;					
	drugs receive gradu behavioral intervent	dents who use psychotropic ual dose reductions, and tions, unless clinically an effort to discontinue these					
	psychotropic drugs unless that medicat	dents do not receive pursuant to a PRN order tion is necessary to treat a condition that is documented d; and					
	are limited to 14 day §483.45(e)(5), if the prescribing practitio appropriate for the l beyond 14 days, he rationale in the resid	orders for psychotropic drugs ys. Except as provided in e attending physician or oner believes that it is PRN order to be extended e or she should document their dent's medical record and n for the PRN order.					
	drugs are limited to renewed unless the prescribing practitio the appropriateness	orders for anti-psychotic 14 days and cannot be attending physician or oner evaluates the resident for s of that medication. NT is not met as evidenced					

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	OF DEFICIENCIES	<u>& MEDICAID SERVICES</u> (X1) PROVIDER/SUPPLIER/CLIA	(Y2) MULT	IPLE CONSTRUCTION		0938-039 E SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER:	. ,	4G		PLETED
						C
		245566	B. WING		07/	09/2021
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
VALLEY	VIEW HEALTHCARE	& REHAB		510 EAST CEDAR STREET HOUSTON, MN 55943		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE	(X5) COMPLETION DATE
F 758	Continued From pa	age 36	F 75	58		
		v and document review facility rationale for the continued use		F758		
	of a PRN (as need beyond 14 days for	ed) psychotropic medication ⁻ 1 of 5 (R14) residents essary medications.		R14 Care Plan and chart have be reviewed as of 7/20/2021 Providers order have discontinue psychotropic medications.		
	R14's electronic he indicated R14 had might require the u anxiety disorder un According to R14's other medications, lorazepam (a scher given for anxiety) o needed, with an or 11/19/21. A PRN Psychotrop was initiated by the on 5/18/21 and pro for review of R14's originally started 5/	ealth record (EHR) face sheet the following diagnosis that se of psychotropic medication: specified. medication orders, among R14 had an order for dule IV controlled substance one(1)MG at bedtime as der start date of 5/19/21 to ic Medication Evaluation Form e facility consulting pharmacist vided to the medical provider lorazepam order that had 10/21. A physician assistant e order to continue for six more		 Valley View Health Care and Rel Policy for psychotropic has been and updated 8/3/2021. Risk of re-occurrence will be min the Director of Nursing or design initiating the following. 1) Any resident that has an order psychotropic drug will be reviewed provider q2 weeks and will havin reasoning behind medication use Pharmacist consultant will review and send via email results on co Director of Nursing or designee to that clinical rational for continuing modifying be connected to order 2) Any resident on a psychotropic 	reviewed imized by ee for a ed by g dx and e. y monthly nsults to o ensure g or	
	months, but no info form as to how ma whether the medica or not R14 had any prompts a respons "brief clinical ration order (required); ho blank by PA-C. According to an inter the Director of Nurse entered the facility	erview 7/09/21, 9:43 a.m. with sing (DON), stated R14 had with the order for lorazepam ould depend on the		 2) Any resident on a psychotropic medication will be discussed wee IDT meeting for effectiveness of medication and dosages used. L staff will record in progress notes shift of dosages used and effective medication. 3) Audits will be conducted 1x we weeks and will be discussed at 0 meeting quarterly with pharmacy consultant and Medical Director. 	ekly at icensed s each veness of eek for 4 QA	

		HAND HUMAN SERVICES					FORM	08/13/2021 APPROVED 0938-0391
STATEMENT	F OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 · ·		CONSTRUCTION		(X3) DATI COM	E SURVEY PLETED C
		245566	B. WING					09/2021
NAME OF F	PROVIDER OR SUPPLIER	·			REET ADDRESS, CITY, STATE,	, ZIP CODE	-	
VALLEY	VIEW HEALTHCARE	& REHAB			EAST CEDAR STREET USTON, MN 55943			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIZ TAG		PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD THE APPROPE	BE	(X5) COMPLETION DATE
F 758	pharmacist to revie recommendations. days a psychotropic should be written for the doctor's orders continue to be on th psychotropic medic during their interdis was unable to locat discussion about R A request for a faci	w the order and make DON was unsure how many c PRN medication order or and stated, "we just follow and whether [R14] should	F 7	758				

		AND HUMAN SERVICES	ГС	000000000000000000000000000000000000000	FORM APPROVED
		& MEDICAID SERVICES		LE CONSTRUCTION	MB NO. 0938-0391
	OF DEFICIENCIES	IDENTIFICATION NUMBER:	• •	G 01 - VALLEY VIEW NURSING HOME	(X3) DATE SURVEY COMPLETED
		245566	B. WING		07/07/2021
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
VALLEY	VIEW HEALTHCARE	& REHAB		510 EAST CEDAR STREET	
			1	HOUSTON, MN 55943	
(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	D BE COMPLÉTION
				DEFICIENCY)	
K 000	INITIAL COMMENT	ſS	K 000	2	
	FIRE SAFETY				
	conducted by the M Public Safety, State 07/07/2021. At the View Nursing Home with the requiremer Medicare/Medicaid 483.70(a), Life Safe edition of National F (NFPA) 101, Life Safe edition of National F (NFPA) 99, Health Car NFPA 99, Health Car NFPA 99, Health Car NFPA 99, Health Car SIGNATURE AT TH PAGE OF THE CM USED AS VERIFIC UPON RECEIPT O	OC WILL SERVE AS YOUR COMPLIANCE UPON THE CCEPTANCE. YOUR HE BOTTOM OF THE FIRST S-2567 FORM WILL BE ATION OF COMPLIANCE. F AN ACCEPTABLE POC, AN DF YOUR FACILITY MAY BE			
	REGULATIONS HA	MPLIANCE WITH THE AS BEEN ATTAINED IN ITH YOUR VERIFICATION.			
	PLEASE RETURN CORRECTION FO DEFICIENCIES (K-	R THE FIRE SAFETY			
		IN THE E-POC PROCESS, A THE PLAN OF CORRECTION D.			
LABORATOR	Y DIRECTOR'S OR PROVID	DER/SUPPLIER REPRESENTATIVE'S SIGN	NATURE	TITLE	(X6) DATE
Electron	ically Signed				08/03/2021

F5566031

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.

DEPARTMENT OF HEALTH AND HUMAN SERVICES

TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE K 000 Continued From page 1 Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR K 000 K 000 By email to: FM.HC.Inspections@state.mn.us K 000 FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: I. A detailed description of the corrective action taken or planned to correct the deficiency. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. 3. Indicate how the facility plans to monitor future performance to ensure solutions are			AND HUMAN SERVICES				FORM	APPROVED
NAME OF PROVIDER OR SUPPLIER VALLEY VIEW HEALTHCARE & REHAB VALLEY VIEW HEALTHCARE & REHAB (X4) ID PREFIX STREET ADDRESS. CITY, STATE, ZIP CODE 510 EAST CEDAR STREET HOUSTON, MN 55943 (X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX TAG PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) K 000 Continued From page 1 Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR By email to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: K 000 1. A detailed description of the corrective action taken or planned to correct the deficiency. I. Address the measures that will be put in place to ensure the deficiency does not reoccur. 3. Indicate how the facility plans to monitor future performance to ensure solutions are	STATEMENT	T OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA			PLE CONSTRUCTION	(X3) DATE	E SURVEY
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE VALLEY VIEW HEALTHCARE & REHAB STREET ADDRESS, CITY, STATE, ZIP CODE (X4) ID PREFIX SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) D PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) COMPLETIC COMPLETIC DATE K 000 Continued From page 1 Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR K 000 By email to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: K 000 1. A detailed description of the corrective action taken or planned to correct the deficiency. 1. A detailed description of the corrective action taken or planned to correct the deficiency. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. 3. Indicate how the facility plans to monitor future performance to ensure solutions are Street formance to ensure solutions are	AND PLAN C	JF CORRECTION	IDENTIFICATION NUMBER:	A. BUILD	DING	G 01 - VALLEY VIEW NURSING HOME	COM	PLETED
VALLEY VIEW HEALTHCARE & REHAB SIJ EAST CEDAR STREET HOUSTON, MN 55943 (X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOLD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) COMMENT COMMENTIFY TAG K 000 Continued From page 1 Healthcare Fire Inspections State Fire Marshal Division 4455 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR K 000 By email to: FM.HC.Inspections@state.mn.us FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: I. A detailed description of the corrective action taken or planned to correct the deficiency. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. 3. Indicate how the facility plans to monitor future performance to ensure solutions are			245566	B. WING			07/	07/2021
VALLEY VIEW HEALTHCARE & REHAB HOUSTON, MN 55943 Image: Constraint of the co	NAME OF	PROVIDER OR SUPPLIER						
PRÉFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PRÉFIX TAG (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCE TO THE APPROPRIATE DEFICIENCY) Convertence DEFICIENCY K 000 Continued From page 1 Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR K 000 K 000 By email to: FM.HC.Inspections@state.mn.us FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: I. A detailed description of the corrective action taken or planned to correct the deficiency. I. A detailed description of the corrective action taken or planned to correct the deficiency. I. Address the measures that will be put in place to ensure the deficiency does not reoccur. 3. Indicate how the facility plans to monitor future performance to ensure solutions are Indicate how the facility plans to monitor	VALLEY	VIEW HEALTHCARE	& REHAB					
Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR By email to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A detailed description of the corrective action taken or planned to correct the deficiency. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. 3. Indicate how the facility plans to monitor future performance to ensure solutions are	PRÉFIX	(EACH DEFICIENCY	Y MUST BE PRECEDED BY FULL	PREFI		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP	BE	COMPLETION
 sustained. 4. Identify who is responsible for the corrective actions and monitoring of compliance. 5. The actual or proposed date for completion of the remedy. Valley View Nursing Home is a 1-story building with no basement. The building was constructed at 4 different times. The original building was constructed in 1957, with additions following in 1976, 1988, and 2011. All to be determined as Type II (111). The original building and all additions have no basement. There is an assisted living facility which is separated from the nursing home by a 2 hour fire separation. Because the original building and addition meet 	K 000	 Healthcare Fire Insistate Fire Marshall 445 Minnesota St., St. Paul, MN 55101 By email to: FM.HC.Inspections THE PLAN OF COPDEFICIENCY MUSFOLLOWING INFO 1. A detailed descentation of planned to 2. Address the mean place to ensure the 3. Indicate how the future performance sustained. 4. Identify who is mactions and monitor 5. The actual or pather remedy. Valley View Nursing with no basement. at 4 different times. constructed in 1957 1976, 1988, and 20 Type II (111). The additions have no b assisted living facilit nursing home by a final state of the state	spections Division Suite 145 1-5145, OR Carlow FOR EACH STINCLUDE ALL OF THE DRMATION: cription of the corrective action of correct the deficiency. easures that will be put in the deficiency does not reoccur. the facility plans to monitor to ensure solutions are responsible for the corrective ring of compliance. proposed date for completion of g Home is a 1-story building The building was constructed The original building was 7, with additions following in pl1. All to be determined as the original building and all pasement. There is an ity which is separated from the 2 hour fire separation.	K	000			

Facility ID: 00286

If continuation sheet Page 2 of 11

		AND HUMAN SERVICES		FORM	08/11/2021 APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E SURVEY PLETED
		245566	B. WING	07/0	07/2021
NAME OF	PROVIDER OR SUPPLIER		·	STREET ADDRESS, CITY, STATE, ZIP CODE	
VALLEY	VIEW HEALTHCARE	& REHAB		510 EAST CEDAR STREET HOUSTON, MN 55943	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	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) COMPLETION DATE
K 000 K 271 SS=D	the construction typ buildings, the facilit building as allowed Fire Protection Assi- Life Safety Code (L Health Care Occup The facility is fully p automatic sprinkler system with smoke spaces open to the that is monitored for notification. The facility has a car census of 40 at the The requirement at NOT MET as evide Discharge from Exi CFR(s): NFPA 101 Discharge from Exi Exit discharge is an provides a level wa provisions of 7.1.7 elevation and shall obstructions. Additi be a hard packed a 18.2.7, 19.2.7 This REQUIREMEN by: Based on observat facility failed to mai and transition to gra NFPA 101 (2012 e sections 19.2.7, 7.	 be allowed for existing y was surveyed as one in the 2012 edition of National ociation (NFPA) Standard 101, SC), Chapter 19 Existing ancies. brotected throughout by an system and has a fire alarm detection in the corridors, corridors, and resident rooms, r automatic fire department apacity of 45 beds and had a time of the survey. 42 CFR, Subpart 483.70(a) is nced by: ts 	K 00		7/14/21

Facility ID: 00286

If continuation sheet Page 3 of 11

		AND HUMAN SERVICES				FORM	08/11/2021 APPROVED 0938-0391
	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MUL [.] A. BUILDI		DATE SURVEY COMPLETED		
		245566	B. WING			07/0	07/2021
NAME OF F	PROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
VALLEY	VIEW HEALTHCARE	& REHAB			0 EAST CEDAR STREET OUSTON, MN 55943		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
	was revealed that t a vertical transition one-half inch betwee the sidewalk. This deficient pract Maintenance Direct Cooking Facilities CFR(s): NFPA 101 Cooking Facilities Cooking equipment with NFPA 96, Star and Fire Protection Operations, unless * residential cookin appliances such as toasters) are used cooking in accorda * cooking facilities of compartments with with the conditions or * cooking facilities if 30 or fewer patients 18.3.2.5.4, 19.3.2.5 Cooking facilities p per 9.2.3 are not re hazardous areas, b corridor.	 facility. ween 09:30 AM to 01:30 PM, it he West corridor exit exhibited to grade, greater than een the exit door threshold and een the exit door threshold and ice was confirmed by the tor at the time of discovery. t is protected in accordance addrd for Ventilation Control of Commercial Cooking gequipment (i.e., small emicrowaves, hot plates, for food warming or limited nce with 18.3.2.5.2, 19.3.2.5.2 open to the corridor in smoke 30 or fewer patients comply under 18.3.2.5.3, 19.3.2.5.3, n smoke compartments with s comply with conditions under 5.4. rotected according to NFPA 96 quired to be enclosed as but shall not be open to the 18.3.2.5.1 through 	К 2		perform spot audits on all exit sidev and thresholds for any change in transition grades in excess of one-finch to ensure continued compliance changes in transition grades greate one-half inch will be corrected. The Maintenance Director will report his findings at the quarterly Quality Ass meeting.	nalf æ. Any r than	7/9/21

If continuation sheet Page 4 of 11

	RS FOR MEDICARE	AND HUMAN SERVICES	1		F(OMB	ORM. NO.	08/11/2021 APPROVED 0938-0391
	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 245566 245566				CONSTRUCTION (X3 1 - VALLEY VIEW NURSING HOME	(X3) DATE SURV COMPLETE	
		245566	B. WING			07/0	07/2021
NAME OF F	PROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
VALLEY	VIEW HEALTHCARE	& REHAB			0 EAST CEDAR STREET DUSTON, MN 55943		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	E	(X5) COMPLETION DATE
K 324	Continued From pa	ge 4	K 32	24			
	by: Based on a review and staff interview, inspect range hood prescribed timefran edition), Life Safety 19.3.2.5, NFPA 99 (Facilities Code, sec (2011 edition), Stan and Fire Protection Operations, section deficient condition of on the residents with Findings include: On 07/07/2021 betw was revealed during range hood suppre- inspected on 12/20. This deficient pract Maintenance Direct Sprinkler System - CFR(s): NFPA 101 Sprinkler System - Automatic sprinkler inspected, tested, a with NFPA 25, Stan Testing, and Mainta Protection Systems maintenance, inspec	ween 09:30 AM to 01:30 PM, it g documentation review that ssion system had last been	K 3	53	K324 The range hood suppression system vinspected on July 9, 2021 by Summit Companies. Documentation of the inspection was received and filed by the Maintenance Director. The range hood suppression system will be inspected every six months, and documentation be retained by the Maintenance Director The Maintenance Director will ensure the range hood suppression inspection scheduled to be completed no later the six months from the prior inspection. Maintenance Director will report the findings of the suppression system inspection at the quarterly Quality Assurance Committee meeting.	ne d or. that n is an The	7/23/21

Facility ID: 00286

If continuation sheet Page 5 of 11

		I AND HUMAN SERVICES E & MEDICAID SERVICES				FORM	08/11/202 APPROVED 0938-039
	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA ND PLAN OF CORRECTION IDENTIFICATION NUMBER:				E CONSTRUCTION 11 - VALLEY VIEW NURSING HOME	(X3) DATE SURVEY COMPLETED	
		245566	B. WING			07/	07/2021
NAME OF	PROVIDER OR SUPPLIER		· [ST	REET ADDRESS, CITY, STATE, ZIP CODE		
VALLEY	VIEW HEALTHCARE	& REHAB			0 EAST CEDAR STREET OUSTON, MN 55943		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
K 353	available. a) Date sprinkler s b) Who provided s c) Water system s Provide in REMAR any non-required of system. 9.7.5, 9.7.7, 9.7.8, This REQUIREME by: Based on observation facility failed to inspect system in accordant edition), Life Safety and NFPA 25 (2017) Inspection, Testing Water-Based Fire I 5.2, 5.2.1.1.1, 5.2.1 deficient condition on the residents with Findings include: 1. On 07/07/2021 PM, it was revealed the laundry washing corrosion and oxida 2. On 07/07/2021 PM, it was revealed the kitchen wash red debris. This deficient pract	system last checked system test supply source KS information on coverage for r partial automatic sprinkler and NFPA 25 NT is not met as evidenced tion and staff interview, the bect and maintain the sprinkler nce with NFPA 101 (2012 / Code, sections 9.7.5, 9.7.6, 1 edition) Standard for the , and Maintenance of Protection Systems, sections 1.1.2, and 5.2.1.1.4. This could have a patterned impact thin the facility. between 09:30 AM to 01:30 d the sprinkler heads above g machined exhibited signs of	K 3	53	K353 All sprinkler heads in the laundry roo were replaced on July 23, 2021 by Summit Fire Protection. Sprinkler h will be monitored and inspected qua by the Maintenance Director in conjunction with the routine quarterl sprinkler inspection and maintenance The Maintenance Director will repor inspection results at the quarterly Qu Assurance Committee meeting.	eads arterly y ce. t	

If continuation sheet Page 6 of 11

TATEMENT	OF DEFICIENCIES F CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION (X3) D	O. 0938-039 ATE SURVEY OMPLETED
		245566	B. WING	0	7/07/2021
NAME OF F	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
VALLEY	VIEW HEALTHCARE	& REHAB		510 EAST CEDAR STREET HOUSTON, MN 55943	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETIC DATE
K 355	Continued From pa	ige 6	K 35	5	
K 355	Portable Fire Exting CFR(s): NFPA 101	-	K 355		8/13/21
	 inspected, and mai NFPA 10, Standard Extinguishers. 18.3.5.12, 19.3.5.12 This REQUIREMENT by: Based on observation facility failed to main fire extinguishers in (2012 edition), Life 19.3.5.12, 9.7.4.1, as Standard for Portation 6.1.3.8. This deficing patterned impact on facility. Findings include: 1. On 07/07/2021 In PM, it was revealed extinguishers (K and access. 2. On 07/07/2021 In PM, it was revealed in the Beauty Shop a hairdryer unit place This deficient pract 	uishers are selected, installed, ntained in accordance with for Portable Fire 2, NFPA 10 NT is not met as evidenced tion and staff interview, the ntain accessibility to portable accordance with NFPA 101 Safety Code, sections and NFPA 10 (2010 edition), ole Fire Extinguishers, section ent condition could have a in the residents within the between 09:30 AM to 01:30 d that both kitchen fire and ABC types) had obstructed between 09:30 AM to 01:30 d the ABC extinguisher located had obstructed access due to ced in front of the unit. ice was confirmed by the tor at the time of discovery.	K 51	K355 The kitchen K and ABC type fire extinguishers were relocated into a more accessible location. Signage was added above the beauty shop fire extinguisher alerting the beauticians not to obstruct access to the fire extinguisher. The Maintenance Director will observe and remove any noted obstructions during hi routine morning rounds. All staff will be educated on August 13, 2021 on fire safety protocols as they pertain to unobstructed fire extinguishers. The Maintenance Director will report his observations at the Quality Assurance Committee meeting.	

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		AND HUMAN SERVICES			F	ORM A	08/11/2021 APPROVED 0938-0391
	AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		· ′		E CONSTRUCTION (X: 01 - VALLEY VIEW NURSING HOME	(X3) DATE SURV COMPLETED	
		245566	B. WING			07/0	7/2021
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		-
VALLEY	VALLEY VIEW HEALTHCARE & REHAB				10 EAST CEDAR STREET IOUSTON, MN 55943		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)		(X5) COMPLETION DATE
K 511	Continued From page 7 Utilities - Gas and Electric Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NFPA 70, National Electric Code. Existing installations can continue in service provided no hazard to life. 18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2		κs	511			
	by: Based on observat facility failed to mai physical accessibili resident accessible NFPA 101 (2012 ec sections 19.5.1.1 at edition), National E and NFPA 99, (201 Facilities Code, sec condition could hav residents within the Findings include: 1. On 07/07/2021 f PM, it was revealed access to the elect Goods Storage Roo 2. On 07/07/2021 f PM, it was revealed access to the elect corridor.	between 09:30 AM to 01:30 I that there was obstructed rical panel in the Kitchen Dry			K511 In the kitchen dry goods storage room shelving was removed, and caution ta was put on the floor alerting staff not to obstruct the area in front of the electri panel. The bench was removed from front of the south hall electrical panel. the boiler room, the portable heaters of removed from in front of the electrical panel and put into storage. In the kitch the carts that were obstructing the electrical panel were removed. Red ta was put around the electrical box and signage was added to alert staff not to park carts and equipment in front of th electrical box. Electrical panels in the south corridor were locked and secure immediately. The Maintenance Direct will observe and remove any noted obstructions during his routine mornin rounds. All staff will be educated on August 13, 2021 on fire safety protoco as they pertain to unobstructed electri panels. The Maintenance Director will	ape to ical in In were hen, hen, ed to ror ng ols ical	

Facility ID: 00286

If continuation sheet Page 8 of 11

		AND HUMAN SERVICES				FORM	: 08/11/202 ² APPROVEI . 0938-039 ²
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION 11 - VALLEY VIEW NURSING HOME		E SURVEY IPLETED
		245566	B. WING			07/	07/2021
NAME OF	PROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		
VALLEY	VIEW HEALTHCARE	& REHAB			0 EAST CEDAR STREET OUSTON, MN 55943		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
	PM, it was revealed access to the elect Room. 4. On 07/07/2021 PM, it was revealed access to the elect 5. On 07/07/2021 PM, it was revealed and LP12 in the resunsecured. This deficient pract Maintenance Direct Electrical Systems CFR(s): NFPA 101 Electrical Systems Hospital-grade rect locations and when anesthesia is admi installation, replace testing is performed documented perfor listed as hospital-g tested at intervals of solation monitors (intervals of less that actuating the LIM to which activates bot LIM circuits with au manual test is performed 6.3.3.3.2 after any electric distribution maintained of requ	age 8 d that there was obstructed rical panels in the Boiler between 09:30 AM to 01:30 d that there was obstructed rical panel in the Kitchen. between 09:30 AM to 01:30 d that electrical panels, LP 11 sident corridor, were tice was confirmed by the tor at the time of discovery. - Maintenance and Testing eptacles at patient bed e deep sedation or general nistered, are tested after initial ement or servicing. Additional d at intervals defined by mance data. Receptacles not rade at these locations are not exceeding 12 months. Line (LIM), if installed, are tested at an or equal to 1 month by est switch per 6.3.2.6.3.6, th visual and audible alarm. For itomated self-testing, this ormed at intervals less than or s. LIM circuits are tested per repair or renovation to the system. Records are ired tests and associated tions, containing date, room or	K 51		report his observations at the Qualit Assurance Committee meeting.	ty	8/3/21

Facility ID: 00286

If continuation sheet Page 9 of 11

		AND HUMAN SERVICES			FORM	0: 08/11/2021 1 APPROVED 0. 0938-0391
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MUL A. BUILD	OATE SURVEY OMPLETED			
		245566	B. WING	·	07	/07/2021
	NAME OF PROVIDER OR SUPPLIER VALLEY VIEW HEALTHCARE & REHAB			5	TREET ADDRESS, CITY, STATE, ZIP CODE 10 EAST CEDAR STREET IOUSTON, MN 55943	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 914 K 920 SS=D	by: Based on document the facility failed to electrical receptacle NFPA 99 (2012 edit Code, sections 6.3. deficient condition of impact on the resid Findings include: On 07/07/2021 betw was revealed during records provided for information content information association outlets located in record Electrical Equipment CFR(s): NFPA 101 Electrical Equipment Extension Cords Power strips in a part used for component patient-care-related (PCREE) assemble by qualified person 10.2.3.6. Power strimay not be used for electronics), except rooms that do not u	Sults. NT is not met as evidenced Int review and staff interview, properly document the annual tetesting in accordance with tion), Health Care Facilities 3.2, 6.3.4.1 and 6.3.4.2. This could have a widespread ents within the facility. Ween 09:30 AM to 01:30 PM, it g documentation review the r review were generic in , not providing detailed ted to the duplex and quad esident rooms. ice was confirmed by the tor at the time of discovery. Int - Power Cords and Extens Int - Power Cords and atient care vicinity are only		914	K914 On July 15, 2021, the Maintenance Director completed outlet resistance testing in all resident rooms. Outlet receptacle monitoring information records were completed by identifying duplex outlets with a single digit, and quad outlets with the single digit, along with side A and side B to specifically identify the outlets tested. The Maintenance Director will revise the monitoring forms with to identify duplex outlets, and quad outlets with identifiers side A and side B. The Maintenance Director will report the results of the resistance testing at the Quality Assurance Committee meeting.	5

Facility ID: 00286

If continuation sheet Page 10 of 11

		AND HUMAN SERVICES				FORM	08/11/202 APPROVED 0938-0391	
			(X2) MUL A. BUILD		(X3) DATE SURVEY COMPLETED			
		245566	B. WING			07/0	07/2021	
NAME OF PROVIDER OR SUPPLIER				5	TREET ADDRESS, CITY, STATE, ZIP CODE 10 EAST CEDAR STREET IOUSTON, MN 55943		110112021	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIZ TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
K 920	(outside of vicinity) care rooms, power standards. All pow precautions. Exten substitute for fixed Extension cords us immediately upon of which it was installed 10.2.4. 10.2.3.6 (NFPA 99) (NFPA 70), 590.3 (D This REQUIREMEN by: Based on observat facility failed to prop implementation and accordance with NI Care Facilities Cod NFPA 70, (2011 ed sections 400-8, 590 could have an isola within the facility. Findings include: On 07/07/2021 betw was revealed that in Office daisy-chained power equipment and This deficient pract	EE in the patient care rooms meet UL 1363. In non-patient strips meet other UL er strips are used with general ision cords are not used as a wiring of a structure. ed temporarily are removed completion of the purpose for ed and meets the conditions of , 10.2.4 (NFPA 99), 400-8 0) (NFPA 70), TIA 12-5 NT is not met as evidenced tion and staff interview, the perly manage the d usage of power strips in FPA 99 (2012 edition), Health e, section 10.2.3.6, 10.2.4 and ition), National Electrical Code, 0.3(D). This deficient condition ited impact on the residents	κg	020	K920 Daisy-chained power strips were rem from the Kitchen Supervisor's office a replaced with a single power strip. Th Kitchen Supervisor was educated by Maintenance Director not to daisy-ch power strips. All staff will be educate August 13, 2021 on fire safety protoc as they pertain to daisy-chained pow strips. The Maintenance Director will check offices to ensure no power stri are daisy-chained. The results of the spot checks will be reported at the Q Assurance Committee meeting.	and he v the hain ed on cols ver l spot ips ese		

If continuation sheet Page 11 of 11



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered July 29, 2021

Administrator Valley View Healthcare & Rehab 510 East Cedar Street Houston, MN 55943

RE: CCN: 245566 Cycle Start Date: July 9, 2021

Dear Administrator:

On July 9, 2021, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

ELECTRONIC PLAN OF CORRECTION (ePoC)

Within **ten (10) calendar days** after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved.

To be acceptable, a provider's ePOC must include the following:

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.
- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

Valley View Healthcare & Rehab July 29, 2021 Page 2

The state agency may, in lieu of an onsite 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:

- Denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417);
- Civil money penalty (42 CFR 488.430 through 488.444).
- Termination of your facility's Medicare and/or Medicaid agreement (488.456(b)).

DEPARTMENT CONTACT

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

Jennifer Kolsrud Brown, RN, Unit Supervisor Rochester District Office Licensing and Certification Program Health Regulation Division Minnesota Department of Health 18 Wood Lake Drive Southeast Rochester, Minnesota 55904-5506 Email: jennifer.kolsrud@state.mn.us Office: (507) 206-2727 Mobile: (507) 461-9125

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a Post Certification Revisit (PCR), of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

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

Valley View Healthcare & Rehab July 29, 2021 Page 3

the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

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

If substantial compliance with the regulations is not verified by October 9, 2021 (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).

In addition, if substantial compliance with the regulations is not verified by January 9, 2022 (six months after the identification of noncompliance) your provider agreement will be terminated. 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.

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.

INFORMAL DISPUTE RESOLUTION (IDR) / INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

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: <u>https://mdhprovidercontent.web.health.state.mn.us/ltc_idr.cfm</u>

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: <u>https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html</u>

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

Valley View Healthcare & Rehab July 29, 2021 Page 4

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:

William Abderhalden, Fire Safety Supervisor Deputy State Fire Marshal Health Care/Corrections Supervisor – Interim Minnesota Department of Public Safety 445 Minnesota Street, Suite 145 St. Paul, MN 55101-5145 Cell: (507) 361-6204 Email: william.abderhalden@state.mn.us Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Joanne Simon, Enforcement Specialist Minnesota Department of Health Licensing and Certification Program Program Assurance Unit Health Regulation Division Telephone: 651-201-4161 Fax: 651-215-9697 Email: joanne.simon@state.mn.us

cc: Licensing and Certification File
Minnesc	ta Department of He	alth				
	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE COMP	SURVEY LETED
		00286	B. WING		07/0	C 9/2021
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
VALLEY	VIEW HEALTHCARE	X REHAB	CEDAR STI N, MN 55943			
(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 APPRON DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 000	Initial Comments		2 000			
	****ATTE	NTION*****				
	NH LICENSING	CORRECTION ORDER				
	144A.10, this correct pursuant to a surver found that the defic herein are not corrected shall with a schedule of f the Minnesota Depa Determination of wh corrected requires of requirements of the number and MN Ru When a rule contain comply with any of lack of compliance. re-inspection with a result in the assess	nether a violation has been				
	that may result from orders provided tha the Department with	hearing on any assessments n non-compliance with these t a written request is made to nin 15 days of receipt of a nt for non-compliance.				
	conducted at your f Minnesota Departm facility was found N State Licensure and orders are issued. F electronic plan of co	FS: licensing survey was acility by surveyors from the ent of Health (MDH). Your OT in compliance with the MN d the following correction Please indicate in your prrection you have reviewed				
LABORATOR	epartment of Health Y DIRECTOR'S OR PROVIE ically Signed	DER/SUPPLIER REPRESENTATIVE'S SIG	NATURE	TITLE		(X6) DATE 08/04/21

Electronically Signed

STATE FORM

If continuation sheet 1 of 22

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE COMP	SURVEY
			A. BUILDING:			
		00286	B. WING		C 07/09/2021	
AME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
ALLEY	VIEW HEALTHCARE	^C & RFHΔB	T CEDAR STR	EET		
			N, MN 55943			(1.1-)
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 000	Continued From pa	age 1	2 000			
	these orders, and identify the date when they will be completed.					
	SUBSTANTIATED (MN00062490),H5 (MN00074068),H5 H5566013C (MN00 (MN00067177), N0					
	AND The following com UNSUBSTANTIAT	blaints were found to be ED:				
	H5566012C (MN00	0062109)				
	the State Licensing federal software. T assigned to Minnes Nursing Homes. Th appears in the far I Tag." The state sta listed in the "Summ column and replace the correction orde the findings which statute after the sta as evidence by." Fo	nent of Health is documenting g Correction Orders using ag numbers have been sota state statutes/rules for ne assigned tag number eft column entitled " ID Prefix atute/rule out of compliance is nary Statement of Deficiencies' es the "To Comply" portion of r. This column also includes are in violation of the state atement, "This Rule is not met ollowing the surveyors findings Method of Correction and rrection.				
	receipt of State lice the Minnesota Dep Informational Bulle http://www.health.s	o participate in the electronic ensure orders consistent with partment of Health tin 14-01, available at state.mn.us/divs/fpc/profinfo/inf e licensing orders are				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		ECONSTRUCTION		E SURVEY PLETED
			A. BUILDING: B. WING		c	
		00286				07/09/2021
AME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
ALLEY	VIEW HEALTHCARE	& RFHAB	T CEDAR STR DN, MN 55943			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 000	Continued From pa	age 2	2 000			
	you electronically. is necessary for Sta enter the word "cor text. You must then State licensure pro completion date, th corrected prior to e Minnesota Departm	Alth orders being submitted to Although no plan of correction ate Statutes/Rules, please rected" in the box available for in indicate in the electronic cess, under the heading be date your orders will be electronically submitting to the nent of Health.				
	FOURTH COLUMN "PROVIDER'S PLA APPLIES TO FEDE THIS WILL APPEA IS NO REQUIREM CORRECTION FO	ARD THE HEADING OF THE N WHICH STATES, AN OF CORRECTION." THIS ERAL DEFICIENCIES ONLY. AR ON EACH PAGE. THERE ENT TO SUBMIT A PLAN OF AR VIOLATIONS OF TE STATUTES/RULES.				
2 830	MN Rule 4658.052 Proper Nursing Ca	0 Subp. 1 Adequate and re; General	2 830			8/13/21
	receive nursing car custodial care, and individual needs an the comprehensive plan of care as des 4658.0405. A nurs of bed as much as written order from t	general. A resident must re and treatment, personal and supervision based on ad preferences as identified in resident assessment and scribed in parts 4658.0400 and sing home resident must be ou possible unless there is a the attending physician that the ain in bed or the resident n bed.	j t			
	This MN Requirem	ent is not met as evidenced				

STATEME	Dita Department of He NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP A. BUILDING	LE CONSTRUCTION	(X3) DATE COMPI	
		00296	B. WING		07/0	
		00286			07/0	9/2021
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
ALLEY	VIEW HEALTHCARE	& REHAB	Г CEDAR ST N, MN 5594			
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORREC		(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPP DEFICIENCY)		COMPLET DATE
2 830	Continued From pa	age 3	2 830			
	by:					
		ion, interview, and document		2830		
		ailed to consistently assess				
	and monitor increa	sing weight, and edema to the		R14 and R4 will have an assess		
		or 2 of 2 resident (R14, R4)		completed by RD by 08/05/2021		
	reviewed for edema	a and hospitalizations.		current weight status. R14 and I		
				have a fluid assessment comple		
	Findings include:			RN by 08/04/2021. Both of these		
				assessments will be communicated		
	0	cility electronic health record		primary provider with document		
		R14 had a diagnosis of primary	'	such and any new interventions	orders as	
		blood pressure), acute		appropriate.		
		vith hypoxia (history of				
		tory function leading to low		All current residents in the facilit		
		pleural effusion (history of		their weights assessed by the C		
		complication that may be renal or infectious problems).		designee and any resident flagg significant change in weight per		
		renar or inflectious problems).		be communicated with primary		
	R1/I's Care Plan in	dicated a care problem of		This will be completed by date of		
		am at increased nutrition risk		compliance.	1	
		d age, adult failure to thrive,		Valley View Healthcare & Rehal	Policy	
		ein calorie malnutrition for R14,		Weight Change was reviewed a		
		11/21/20. Corresponding care		updated on 08/04/2021.		
		ed providing a general diet with				
		nal supplement three times		Risk of re-occurrence will be mi	nimized by	
		tion, monitoring intake of food		the Certified Dietary Manager or		
		monitoring and recording		initiating the following:	J J	
	R14's weight at lea	st weekly. Additionally, nursing				
	staff was to notify the	he primary care provider of any		1)All licensed staff will be educated		
	significant weight c	hanges.		facility policy Valley View Health		
	_			Rehab Weight Change Policy p		
		sician assistant's (PA-C)		compliance date. On-call staff w		
		d 11/17/20, R14 had no lower		not been scheduled to work price		
		luid accumulation in the		compliance date will be educate		
	tissues).			their next scheduled shift. RD w		
				educated on Valley View Health		
		sician's progress note by a		Rehab Policy Weight Change po	blicy and	
		D-A) dated 1/20/21, R14 was		procedure.		
		utine visit post-hospitalization		2) All regidents with simplificant	oight	
	epartment of Health	respiratory failure related to		2)All residents with significant w	eigni	

ONVZ11

If continuation sheet 4 of 22

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00286	B. WING		C 07/09/2021	
IAME OF	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY,	STATE, ZIP CODE		
ALLEY	VIEW HEALTHCARE	& REHAR	r cedar St N, MN 5594			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TION SHOULD BE COMPLE THE APPROPRIATE DATE	
2 830	Continued From pa	ge 4	2 830			
	pulmonary edema (tissue of the lungs) provision of medica function to remove indicated nursing st at that time. MD-A i regular and lungs w was noted in the low According to progre R14 had 3+ edema where pressing on will result in an inde that lasts for a minu and R14 was not w compression hose) by PA-C indicated F nursing staff should changes or decomp Additional progress after March of 2021 provided. According to a nutri dietary manager (C 5/12/2021: "Diet order is gener does prefer to eat r reports appetite is g 50-100% of food or oz nutrition supplen nutrition. Resident of continue having sup 141# on 5/11/21. W admission. Weight 11/12/20, this does	(fluid accumulation in the which required diuresis (the titions to enhance renal fluid overload). The note taff had no concerns for R14 indicated that heart rate was vere clear, but chronic edema wer extremities. ess note by PA-C dated 3/9/21, (edema of significant severity the tissue for several seconds entation of 4-6mm (millimeters) ute or more) of both lower legs earing any tubi-grips (a knitted . A progress note date 3/16/21 R14 had slight edema and d monitor and notify of any bensation in R14's condition. Inotes by medical providers were requested but not ition note written by a certified DM) in the EHR dated ral, cut up foods. Resident neals in her room. Resident good. Resident does consume n most meal trays. Offering 4 nent TID with meals for extra does like this and wishes to oplement. Recent weight was /eight has increased since on admission was 115# on represent a 22.6% weight 5 months. Will continue to		changes will be audited r months to ensure the pol The audit will be ongoing QA and a determination i are no longer necessary. 3)Audits will be brought to committee quarterly to di and need for further audi additional staff training.	icy is followed. until reviewed at is made that they o the QA scuss findings	

TATEME	ota Department of He NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	COM	E SURVEY PLETED C
		00286	B. WING		07/09/2021	
IAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
ALLEY	VIEW HEALTHCARE	& REHAR	T CEDAR STR N, MN 55943	EET		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 830	Continued From pa	qe 5	2 830			
	According to R14's weighed: 115 pound (lbs) on 121 lbs on 12/09/20 130.3 lbs on 1/13/2 133.2 lbs on 2/16/2 135.2 lbs on 3/9/21 135.4 lbs on 4/20/2 140.5 lbs on 5/11/2 142.9 lbs on 6/22/2 145.1 lbs on 7/6/21 During an observati R14 was sitting in h her feet dependent visual swelling of bo stockings or tubi-gr On 7/07/21, 11:25 a recliner in room, leg swollen and tubi-gri On 7/08/21, 9:25 a. recliner napping wit swollen and tubi-gri During an observati registered nurse (R technique for check recliner with feet elec compression tube of had moved. The lo was ballooned up to of the portion that w RN-C stated, "well,	EHR weight record, R14 11/12/20 1 1 1 1 1 1 1 1 1 1 1 1 1				

If continuation sheet 6 of 22

STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		E SURVEY PLETED
		00286	B. WING		C 07/09/2021	
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
/ALLEY	VIEW HEALTHCARE	& REHAR	T CEDAR STR DN, MN 55943			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	FION SHOULD BE	(X5) COMPLET DATE
2 830	Continued From pa	age 6	2 830			
	receiving diuretics should have edema checks done daily and documented in the medication administration record.					
	of Nursing (DON) s weights from the C responsible to mon unless there are sp sure weights do no as when someone nurses should notic weights, but that th any significant char interdisciplinary tea was told that is not (weight increase) s DON also said the resident weights inter	7/09/21, 1:08 PM the Director stated she receives a list of DM and the CDM is itor the resident weights becific orders for nurses to be t go over a defined limit, such has edema. DON did say that ce if there are changes in e CDM should be bringing up nges in weight at the am meetings. DON state, "I my area to monitor and this hould have been caught." nursing assistants enter the to the EHR, but they are a previous weight had been change in weight.				
	stated she did not had reported or dis with the registered was unable to find had reviewed or as unsure when she s said she did not do with the RD. CDM dietary supplement them with the nursi	7/09/21, 1:55 p.m. CDM have documentation that she cussed R14's 22% weight gain dietician (RD). She sated she any documentation that the RE sessed R14, and she was hould report to the RD. She cument conversations she had did state that R14 liked her and had discussed continuing ng team, but did not recall department about the weight	1			
	stated any resident respiratory problem	v on 7/9/21, 2:07 p.m. RN-B with cardiovascular and/or ns related to fluid overload ing assessment and evaluation				

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED C	
		00286	D. WING	·····	07/	09/2021
IAME OF I	PROVIDER OR SUPPLIER		DDRESS, CITY, S			
ALLEY	VIEW HEALTHCARE	& REHAB	T CEDAR STR N, MN 55943	EEI		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 830	Continued From pa	ge 7	2 830			
	medical care provid significant or on-go condition. RN-B sta to assess weights, lung sounds on a re cardiopulmonary pr be done for R14. R in weight should be this could indicate a which might "lead to out of control." RN- significant weight c decrease of about 4 RN-B stated he was documentation in th assessment or eva related to edema of 2021. RN-B was ab checks, but no furth	nd nurses should report to the der if the person has a ing change in their weight or ited an expectation for nurses edema, vital signs, heart and egular basis for persons with roblems and said this should N-B also stated that increases e evaluated and reported as a problem with fluid overload to a lot of problems and spiral B gave a definition of hange of an increase or 5% in a three month period. Is unable to find nursing the nurses' notes of luation of R14's condition r weight gain since March ole to locate a list of edema ther evaluation or reporting.				
	stated a trained me brought it to their at residents were wea wondered if that inc stated she had initia improvement proje- said she thought sh prior to the survey,	dication aid (TMA) had ttention that quite a few iring tubi-grips and TMA dicated a problem. DON ated a performance ct on edema and fluids and he had started it about a week and this consisted of adding				
	person was receivin had not provided an nurses, but had pos should come to her said she wrote the checks for edema of done in the morning	ne nurses' tasks when a ng diuretics. She stated she n educational session for sted a sign and indicated they if they had questions. DON note in May. DON stated or fluid overload should be g when tubi-grips were applied on they were removed to				

	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
					С	
		00286	B. WING		07/	09/2021
IAME OF F	PROVIDER OR SUPPLIER		DRESS, CITY, S			
ALLEY	VIEW HEALTHCARE	& REHAB	T CEDAR STR N, MN 55943			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 830	Continued From pa	ige 8	2 830			
	a gentle but firm privite enough force to tissue when doing a edema. Anything left Facility provided the described dated 5/7 as follows: "Nurses- when cha when giving Lasix [please chart amount TMAs-please ask y when charting. In p tenderness, skin che evaluated. Pitting: to pitting and non-pitti described as an inde edematous area af determine the exter can push on the ski indention [sic] and to skin to rebound bac grade it on a scale swollen area with y an indentation in th non-pitting edema.	bected that nurses would apply essure for several seconds to indent/compress resident an assessment for pitting ess would not be sufficient. e education posting DON 19/21; the education in total is rting edema on residents diuretic] don't put yes or no- nt of edema Example 0 +1 +2 . your nurse to assess edema hysical examination pitting, hanges and temperature are there are two types of edema, ng edema. Pitting edema is dentation that remains in the ter pressure is applied. To nt of the pitting edema, you in, measure the depth of the record how long takes for your ck to its original position. Then from 1-2. If you press a our finger and it doesn't cause e skin, it's considered If you need additional asing edema please see me				
	4/15/21, and includ diagnosis of acute diagnosis included fluid overload, dem	entified a re-admission date of ed primary readmission diastolic heart failure. Other chronic systolic heart failure, entia with Lewy bodies, and				
		egular heart beat).				

	ta Department of He T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		ECONSTRUCTION	(X3) DATE SURVEY COMPLETED	
	OF CONNECTION	IDENTIFICATION NOMBER.	A. BUILDING:			
		00286	B. WING		C 07/09/2021	
IAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
ALLEY	VIEW HEALTHCARE	& REHAB	T CEDAR STR DN, MN 55943			
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF	CORRECTION (X5)	
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	THE APPROPRIATE DATE	
2 830	Continued From pa	age 9	2 830			
	assessment dated 2/2/21, identified R4 to have intact cognition. R4 required extensive assistance of two with transfers, and toileting, received antipsychotic medication daily over past seven days and no diuretic. Weight was recorded as 136 pounds with no weight gain or loss.					
	indicated a signification in last 30 days or 1	PS assessment dated 4/11/21, ant weight gain of >5% or more 0% or greater over past 6 as documented as 168	9			
	increased nutrition hospitalization for f history of moderate Goal included R4 v pound plus or minu dated 10/30/20, inc record intake of fo monitor and record	ed 10/30/20, included R4 is at risk related to recent fluid overload and CHF with e calorie/protein malnutrition. vill maintain weight at 150 us 5 pounds. Interventions cluded staff will monitor and od and fluid daily, and staff will weights at least weekly and provider (PCP) and family of changes.				
	(compression stock a.m., and off at bee 3/19/21 included w bath day and manu on Monday, Wedne	ted 3/11/21, included Tubigrips kings used for swelling) on dtime. Order written on eigh weekly in bath chair on ual blood pressure and pulse esday and Friday with special obtain blood pressure with e.				
	Review of R4's doc 1/8/2021 weighed 7 2/5/2021 weighed 7 2/19/21 weighed 1 3/12/2021 weighted epartment of Health	140.2 pounds. 53 pounds.				

STATEMEN	Ita Department of He NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00286	B. WING		C 07/09/2021	
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
/ALLEY	VIEW HEALTHCARE	& RFHAR	T CEDAR STR N, MN 55943	EET		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT) CROSS-REFERENCED TO T DEFICIENC'	ION SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
2 830	Continued From pa	age 10	2 830			
	4/7/2021 weighed ?	168.1 pounds.				
	Total weight gain w until 4/7/21.	as 40.4 pounds from 1/8/21				
	recent weight was is up from admit we This does represer	s note dated 1/19/21 included 131 pounds on 1/15/21, which eight of 124#'s on 10/28/20. It a 5.6% weight gain over the Il continue to monitor weight				
	visit was to follow-u and R4 has been o with blood pressure	s note dated 1/28/21 included up to elevated blood pressure n metoprolol 75 twice daily es as follows 156/84, 170/88, 9/81 and 160/74. Amlodipine d pressure.				
	discussion on blood all over the place. to decreased heart today of 131/55 but	s note dated 2/11/21 included d pressure and how they are Metoprolol was decreased due rates with blood pressures t others included 185/46, 1 164/53. Weight was present nds.				
	continue to review recorded as 138/63	s note dated 3/11/21 included of blood pressures which were 3, 160/62, 141/45, 150/55, 48/62. Weight was present as				
	indicated nursing re and resident is to w edema, size E. No	ated 3/11/21 at 10:32 a.m., eceived an order from therapy year bilateral Tubigrips for mention in progress notes rior to or after this note.				
	A provider progress	s note dated 3/25/21 included				

	NT OF DEFICIENCIES OF CORRECTION	Ealth (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING: _	CONSTRUCTION	COM	E SURVEY PLETED C
		00286	B. WING		07/09/2021	
AME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
ALLEY	VIEW HEALTHCARE	& REHAB	T CEDAR STR N, MN 55943	EET		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 830	Continued From pa	age 11	2 830			
	blood pressures be	lood pressures with some ing much lower at 136/75, 1 148/49. No mention of				
	indicated R4 was h children and contin children throughou	ited 4/10/21 at 6:10 a.m. aving hallucinations about ued to have thoughts about t shift and also told staff there r closet all day but they left				
	indicated resident of	ted 4/11/21 at 4:03 a.m. continued to talk to someone m and stated that there was a ⁷ .				
	indicated the reside hallucinations and VS: 168/99, HR 55 and temperature 9	tted 4/11/21 at 11:26 a.m. ent has been experiencing has not slept in over 24 hours. 5, pulse oximetry 84%, RR 24 7.1. On-call physician dent be transferred to ED, d and completed.				
	was present on mu run weekly from 11 Variance Report da indicated a 9.1% w	Variance Reports indicated R4 Iltiple weight variance reports /22/20 through 4/12/21. The ated 1/12/21 through 4/12/21 reight gain from 2/5/21 to and from 3/31/21 to 4/7/21 gain in 7 days.				
	February 2021 incl was 154, and 30 d weight change. Six for 15.8% change a 137 for 12.4% weight	e report dated 12/2020 through uded R4's most recent weight lays ago was 140 with 10% kty days ago weight was 133 and 90 days ago weight was ght gain. Findings included a lain over the past 30/90 days.				

STATEME	ta Department of He	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
	00286		B. WING			C 09/2021
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	TATE, ZIP CODE		
VALLEY	VIEW HEALTHCARE	& REHAB	CEDAR STR N, MN 55943	EET		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 830	Continued From pa	ge 12	2 830			
	Recommendations Resident does prefe	included diet order is general. er small portions. R4 has ie and protein malnutrition.				
	certified dietary mai weights were comp there is a significan nursing is notified. weight gain was sig was transferred to t trained medication about edema and h indicated she review comparison over th staff questions rega eating or may ask to CDM added the fan gain. The CDM ind any of the above no TMA-A and was un notified regarding R indicate she brough	7/9/21, at 1:01 p.m., the nager (CDM) indicated weekly leted on R4 and whenever t change, the director of The CDM did indicate this unificant and shortly before R4 the hospital, she spoke with aide (TMA)-A questioning her low she was eating. The CDM ws weekly weights and does a e past 3 months then may ask arding edema, how they are o have them re-weighed. nily also questioned the weight licated she did not document or the conversation with sure if registered dietician was R4's weight gain. The CDM did at reports multiple times to the etings (IDT) and shared those nursing.				
	indicated she does the CDM but had be to monitor. The DC present to not exce provider with a certa would be responsib symptoms like leg e this instance, the C communicated the or brought it up at II	7/9/21, 1:08 p.m., the DON receive a list of weights from een told that it is not her area DN indicated if orders are ed a certain weight or contact ain weight parameter, nursing le or if resident is having edema. The DON indicated in DM should have weight gain to the nursing staff DT meeting versus handing DON further indicated R4's				

STATEME	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00286	B. WING			C 09/2021
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S ⁻	TATE, ZIP CODE		
VALLEY	VIEW HEALTHCARE	& REHAR	T CEDAR STR)N, MN 55943	EET		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETI DATE
2 830	Continued From pa	age 13	2 830			
	questioned and rep someone.	ported to the provider by				
	indicated she was a the time of the hosp exact date but assu the weight. TMA-A of the conversation	7/9/21, at 1:16 p.m., TMA-A asked to reweigh R4 around pitalization but was unsure the umed something was off with indicated that was the extent and the CDM did not question ptoms of fluid overload.				
	registered nurse (R monitor weights tha weekly weights are dietary to monitor. provider orders incl	a 7/09/21, at 1:45 p.m., RN) -C indicated nursing staff at are completed daily but generally the responsibility of RN-C further indicated if lude weight parameters, ne one to contact the provider.				
	3:30 p.m., R4 indic working for her and that great of conditi R4 did not recall be edema or any brea months. R4 was si	and interview on 7/09/21, at ated the fluid pill has been I she was told her heart isn't in ion and she has heart failure. eing in the hospital, having thing difficulty in the past 6 itting in her wheelchair, on respirations and no pedal				
	primary care provid Did receive a call b (RN)-D on 7/9/21, a above weights show	vere made to contact R4's ler (PCP) without return call. ack from registered nurse at 2:39 p.m. who indicated the uld have been initially reported ight gain from January until				
	3:49 p.m., and rece	medical director 7/9/21, at eived a return call from , certified (PA-C) on 7/9/21, at				

	NT OF DEFICIENCIES OF CORRECTION	ealth (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED C			
	00286		B. WING			09/2021		
IAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE				
VALLEY VIEW HEALTHCARE & REHAB 510 EAST CEDAR STREET HOUSTON, MN 55943								
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE		
2 830	Continued From pa	age 14	2 830	DEFICIENC	Y)			
	specific parameters weight gain over 30 PA-C further indica associated with we breath or edema, it attention of the PCI weights should hav facility and the nurs significant weight g someone should hav An "After Visit Sum hospital indicated F	dicated she does not have s but generally a 10 pound 0 days would be significant. ted if any symptoms are ight gain such as shortness of should be brought to the P. PA-C indicated the above re been discussed by the ses made aware of the ain. PA-C further indicated ave to notified the PCP. mary" dated 4/15/21 from the R4 was hospitalized with acute re) Heart Failure 4/11/21						
	10/28/20 written by included: - All residents are to otherwise ordered linsure adequate nu by lab within norma body weight range supervisor or regist - Any resident with more pounds in 1 v done to determine - Significant weight days or 7.5% in 90 - The attending phy weight change and on physician round - Care plan will be to A policy related to r	a weight change of five (5) or veek will have a re-weight the accuracy of the change. change is defined as 5% in 30 days, or 10% in 180 days. vsician will be notified of the orders requested as indicated s or per fax. updated accordingly. monitoring edema or fluid						
	•	ested, but not provided. FHOD OF CORRECTION: The						

	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			TE SURVEY MPLETED
00286		B. WING		C 07/09/2021	
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE	
/ALLEY	VIEW HEALTHCARE	& REHAB	F CEDAR STE N, MN 55943		
(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) COMPLET DATE
2 830	interdisciplinary tea and compentency f monitoring of weigh then develop and in and staff complete could then develop ensure ongoing imp being performed by quality assurance p performance evalua	m could review staff education or residents who need nts and edema. The IDT could nplement a training program competency testing. The IDT and implement audits to olementation strategies are y staff as part the facilities program and ongoing staff	2 830		
2 895	Motion Subp. 2. Range of that is directed towa through positioning implemented and m comprehensive res of nursing services development of a n provides that: B. a resident wit receives appropriat increase range of m decrease in range of This MN Requireme by: Based on observati review, the facility factors	ent is not met as evidenced ion, interview and document ailed to ensure range of ices were offered and	2 895	2895 R19 completed reassessment by physica therapy on 7/28/21 for ROM exercises. A	

Minnesc	ta Department of He	alth			FORMA	PPROVED
STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE S COMPL	ETED
		00286	B. WING		C 07/09	9/2021
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
VALLEY	VIEW HEALTHCARE	X REHAR	CEDAR ST N, MN 5594			
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	ON	(X5)
PREFIX TAG		(MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)		COMPLETE DATE
2 895	Continued From pa	ge 16	2 895			
	reviewed for limited	l range of motion.		reassessed by physical therapies of compliance. Valley View Health		
	Findings include:			and Rehab Policy Range of motion Exercises has been viewed and u	n	
		ncluded diagnosis of		8/3/2021	paaroa	
		niparesis following cerebral left side, major depressive		Risk of reoccurrence will be minim	nized by	
	disorder, weakness			the Director of Nursing or Nursing designee initiating the following:		
	R19's quarterly Min	imum Data Set (MDS)		designee mitating the following.		
		6/21/21, included R19		1. All nursing staff will be educated		
		noderate cognitive impairment sive assist of two for bed		ROM exercises. All nursing staff w where to find instructions on each		
	mobility, toileting ar	nd transfers, and extensive		individual resident's plan of care.		
		or personal hygiene. The I R19 had functional limitations		staff who have not been schedule work prior to compliance date will		
		(ROM) in upper and lower		educated prior to their next sched shift.		
	care deficit in trans related to left sided R19 is non-ambula R19 will be encoura with activities and v needed, use of a B	dated 6/21/21, indicated a self fers, bed mobility, locomotion weakness, stroke and falls. tory. Interventions included aged to complete exercises vill use heat to his shoulder as roda chair to decrease to realign posture and	tionhave a ROM care plan will be a audited 2 times a week for 4 w time a week for 4 weeks then r audits as needed to concur exp being completed and being con correctly.ype3. Audits will be brought to the committee quarterly to discuss	2. Nursing staff working with resid have a ROM care plan will be rand audited 2 times a week for 4 week time a week for 4 weeks then rand audits as needed to concur exerci being completed and being compl correctly.	domly ks then 1 dom ses are	
	function, to enhanc overcome limitation of chair, and to prev	e my range of motion and is prohibited by a recline type vent contractures and ties, and staff will follow		3. Audits will be brought to the QA committee quarterly to discuss find the need for further auditing and/or staff training.	ding and	
<i>l</i> innesota D	2:15 p.m., R19 was room. R19's left ha was able to open hi upon request with f	and interview on 7/06/21, at sitting in Broda chair in his and was curled into a fist. R19 is fingers and wiggle them ourth digit remaining lowered an other fingers. R19 indicated				

STATEME	ta Department of He	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	COM	E SURVEY PLETED
	00286		B. WING			C 09/2021
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	TATE, ZIP CODE		
VALLEY	VIEW HEALTHCARE	& REHAB	CEDAR STR N, MN 55943	EET		
(X4) ID			ID	PROVIDER'S PLAN OF		(X5)
PREFIX TAG		YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	HE APPROPRIATE	COMPLET DATE
2 895	Continued From pa	ge 17	2 895			
		eat or exercise either of his ling "they don't do anything like				
	R19 is in the dining right hand. Left har curled into a fist. R move both arms an remained down and	on 7/07/21, at 12:25 p.m., room feeding himself with his nd was on arm of chair and 19 upon request was able to d all fingers except 4th digit less mobile than other digits. do not exercise has hands.				
	and signed by certif assistant (COTA)-A program to include minutes prior to ses passive range of m upper extremity, an free range as tolera is to decrease pain	Program sheet dated 9/11/20 fied occupational therapy a included R19 updated apply heat pack for 15 ssion, complete active and otion (AROM, PROM) to right d should do digits within pain ated 10 times and 2 sets. Goal , increase range of motion and of daily living participation.				
	4/20/21-7/7/21. Ou of motion was comp documented for not observed, unavailal	Nursing document dated it of 111 opportunities, range pleted 29 times. Reasons t performing included not ble, could not assess, no ed due to condition and one				
	COTA-B indicated I shoulder pain and in was cooperative with range of motion wa Heat would help loc be done with less d R19 did participate	7/08/21, at 9:11 a.m., R19 was treated for his ncluded his entire arm. R19 th heat stating it felt good and s done as he could tolerate. osen the joints so ROM could iscomfort. COTA-B indicated in therapy and would actively right hand on demand.				

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED C 07/09/2021	
		00286	B. WING			
NAME OF	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, ST	ATE, ZIP CODE		
ALLEY	VIEW HEALTHCARE	& REHAB	T CEDAR STRI N, MN 55943	ET		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE
2 895	COTA-B indicated s issues with his left h hand being any diffe with position or movindicated they can d the order includes a shoulder, arm and h During interview on assistant (NA)-A indo of the time and will exercises on the rig to work with him for included R19 does further indicated showith his left hand. During interview on director of nursing (staff do not know he the "Restorative Nu indicated the process few months with NA restorative aide the further indicated the paper prior but she no records that go p the "Restorative Nu During observation 11:01 a.m., R19 with heat on his right sho no, and they do not further indicated he but cooperated with arm and opening ar digit remained less	she did not remember any nand or the 4th digit on his left erent than his other fingers vement. COTA-B further only treat and evaluate what and for this one it was the right hand, not the left. 7/8/21, at 9:32 a.m., nursing dicated R19 refuses heat most participate in range of motion th side but requires someone him to complete it. NA-A refuse sometimes. NA-A e wasn't aware of any issues 7/8/21, at 10:56 a.m., the DON) stated apparently the ow to document refused on irsing". The DON further ss has changed over the past A performing versus a y had previously. The DON e process was documented on shredded them so there are past what is documented on rsing" record. and interview on 7/8/21. at hen asked if they offer to put oulder or arm and he stated do ROM with him either. R19 does not want heat applied, n moving both right and left hd closing both fists. Left 4th mobile and more curled n other digits. R19 at rest has				

AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING		(X3) DATE SURVEY COMPLETED C	
		00286			07/	09/2021
AME OF F	PROVIDER OR SUPPLIER			TATE, ZIP CODE		
ALLEY	VIEW HEALTHCARE	& REHAB	CEDAR STR I, MN 55943	EET		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC'	ION SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
2 895	Continued From pa	ge 19	2 895			
	indicated staff shou he refuses which sl agreed R19 would own with some prov During interview on indicated R19 will s own, but most of th NA-B indicated R19 will move both his a	7/9/21, at 8:24 a.m., the DON Id be documenting refused if the believes is happening but cooperate with ROM on his mpting by staff. 8/9/21 at 8:33 a.m., NA-B ometimes do ROM on his e time requires prompting. 9 generally cooperatives and arms and hands upon request. e of any issues with R19's left				
	undated included: - The purpose of th resident's joints and - Review the reside any special needs of - Be gentle with the procedure - If the resident beo pain, cease the exec staff/charge nurse. - Support the extreme exercised. - Move each joint the times unless otherw - Move each joint g through its range of	nt's care plan to assess for of the resident. resident and do not rush the comes weak, or complains of ercise and summon the mity at the joint as it is being nrough its range of motion 3 vise instruction ently, smoothly and slowly				
	director of nursing (inservice nursing st of the care plan to i	HOD OF CORRECTION: The (DON) or designee could aff regarding implementation nclude completing range of and then audit to ensure				

ONVZ11

If continuation sheet 20 of 22

WIIIIIIE30	ta Department of He	ealth	1		
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		L` ´COM	E SURVEY PLETED
			A. BUILDING	:	
00286		00286	B. WING		C 109/2021
NAME OF F	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY,	STATE, ZIP CODE	
		510 EAS	T CEDAR ST	REET	
VALLEY	VIEW HEALTHCARE	& REHAB HOUSTO	N, MN 5594	3	
(X4) ID			ID	PROVIDER'S PLAN OF CORRECTION	(X5) COMPLETE
PREFIX TAG		/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	DATE
2 895	Continued From pa	ge 20	2 895		
	TIME PERIOD FOF (21) days.	R CORRECTION: Twenty-one			
21600	MN Rule 4658.133 Emergency Supply	5 Subp. 2 Stock Medications;	21600		8/13/21
	nursing home may medication supply the QAA committee	cy medication supply. A have an emergency which must be approved by e. The contents, maintenance, ergency medication supply art 6800.6700.			
	by: Based on observati	ent is not met as evidenced on, interview and document ailed to ensure their system for		21600	
	medication reconcil timely identification	iation was adequate to ensure of loss or diversion of narcotic f 1 medication room		A 7/10/21 new systems are in place for loose leaf papers and verification process of EKIT and its tag verification. There is a Binder with pages that are numerically number and dated. Nursing	
	Findings include:			staff are to verify five tag system at each start of shift. This will be done by 2 staff	
	was reviewed with emergency kit (E-ki	a.m. the medication room registered nurse (RN)-A. The it) was behind a locked door room and a locked cupboard		members at the same time. Verifying page number, date and time of tag checks from their shift and the shift prior to them.	
	both opened with a included narcotic m	physical key. The E-kit edications and controlled		Valley View Healthcare and Rehab Policy E-Kit Medication and Reconciliation was	
	numbered lock tage	E-kit was secured with green s with an identifier number se leafed three ring binder		reviewed and updated on 8/3/2021. Risk of reoccurrence will be minimized by:	
	was placed next to container of additio	the E-kit along with a nal green numbered tags. ocumented the five tag		1) Director of Nursing or designee to do 12 week audits for 4 weeks to ensure proper procedure is being followed by nursing	
	identifiers at shift cl	nanges, and documented the in the loose leafed three ring		staff. Then biweekly for 1 month, then monthly until QA determines an end date.	

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00286	B. WING		C 07/09/2021
AME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY,	STATE, ZIP CODE	
ALLEY	VIEW HEALTHCARE	X REHAR	T CEDAR ST DN, MN 5594		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TION SHOULD BE COMPLET THE APPROPRIATE DATE
21600	binder next to the E would be no way of removed medicatio page from the three green numbered lo During interview on of nursing (DON) c for diversion with th system for the E-kit not say for sure the dates or verifying th changes. During interview on consultant pharmac potential for diversi- binder for verification Requested a copy of reconciliation policy receive one. SUGGESTED MET administrator, cons could review and re to include processes substances stored consultant pharmac random observation compliance.	E-kit. RN-A verified there knowing if someone had ns from the E-kit along with a ering binder and changed the ck tags. 7/7/21, at 10:29 a.m. director onfirmed there was a potential te loose leaf binder verification t. The DON indicated she can e staff are looking at previous ne numbers during shift 7/8/21, at 1:49 p.m. the cist indicated there could be a on using a loose leaf three ring on of green tag identifiers.		 2) All staff were educated next procedure and sign education. Any licensed seducated prior to their net to work. 3) Results of audits will b quarterly QA meetings to procedure is working or if updating. 	d in 7/9/21 to the off on the staff will be xt scheduled shift e brought to determine if