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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: ONVZ

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00286

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245566**

2.STATE VENDOR OR MEDICAID NO.
(L2) **844240100**

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

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **09/10/2021** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY **02** (L7)

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

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

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

10.THE FACILITY IS CERTIFIED AS:

A. In Compliance With
Program Requirements
Compliance Based On:
___1. Acceptable POC

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

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

* Code: **A*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

17. SURVEYOR SIGNATURE Date :
Jennifer Kolsrud Brown, Unit Supervisor 09/15/2021 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Melissa Poepping, Enforcement Specialist 09/15/2021 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
00131
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
08/30/2021
(L33)

DETERMINATION APPROVAL

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

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,

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

Protecting, Maintaining and Improving the Health of All Minnesotans

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,

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

Protecting, Maintaining and Improving the Health of All Minnesotans

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,

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 & MEDICAID SERVICES**

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: ONVZ

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Facility ID: 00286

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(L1) **245566**

2.STATE VENDOR OR MEDICAID NO.
(L2) **844240100**

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(L3) **VALLEY VIEW HEALTHCARE & REHAB**
(L4) **510 EAST CEDAR STREET**
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1. Initial	**2. Recertification**
3. Termination	**4. CHOW**
5. Validation	**6. Complaint**
7. On-Site Visit	**9. Other**
8. Full Survey After Complaint	

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY 08/24/2021 (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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From (a) :
To (b) :

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___1. Acceptable POC

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

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

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

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

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1861 (e) (1) or 1861 (j) (1): (L15)

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

17. SURVEYOR SIGNATURE Date :
Ruth Furan, HFE NE II 09/09/2021 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Melissa Poepping, Enforcement Specialist 09/14/2021 (L20)

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

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____ 2. Facility is not Eligible
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3. Both of the Above :
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22. ORIGINAL DATE OF PARTICIPATION
07/01/1991
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30)

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

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

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
00131
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

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

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.

- 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

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 Tamika.Brown@cms.hhs.gov.

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

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

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,

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245566	A. BUILDING _____ B. WING _____	R 08/24/2021

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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{E 000}	Initial Comments No Appendix Z, Emergency Preparedness Requirements for Long Term Care facilities, CFR §483.73, deficiencies were noted at the time of the standard recertification survey exited on 7/09/2021.	{E 000}		
{F 000}	INITIAL COMMENTS On 8/23/2021 and 8/24/2021, an offsite revisit was conducted to follow up on deficiencies issued related to a standard recertification survey exited on 7/9/2021. Your facility was NOT IN compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. The following tag was recited: (F698). The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.	{F 000}		
{F 698} SS=D	Dialysis CFR(s): 483.25(l) §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences.	{F 698}		9/1/21

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

Electronically 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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245566	A. BUILDING _____ B. WING _____	R 08/24/2021

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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 698}	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to ensure the dialysis access site was consistently monitored and assessed for 1 of 1 residents (R25) receiving hemodialysis. In addition, the facility failed to provide comprehensive dialysis care plan to reflect frequency and time periods for completing pre-and post-dialysis assessments, or standards for nursing documentation to include clarity on coordination of care with the dialysis center. Findings include: According to R25's electronic health record (EHR) facesheet, R25 had the following diagnosis: Dependence on renal dialysis with end stage renal disease According to R25's EHR care plan, an intervention dated 07/08/21, "check my port for any unusual redness, swelling temperature greater than 100.5 F or 38 C or other problems, contact dialysis unit immediately." The intervention failed to include a frequency for this nursing assessment. On 07/08/21 an intervention was added to R25's care plan directing nurses how to contact the dialysis unit if they had questions about R25's port or where to send him in the case of a medical emergency. This intervention indicated this activity would be listed on R25's treatment administration record (TAR) for all three shifts to document, days, evenings and nights. According to R25's physician orders, dated	{F 698}	On August 25, 2021, written communication was given to floor nurses and TMAS to read and sign to acknowledge. The communication document stated the following: We must communicate with the dialysis unit every day that R25 goes to dialysis. A communication book was developed back in July to be sent with R25, and this had not been utilized. There are new orders in the MAR that need to be signed off and completed each dialysis day. The communication book will go out with R25 with the condition he leaves in, and when he returns the TMA/nurse will read the book and document in progress notes what was communicated. It was also added to MAR that the nurse on the day and evening shift are to evaluate port and document that this was completed. Dialysis unit was called and notified on 8/24/2021 that R25 was diagnosed with pneumonia, they were also notified on this day that R25 is considering ending dialysis, and that VV social worker would inform them of specific date. Dialysis notified on 8/24/21 by VV social worker to confirm the ending date of dialysis. Resident (R25) has ended dialysis as of 8/30/2021 and has returned to his private	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245566	A. BUILDING _____ B. WING _____	R 08/24/2021

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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 698}	Continued From page 2 3/23/21 directed nurses to check R25's port (central venous access site for dialysis) once a day between 6:30 a.m. and 10:30 a.m. On 07/08/2021 an additional intervention was added the R25's care plan providing information on what to do if there was bleeding from R25's port, and this also was listed as being on the TAR for documentation for all three shifts. Two previous interventions, both dated 3/23/21 remained on R25's care plan. One indicated "I have a Central Venous Catheter port on my upper right chest for dialysis, report changes to dialysis team" and showed this was to be marked on the TAR twice a day between 6:30 a.m. and 10:30 a.m. and also between 7:00 p.m. and 10:30 p.m. The second intervention also dated 3/23/2021 indicated the nurses should assess the port for signs and symptoms of infection every shift and report changes to the dialysis team. This was to be marked on the TAR. According to R25's medication administration record (MAR) for 08/1/2021 thru 08/16/2021, the physician's order for monitoring the port daily was not completed two times because he had already left the building (dialysis days) and five times the MAR indicated the assessment was not completed within the ordered time frame. A request was made for R25's TAR, but the facility did not provide this. According to R25's EHR progress notes from 8/13/2021 through 8/20/21, two episodes of documentation on R25's port were seen. In addition, the progress notes indicated that R25	{F 698}	home with family and hospice. Valley View at this time had no residents receiving dialysis. If Valley View were to experience another resident receiving dialysis treatment the following would be implemented immediately upon admission. 1.Memorandum of Understanding from the dialysis team. This would be placed in residents paper chart and scanned in to Matrix. 2.The care plan would be correct and updated and would be accurate to what the dialysis team sets forth. 3.The dialysis team phone number will be posted at the nurse’s station, and in the resident’s chart. 4.There would be an accurate order on how, and when to check the port or fistula site. What to document when inspecting. 5.There would be a set way of communication between the dialysis unit and Valley View. At this time it would be a communication book that would be transferred back and forth. 6.DON or designee would audit communication book weekly to ensure that it is being utilized. This audit will be brought forth to the QA/QAPI team.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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{F 698}	Continued From page 3 developed symptoms of a respiratory infection starting 8/16/2021 and on 8/17/2021 was diagnosed with pneumonia. No documentation indicating the dialysis unit was advised of R25's change in condition. According to an interview with the director of nursing (DON) on 08/24/2021, at 10:36 a.m. DON stated an expectation for nurses to monitor and document on R25's dialysis port twice daily, during the day shift and the evening shift. DON stated this was to be documented in the MAR and TAR. DON stated she also had not had expectations for nurses to document assessments in the progress notes, but as of 08/23/2021 she had changed her mind and would be asking the nurses to do a daily note. DON said it was important for all entities, the dialysis unit, the facility and the resident to communicate about changes in condition. DON also said the facility sent a copy of R25's MAR with him to all dialysis appointments and believed it to be adequate communication since the dialysis care team could access the medical provider's notes on R25 if they saw him when they made rounds at the facility. DON said the facility had initiated a spiral bound communication book for R25 to carry to and from dialysis so the facility and the dialysis care team could share information, but said, "there is like only one note, we haven't had concerns about his condition." Alternately, DON stated an expectation for nurses to communicate a change in condition to the dialysis care team and to document that communication in the EHR. DON confirmed that no such communication had been documented when R25 was diagnosed with pneumonia. DON also stated R25 had recently	{F 698}	7.DON or designee would audit care plan weekly x 3 weeks then monthly and results would be brought forth to the QA/ QAPI quarterly meetings. 8.There would be education given by the DON or designee to all nursing staff on the care plan that the resident would need to have the safe quality of life they would deserve. Education would also be give on all the above information.	

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{F 698}	Continued From page 4 decided to stop dialysis and to return to his home for end-of-life care with hospice, but DON was unsure of any specific date. R25's EHR progress notes between 8/01/2021 and 08/16/21 did not include any information about stopping dialysis treatment, discharge planning or a referral to hospice care. Notes provided from an 8/19/2021 interdisciplinary team meeting at the facility failed to show any discussion related to R25's pneumonia or decision to stop dialysis. During a phone interview 8/24/21, 2:03 p.m. a registered nurse (RN-A) from R25's dialysis care unit stated an expectation for any facility to call the unit whenever a dialysis patient has a change of condition. RN-A said the dialysis unit had their own medical notes and they could access other notes from outside their own, but they would not do so unless they had been advised of a change in condition. RN-A said the dialysis unit would check R25's vital signs (VS) but stated the facility should send information on VS and anything else outside the patient's normal, even a change in skin condition. RN-A said a list of medication would not be adequate information to describe R25's current condition or any changes. RN-A further stated that when a facility provides information about a patient's condition it helps the dialysis nurse know to watch for any problems that may be further exacerbated by dialysis, such as significant changes in blood pressure. Following a dialysis run, RN-A said the patient is most likely to develop problems within the first few hours and stated it is good practice for a facility to do a set of VS immediately upon return,	{F 698}		

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{F 698}	Continued From page 5 and to monitor for adverse events for several hours. Symptoms of problems that might be noted could be nausea, vomiting, muscle cramping, change in cognition or a swing in blood pressure. RN-A stated he was not aware that R25 had been diagnosed with pneumonia earlier in the month and did not recall any communication from the facility regarding an infection. RN-A stated this was information that should have been reported to the dialysis care team. According to the facility Administrator during a phone interview 8/24/21, 2:41 p.m. communication between the facility and contracted care entities needed to go both ways, stating "if we have relevant issues we would communicate to them and vice versa." The Administrator said that in the case of dialysis, facility nurses should communicate anything that is relevant that might affect the care the resident receives at dialysis. Administrator also said that documentation should be as timely as possible, saying, "I would hope they would document right away," indicating that other persons who provide care rely on that information.	{F 698}		

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: ONVZ

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00286

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245566**

2.STATE VENDOR OR MEDICAID NO.
(L2) **844240100**

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **07/09/2021** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

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

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

10.THE FACILITY IS CERTIFIED AS:

A. In Compliance With Program Requirements Compliance Based On:
___1. Acceptable POC

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

17. SURVEYOR SIGNATURE Date :
Kathy Hahn, HFE NE II 08/13/2021 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Melissa Poepping, Enforcement Specialist 08/27/2021 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
00131
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

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 only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the 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.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245566	A. BUILDING _____ B. WING _____	C 07/09/2021

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E 000	Initial Comments A survey with CMS Appendix Z Emergency Preparedness Requirements was conducted on 7/09/2021, during a recertification survey. The facility was found to be in compliance with the Appendix Z Emergency Preparedness Requirements. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	E 000		
F 000	INITIAL COMMENTS On 7/6/2021-7/9/2021, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was found to be NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were found to be SUBSTANTIATED , H5566014C (MN00062490),H5566016C (MN00074068),H5566017C (MN00060276) H5566013C (MN00062640) and H5566018C (MN00067177), NO deficiencies were cited due to actions implemented by the facility prior to survey: AND The following complaints were found to be UNSUBSTANTIATED: H5566012C (MN00062109)	F 000		

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

Electronically Signed | 08/04/2021

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F 000	Continued From page 1 The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.	F 000		
F 658 SS=E	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation and interview the facility failed to ensure staff followed professional standards of practice of medication administration for 6 of 12 residents (R19, R13, R288, R7, R289, and R286) observed during medication pass. Additionally, the facility failed to ensure staff were properly assessing appropriate placement of a gastronomy tube (G-tube) (a tube inserted through the abdomen delivering nutrition directly into the stomach) per policy before administration of nutrition to 1 of 1 resident (R1) with a G-tube. Findings include: R288's Face Sheet indicated R288 was admitted	F 658	F658 Valley View Healthcare & Rehab's following policies titled Administering Medications and Enteral Tube Feeding via Continuous Pump were reviewed on 08/03/2021. 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 competency of the above.	8/13/21

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F 658	Continued From page 2 to the facility with a principle diagnosis of fracture of left acetabulum (break in the socket portion of the "ball-and-socket" hip joint), long term current use of anticoagulants and glaucoma. R7's Face Sheet indicated R7 was admitted to the facility with a principle diagnosis of muscle weakness and congestive heart failure. On 7/6/21, at 4:45 p.m., licensed practical nurse (LPN)-A was administering medications to residents after they arrived to the dining room for evening meal. LPN-A entered the dining room with 2 medicine cups of medication and administered one medicine cup to R7 and the second medicine cup to R288 who were seated at the same table. Review of medications indicated R7 was administered acetaminophen 650 mg tablet and metoprolol succinate extended release 100 mg tablet and R288 was administered warfarin 1 mg tablet, The medication cups did not have any identifiers for resident name or medications present. R19's Face Sheet indicated R19 was admitted to the facility with a principle diagnosis of hemiplegia (severe of complete loss of strength or paralysis on one side of the body) and hemiparesis (partial weakness or loss of strength on one side of the body) following cerebral infarction (injury to parts of the brain that control movement, resulting in inability to control voluntary movement of group of muscles) affecting left non-dominate side. R13's Face Sheet indicated R13 was admitted to the facility with a principle diagnosis of non-traumatic intracerebral hemorrhage (bleeding within the brain).	F 658	All licensed staff and TMAs will receive an education course on medication administration through Educare and are required to have it completed by 08/08/2021. Risk of re-occurrence will be minimized by the Director of Nursing or designee initiating the following: 1)All licensed staff and TMAs will be educated on the facility policy Administering Medications prior to our compliance date. Education included that the individual administering the medication checks the label against the EMAR 3 times to verify the right resident, right medication, right dosage, right time and right route of administration before giving the medication. Education on the policy was initiated on 08/03/21. On-call staff who have not been scheduled to work prior to our compliance date will be educated prior to their next scheduled shift. All licensed staff will be educated on the facility policy Enteral Tube Feeding via Continuous Pump prior to our compliance date. Education will include checking for appropriate placement of G tube and flushing of the G-tube. Education on the policy was initiated on 08/03/2021. On-call staff who have not been scheduled to work prior to our compliance date will be educated prior to their next scheduled shift. 2)10 medication pass audits will be completed monthly x3 months to ensure Licensed Staff and TMAs are following the	

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F 658	Continued From page 3 During observation on 7/6/21, at 5:05 p.m., LPN-A arrived into the dining room with 2 medicine cups of medication and administered one medicine cup to R19 and observed R19 take them. LPN-A then set down the medication cup next to R13 who was at the same table, and walked away. Neither medicine cup had a resident identifier or medication name present. Review of medications administered included R13 received Vitamin C (Ascorbic Acid) 500 mg tablet, and R19 received Tylenol 500 mg tablets 2 tablets, atrovastatin 40 mg tablet, Depakote 500 mg tablet, Metformin 1000 mg tablet, and metoprolol tartrate tablet 50 mg tablet. During interview on 7/6/21, at 5:10 p.m., LPN-A indicated she did set up and administer R288 and R7's medications and R18 and R13's medications at the same time. LPN-A was able to identify the medications administered and when asked if setting up and administering 2 separate residents at the same time is standard of practice she stated "no my bad, I shouldn't have done that." During medication administration on 7/6/21, at 5:30 p.m., LPN-A had electronic medication administration record (EMAR) for R286 on the computer screen. Two medications were visible that included Novolog (insulin) 100 units/ml to give 8 units and warfarin (blood thinner) 4 mg 1 tablet orally. LPN-A indicated she had previously set up the insulin dose and had it pre-checked with another nurse and showed 8 units was preset on the insulin pen injector. LPN-A placed warfarin 4 mg in a medicine cup. LPN-A then placed metformin 1000 mg tablet into the medication cup. When asked how LPN-A knew he was to receive metformin 1000 mg, since it	F 658	Administering Medications policy and procedure. 3 licensed staff will be audited monthly x3 months to ensure they are following the Enteral Tube Feeding via continuous Pump Policy and Procedure. Audits will be ongoing until reviewed at QA and a determination is made that they are no longer necessary. 3)Audits will be brought to the QA committee quarterly to discuss findings and need for further auditing and/or additional staff training.	

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F 658	Continued From page 4	F 658		

was not visible on the computer screen, LPN-A indicated she knows what he gets as she has given it the last 2-3 nights. LPN-A administered medications to R286 and returned to the medication cart. LPN-A opened R289's EMAR and viewed vancomycin 125 mg 1 capsule four times a day orally for 10 days. LPN-A pulled the Vancomycin medication card 125 mg and placed medicine in cup and administered to R289. When questioned if she verified the correct medication and dosage to the EMAR on the medications she administered, LPN-A indicated she looked at the EMAR prior to sitting down but did not verify the medication, or dosage pulled from the cart with the EMAR order.

R1

R1's Face Sheet printed 7/8/21 included primary diagnosis of esophageal obstruction, gastro-esophageal reflux disease with esophagitis without bleeding.

R1's quarterly Minimum Data Set (MDS) dated 3/30/21, indicated R1 was cognitively intact, and received 51% or greater of calories from tube feeding.

R1's Physician's Orders dated 6/15/21, included check placement of G-tube every shift, Nutren 1.5 liquid; 0.07 gram-1.5 kcal/ml at 75 milliliters (ml's) per hour giving 1200 ml's total from 6:00 p.m. until 8:00 a.m. and flush G-tube with 120 ml of water every 4 hours.

During observation and interview on 7/6/21, at 6:05 p.m., LPN-A retrieved 5 cartons of Nutren 1.5 kcal/ml, 240 ml's per carton from refrigerator and placed on the medication cart. The computer

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screen was black and LPN-A confirmed the battery was dead on the computer. LPN-A entered R1's room, and using tap water flushed the g-tube with 60 ml's of water. LPN-A then filled a new infusion bag with the 5 cartons of Nutren 1.5 kcal/ml. When questioned how she knows to flush with 60 ml's of water and the amount of Nutren to give and at what rate, she stated she just knows. LPN-A then primed the tubing on the pump, connected to R1's g-tube and set the pump to run at 75 ml/hour and left the room. The administration pump hung on a pole with a stethoscope hanging on the top. LPN-A indicated she did not check placement of the g-tube and did not look at the medication administration record (MAR) prior to administration of the water or Nutren stating she knows she is supposed to, but the computer died and she has done this many times and knows what to give and how to do it.

A review of LPN-A competencies included medication administration monitoring was completed 3/1/21 with identification of resident, medication, dosage, route, time, including order verification in EMAR was satisfactory completed. A competency on Enteral Nutritional therapy was last satisfactorily completed on 1/19/13 that included checking position of the tube by listening for breath sounds at end of tube...Place stethoscope over stomach and instill a small amount of air into enteral feeding tube and listen for air to enter the stomach.

During interview on 7/09/21, at 8:20 a.m., the director of nursing (DON) confirmed the same process is followed for tube feedings as for medication administration and should be verified with the EMAR prior to administration as this is

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F 658	Continued From page 6 part of the five rights of medication administration., and includes tube feeding solutions and water flushes of g-tubes. The DON also confirmed, medications should not be set up and administered for 2 residents at the same time but should be done one person at a time. The DON indicated if a computer battery was dead, it should have been plugged in or a new cart retrieved to verify the tube feeding instructions with physician orders prior to administration. A policy titled "Administering Medications" dated 4/2019 included: - The individual administering the medication checks the label THREE (3) times to verify the right resident, right medication, right dosage, right time and right method (route) of administration before giving the medication. A policy titled, Enteral Tube Feeding via Continuous Pump, dated 11/2018 included: - Verify that there is a physician's order for this procedure. - Check the enteral nutrition label against the order before administration checking the following information: - Resident name, ID and room number; - Type of formula; - Date and time formula was prepared - Route of deliver - Access site - Method (pump, gravity, syringe): and - Rate of administration - Verify placement of tube and once correct tube placement has been verified, flush tubing with at least 30 ml's of warm water or prescribed amount.	F 658		
F 684 SS=D	Quality of Care	F 684		8/13/21

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F 684	Continued From page 7 CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to consistently assess and monitor increasing weight, and edema to the lower extremities for 2 of 2 resident (R14, R4) reviewed for edema and hospitalizations. Findings include: According to the facility electronic health record (EHR) face sheet, R14 had a diagnosis of primary hypertension (high blood pressure), acute respiratory failure with hypoxia (history of inadequate respiratory function leading to low oxygen levels) and pleural effusion (history of fluid in the lungs a complication that may be related to cardiac, renal or infectious problems). R14's Care Plan indicated a care problem of Nutritional status: I am at increased nutrition risk related to advanced age, adult failure to thrive, and moderate protein calorie malnutrition for R14, with a start date of 11/21/20. Corresponding care approaches included providing a general diet with 4 ounces of nutritional supplement three times daily for extra nutrition, monitoring intake of food and fluid daily and monitoring and recording	F 684	F684 R14 and R4 will have an assessment completed by RD by 08/05/2021 on current weight status. R14 and R4 will have a fluid assessment completed by an RN by 08/04/2021. Both of these assessments will be communicated to the primary provider with documentation of such and any new interventions/orders as appropriate. All current residents in the facility will have their weights assessed by the CDM or designee and any resident flagging for significant change in weight per policy will be communicated with primary provider. This will be completed by date of compliance. Valley View Healthcare & Rehab Policy Weight Change was reviewed and updated on 08/04/2021. Risk of re-occurrence will be minimized by the Certified Dietary Manager or designee initiating the following:	

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F 684	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 tissues). According to a physician's progress note by a medical doctor (MD-A) dated 1/20/21, R14 was being seen for a routine visit post-hospitalization (11/3/20) for acute respiratory failure related to pulmonary edema (fluid accumulation in the tissue of the lungs) which required diuresis (the provision of medications to enhance renal function to remove fluid overload). The note indicated nursing staff had no concerns for R14 at that time. MD-A indicated that heart rate was regular and lungs were clear, but chronic edema was noted in the lower extremities. According to progress note by PA-C dated 3/9/21, R14 had 3+ edema (edema of significant severity where pressing on the tissue for several seconds will result in an indentation of 4-6mm (millimeters) that lasts for a minute or more) of both lower legs and R14 was not wearing any tubi-grips (a knitted compression hose). A progress note date 3/16/21 by PA-C indicated R14 had slight edema and nursing staff should monitor and notify of any changes or decompensation in R14's condition. Additional progress notes by medical providers after March of 2021 were requested but not provided. According to a nutrition note written by a certified dietary manager (CDM) in the EHR dated	F 684	1)All licensed staff will be educated on the facility policy Valley View Healthcare & Rehab Weight Change Policy prior to our compliance date. On-call staff who have not been scheduled to work prior to our compliance date will be educated prior to their next scheduled shift. RD will be educated on Valley View Healthcare & Rehab Policy Weight Change policy and procedure. 2)All residents with significant weight changes will be audited monthly x 3 months to ensure the policy is followed. The audit will be ongoing until reviewed at QA and a determination is made that they are no longer necessary. 3)Audits will be brought to the QA committee quarterly to discuss findings and need for further auditing and/or additional staff training.	

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5/12/2021:
"Diet order is general, cut up foods. Resident does prefer to eat meals in her room. Resident reports appetite is good. Resident does consume 50-100% of food on most meal trays. Offering 4 oz nutrition supplement TID with meals for extra nutrition. Resident does like this and wishes to continue having supplement. Recent weight was 141# on 5/11/21. Weight has increased since admission. Weight on admission was 115# on 11/12/20, this does represent a 22.6% weight gain over the past 6 months. Will continue to monitor weight and oral intake."

According to R14's EHR weight record, R14 weighed:
115 pound (lbs) on 11/12/20
121 lbs on 12/09/20
130.3 lbs on 1/13/21
133.2 lbs on 2/16/21
135.2 lbs on 3/9/21
135.4 lbs on 4/20/21
140.5 lbs on 5/11/21
142.9 lbs on 6/22/21
145.1 lbs on 7/6/21

During an observation on 7/6/21, at 2:50 p.m. R14 was sitting in her recliner in her room with her feet dependent (hanging down) and she had visual swelling of both feet, but no compression stockings or tubi-grip observed.

On 7/07/21, 11:25 a.m. R14 was observed in her recliner in room, legs dependent and legs visually swollen and tubi-grip compression were on.

On 7/08/21, 9:25 a.m. R14 was observed in her recliner napping with legs dependent and visually swollen and tubi-grip compression were on.

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During an observation 7/09/21, 2:04 p.m. registered nurse (RN-C) demonstrated personal technique for checking edema. R14 was sitting in recliner with feet elevated, wearing tubi-grip. The compression tube on the right lower extremity had moved. The lower portion of the right foot was ballooned up to approximately twice the size of the portion that was compressed by the hose. RN-C stated, "well, that doesn't look like it was put on right." RN-C then checked for edema by quickly touching the puffy portion of the right foot without pressure. RN-C stated a firm touch to compress the tissue was not necessary to check for edema. RN-C also stated that persons receiving diuretics should have edema checks done daily and documented in the medication administration record.

During an interview 7/09/21, 1:08 PM the Director of Nursing (DON) stated she receives a list of weights from the CDM and the CDM is responsible to monitor the resident weights unless there are specific orders for nurses to be sure weights do not go over a defined limit, such as when someone has edema. DON did say that nurses should notice if there are changes in weights, but that the CDM should be bringing up any significant changes in weight at the interdisciplinary team meetings. DON state, "I was told that is not my area to monitor and this (weight increase) should have been caught." DON also said the nursing assistants enter the resident weights into the EHR, but they are unable to see what a previous weight had been so cannot report a change in weight.

During an interview 7/09/21, 1:55 p.m. CDM stated she did not have documentation that she

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had reported or discussed R14's 22% weight gain with the registered dietician (RD). She sated she was unable to find any documentation that the RD had reviewed or assessed R14, and she was unsure when she should report to the RD. She said she did not document conversations she had with the RD. CDM did state that R14 liked her dietary supplement and had discussed continuing them with the nursing team, but did not recall telling the nursing department about the weight change.

During an interview on 7/9/21, 2:07 p.m. RN-B stated any resident with cardiovascular and/or respiratory problems related to fluid overload should have on-going assessment and evaluation of their condition, and nurses should report to the medical care provider if the person has a significant or on-going change in their weight or condition. RN-B stated an expectation for nurses to assess weights, edema, vital signs, heart and lung sounds on a regular basis for persons with cardiopulmonary problems and said this should be done for R14. RN-B also stated that increases in weight should be evaluated and reported as this could indicate a problem with fluid overload which might "lead to a lot of problems and spiral out of control." RN-B gave a definition of significant weight change of an increase or decrease of about 5% in a three month period. RN-B stated he was unable to find nursing documentation in the nurses' notes of assessment or evaluation of R14's condition related to edema or weight gain since March 2021. RN-B was able to locate a list of edema checks, but no further evaluation or reporting.

During an interview 7/09/21, 3:03 p.m. DON stated a trained medication aid (TMA) had

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brought it to their attention that quite a few residents were wearing tubi-grips and TMA wondered if that indicated a problem. DON stated she had initiated a performance improvement project on edema and fluids and said she thought she had started it about a week prior to the survey, and this consisted of adding edema checks to the nurses' tasks when a person was receiving diuretics. She stated she had not provided an educational session for nurses, but had posted a sign and indicated they should come to her if they had questions. DON said she wrote the note in May. DON stated checks for edema or fluid overload should be done in the morning when tubi-grips were applied and then again when they were removed to determine effectiveness of the treatment. DON also said it was expected that nurses would apply a gentle but firm pressure for several seconds with enough force to indent/compress resident tissue when doing an assessment for pitting edema. Anything less would not be sufficient.

Facility provided the education posting DON described dated 5/19/21; the education in total is as follows:
"Nurses- when charting edema on residents when giving Lasix [diuretic] don't put yes or no- please chart amount of edema Example 0 +1 +2 . TMAs-please ask your nurse to assess edema when charting. In physical examination pitting, tenderness, skin changes and temperature are evaluated. Pitting: there are two types of edema, pitting and non-pitting edema. Pitting edema is described as an indentation that remains in the edematous area after pressure is applied. To determine the extent of the pitting edema, you can push on the skin, measure the depth of the indention [sic] and record how long takes for your

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skin to rebound back to its original position. Then grade it on a scale from 1-2. If you press a swollen area with your finger and it doesn't cause an indentation in the skin, it's considered non-pitting edema. If you need additional education on assessing edema please see me (DON)."

A policy related to monitoring edema or fluid overload was requested, but not provided.

R4
R4's face sheet identified a re-admission date of 4/15/21, and included primary readmission diagnosis of acute diastolic heart failure. Other diagnosis included chronic systolic heart failure, fluid overload, dementia with Lewy bodies, and atrial fibrillation (irregular heart beat).

R4's quarterly Minimum Data Set (MDS) 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.

R4's discharge MDS assessment dated 4/11/21, indicated a significant weight gain of >5% or more in last 30 days or 10% or greater over past 6 months. Weight was documented as 168 pounds.

R4's care plan dated 10/30/20, included R4 is at increased nutrition risk related to recent hospitalization for fluid overload and CHF with

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history of moderate calorie/protein malnutrition. Goal included R4 will maintain weight at 150 pound plus or minus 5 pounds. Interventions dated 10/30/20, included staff will monitor and record intake of food and fluid daily, and staff will monitor and record weights at least weekly and notify primary care provider (PCP) and family of significant weight changes.

Provider orders dated 3/11/21, included Tubigrips (compression stockings used for swelling) on a.m., and off at bedtime. Order written on 3/19/21 included weigh weekly in bath chair on bath day and manual blood pressure and pulse on Monday, Wednesday and Friday with special instructions to not obtain blood pressure with automatic machine.

Review of R4's documented weights indicated:
1/8/2021 weighed 127.2 pounds.
2/5/2021 weighed 140.2 pounds.
2/19/21 weighed 153 pounds.
3/12/2021 weighted 156.5 pounds.
4/7/2021 weighed 168.1 pounds.

Total weight gain was 40.4 pounds from 1/8/21 until 4/7/21.

A nutrition progress note dated 1/19/21 included recent weight was 131 pounds on 1/15/21, which is up from admit weight of 124#'s on 10/28/20. This does represent a 5.6% weight gain over the past 3 months. Will continue to monitor weight and oral intake.

A provider progress note dated 1/28/21 included visit was to follow-up to elevated blood pressure and R4 has been on metoprolol 75 twice daily with blood pressures as follows 156/84, 170/88,

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148/54, 184/78, 199/81 and 160/74. Amlodipine was added for blood pressure.

A provider progress note dated 2/11/21 included discussion on blood pressure and how they are all over the place. Metoprolol was decreased due to decreased heart rates with blood pressures today of 131/55 but others included 185/46, 145/64, 152/93 and 164/53. Weight was present in note as 140 pounds.

A provider progress note dated 3/11/21 included continue to review of blood pressures which were recorded as 138/63, 160/62, 141/45, 150/55, 175/48 and today 148/62. Weight was present as 156.7 pounds.

A nurse progress dated 3/11/21 at 10:32 a.m., indicated nursing received an order from therapy and resident is to wear bilateral Tubigrips for edema, size E. No mention in progress notes regarding edema prior to or after this note.

A provider progress note dated 3/25/21 included a follow up of her blood pressures with some blood pressures being much lower at 136/75, 149/49, 151/62 and 148/49. No mention of weight present.

A progress note dated 4/10/21 at 6:10 a.m. indicated R4 was having hallucinations about children and continued to have thoughts about children throughout shift and also told staff there was two men in her closet all day but they left now.

A progress note dated 4/11/21 at 4:03 a.m. indicated resident continued to talk to someone who was in the room and stated that there was a

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girl there she knew.

A progress note dated 4/11/21 at 11:26 a.m. indicated the resident has been experiencing hallucinations and has not slept in over 24 hours. VS: 168/99, HR 55, pulse oximetry 84%, RR 24 and temperature 97.1. On-call physician recommended resident be transferred to ED, which was arranged and completed.

Review of Weight Variance Reports indicated R4 was present on multiple weight variance reports run weekly from 11/22/20 through 4/12/21. The Variance Report dated 1/12/21 through 4/12/21 indicated a 9.1% weight gain from 2/5/21 to 2/19/21 in 14 days, and from 3/31/21 to 4/7/21 was a 7.4% weight gain in 7 days.

A quality assurance report dated 12/2020 through February 2021 included R4's most recent weight was 154, and 30 days ago was 140 with 10% weight change. Sixty days ago weight was 133 for 15.8% change and 90 days ago weight was 137 for 12.4% weight gain. Findings included a significant weight gain over the past 30/90 days. Recommendations included diet order is general. Resident does prefer small portions. R4 has history of mal calorie and protein malnutrition. Staff reports she eats well.

During interview on 7/9/21, at 1:01 p.m., the certified dietary manager (CDM) indicated weekly weights were completed on R4 and whenever there is a significant change, the director of nursing is notified. The CDM did indicate this weight gain was significant and shortly before R4 was transferred to the hospital, she spoke with trained medication aide (TMA)-A questioning her about edema and how she was eating. The CDM

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indicated she reviews weekly weights and does a comparison over the past 3 months then may ask staff questions regarding edema, how they are eating or may ask to have them re-weighed. CDM added the family also questioned the weight gain. The CDM indicated she did not document any of the above nor the conversation with TMA-A and was unsure if registered dietician was notified regarding R4's weight gain. The CDM did indicate she brought reports multiple times to the interdisciplinary meetings (IDT) and shared those with the director of nursing.

During interview on 7/9/21, 1:08 p.m., the DON indicated she does receive a list of weights from the CDM but had been told that it is not her area to monitor. The DON indicated if orders are present to not exceed a certain weight or contact provider with a certain weight parameter, nursing would be responsible or if resident is having symptoms like leg edema. The DON indicated in this instance, the CDM should have communicated the weight gain to the nursing staff or brought it up at IDT meeting versus handing her a report. The DON further indicated R4's significant weight gain should have been questioned and reported to the provider by someone.

During interview on 7/9/21, at 1:16 p.m., TMA-A indicated she was asked to reweigh R4 around the time of the hospitalization but was unsure the exact date but assumed something was off with the weight. TMA-A indicated that was the extent of the conversation and the CDM did not question her regarding symptoms of fluid overload.

During interview on 7/09/21, at 1:45 p.m., registered nurse (RN) -C indicated nursing staff

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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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F 684	Continued From page 19 An "After Visit Summary" dated 4/15/21 from the hospital indicated R4 was hospitalized with acute diastolic (congestive) Heart Failure 4/11/21 through 4/15/21. A policy titled "Weight Change" last updated 10/28/20 written by Nutrition Services Director included: - All residents are to be weighed weekly, unless otherwise ordered by their attending physician to insure adequate nutritional status as evidenced by lab within normal limits and weight within ideal body weight range as determined by the dietary supervisor or registered dietitian. - Any resident with a weight change of five (5) or more pounds in 1 week will have a re-weight done to determine the accuracy of the change. - Significant weight change is defined as 5% in 30 days or 7.5% in 90 days, or 10% in 180 days. - The attending physician will be notified of the weight change and orders requested as indicated on physician rounds or per fax. - Care plan will be updated accordingly.	F 684		
F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion.	F 688		8/13/21

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F 688	Continued From page 20 §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure range of motion (ROM) services were offered and provided according to the therapy recommendations for 1 of 2 resident (R19) reviewed for limited range of motion. Findings include: R19's face sheet, included diagnosis of hemiplegia and hemiparesis following cerebral infarction affecting left side, major depressive disorder, weakness and chronic pain. R19's quarterly Minimum Data Set (MDS) assessment dated 6/21/21, included R19 understands, had moderate cognitive impairment and required extensive assist of two for bed mobility, toileting and transfers, and extensive assistance of one for personal hygiene. The MDS also indicated R19 had functional limitations of range of motion (ROM) in upper and lower extremities on one side. R19's plan of care dated 6/21/21, indicated a self care deficit in transfers, bed mobility, locomotion related to left sided weakness, stroke and falls. R19 is non-ambulatory. Interventions included R19 will be encouraged to complete exercises with activities and will use heat to his shoulder as needed, use of a Broda chair to decrease	F 688	F688 R19 completed reassessment by physical therapy on 7/28/21 for ROM exercises. All residents with contractures will be reassessed by physical therapies by date of compliance. Valley View Healthcare and Rehab Policy Range of motion Exercises has been viewed and updated 8/3/2021 Risk of reoccurrence will be minimized by the Director of Nursing or Nursing or designee initiating the following: 1. All nursing staff will be educated on ROM exercises. All nursing staff will know where to find instructions on each individual resident's plan of care. On-call staff who have not been scheduled to work prior to compliance date will be educated prior to their next scheduled shift. 2. Nursing staff working with residents that have a ROM care plan will be randomly audited 2 times a week for 4 weeks then 1 time a week for 4 weeks then random audits as needed to concur exercises are being completed and being completed correctly.	

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F 688	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. 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 4/20/21-7/7/21. Out of 111 opportunities, range	F 688	3. Audits will be brought to the QA committee quarterly to discuss finding and the need for further auditing and/or further staff training	

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of motion was completed 29 times. Reasons documented for not performing included not observed, unavailable, could not assess, no information. deferred due to condition and one refusal.

During interview on 7/08/21, at 9:11 a.m., COTA-B indicated R19 was treated for his shoulder pain and included his entire arm. R19 was cooperative with heat stating it felt good and range of motion was done as he could tolerate. Heat would help loosen the joints so ROM could be done with less discomfort. COTA-B indicated R19 did participate in therapy and would actively open and close his right hand on demand. COTA-B indicated she did not remember any issues with his left hand or the 4th digit on his left hand being any different than his other fingers with position or movement. COTA-B further indicated they can only treat and evaluate what the order includes and for this one it was the right shoulder, arm and hand, not the left.

During interview on 7/8/21, at 9:32 a.m., nursing assistant (NA)-A indicated R19 refuses heat most of the time and will participate in range of motion exercises on the right side but requires someone to work with him for him to complete it. NA-A included R19 does refuse sometimes. NA-A further indicated she wasn't aware of any issues with his left hand.

During interview on 7/8/21, at 10:56 a.m., the director of nursing (DON) stated apparently the staff do not know how to document refused on the "Restorative Nursing". The DON further indicated the process has changed over the past few months with NA performing versus a restorative aide they had previously. The DON

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further indicated the process was documented on paper prior but she shredded them so there are no records that go past what is documented on the "Restorative Nursing" record.

During observation and interview on 7/8/21. at 11:01 a.m., R19 when asked if they offer to put heat on his right shoulder or arm and he stated no, and they do not do ROM with him either. R19 further indicated he does not want heat applied, but cooperated with moving both right and left arm and opening and closing both fists. Left 4th digit remained less mobile and more curled towards his fist than other digits. R19 at rest has left digits curled into a fist.

During interview on 7/9/21, at 8:24 a.m., the DON indicated staff should be documenting refused if he refuses which she believes is happening but agreed R19 would cooperate with ROM on his own with some prompting by staff.

During interview on 8/9/21 at 8:33 a.m., NA-B indicated R19 will sometimes do ROM on his own, but most of the time requires prompting. NA-B indicated R19 generally cooperatives and will move both his arms and hands upon request. NA-B was not aware of any issues with R19's left hand or fingers.

A policy titled "Range of Motion Exercises" undated included:
- The purpose of this procedure is to exercise the resident's joints and muscles.
- Review the resident's care plan to assess for any special needs of the resident.
- Be gentle with the resident and do not rush the procedure
- If the resident becomes weak, or complains of

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F 688	Continued From page 24 pain, cease the exercise and summon the staff/charge nurse. - Support the extremity at the joint as it is being exercised. - Move each joint through its range of motion 3 times unless otherwise instruction - Move each joint gently, smoothly and slowly through its range of motion - Remember to stop an exercise before the point of pain.	F 688		
F 693 SS=D	Tube Feeding Mgmt/Restore Eating Skills CFR(s): 483.25(g)(4)(5) §483.25(g)(4)-(5) Enteral Nutrition (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(4) A resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical condition demonstrates that enteral feeding was clinically indicated and consented to by the resident; and §483.25(g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document	F 693	F693	8/13/21

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F 693	Continued From page 25 review the facility failed to verify physician orders prior to enteral feeding (nutrition taken through a tube that goes directly to the stomach) and check placement of a gastrostomy tube (g-tube) per facility policy prior to administration for 1 of 1 resident (R1) observed with a g-tube. Findings include: R1's Face Sheet, included primary diagnosis of esophageal obstruction, gastro-esophageal reflux disease with esophagitis without bleeding. R1's quarterly Minimum Data Set (MDS) assessment dated 3/30/21, indicated R1 was cognitively intact, and received 51% or greater of calories from tube feeding. R1's Physician's Orders dated 6/15/21, included check placement of G-tube every shift, Nutren (tube feeding formula) 1.5 calorie liquid; 0.07 gram-1.5 kcal/ml at 75 milliliters (ml's) per hour giving 1200 ml's total from 6:00 p.m. until 8:00 a.m. and flush G-tube with 120 ml of water every 4 hours. During observation and interview on 7/6/21, at 6:05 p.m., LPN-A retrieved 5 cartons of Nutren 1.5 kcal/ml, 240 ml's per carton from refrigerator and placed on the medication cart. The computer screen was black and LPN-A confirmed the battery was dead on the computer. LPN-A entered R1's room, and using tap water flushed the g-tube with 60 ml's of water. LPN-A then filled a new infusion bag with the 5 cartons of Nutren 1.5 kcal/ml. When questioned how she knows to flush with 60 ml's of water and the amount of Nutren to give and at what rate, she stated she just knows. LPN-A then primed the	F 693	Valley View Heath Care and Rehab's following policies titled Administering Medications and Enteral Tube Feeding via continuous Pump were reviewed on 8/3/21. LPN was reoriented on medication administration and G-tube feedings (including placement and flushing) On July 17th,18th, and 19th. LPN has documented competency of the above. All licensed staff and TMAs will receive an education course on medication administration through Educare and have required to have completed by August 08, 2021. Risk of re-occurrence will be minimized by the Director of Nursing or designee initiating the following: 1) All licensed staff and TMAs will be reeducated on the facility policy Administering Medications and Enteral Tube Feeding prior to the compliance date. Education includes that the individual administering the medication checks label against the EMAR 3 times to verify the right medication, right dosage, right time, and right route of medication before administrating medication. Education on the policy was initiated on 7/19/21. On call staff who have not been scheduled to work prior to compliance date will be educated prior to their next scheduled shift to work. All licensed staff will be educated facility policy Enteral Tube Feeding via continuous pump prior	

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F 693	Continued From page 26 tubing on the pump, connected to R1's g-tube and set the pump to run at 75 ml/hour and left the room. The administration pump hung on a pole with a stethoscope hanging on the top. LPN-A indicated she did not check placement of the g-tube and did not look at the medication administration record (MAR) prior to administration of the water or Nutren stating she knows she is supposed to, but the computer died and she has done this many times and knows what to give and how to do it. During interview on 7/08/21, at 11:06 a.m., registered nurse (RN)-C indicated tube placement for R1 is checked by inserting 15 ml of water into the g-tube, placing a stethoscope on abdomen next to tube site and listening for gurgles. During interview on 7/09/21, at 8:20 a.m., the director of nursing (DON), confirmed the same process is followed for tube feedings as for medication administration including checking the order and the product three times and following the five rights of medication administration. The DON confirmed if a computer battery was dead, it should have been plugged in or a new cart retrieved to verify the tube feeding product to the provider order prior to administration. A policy titled, Enteral Tube Feeding via Continuous Pump, dated 11/2018 included: - Verify that there is a physician's order for this procedure. - Check the enteral nutrition label against the order before administration checking the following information: - Resident name, ID and room number; - Type of formula;	F 693	to our compliance date. Education will include checking for appropriate placement of G tune and flushing of the G tube Education was initiated on 8/3/21. On call staff who have not been scheduled to work prior to our compliance date will be educated prior to their next scheduled shift to work. 2)10 medication pass audits will be completed monthly x 3 months to ensure that licensed staff and TMAs are following the Administering Medication policy and procedure. 3 licensed staff will be randomly audited monthly x3 months to ensure that they are following the Enteral Tube Feeding via continuous Pump Policy and Procedure. Audits will be on going until reviewed at QA and a determination is made that they are no longer necessary. All new licensed staff will be trained on upon hire. 3) Audits will be bought to the QA committee quarterly to discuss findings and need for further auditing and/or additional staff training	

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F 693	Continued From page 27 - Date and time formula was prepared - Route of deliver - Access site - Method (pump, gravity, syringe): and - Rate of administration - Verify placement of tube and once correct tube placement has been verified, flush tubing with at least 30 ml's of warm water or prescribed amount.	F 693		
F 698 SS=D	Dialysis CFR(s): 483.25(l) §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review facility failed to ensure the dialysis access site was consistently monitored and assessed for 1 of 1 residents (R25) receiving hemodialysis. In addition, the facility failed to provide a comprehensive dialysis care plan to reflect signs and symptoms of complications with corresponding interventions and clarity on when or how to coordinate care with the dialysis center. Findings include: According to R25's electronic health record (EHR) facesheet, R14 had the following diagnosis: Dependent on renal dialysis with end stage renal disease According to a physician's order dated 3/23/21	F 698	F698 R14 Care plan has been updated as of 7/8/21 to reflect checking port for any unusual redness, swelling temperature greater than 100.5 F or 38 C or other problems, contact dialysis unit immediately. If patient experiences excessive bleeding from upper right access port, the nurse should apply direct pressure on access site. Nursing home staff should call 911 immediately if bleeding time is more than 1-2 min or if the nurse is unable to control bleeding from access port. Nurse Only to assess.	8/13/21

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F 698	Continued From page 28 nurses were to "check PORT [a central venous access site for dialysis] on right chest. Check for redness warmth, and signs of infection. Special Instructions: THIS IS TO BE DONE BY THE NURSE!!!!!!!!!!!!!!!! [sic]" ordered to be done once a day between 6:30 a.m. and 10:30 a.m. According to a physician's order dated 4/16/21 nurses were to "notify provider of any blood pressures that are >150/90. Special instructions: Please continue to check blood pressures as ordered, but you do not need to notify of blood pressures >150/90 as long as he doesn't have any symptoms of chest pain, dyspnea or headache. Please notify if he does have these symptoms. Otherwise is he is asymptomatic you don't need to notify." ordered to be done between 6:30 a.m. and 10:30 a.m. and 7:00 p.m. and 10:30 p.m. daily. Order does not state which provider to notify nor direct nurses to notify dialysis. During an interview 7/07/21, 3:00p.m. a registered nurse (RN-A) stated they communicated with the dialysis unit if R25 had a change in status, but then RN-A said she was not sure and needed to check with the DON. RN-A said they sent a list of R25's medications and diagnosis with him whenever he went to his dialysis treatment, but did not routinely send any other information. RN-A said the facility checked R25's port, blood pressure and temp before he would go to dialysis, but when he came back he "is drained and just wants to rest." RN-A said after dialysis they would put R25 in bed and let him rest, bringing him a late supper. According to an interview 7/08/21, 7:35 a.m. RN-C stated they were to check R25's dialysis	F 698	For any general questions about dialysis port: Contact dialysis unit during working hours (5am-430pm) at 608-392-5011, after hour urgent related questions contact 507-284-2511. In the event of an acute illness, resident should be sent to emergency room at Saint Mary's Hospital 507-255-5992 or MCHS La Crosse, WI emergency room. Order in computer now reads to contact main provider if BP readings are greater than 150/90 if he were to have symptoms of chest pain, dyspnea, or headache. Included in R14 chart is now Memorandum of Understanding Mayo Clinic Dialysis Services. Risk of re-occurrence will be reduced by the following 1) All licensed staff have been educated on the importance of checking the port on each shift. Licensed staff have been educated on the Valley View Policy of Dialysis residents. Licensed staff have been educated on were the dialysis unit phone numbers are kept and how to reach dialysis unit if needed. There is a communication book that will be carried by resident to and from each dialysis appointment for any necessary communication between each team. A license staff will document each shift on any communication they had with the dialysis team, including and not limited to concerning weight changes, skin tone, port concerns or general condition of resident if off baseline,	

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	245566	A. BUILDING _____ B. WING _____	C 07/09/2021

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VALLEY VIEW HEALTHCARE & REHAB	**510 EAST CEDAR STREET HOUSTON, MN 55943**

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F 698	Continued From page 29 port every morning for redness, warmth and swelling, but they did not need to be concerned about bleeding or other complications. RN-C also stated his blood-pressure needed to be monitored twice daily because he had been having problems with swings in his blood pressure, both high and low. RN-C also said that R25's blood-pressure should be checked as soon as possible after his return from dialysis. RN-C was unable to say who she would call if R25 was showing complications related to his dialysis and confirmed that this information was not readily available in R25's chart. RN-C said "I can't say for 100% but it might be in his admission notes." RN-C did not know the name of a contact person nor a direct phone number to dial, but said, "I guess I'm not sure who they should talk to there, maybe the care manager? That's how it was where I worked before." RN-C said that at a facility where she had previously worked they would send people with symptoms of infection to the emergency room and said, "I guess that's probably what we should do [here]". RN-C said she knew how to care for R25 because she had previous dialysis experience, but did not relate any facility acquired training. According to an interview 7/08/21, 8:00 a.m. RN-B stated R25's care plan should include information directing nurses on how to monitor a dialysis port and what to do if there were complications or the dressing came off. RN-B also said the care plan should include directions to monitor for fluid or electrolyte imbalances and specifically who to contact if R25 was to have any complications or symptoms indicating a problem. RN-B confirmed that this information was not included in R25's current care plan, and that information about who to contact was not in R25's	F 698	2) Director of Nursing or designee will audit 1x a week for 4 weeks for charting of R14 condition and documentation of port site condition. Then will continue audits biweekly for 1 month then monthly until QA determines an end to the audits or more education training is required. All new licensed staff will complete dialysis training upon hire and license staff will complete q 6 months as long as there is a dialysis patient at Valley View Health Care and Rehab 3) Dialysis residents will be discussed weekly at IDT meetings. Audits will be discussed at quarterly QA meetings and with Medical Director as needed.	

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F 698	Continued From page 30	F 698		

chart. RN-B located a document titled "Memorandum of Understanding Mayo Clinic Dialysis Services" and said, "this was not in his chart, it was in a folder at the nurses station. So I am going to put this in his chart and update his care plan now." RN-B reviewed the EHR and confirmed progress notes failed to show any regular communication with the dialysis unit.

According to an interview 7/09/21, 9:10 a.m. R25 stated that the nurses checked his port daily, "most of the time, well, usually, well, sometimes they do."

According to an interview 7/9/21, 9:34 a.m. the Director of Nursing (DON) stated that only nurses could do an assessment, and an assessment, in general, would be the observation of condition through the nurse's senses and a skill only licensed individuals could do. DON stated an expectation of documentation of assessments and notification to a medical provider if there was a significant change in condition. A dialysis assessment, according to the DON should include as assessment of the access site, the resident's weight, blood pressure, skin color and how they were feeling. Additionally, DON described possible complications of dialysis to be infection, fluid imbalance, weakness, dizziness, nausea, fatigue and changes in blood pressure. DON said a dialysis assessment should be done every day before the resident leaves for their treatment and then again upon return to the facility. DON also said the access site should be checked every shift, and DON said, "I just learned that actually." The DON stated the facility should send any abnormal findings with the resident when going to dialysis and confirmed the facility sends R25's medication orders, but does not

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include the results of any assessments done. DON was unable to recall if education had been provided to the nursing staff.

A document titled The Memorandum of Understanding Mayo Clinic Dialysis Services (MCDS) Patients Who Are Residents in Long-Term Care Facilities/Nursing Homes dated 12/24/20 with R25's name at the top was received. The document includes all contact information for the dialysis unit and indicates, "effective and close communication between the dialysis unit and the long-term care facility is essential to develop an efficient and effective plan of care for each patient." In addition, the document includes the following information, "Please remember the patient's access is her/his "lifeline". Special attention should be paid to this vascular access so that it does not clot. Patients can experience infections of these fistulas, grafts or intravenous catheters. If there is any unusual redness, swelling, temperature greater than 100.5 F or 38 C or other problems, contact the patient's dialysis unit immediately. If you wish to receive further education regarding the dare of dialysis access sites, please contact the dialysis unit."

A policy related to dialysis assessments, cares and communication with the dialysis care team was requested:
A document was provided titled End-Stage Renal Disease, Care of a Resident with (no date) indicated staff caring for residents with end-stage renal disease "shall be trained in the care and special needs of these residents," and also it indicated the resident's comprehensive care plan will reflect the resident's needs related to ESRD/dialysis care.

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F 698	Continued From page 32 A document titled Hemodialysis care (no date) was provided and indicated the purpose to be: "hemodialysis devices may only be accessed by medical personnel who have received training and demonstrated clinical competency regarding use of these devices." It describes the care of Central Dialysis Catheters: "Do not allow non-dialysis personnel to access the catheter ....the general medical nurse should document in the resident's medical record every shift as follows: 1. location of catheter. 2. condition of dressing (interventions if needed). 3. Any part of report from dialysis nurse post-dialysis being given. 4. Observations post-dialysis. A request was made for evidence of education or competency testing of nursing staff related to the care of a dialysis patient, but none was provided. A request for any dialysis assessments for the past three months were requested, but were not provided.	F 698		
F 755 SS=E	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and	F 755		8/13/21

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F 755	Continued From page 33 biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure their system for medication reconciliation was adequate to ensure timely identification of loss or diversion of narcotic medications for 1 of 1 medication room emergency kit. Findings include: 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 both opened with a physical key. The E-kit included narcotic medications and controlled substances. The E-kit was secured with green numbered lock tags with an identifier number present on it. A loose leafed three ring binder was placed next to the E-kit along with a	F 755	F755 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 staff are to verify five tag system at each start of shift. This will be done by 2 staff members at the same time. Verifying page number, date and time of tag checks from their shift and the shift prior to them. Valley View Healthcare and Rehab Policy E-Kit Medication and Reconciliation was reviewed and updated on 8/3/2021. Risk of reoccurrence will be minimized by:	

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F 755	Continued From page 34 container of additional green numbered tags. RN-A stated staff documented the five tag identifiers at shift changes, and documented the green tag numbers in the loose leafed three ring binder next to the E-kit. RN-A verified there would be no way of knowing if someone had removed medications from the E-kit along with a page from the three ring binder and changed the green numbered lock tags. During interview on 7/7/21, at 10:29 a.m. director of nursing (DON) confirmed there was a potential for diversion with the loose leaf binder verification system for the E-kit. The DON indicated she can not say for sure the staff are looking at previous dates or verifying the numbers during shift changes. During interview on 7/8/21, at 1:49 p.m. the consultant pharmacist indicated there could be a potential for diversion using a loose leaf three ring binder for verification of green tag identifiers. Requested a copy of E-kit medication reconciliation policy and procedure, but did not receive one.	F 755	1) Director of Nursing or designee to do 1x week audits for 4 weeks to ensure proper procedure is being followed by nursing staff. Then biweekly for 1 month, then monthly until QA determines an end date. 2) All staff were educated in 7/9/21 to the next procedure and sign off on the education. Any licensed staff will be educated prior to their next scheduled shift to work. 3) Results of audits will be brought to quarterly QA meetings to determine if procedure is working or if system needs updating.	
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and	F 758		8/13/21

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F 758	Continued From page 35 (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by:	F 758		

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F 758	Continued From page 36 Based on interview and document review facility failed to document rationale for the continued use of a PRN (as needed) psychotropic medication beyond 14 days for 1 of 5 (R14) residents reviewed for unnecessary medications. Findings include: R14's electronic health record (EHR) face sheet indicated R14 had the following diagnosis that might require the use of psychotropic medication: anxiety disorder unspecified. According to R14's medication orders, among other medications, R14 had an order for lorazepam (a schedule IV controlled substance given for anxiety) one(1)MG at bedtime as needed, with an order start date of 5/19/21 to 11/19/21. A PRN Psychotropic Medication Evaluation Form was initiated by the facility consulting pharmacist on 5/18/21 and provided to the medical provider for review of R14's lorazepam order that had originally started 5/10/21. A physician assistant (PA-C) updated the order to continue for six more months, but no information was provided on the form as to how many doses R14 had taken, whether the medication was effective or whether or not R14 had any side effects. The form prompts a response for the following questions, "brief clinical rationale for continuing or modifying order (required); however, this section was left blank by PA-C. According to an interview 7/09/21, 9:43 a.m. with the Director of Nursing (DON), stated R14 had entered the facility with the order for lorazepam and they [facility] would depend on the	F 758	F758 R14 Care Plan and chart have been reviewed as of 7/20/2021 Providers order have discontinued use of psychotropic medications. Valley View Health Care and Rehab Policy for psychotropic has been reviewed and updated 8/3/2021. Risk of re-occurrence will be minimized by the Director of Nursing or designee initiating the following. 1) Any resident that has an order for a psychotropic drug will be reviewed by provider q2 weeks and will having dx and reasoning behind medication use. Pharmacist consultant will review monthly and send via email results on consults to Director of Nursing or designee to ensure that clinical rational for continuing or modifying be connected to order. 2) Any resident on a psychotropic medication will be discussed weekly at IDT meeting for effectiveness of medication and dosages used. Licensed staff will record in progress notes each shift of dosages used and effectiveness of medication. 3) Audits will be conducted 1x week for 4 weeks and will be discussed at QA meeting quarterly with pharmacy consultant and Medical Director.	

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F 758	Continued From page 37 pharmacist to review the order and make recommendations. DON was unsure how many days a psychotropic PRN medication order should be written for and stated, "we just follow the doctor's orders and whether [R14] should continue to be on them." DON stated psychotropic medication use was discussed during their interdisciplinary team meetings, but was unable to locate a note documenting a discussion about R14's PRN lorazepam order. A request for a facility policy related to PRN psychotropic medication use was requested but not provided.	F 758		

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K 000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety Code survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 07/07/2021. At the time of this survey, Valley View Nursing Home was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: IF PARTICIPATING IN THE E-POC PROCESS, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED.	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		08/03/2021

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.

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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 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

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	Continued From page 2 the construction type allowed for existing buildings, the facility was surveyed as one building as allowed in the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care Occupancies. The facility is fully protected throughout by an automatic sprinkler system and has a fire alarm system with smoke detection in the corridors, spaces open to the corridors, and resident rooms, that is monitored for automatic fire department notification. The facility has a capacity of 45 beds and had a census of 40 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 271 SS=D	Discharge from Exits CFR(s): NFPA 101 Discharge from Exits Exit discharge is arranged in accordance with 7.7, provides a level walking surface meeting the provisions of 7.1.7 with respect to changes in elevation and shall be maintained free of obstructions. Additionally, the exit discharge shall be a hard packed all-weather travel surface. 18.2.7, 19.2.7 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain proper exit discharge and transition to grade in accordance with the NFPA 101 (2012 edition), Life Safety Code, sections 19.2.7, 7.1.7, and 7.7. This deficient condition could have an isolated impact on the	K 271	K271 On July 14, 2021 the Maintenance Director added concrete and tapered it off between the exit door threshold and the sidewalk. The Maintenance Director will	7/14/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245566	A. BUILDING **01 - VALLEY VIEW NURSING HOME** B. WING _____	**07/07/2021**

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K 271	Continued From page 3 residents within the facility. Findings include: On 07/07/2021 between 09:30 AM to 01:30 PM, it was revealed that the West corridor exit exhibited a vertical transition to grade, greater than one-half inch between the exit door threshold and the sidewalk. This deficient practice was confirmed by the Maintenance Director at the time of discovery.	K 271	perform spot audits on all exit sidewalks and thresholds for any change in transition grades in excess of one-half inch to ensure continued compliance. Any changes in transition grades greater than one-half inch will be corrected. The Maintenance Director will report his findings at the quarterly Quality Assurance meeting.	
K 324 SS=D	Cooking Facilities CFR(s): NFPA 101 Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2	K 324		7/9/21

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	245566	A. BUILDING **01 - VALLEY VIEW NURSING HOME** B. WING _____	**07/07/2021**

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K 324	Continued From page 4 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to test and inspect range hood suppression system in the prescribed timeframe per NFPA 101 (2012 edition), Life Safety Code, section 9.2.3, and 19.3.2.5, NFPA 99 (2012 edition), Health Care Facilities Code, section 15.5.2.3, and NFPA 96 (2011 edition), Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, sections 11.2, and 11.2.2. This deficient condition could have a isolated impact on the residents within the facility. Findings include: On 07/07/2021 between 09:30 AM to 01:30 PM, it was revealed during documentation review that range hood suppression system had last been inspected on 12/20/2020. This deficient practice was confirmed by the Maintenance Director at the time of discovery.	K 324	K324 The range hood suppression system was inspected 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 will be retained by the Maintenance Director. The Maintenance Director will ensure that the range hood suppression inspection is scheduled to be completed no later than six months from the prior inspection. The Maintenance Director will report the findings of the suppression system inspection at the quarterly Quality Assurance Committee meeting.	
K 353 SS=E	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily	K 353		7/23/21

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K 353	Continued From page 5 available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to inspect and maintain the sprinkler system in accordance with NFPA 101 (2012 edition), Life Safety Code, sections 9.7.5, 9.7.6, and NFPA 25 (2011 edition) Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, sections 5.2, 5.2.1.1.1, 5.2.1.1.2, and 5.2.1.1.4. This deficient condition could have a patterned impact on the residents within the facility. Findings include: 1. On 07/07/2021 between 09:30 AM to 01:30 PM, it was revealed the sprinkler heads above the laundry washing machined exhibited signs of corrosion and oxidation. 2. On 07/07/2021 between 09:30 AM to 01:30 PM, it was revealed the sprinkler heads located in the kitchen wash room were heavily loaded with debris. This deficient practice was confirmed by the Maintenance Director at the time of discovery.	K 353	K353 All sprinkler heads in the laundry room were replaced on July 23, 2021 by Summit Fire Protection. Sprinkler heads will be monitored and inspected quarterly by the Maintenance Director in conjunction with the routine quarterly sprinkler inspection and maintenance. The Maintenance Director will report inspection results at the quarterly Quality Assurance Committee meeting.	

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K 355	Continued From page 6	K 355		
K 355 SS=E	Portable Fire Extinguishers CFR(s): NFPA 101 Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain accessibility to portable fire extinguishers in accordance with NFPA 101 (2012 edition), Life Safety Code, sections 19.3.5.12, 9.7.4.1, and NFPA 10 (2010 edition), Standard for Portable Fire Extinguishers, section 6.1.3.8. This deficient condition could have a patterned impact on the residents within the facility. Findings include: 1. On 07/07/2021 between 09:30 AM to 01:30 PM, it was revealed that both kitchen fire extinguishers (K and ABC types) had obstructed access. 2. On 07/07/2021 between 09:30 AM to 01:30 PM, it was revealed the ABC extinguisher located in the Beauty Shop had obstructed access due to a hairdryer unit placed in front of the unit. This deficient practice was confirmed by the Maintenance Director at the time of discovery.	K 355	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 his 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.	8/13/21
K 511 SS=F	Utilities - Gas and Electric CFR(s): NFPA 101	K 511		8/13/21

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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 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain proper security and physical accessibility to electrical panel in a resident accessible corridor in accordance with NFPA 101 (2012 edition), Life Safety Code, sections 19.5.1.1 and 9.1.2, NFPA 70 (2011 edition), National Electrical Code, section 110.26, and NFPA 99, (2012 edition), Health Care Facilities Code, section 6.3.2.2.1.3. This deficient condition could have a widespread impact on the residents within the facility. Findings include: 1. On 07/07/2021 between 09:30 AM to 01:30 PM, it was revealed that there was obstructed access to the electrical panel in the Kitchen Dry Goods Storage Room. 2. On 07/07/2021 between 09:30 AM to 01:30 PM, it was revealed that there was obstructed access to the electrical panel in the South corridor. 3. On 07/07/2021 between 09:30 AM to 01:30	K 511	K511 In the kitchen dry goods storage room, the shelving was removed, and caution tape was put on the floor alerting staff not to obstruct the area in front of the electrical panel. The bench was removed from in front of the south hall electrical panel. In the boiler room, the portable heaters were removed from in front of the electrical panel and put into storage. In the kitchen, the carts that were obstructing the electrical panel were removed. Red tape was put around the electrical box and signage was added to alert staff not to park carts and equipment in front of the electrical box. Electrical panels in the south corridor were locked and secured immediately. The Maintenance Director will observe and remove any noted obstructions during his routine morning rounds. All staff will be educated on August 13, 2021 on fire safety protocols as they pertain to unobstructed electrical panels. The Maintenance Director will	

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K 511	Continued From page 8 PM, it was revealed that there was obstructed access to the electrical panels in the Boiler Room. 4. On 07/07/2021 between 09:30 AM to 01:30 PM, it was revealed that there was obstructed access to the electrical panel in the Kitchen. 5. On 07/07/2021 between 09:30 AM to 01:30 PM, it was revealed that electrical panels, LP 11 and LP12 in the resident corridor, were unsecured. This deficient practice was confirmed by the Maintenance Director at the time of discovery.	K 511	report his observations at the Quality Assurance Committee meeting.	
K 914 SS=F	Electrical Systems - Maintenance and Testing CFR(s): NFPA 101 Electrical Systems - Maintenance and Testing Hospital-grade receptacles at patient bed locations and where deep sedation or general anesthesia is administered, are tested after initial installation, replacement or servicing. Additional testing is performed at intervals defined by documented performance data. Receptacles not listed as hospital-grade at these locations are tested at intervals not exceeding 12 months. Line isolation monitors (LIM), if installed, are tested at intervals of less than or equal to 1 month by actuating the LIM test switch per 6.3.2.6.3.6, which activates both visual and audible alarm. For LIM circuits with automated self-testing, this manual test is performed at intervals less than or equal to 12 months. LIM circuits are tested per 6.3.3.3.2 after any repair or renovation to the electric distribution system. Records are maintained of required tests and associated repairs or modifications, containing date, room or	K 914		8/3/21

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K 914	Continued From page 9 area tested, and results. 6.3.4 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on document review and staff interview, the facility failed to properly document the annual electrical receptacle testing in accordance with NFPA 99 (2012 edition), Health Care Facilities Code, sections 6.3.3.2, 6.3.4.1 and 6.3.4.2. This deficient condition could have a widespread impact on the residents within the facility. Findings include: On 07/07/2021 between 09:30 AM to 01:30 PM, it was revealed during documentation review the records provided for review were generic in information content, not providing detailed information associated to the duplex and quad outlets located in resident rooms. This deficient practice was confirmed by the Maintenance Director at the time of discovery.	K 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.	
K 920 SS=D	Electrical Equipment - Power Cords and Extens CFR(s): NFPA 101 Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power	K 920		8/13/21

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K 920	Continued From page 10 strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to properly manage the implementation and usage of power strips in accordance with NFPA 99 (2012 edition), Health Care Facilities Code, section 10.2.3.6, 10.2.4 and NFPA 70, (2011 edition), National Electrical Code, sections 400-8, 590.3(D). This deficient condition could have an isolated impact on the residents within the facility. Findings include: On 07/07/2021 between 09:30 AM to 01:30 PM, it was revealed that in the Kitchen Supervisors Office daisy-chained power strips were in use to power equipment and devices. This deficient practice was confirmed by the Maintenance Director at the time of discovery.	K 920	K920 Daisy-chained power strips were removed from the Kitchen Supervisor's office and replaced with a single power strip. The Kitchen Supervisor was educated by the Maintenance Director not to daisy-chain power strips. All staff will be educated on August 13, 2021 on fire safety protocols as they pertain to daisy-chained power strips. The Maintenance Director will spot check offices to ensure no power strips are daisy-chained. The results of these spot checks will be reported at the Quality Assurance Committee meeting.	

DEPARTMENT OF HEALTH

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.

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

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

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

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

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00286	A. BUILDING: _____ B. WING _____	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 PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 7/6/21-7/9/21, a licensing survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was found NOT in compliance with the MN State Licensure and the following correction orders are issued. Please indicate in your electronic plan of correction you have reviewed	2 000		

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	00286	A. BUILDING: _____ B. WING _____	C 07/09/2021

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2 000	Continued From page 1 these orders, and identify the date when they will be completed. The following complaints were found to be SUBSTANTIATED , H5566014C (MN00062490),H5566016C (MN00074068),H5566017C (MN00060276) H5566013C (MN00062640) and H5566018C (MN00067177), NO deficiencies were cited due to actions implemented by the facility prior to survey: AND The following complaints were found to be UNSUBSTANTIATED: H5566012C (MN00062109) Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled " ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm The State licensing orders are	2 000		

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2 000	Continued From page 2 delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced	2 830		8/13/21

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2 830	Continued From page 3 by: Based on observation, interview, and document review, the facility failed to consistently assess and monitor increasing weight, and edema to the lower extremities for 2 of 2 resident (R14, R4) reviewed for edema and hospitalizations. Findings include: According to the facility electronic health record (EHR) face sheet, R14 had a diagnosis of primary hypertension (high blood pressure), acute respiratory failure with hypoxia (history of inadequate respiratory function leading to low oxygen levels) and pleural effusion (history of fluid in the lungs a complication that may be related to cardiac, renal or infectious problems). R14's Care Plan indicated a care problem of Nutritional status: I am at increased nutrition risk related to advanced age, adult failure to thrive, and moderate protein calorie malnutrition for R14, with a start date of 11/21/20. Corresponding care approaches included providing a general diet with 4 ounces of nutritional supplement three times daily for extra nutrition, monitoring intake of food and fluid daily and monitoring and recording 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 tissues). According to a physician's progress note by a medical doctor (MD-A) dated 1/20/21, R14 was being seen for a routine visit post-hospitalization (11/3/20) for acute respiratory failure related to	2 830	2830 R14 and R4 will have an assessment completed by RD by 08/05/2021 on current weight status. R14 and R4 will have a fluid assessment completed by an RN by 08/04/2021. Both of these assessments will be communicated to the primary provider with documentation of such and any new interventions/orders as appropriate. All current residents in the facility will have their weights assessed by the CDM or designee and any resident flagging for significant change in weight per policy will be communicated with primary provider. This will be completed by date of compliance. Valley View Healthcare & Rehab Policy Weight Change was reviewed and updated on 08/04/2021. Risk of re-occurrence will be minimized by the Certified Dietary Manager or designee initiating the following: 1)All licensed staff will be educated on the facility policy Valley View Healthcare & Rehab Weight Change Policy prior to our compliance date. On-call staff who have not been scheduled to work prior to our compliance date will be educated prior to their next scheduled shift. RD will be educated on Valley View Healthcare & Rehab Policy Weight Change policy and procedure. 2)All residents with significant weight	

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2 830	Continued From page 4 pulmonary edema (fluid accumulation in the tissue of the lungs) which required diuresis (the provision of medications to enhance renal function to remove fluid overload). The note indicated nursing staff had no concerns for R14 at that time. MD-A indicated that heart rate was regular and lungs were clear, but chronic edema was noted in the lower extremities. According to progress note by PA-C dated 3/9/21, R14 had 3+ edema (edema of significant severity where pressing on the tissue for several seconds will result in an indentation of 4-6mm (millimeters) that lasts for a minute or more) of both lower legs and R14 was not wearing any tubi-grips (a knitted compression hose). A progress note date 3/16/21 by PA-C indicated R14 had slight edema and nursing staff should monitor and notify of any changes or decompensation in R14's condition. Additional progress notes by medical providers after March of 2021 were requested but not provided. According to a nutrition note written by a certified dietary manager (CDM) in the EHR dated 5/12/2021: "Diet order is general, cut up foods. Resident does prefer to eat meals in her room. Resident reports appetite is good. Resident does consume 50-100% of food on most meal trays. Offering 4 oz nutrition supplement TID with meals for extra nutrition. Resident does like this and wishes to continue having supplement. Recent weight was 141# on 5/11/21. Weight has increased since admission. Weight on admission was 115# on 11/12/20, this does represent a 22.6% weight gain over the past 6 months. Will continue to monitor weight and oral intake."	2 830	changes will be audited monthly x 3 months to ensure the policy is followed. The audit will be ongoing until reviewed at QA and a determination is made that they are no longer necessary. 3)Audits will be brought to the QA committee quarterly to discuss findings and need for further auditing and/or additional staff training.	

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2 830	Continued From page 5 According to R14's EHR weight record, R14 weighed: 115 pound (lbs) on 11/12/20 121 lbs on 12/09/20 130.3 lbs on 1/13/21 133.2 lbs on 2/16/21 135.2 lbs on 3/9/21 135.4 lbs on 4/20/21 140.5 lbs on 5/11/21 142.9 lbs on 6/22/21 145.1 lbs on 7/6/21 During an observation on 7/6/21, at 2:50 p.m. R14 was sitting in her recliner in her room with her feet dependent (hanging down) and she had visual swelling of both feet, but no compression stockings or tubi-grip observed. On 7/07/21, 11:25 a.m. R14 was observed in her recliner in room, legs dependent and legs visually swollen and tubi-grip compression were on. On 7/08/21, 9:25 a.m. R14 was observed in her recliner napping with legs dependent and visually swollen and tubi-grip compression were on. During an observation 7/09/21, 2:04 p.m. registered nurse (RN-C) demonstrated personal technique for checking edema. R14 was sitting in recliner with feet elevated, wearing tubi-grip. The compression tube on the right lower extremity had moved. The lower portion of the right foot was ballooned up to approximately twice the size of the portion that was compressed by the hose. RN-C stated, "well, that doesn't look like it was put on right." RN-C then checked for edema by quickly touching the puffy portion of the right foot without pressure. RN-C stated a firm touch to compress the tissue was not necessary to check for edema. RN-C also stated that persons	2 830		

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2 830	Continued From page 6	2 830		

receiving diuretics should have edema checks done daily and documented in the medication administration record.

During an interview 7/09/21, 1:08 PM the Director of Nursing (DON) stated she receives a list of weights from the CDM and the CDM is responsible to monitor the resident weights unless there are specific orders for nurses to be sure weights do not go over a defined limit, such as when someone has edema. DON did say that nurses should notice if there are changes in weights, but that the CDM should be bringing up any significant changes in weight at the interdisciplinary team meetings. DON state, "I was told that is not my area to monitor and this (weight increase) should have been caught." DON also said the nursing assistants enter the resident weights into the EHR, but they are unable to see what a previous weight had been so cannot report a change in weight.

During an interview 7/09/21, 1:55 p.m. CDM stated she did not have documentation that she had reported or discussed R14's 22% weight gain with the registered dietician (RD). She sated she was unable to find any documentation that the RD had reviewed or assessed R14, and she was unsure when she should report to the RD. She said she did not document conversations she had with the RD. CDM did state that R14 liked her dietary supplement and had discussed continuing them with the nursing team, but did not recall telling the nursing department about the weight change.

During an interview on 7/9/21, 2:07 p.m. RN-B stated any resident with cardiovascular and/or respiratory problems related to fluid overload should have on-going assessment and evaluation

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2 830	Continued From page 7 of their condition, and nurses should report to the medical care provider if the person has a significant or on-going change in their weight or condition. RN-B stated an expectation for nurses to assess weights, edema, vital signs, heart and lung sounds on a regular basis for persons with cardiopulmonary problems and said this should be done for R14. RN-B also stated that increases in weight should be evaluated and reported as this could indicate a problem with fluid overload which might "lead to a lot of problems and spiral out of control." RN-B gave a definition of significant weight change of an increase or decrease of about 5% in a three month period. RN-B stated he was unable to find nursing documentation in the nurses' notes of assessment or evaluation of R14's condition related to edema or weight gain since March 2021. RN-B was able to locate a list of edema checks, but no further evaluation or reporting. During an interview 7/09/21, 3:03 p.m. DON stated a trained medication aid (TMA) had brought it to their attention that quite a few residents were wearing tubi-grips and TMA wondered if that indicated a problem. DON stated she had initiated a performance improvement project on edema and fluids and said she thought she had started it about a week prior to the survey, and this consisted of adding edema checks to the nurses' tasks when a person was receiving diuretics. She stated she had not provided an educational session for nurses, but had posted a sign and indicated they should come to her if they had questions. DON said she wrote the note in May. DON stated checks for edema or fluid overload should be done in the morning when tubi-grips were applied and then again when they were removed to determine effectiveness of the treatment. DON	2 830		

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2 830	Continued From page 8 also said it was expected that nurses would apply a gentle but firm pressure for several seconds with enough force to indent/compress resident tissue when doing an assessment for pitting edema. Anything less would not be sufficient. Facility provided the education posting DON described dated 5/19/21; the education in total is as follows: "Nurses- when charting edema on residents when giving Lasix [diuretic] don't put yes or no- please chart amount of edema Example 0 +1 +2 . TMAs-please ask your nurse to assess edema when charting. In physical examination pitting, tenderness, skin changes and temperature are evaluated. Pitting: there are two types of edema, pitting and non-pitting edema. Pitting edema is described as an indentation that remains in the edematous area after pressure is applied. To determine the extent of the pitting edema, you can push on the skin, measure the depth of the indention [sic] and record how long takes for your skin to rebound back to its original position. Then grade it on a scale from 1-2. If you press a swollen area with your finger and it doesn't cause an indentation in the skin, it's considered non-pitting edema. If you need additional education on assessing edema please see me (DON)." R4 R4's face sheet identified a re-admission date of 4/15/21, and included primary readmission diagnosis of acute diastolic heart failure. Other diagnosis included chronic systolic heart failure, fluid overload, dementia with Lewy bodies, and atrial fibrillation (irregular heart beat). R4's quarterly Minimum Data Set (MDS)	2 830		

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2 830	Continued From page 9 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. R4's discharge MDS assessment dated 4/11/21, indicated a significant weight gain of >5% or more in last 30 days or 10% or greater over past 6 months. Weight was documented as 168 pounds. R4's care plan dated 10/30/20, included R4 is at increased nutrition risk related to recent hospitalization for fluid overload and CHF with history of moderate calorie/protein malnutrition. Goal included R4 will maintain weight at 150 pound plus or minus 5 pounds. Interventions dated 10/30/20, included staff will monitor and record intake of food and fluid daily, and staff will monitor and record weights at least weekly and notify primary care provider (PCP) and family of significant weight changes. Provider orders dated 3/11/21, included Tubigrips (compression stockings used for swelling) on a.m., and off at bedtime. Order written on 3/19/21 included weigh weekly in bath chair on bath day and manual blood pressure and pulse on Monday, Wednesday and Friday with special instructions to not obtain blood pressure with automatic machine. Review of R4's documented weights indicated: 1/8/2021 weighed 127.2 pounds. 2/5/2021 weighed 140.2 pounds. 2/19/21 weighed 153 pounds. 3/12/2021 weighted 156.5 pounds.	2 830		

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2 830	Continued From page 10 4/7/2021 weighed 168.1 pounds. Total weight gain was 40.4 pounds from 1/8/21 until 4/7/21. A nutrition progress note dated 1/19/21 included recent weight was 131 pounds on 1/15/21, which is up from admit weight of 124#'s on 10/28/20. This does represent a 5.6% weight gain over the past 3 months. Will continue to monitor weight and oral intake. A provider progress note dated 1/28/21 included visit was to follow-up to elevated blood pressure and R4 has been on metoprolol 75 twice daily with blood pressures as follows 156/84, 170/88, 148/54, 184/78, 199/81 and 160/74. Amlodipine was added for blood pressure. A provider progress note dated 2/11/21 included discussion on blood pressure and how they are all over the place. Metoprolol was decreased due to decreased heart rates with blood pressures today of 131/55 but others included 185/46, 145/64, 152/93 and 164/53. Weight was present in note as 140 pounds. A provider progress note dated 3/11/21 included continue to review of blood pressures which were recorded as 138/63, 160/62, 141/45, 150/55, 175/48 and today 148/62. Weight was present as 156.7 pounds. A nurse progress dated 3/11/21 at 10:32 a.m., indicated nursing received an order from therapy and resident is to wear bilateral Tubigrips for edema, size E. No mention in progress notes regarding edema prior to or after this note. A provider progress note dated 3/25/21 included	2 830		

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2 830	Continued From page 11 a follow up of her blood pressures with some blood pressures being much lower at 136/75, 149/49, 151/62 and 148/49. No mention of weight present. A progress note dated 4/10/21 at 6:10 a.m. indicated R4 was having hallucinations about children and continued to have thoughts about children throughout shift and also told staff there was two men in her closet all day but they left now. A progress note dated 4/11/21 at 4:03 a.m. indicated resident continued to talk to someone who was in the room and stated that there was a girl there she knew. A progress note dated 4/11/21 at 11:26 a.m. indicated the resident has been experiencing hallucinations and has not slept in over 24 hours. VS: 168/99, HR 55, pulse oximetry 84%, RR 24 and temperature 97.1. On-call physician recommended resident be transferred to ED, which was arranged and completed. Review of Weight Variance Reports indicated R4 was present on multiple weight variance reports run weekly from 11/22/20 through 4/12/21. The Variance Report dated 1/12/21 through 4/12/21 indicated a 9.1% weight gain from 2/5/21 to 2/19/21 in 14 days, and from 3/31/21 to 4/7/21 was a 7.4% weight gain in 7 days. A quality assurance report dated 12/2020 through February 2021 included R4's most recent weight was 154, and 30 days ago was 140 with 10% weight change. Sixty days ago weight was 133 for 15.8% change and 90 days ago weight was 137 for 12.4% weight gain. Findings included a significant weight gain over the past 30/90 days.	2 830		

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2 830	Continued From page 12	2 830		

Recommendations included diet order is general. Resident does prefer small portions. R4 has history of mal calorie and protein malnutrition. Staff reports she eats well.

During interview on 7/9/21, at 1:01 p.m., the certified dietary manager (CDM) indicated weekly weights were completed on R4 and whenever there is a significant change, the director of nursing is notified. The CDM did indicate this weight gain was significant and shortly before R4 was transferred to the hospital, she spoke with trained medication aide (TMA)-A questioning her about edema and how she was eating. The CDM indicated she reviews weekly weights and does a comparison over the past 3 months then may ask staff questions regarding edema, how they are eating or may ask to have them re-weighed. CDM added the family also questioned the weight gain. The CDM indicated she did not document any of the above nor the conversation with TMA-A and was unsure if registered dietician was notified regarding R4's weight gain. The CDM did indicate she brought reports multiple times to the interdisciplinary meetings (IDT) and shared those with the director of nursing.

During interview on 7/9/21, 1:08 p.m., the DON indicated she does receive a list of weights from the CDM but had been told that it is not her area to monitor. The DON indicated if orders are present to not exceed a certain weight or contact provider with a certain weight parameter, nursing would be responsible or if resident is having symptoms like leg edema. The DON indicated in this instance, the CDM should have communicated the weight gain to the nursing staff or brought it up at IDT meeting versus handing her a report. The DON further indicated R4's significant weight gain should have been

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2 830	Continued From page 13 questioned and reported to the provider by someone. During interview on 7/9/21, at 1:16 p.m., TMA-A indicated she was asked to reweigh R4 around the time of the hospitalization but was unsure the exact date but assumed something was off with the weight. TMA-A indicated that was the extent of the conversation and the CDM did not question her regarding symptoms of fluid overload. During interview on 7/09/21, at 1:45 p.m., registered nurse (RN) -C indicated nursing staff 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	2 830		

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2 830	Continued From page 14 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. An "After Visit Summary" dated 4/15/21 from the hospital indicated R4 was hospitalized with acute diastolic (congestive) Heart Failure 4/11/21 through 4/15/21. A policy titled "Weight Change" last updated 10/28/20 written by Nutrition Services Director included: - All residents are to be weighed weekly, unless otherwise ordered by their attending physician to insure adequate nutritional status as evidenced by lab within normal limits and weight within ideal body weight range as determined by the dietary supervisor or registered dietitian. - Any resident with a weight change of five (5) or more pounds in 1 week will have a re-weight done to determine the accuracy of the change. - Significant weight change is defined as 5% in 30 days or 7.5% in 90 days, or 10% in 180 days. - The attending physician will be notified of the weight change and orders requested as indicated on physician rounds or per fax. - Care plan will be updated accordingly. A policy related to monitoring edema or fluid overload was requested, but not provided. SUGGESTED METHOD OF CORRECTION: The	2 830		

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2 830	Continued From page 15 interdisciplinary team could review staff education and compentency for residents who need monitoring of weights and edema. The IDT could then develop and implement a training program and staff complete competency testing. The IDT could then develop and implement audits to ensure ongoing implementation strategies are being performed by staff as part the facilities quality assurance program and ongoing staff performance evaluations. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 830		
2 895	MN Rule 4658.0525 Subp. 2.B Rehab - Range of Motion Subp. 2. Range of motion. A supportive program that is directed toward prevention of deformities through positioning and range of motion must be implemented and maintained. Based on the comprehensive resident assessment, the director of nursing services must coordinate the development of a nursing care plan which provides that: B. a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and to prevent further decrease in range of motion. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure range of motion (ROM) services were offered and provided according to the therapy recommendations for 1 of 2 resident (R19)	2 895	2895 R19 completed reassessment by physical therapy on 7/28/21 for ROM exercises. All residents with contractures will be	8/13/21

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2 895	Continued From page 16 reviewed for limited range of motion. Findings include: R19's face sheet, included diagnosis of hemiplegia and hemiparesis following cerebral infarction affecting left side, major depressive disorder, weakness and chronic pain. R19's quarterly Minimum Data Set (MDS) assessment dated 6/21/21, included R19 understands, had moderate cognitive impairment and required extensive assist of two for bed mobility, toileting and transfers, and extensive assistance of one for personal hygiene. The MDS also indicated R19 had functional limitations of range of motion (ROM) in upper and lower extremities on one side. R19's plan of care dated 6/21/21, indicated a self care deficit in transfers, bed mobility, locomotion related to left sided weakness, stroke and falls. R19 is non-ambulatory. Interventions included R19 will be encouraged to complete exercises with activities and will use heat to his shoulder as needed, use of a Broda chair to decrease 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. 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	2 895	reassessed by physical therapies by date of compliance. Valley View Healthcare and Rehab Policy Range of motion Exercises has been viewed and updated 8/3/2021 Risk of reoccurrence will be minimized by the Director of Nursing or Nursing or designee initiating the following: 1. All nursing staff will be educated on ROM exercises. All nursing staff will know where to find instructions on each individual resident's plan of care. On-call staff who have not been scheduled to work prior to compliance date will be educated prior to their next scheduled shift. 2. Nursing staff working with residents that have a ROM care plan will be randomly audited 2 times a week for 4 weeks then 1 time a week for 4 weeks then random audits as needed to concur exercises are being completed and being completed correctly. 3. Audits will be brought to the QA committee quarterly to discuss finding and the need for further auditing and/or further staff training.	

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2 895	Continued From page 17	2 895		

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 4/20/21-7/7/21. Out of 111 opportunities, range of motion was completed 29 times. Reasons documented for not performing included not observed, unavailable, could not assess, no information. deferred due to condition and one refusal.

During interview on 7/08/21, at 9:11 a.m., COTA-B indicated R19 was treated for his shoulder pain and included his entire arm. R19 was cooperative with heat stating it felt good and range of motion was done as he could tolerate. Heat would help loosen the joints so ROM could be done with less discomfort. COTA-B indicated R19 did participate in therapy and would actively open and close his right hand on demand.

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2 895	Continued From page 18 COTA-B indicated she did not remember any issues with his left hand or the 4th digit on his left hand being any different than his other fingers with position or movement. COTA-B further indicated they can only treat and evaluate what the order includes and for this one it was the right shoulder, arm and hand, not the left. During interview on 7/8/21, at 9:32 a.m., nursing assistant (NA)-A indicated R19 refuses heat most of the time and will participate in range of motion exercises on the right side but requires someone to work with him for him to complete it. NA-A included R19 does refuse sometimes. NA-A further indicated she wasn't aware of any issues with his left hand. During interview on 7/8/21, at 10:56 a.m., the director of nursing (DON) stated apparently the staff do not know how to document refused on the "Restorative Nursing". The DON further indicated the process has changed over the past few months with NA performing versus a restorative aide they had previously. The DON further indicated the process was documented on paper prior but she shredded them so there are no records that go past what is documented on the "Restorative Nursing" record. During observation and interview on 7/8/21. at 11:01 a.m., R19 when asked if they offer to put heat on his right shoulder or arm and he stated no, and they do not do ROM with him either. R19 further indicated he does not want heat applied, but cooperated with moving both right and left arm and opening and closing both fists. Left 4th digit remained less mobile and more curled towards his fist than other digits. R19 at rest has left digits curled into a fist.	2 895		

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2 895	Continued From page 19 During interview on 7/9/21, at 8:24 a.m., the DON indicated staff should be documenting refused if he refuses which she believes is happening but agreed R19 would cooperate with ROM on his own with some prompting by staff. During interview on 8/9/21 at 8:33 a.m., NA-B indicated R19 will sometimes do ROM on his own, but most of the time requires prompting. NA-B indicated R19 generally cooperatives and will move both his arms and hands upon request. NA-B was not aware of any issues with R19's left hand or fingers. A policy titled "Range of Motion Exercises" undated included: - The purpose of this procedure is to exercise the resident's joints and muscles. - Review the resident's care plan to assess for any special needs of the resident. - Be gentle with the resident and do not rush the procedure - If the resident becomes weak, or complains of pain, cease the exercise and summon the staff/charge nurse. - Support the extremity at the joint as it is being exercised. - Move each joint through its range of motion 3 times unless otherwise instruction - Move each joint gently, smoothly and slowly through its range of motion - Remember to stop an exercise before the point of pain. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could inservice nursing staff regarding implementation of the care plan to include completing range of motion as directed, and then audit to ensure compliance.	2 895		

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2 895	Continued From page 20 TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 895		
21600	MN Rule 4658.1335 Subp. 2 Stock Medications; Emergency Supply Subp. 2. Emergency medication supply. A nursing home may have an emergency medication supply which must be approved by the QAA committee. The contents, maintenance, and use of the emergency medication supply must comply with part 6800.6700. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure their system for medication reconciliation was adequate to ensure timely identification of loss or diversion of narcotic medications for 1 of 1 medication room emergency kit. Findings include: 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 both opened with a physical key. The E-kit included narcotic medications and controlled substances. The E-kit was secured with green numbered lock tags with an identifier number present on it. A loose leafed three ring binder was placed next to the E-kit along with a container of additional green numbered tags. RN-A stated staff documented the five tag identifiers at shift changes, and documented the green tag numbers in the loose leafed three ring	21600	21600 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 staff are to verify five tag system at each start of shift. This will be done by 2 staff members at the same time. Verifying page number, date and time of tag checks from their shift and the shift prior to them. Valley View Healthcare and Rehab Policy E-Kit Medication and Reconciliation was reviewed and updated on 8/3/2021. Risk of reoccurrence will be minimized by: 1) Director of Nursing or designee to do 1x week audits for 4 weeks to ensure proper procedure is being followed by nursing staff. Then biweekly for 1 month, then monthly until QA determines an end date.	8/13/21

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21600	Continued From page 21 binder next to the E-kit. RN-A verified there would be no way of knowing if someone had removed medications from the E-kit along with a page from the three ring binder and changed the green numbered lock tags. During interview on 7/7/21, at 10:29 a.m. director of nursing (DON) confirmed there was a potential for diversion with the loose leaf binder verification system for the E-kit. The DON indicated she can not say for sure the staff are looking at previous dates or verifying the numbers during shift changes. During interview on 7/8/21, at 1:49 p.m. the consultant pharmacist indicated there could be a potential for diversion using a loose leaf three ring binder for verification of green tag identifiers. Requested a copy of E-kit medication reconciliation policy and procedure, but did not receive one. SUGGESTED METHOD OF CORRECTION: The administrator, consultant pharmacist or designee could review and revise policies and procedures to include processes for monitoring controlled substances stored in the E-Kit. The administrator, consultant pharmacist or designee could perform random observational audits to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21600	2) All staff were educated in 7/9/21 to the next procedure and sign off on the education. Any licensed staff will be educated prior to their next scheduled shift to work. 3) Results of audits will be brought to quarterly QA meetings to determine if procedure is working or if system needs updating.	