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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: PD73

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00414

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245419**
2.STATE VENDOR OR MEDICAID NO.
(L2) **546242800**

3. NAME AND ADDRESS OF FACILITY
(L3) **TWIN VALLEY LIVING CENTER**
(L4) **208 OPPEGARD AVENUE NORTHWEST, PO BOX 480**
(L5) **TWIN VALLEY, MN** (L6) **56584**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **07/02/2014** (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 **58** (L18)

13.Total Certified Beds **58** (L17)

10.THE FACILITY IS CERTIFIED AS:
X A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC

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

B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: **A** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	58			
(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 :
Debra Vincent, HFE NEII 07/16/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath
Enforcement Specialist 09/02/2014 (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
02/01/1987
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
07/02/2014
(L33)

DETERMINATION APPROVAL

Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 24-5419

September 2 , 2014

Ms. Shari Schreiner, Administrator
Twin Valley Living Center
208 Oppegard Avenue Northwest, PO Box 480
Twin Valley, Minnesota 56584

Dear Ms. Schreiner:

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 June 9, 2014 the above facility is certified for:

58 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 58 skilled nursing facility beds.

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

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

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

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Division of Compliance Monitoring
P.O. Box 64900
St. Paul, Minnesota 55164-0900
Telephone: (651) 201-4118 Fax: (651) 215-9697
Email: mark.meath@state.mn.us

cc: Licensing and Certification File

Protecting, Maintaining and Improving the Health of Minnesotans

July 16, 2014

Ms. Shari Schreiner, Administrator
Twin Valley Living Center
208 Oppegard Avenue Northwest, PO Box 480
Twin Valley, Minnesota 56584

RE: Project Number S5419024

Dear Ms. Schreiner:

On May 23, 2014, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on May 15, 2014. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), whereby corrections were required.

On July 2, 2014, the Minnesota Department of Health completed a Post Certification Revisit (PCR) and on June 16, 2014 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on May 15, 2014. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of June 9, 2014. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on May 15, 2014, effective June 9, 2014 and therefore remedies outlined in our letter to you dated May 23, 2014, will not be imposed.

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

Enclosed is a copy of the Post Certification Revisit Form, (CMS-2567B) from this visit.

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

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: (651) 201-4118 Fax: (651) 215-9697
Email: mark.meath@state.mn.us

Enclosure

cc: Licensing and Certification File 5419r14.rtf

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245419	A. Building B. Wing	7/2/2014

Name of Facility	Street Address, City, State, Zip Code
TWIN VALLEY LIVING CENTER	208 OPPEGARD AVENUE NORTHWEST, PO BOX 480 TWIN VALLEY, MN 56584

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

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix		ID Prefix **F0279**	**06/09/2014**	ID Prefix **F0285**	**06/09/2014**
Reg. #		Reg. # **483.20(d), 483.20(k)(1)**		Reg. # **483.20(m), 483.20(e)**	
LSC		LSC		LSC	
ID Prefix **F0309**	**06/09/2014**	ID Prefix **F0329**	**06/09/2014**	ID Prefix **F0428**	**06/09/2014**
Reg. # **483.25**		Reg. # **483.25(l)**		Reg. # **483.60(c)**	
LSC		LSC		LSC	
ID Prefix **F0431**	**06/09/2014**	ID Prefix **F0492**	**06/09/2014**	ID Prefix	
Reg. # **483.60(b), (d), (e)**		Reg. # **483.75(b)**		Reg. #	
LSC		LSC		LSC	
ID Prefix		ID Prefix		ID Prefix	
Reg. #		Reg. #		Reg. #	
LSC		LSC		LSC	
ID Prefix		ID Prefix		ID Prefix	
Reg. #		Reg. #		Reg. #	
LSC		LSC		LSC	

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	PS/mm	07/17/2014	27200	07/02/2014
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
5/15/2014			

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245419	A. Building B. Wing	7/2/2014

Name of Facility	Street Address, City, State, Zip Code
TWIN VALLEY LIVING CENTER	208 OPPEGARD AVENUE NORTHWEST, PO BOX 480 TWIN VALLEY, MN 56584

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

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **F0243** Reg. # **483.15(c)(1)-(5)** LSC	Correction Completed **06/09/2014**	ID Prefix **F0279** Reg. # **483.20(d), 483.20(k)(1)** LSC	Correction Completed **06/09/2014**	ID Prefix **F0285** Reg. # **483.20(m), 483.20(e)** LSC	Correction Completed **06/09/2014**
ID Prefix **F0309** Reg. # **483.25** LSC	Correction Completed **06/09/2014**	ID Prefix **F0329** Reg. # **483.25(l)** LSC	Correction Completed **06/09/2014**	ID Prefix **F0428** Reg. # **483.60(c)** LSC	Correction Completed **06/09/2014**
ID Prefix **F0431** Reg. # **483.60(b), (d), (e)** LSC	Correction Completed **06/09/2014**	ID Prefix **F0492** Reg. # **483.75(b)** LSC	Correction Completed **06/09/2014**	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By _____ **State Agency**	**Reviewed By** PS/mm	**Date:** 07/17/2014	**Signature of Surveyor:** 27200	**Date:** 07/02/2014
Reviewed By _____ **CMS RO**	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on: 5/15/2014

Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? **YES** **NO**

Department of Health and Human Services
Centers for Medicare & Medicaid Services

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245419	A. Building B. Wing 01 - MAIN BUILDING 01	6/16/2014

Name of Facility	Street Address, City, State, Zip Code
TWIN VALLEY LIVING CENTER	208 OPPEGARD AVENUE NORTHWEST, PO BOX 480 TWIN VALLEY, MN 56584

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

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix Reg. # NFPA 101 LSC K0056	Correction Completed 05/20/2014	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By State Agency	Reviewed By LB/mm	Date: 07/17/2014	Signature of Surveyor: 32981	Date: 06/16/2014
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:
Followup to Survey Completed on: 5/14/2014		Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO

Protecting, Maintaining and Improving the Health of Minnesotans

July 17, 2014

Ms. Shari Schreiner, Administrator
Twin Valley Living Center
208 Oppegard Avenue Northwest, PO Box 480
Twin Valley, Minnesota 56584

Re: Enclosed Reinspection Results - Project Number SS5419024

Dear Ms. Schreiner:

On July 2, 2014 survey staff of the Minnesota Department of Health, Licensing and Certification Program completed a reinspection of your facility, to determine correction of orders found on the survey completed on May 15, 2014, with orders received by you on May 30, 2014. At this time these correction orders were found corrected and are listed on the attached Revisit Report Form.

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

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

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Division of Compliance Monitoring
P.O. Box 64900
St. Paul, Minnesota 55164-0900
Telephone: (651) 201-4118 Fax: (651) 215-9697
Email: mark.meath@state.mn.us

Enclosure(s)

cc: Original - Facility
Licensing and Certification File

5419r14lic.rtf

State Form: Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
00414	A. Building B. Wing	7/2/2014

Name of Facility	Street Address, City, State, Zip Code
TWIN VALLEY LIVING CENTER	208 OPPEGARD AVENUE NORTHWEST, PO BOX 480 TWIN VALLEY, MN 56584

This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **20005** Reg. # **MN Rule 4658.0015** LSC	Correction Completed **06/09/2014**	ID Prefix **20555** Reg. # **MN Rule 4658.0405 Subp. 1** LSC	Correction Completed **06/09/2014**	ID Prefix **20830** Reg. # **MN Rule 4658.0520 Subp. 1** LSC	Correction Completed **06/09/2014**
ID Prefix **21530** Reg. # **MN Rule 4658.1310 A.B.C** LSC	Correction Completed **06/09/2014**	ID Prefix **21535** Reg. # **MN Rule4658.1315 Subp.1 AB(** LSC	Correction Completed **06/09/2014**	ID Prefix **21600** Reg. # **MN Rule 4658.1335 Subp. 2** LSC	Correction Completed **06/09/2014**
ID Prefix **21942** Reg. # **MN St. Statute 144A.10 Subd. 4** LSC	Correction Completed **06/09/2014**	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By _____ **State Agency**	**Reviewed By** LB/mm	**Date:** 07/17/2014	**Signature of Surveyor:** 32981	**Date:** 07/02/2014
Reviewed By _____ **CMS RO**	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on: 5/15/2014

Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? **YES** **NO**

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: PD73

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00414

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245419**

2.STATE VENDOR OR MEDICAID NO.
(L2) **546242800**

3. NAME AND ADDRESS OF FACILITY
(L3) **TWIN VALLEY LIVING CENTER**
(L4) **208 OPPEGARD AVENUE NORTHWEST, PO BOX 480**
(L5) **TWIN VALLEY, MN** (L6) **56584**

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 **05/15/2014** (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 **58** (L18)

13.Total Certified Beds **58** (L17)

10.THE FACILITY IS CERTIFIED AS:
A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC

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

X B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	58			
(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 :
Debra Vincent, HFE NEII — 06/16/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Mark Meath
Enforcement Specialist — 07/02/2014 (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
02/01/1987
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7011 2000 0002 5143 4936

May 23, 2014

Ms. Shari Schreiner, Administrator
Twin Valley Living Center
208 Oppegard Avenue Northwest, POBox 480
Twin Valley, Minnesota 56584

RE: Project Number S5419024

Dear Ms. Schreiner:

On May 15, 2014, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

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

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

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

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

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

<u>Potential Consequences</u> - the consequences of not attaining substantial compliance 3 and 6 months after the survey date; and

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

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

DEPARTMENT CONTACT

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

Lyla Burkman, Unit Supervisor
Minnesota Department of Health
705 5th Street Northwest, Suite A
Bemidji, Minnesota 56601-2933

Phone: (218) 308-2104
Fax: (218) 308-2122

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by June 24, 2014, the Department of Health will impose the following remedy:

• State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by June 24, 2014 the following remedy will be imposed:

• Per instance civil money penalties. (42 CFR 488.430 through 488.444)

PLAN OF CORRECTION (PoC)

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

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;

- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;

- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;

- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;

- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,

- Include signature of provider and date.

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

• Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));

• Per day civil money penalty (42 CFR 488.430 through 488.444).

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's 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. In order for your allegation of compliance to be acceptable to the Department, the PoC 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 PoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL 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. A

Post Certification Revisit (PCR) will occur after the date you identified that compliance was achieved in your plan of correction.

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

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

If new deficiencies are identified at the time of the revisit, those deficiencies may be disputed through the informal dispute resolution process. However, the remedies specified in this letter will be imposed for original deficiencies not corrected. If the deficiencies identified at the revisit require the imposition

of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed.

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by August 15, 2014 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by November 15, 2014 (six months after the

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

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

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

Mr. Patrick Sheehan, Supervisor
Health Care Fire Inspections
State Fire Marshal Division
444 Cedar Street, Suite 145
St. Paul, Minnesota 55101-5145

Telephone: (651) 201-7205

Fax: (651) 215-0541

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

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Division of Compliance Monitoring
P.O. Box 64900
St. Paul, Minnesota 55164-0900
Telephone: (651) 201-4118 Fax: (651) 215-9697
Email: mark.meath@state.mn.us

Enclosure

cc: Licensing and Certification File 5419s14.rtf

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245419	A. BUILDING _____ B. WING _____ RECEIVED JUN 09 2014	05/15/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TWIN VALLEY LIVING CENTER	208 OPPEGARD AVENUE NORTHWEST, PO BOX 480 TWIN VALLEY, MN 56584

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. 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 on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 243 SS=C	483.15(c)(1)-(5) RIGHT TO PARTICIPATE IN RESIDENT/FAMILY GROUP A resident has the right to organize and participate in resident groups in the facility; a resident's family has the right to meet in the facility with the families of other residents in the facility; the facility must provide a resident or family group, if one exists, with private space; staff or visitors may attend meetings at the group's invitation; and the facility must provide a designated staff person responsible for providing assistance and responding to written requests that result from group meetings. This REQUIREMENT is not met as evidenced by: Based on interview, the facility failed to attempt to form a family council within the past calendar year as required. This had the potential to impact all 58 residents who resided in the facility. Findings include: On 5/14/14, at 8:29 a.m. the social worker (SW)	F 243	Twin Valley Living Center must provide a resident of family group if one exists, with private space; staff or visitors may attend meetings at the group's invitation; and the facility must provide a designated staff person responsible for providing assistance and responding to written requests that result from group meetings. Based on interview, the facility failed to attempt for form a family council within the past colander year as required. This had the potential to impact all 58 residents who resided in the facility.	Approved Le 6/16/14 JB

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Shari Schreiber, Executive Director — TITLE — (X6) DATE: 4/8/14

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
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F 243	Continued From page 1 indicated the facility did not currently have a family council and stated the last attempt to form a family council was in March 2013. However, the SW stated she did not have documentation of the attempt made in March 2013. On 5/15/14, at 10:42 a.m. the Administrator verified the facility did not have a family council and confirmed the last attempt to form the council was March 2013. The Administrator stated the facility should have attempted to organize the council every twelve months and stated it was her expectation that attempts to form a family council would be made annually within a twelve month period.	F 243	Twin Valley Social Service Department sent out invitations to form a family council on 5/16/2014. Social Service will send out yearly invitations in attempt to form a family council if there is a desire by families. This will be monitored by the Social Service Director; this information will be brought to the Quality Assurance Team for review.	6/9/14
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).	F 279	The Twin Valley Living Center must use the results of the assessment to develop, review, and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental, and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being.	

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F 279	Continued From page 2 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure care plan interventions were developed for 1 of 1 resident (R27) with wheelchair positioning needs during meals. Findings include: R27's Physician's Progress Note dated 2/12/14, indicated R27 was diagnosed with right sided weakness. R27's care plan dated 3/19/14, indicated R27 received a mechanical soft diet with dysphagia (difficulty swallowing) features and nectar thick liquids and was independent with eating after set up. The care plan directed staff to monitor R27 for choking/coughing while eating. On 5/14/14, from 6:55 a.m. until 7:56 a.m. R27 was observed in his wheelchair at the dining room table. R27 was observed to have bilateral footrests on the wheelchair. The table pedestal was observed to have four legs which extended out preventing R27 from sitting close to the table while eating. At 7:31 a.m. R27 was served breakfast. R27 was observed leaning forward in his wheelchair in order to reach his food that was placed on the table in front of him. At 7:56 a.m. R27 was observed to drop a piece of pancake on his clothing protector. At this time, the surveyor approached R27 and R27 stated he was too far away from the table for eating. R27 also stated his right collar bone area was sore	F 279	Based on observations, interview, and document review the facility failed to ensure care plan interventions were developed for 1 of 1 resident with wheelchair positioning needs during meals. This resident's care plan was updated on 5/16/2014 to include the need to remove leg rests or swing them to the side of his wheelchair to enable him to sit closer to the table. Education was provided to the RN's regarding updating care plans as conditions change. A monitoring program was established which includes and RN and a member of the therapy department who will conduct monthly audits of resident positioning in the dining room and who will present potential problems to the nursing or therapy department as indicated.	6/9/14

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F 279	Continued From page 3 from leaning forward in the chair to eat. On 5/14/14, from 11:27 a.m. until 11:46 a.m. R27 was observed seated in his wheelchair at the dining room table. His left footrest was observed up against the leg of the table which prevented R27 from sitting closer to the table. At 11:43 a.m. R27 was observed to pull his plate of food closer to him and took a bite of the potatoes. R27 was approximately 18 inches away from the table. At 11:46 a.m. upon request of the surveyor, the certified occupational therapy assistant (COTA) asked R27 if he would like to be closer to the table. The COTA was observed to measure the distance from the table to R27's chest which was 15 1/4 inches away. The COTA released R27's wheelchair leg rests and swung them to the side of R27's wheelchair and moved R27 closer to the table. After this was completed, the COTA measured the distance from the table to R27's chest which was 8-1/2 inches away. At 11:51 a.m. the COTA stated she had not instructed the nursing assistants (NA's) to move R27's leg rests out of the way during meals. The COTA stated based on the NA's training, they should have known to do that. The COTA added, she did not think moving the leg rests out of the way for meals would have to be on the care plan as that was a standard of practice. At 12:10 p.m. registered nurse (RN)-B verified the removal of R27's leg rests during meals was not addressed on the care plan. A care plan policy was requested and none was provided.	F 279	Care plans are reviewed monthly by the RN and random audits will be completed to ensure accuracy of care plans. Audit finding will be brought to the Quality Assurance team until compliance is met. Director of Nursing or designee will monitor for compliance.	

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F 285 SS=D	483.20(m), 483.20(e) PASRR REQUIREMENTS FOR MI & MR A facility must coordinate assessments with the pre-admission screening and resident review program under Medicaid in part 483, subpart C to the maximum extent practicable to avoid duplicative testing and effort. A nursing facility must not admit, on or after January 1, 1989, any new residents with: (i) Mental illness as defined in paragraph (m)(2)(i) of this section, unless the State mental health authority has determined, based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority, prior to admission; (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services for mental retardation. (ii) Mental retardation, as defined in paragraph (m)(2)(ii) of this section, unless the State mental retardation or developmental disability authority has determined prior to admission-- (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services for mental retardation. For purposes of this section: (i) An individual is considered to have "mental illness" if the individual has a serious mental illness defined at §483.102(b)(1).	F 285	Twin Valley Living Center must not admit any resident into the facility that has a diagnosis of MR or MI without the proper Preadmission screening and Resident Review. Based on the interview and document review, the facility failed to ensure a Level II screening was completed to determine need for specialized services for 2 of 2 residents that has a diagnosis of a developmental disability. Those residents who were identified had a level II screening completed 6/6/2014 by the appropriate counties. A policy was developed to guide employee's regarding prescreening of potential admissions. All staff responsible for pre-screening will be educated on the new policy. Social Service or her designee will monitor for compliance.	4/9/14

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F 285	Continued From page 5 (ii) An individual is considered to be "mentally retarded" if the individual is mentally retarded as defined in §483.102(b)(3) or is a person with a related condition as described in 42 CFR 1009. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure a Level II (Preadmission Screening and Resident Review) PASRR screening was completed to determine need for specialized services for 2 of 2 residents (R9, R31) reviewed for PASRR pre-admission screening who had diagnoses of a developmental disability. Findings include: R9 was admitted to the facility on 3/18/14. R9's most current diagnoses, according to her admission history and physical, dated 3/12/14, revealed a diagnosis of mild mental retardation. R9's OBRA Level I Screening for Developmental Disabilities or Mental Illness, dated 3/7/14, did not identify R9 as having a diagnosis of developmental disability or a related condition. R9 was not referred to the county offices for persons with developmental disabilities or related conditions for evaluation and determination of need for specialized services. R31 was admitted to the facility on 6/08/10. R31's diagnoses according to her admission history and physical, dated 6/5/10, revealed a diagnosis of mild mental retardation. No evidence of an OBRA Level I or II screening was present on R31's chart. During interview on 5/14/14, at 8:33 a.m. the facility's licensed social worker (LSW) said Mahnomen County was responsible for the Level	F 285		

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 285	Continued From page 6 II PASRR screenings. The LSW remarked that she thought she had been asked about R31's PASRR information last year and had obtained a copy from the county. The LSW believed R9 had a Level II PASRR screening on their chart and said she would place a call to Mahnomen County to clarify the status of the screening information for R9 and R31. During further interview on 5/15/14, at 8:50 a.m. the LSW said she still had not received word from Mahnomen County regarding the status of the PASRR screenings for R31 and R9. The LSW said Mahnomen County had faxed over R31's information to the facility, which were reviewed and did not contain evidence of a Level II PASRR screening. During interview on 5/15/14, at 9:06 a.m., R9's county social worker (CW) stated she did not do a Level II screening on R9 and was unfamiliar with R31's case. The CW further indicated that R9's diagnosis must be a "mistake" and that she did not believe R9 was developmentally disabled. On 5/15/14, at approximately 10:30 a.m. the Administrator stated the facility did not have a policy related to PASRR screening information but would be developing one.	F 285		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.	F 309	The Twin Valley Living Center must ensure each resident receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.	

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F 309	Continued From page 7 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure proper wheelchair positioning for 1 of 1 resident (R27) in order to enhance independent eating during meals. Findings include: R27's quarterly Minimum Data Set (MDS) dated 3/13/14, indicated R27 had moderate cognitive impairment and required supervision with eating. R27's Physician's Progress Note dated 2/12/14, indicated R27 was diagnosed with right sided weakness. R27 received an occupational therapy (OT) evaluation dated 2/11/14. The OT implemented side bolsters on R27's tilt and space wheelchair and provided trunk strengthening exercises three times a week. A follow up OT note dated 3/11/14, indicated R27 continued to lean to the right, however, it was less than in past observations. R27's care plan dated 3/19/14, indicated R27 was independent in eating after set-up and received a mechanical soft diet with dysphagia (difficulty swallowing) features and nectar thick liquids. The care plan directed staff to monitor R27 for choking and / or coughing. On 5/14/14, at 6:55 a.m. R27 was observed seated in his wheelchair at the dining room table. R27 was observed leaning to the right in his wheelchair with side bolsters and leg rests in place. The dining table pedestal was observed to have four legs which extended out around the post.	F 309	Based on observation, interview, and document review, the facility failed to ensure proper wheelchair positioning for 1 of 1 residents in order to enhance independent eating during meals. This resident's wheelchair positioning was reviewed with the COTA and it was determined that staff should remove the resident's wheelchair foot rests or swing the root rests to the side of the wheelchair to enable the resident to sit closer to the table. This intervention was added to the president's plan of care on 05/16/2014. The nursing assistants have been educated on the importance of appropriate positioning of the residents at the dining room table.	

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F 309	Continued From page 8 At 7:23 a.m. R27's wheelchair was observed to be positioned approximately 18 inches away from the table. R27's left foot rest pedal was up against the pedestal's extended table leg. R27 was observed to take a drink of thickened milk from a cup. At 7:31 a.m. R27 was served breakfast. R27 received a pancake and a fried egg served on a scoop plate. R27 was observed to pick up his fork with his right hand and independently take a bite of the pancake. R27 was observed leaning forward in his wheelchair in order to reach his food that was placed on the table in front of him. At 7:56 a.m. R27 was observed to drop a piece of pancake on his clothing protector. At this time, the surveyor approached R27. He stated he was too far away from the table for eating. R27 added, his right collar bone area was sore from leaning forward in the chair in order to eat. R27 was observed to consume 90% of his egg and pancake and 50% of the milk and juice. At 11:12 a.m. the certified occupational therapy assistant (COTA), stated R27's leg rests could be swung back out of the way or removed while he was at the dining table. At 11:27 a.m. R27 was observed seated in his wheelchair at the dining room table. R27's wheelchair was observed to have side bolsters and leg rests in place. R27's left footrest was observed up against the extended table leg. A cup of thickened milk and water was positioned on the table in front of R27. At 11:36 a.m. R27 was served his meal on a	F 309	A monitoring program was established which includes an RN and a member of the therapy department who will conduct monthly audits of resident positioning in the dining room and who will present potential problems to the nursing or therapy department as indicated. Audit finding will be brought to Quality Assurance team until compliance is met (see attachment C) Director of Nursing or designee will monitor for compliance.	06/09/2014

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F 309	Continued From page 9	F 309		

scoop plate. He was served a buttered bun, ground meat, fried potatoes and green beans. At 11:43 a.m. R27 pulled his plate closer to him and took a bite of the potatoes. R27 was approximately 18 inches away from the table.

At 11:45 a.m. R27 motioned for nursing assistant (NA)-A to come over to him. R27 was observed telling something to NA-A. NA-A responded to R27, "You want to go backwards?" NA-A then told R27 she did not want to tilt his wheelchair back while he was going to eat.

At 11:46 a.m. upon request of the surveyor, the COTA asked R27 if he would like to be closer to the table? The COTA was observed to measure the distance from the table to R27s chest which was 15-1/4 inches away. The COTA then swung R27's wheelchair leg rests to the sides of the wheelchair and moved R27 closer to the table. After this was completed, the COTA measured the distance from the table to R27s chest which was 8-1/2 inches away.

At 11:51 a.m. the COTA stated she had not instructed the NA's to move R27's leg rests out of the way during meals. The COTA stated based on the NA's training, they should have known to do that. The COTA added, she did not think moving the leg rests out of the way for meals would have to be on the care plan as that was a standard of practice.

At 12:05 p.m. registered nurse (RN)-C stated he taught the NA course and moving the leg rests out of the way for meals was not part of the NA curriculum.

At 12:10 p.m. (RN)-B verified the removal of leg

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F 309	Continued From page 10 rests during meals was not addressed on the care plan. At 1:16 p.m. NA-A stated it made sense to move R27's leg rests out of the way for meals. NA-A stated she had not been instructed to do that. On 5/15/14, at 8:55 a.m. the director of nursing (DON) stated there would not be a policy addressing proper wheelchair positioning.	F 309		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.	F 329	The Twin Valley Living Center must ensure that each resident's drug regimen be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy; or for excessive duration; or without adequate monitoring; or without adequate indication for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reason above. Based on observation, interview, and document review the facility failed to ensure there was adequate indications for use and adequate monitoring of an antipsychotic medication (Risperdal) for 1 of 5 residents whose drug regimen was reviewed.	

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F 329	Continued From page 11 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure there was adequate indications for use and adequate monitoring of an antipsychotic medication (Risperdal) for 1 of 5 residents (R57) whose drug regimen was reviewed. Findings include: R57's psychologist note dated 6/14/13, indicated R57 was diagnosed with delirium and confusion while recently in the hospital prior to admission. R57's physician's order dated 6/17/13, indicated R57 received Risperdal 0.5 milligrams (mg) every evening and 0.25 mg every morning for dementia with behaviors such as striking out with cares. R57's quarterly Minimum Data Set (MDS) dated 2/27/14, indicated R57's diagnoses included psychotic disorder, dementia and depression. The MDS also indicated R57 was cognitively intact and had no mood or behavior symptoms. R57's physician's progress note dated 8/14/13, indicated R57 was transferred out of the facility's secured memory unit. R57's physician's orders dated 9/25/13, indicated R57's morning dose of Risperdal was discontinued. R57's physician's orders dated 10/23/13, indicated Risperdal was decreased to 0.25 mg every evening. R57's physician's orders dated 12/4/13, indicated	F 329	This resident antipsychotic medication (Risperdal) was reviewed with her primary care physician on 05/21/2014 and the physician wrote order to "Change Risperdal 0.25mg orally to every other day x 2 weeks, then discontinues". The order was changed at that time. The consultant pharmacist will provide education to all RN's and LPN's regarding the use, indications for use, and monitoring of psychotropic medications. This in-service is scheduled for 06/25/2014. (See attachment B) Psychotropic medication monitoring will occur quarterly in combination with the resident's scheduled Minimum Data Set assessment. Random audits of resident's drug regimens will be conducted monthly and finding reviewed with the Quality Assurance tem until compliance is met. Director of Nursing or designee will monitor for compliance.	4/9/14

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F 329	Continued From page 12 Risperdal was discontinued. R57's nurses notes dated 12/8/13, indicated after the Risperdal was discontinued on 12/4/13, R57 had no signs/symptoms of psychosis (impaired contact with reality) noted. The note also indicated R57 did become anxious when worried about her children driving in bad weather and her first care conference meeting. R57's nurses note dated 12/12/13, at 10:50 a.m. indicated R57 had complaints of chest pain and had received 3 nitroglycerin tablets (used to treat episodes of chest pain) with relief noted. At 2:16 p.m. R57's family reported R57 seemed more anxious and confused, thinking today was church, nervousness and worried about not receiving her bath due to not feeling well. R57's nurses notes dated 12/13/13, at 1:37 p.m. indicated registered nurse (RN)-A spoke with R57's physician on the phone and reported R57's increased anxiety, episode of chest pain and increased confusion yesterday. RN-A documented she had informed R57's physician the Risperdal was discontinued on 12/4/13. The note also indicated the physician restarted the R57's Risperdal at 0.25 mg everyday for dementia with psychosis. On 12/20/13, the consulting pharmacist documented R57's Risperdal was stopped but then restarted 2 weeks later. On 5/13/14, at 12:59 p.m. R57 was observed doing a puzzle in her room. At 1:00 p.m. licensed practical nurse (LPN)-A stated R57 was admitted to the memory care unit and stated now R57 was more oriented than a lot	F 329		

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F 329	Continued From page 13 of the other residents. On 5/14/14, at 8:33 a.m. R57 was observed in her room working on a puzzle. R57 stated she just had some nervousness and no anxious feelings. R57 also stated she was mentally pretty clear but would forget for a few seconds or minutes. At 10:49 a.m. nursing assistant (NA)-A stated R57 would attempt to self transfer once and a while. NA-A stated she had not noticed any confusion. At 12:04 p.m. RN-B stated the only behavior of R57 that was tracked was attempts at self transfers. RN-B further stated there was no documentation to support the restart of the Risperdal. RN-B stated she would have had the NA's report hallucinations and increased confusion prior to restarting. On 5/15/14, at 8:17 a.m. the consulting pharmacist was interviewed via phone. The pharmacist stated another pharmacist had done R57's December 2013, medication review for her. The pharmacist stated her impression was that R57 had delirium while in the hospital just prior to admission and she wanted the Risperdal discontinued. The pharmacist stated she would need to see more specific behaviors other than to monitor attempts at self transfers to justify the use of the Risperdal. The pharmacist stated when she did the January 2014, review she did not review the explanation for the restart of Risperdal. The pharmacist also stated R57 was having more nervousness and that an increase in Remeron (antidepressant) would be more appropriate for those symptoms, and not the use of Risperdal.	F 329		

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F 329	Continued From page 14 On 5/15/14, at 9:28 a.m. RN-A stated she did not see any documentation of R57 having hallucinations. RN-A verified on 12/13/13, she had notified R57's physician regarding the chest pain and increased nervousness and also informed the physician that R57's Risperdal was recently discontinued. RN-A stated she would have wanted the NA's to track hallucinations or paranoia to justify the Risperdal use. RN-A verified there was not adequate documentation to justify the restart of the Risperdal. The Psychotropic Drug Monitoring policy dated 7/18/01, indicated the use of unnecessary medications would not be used outside regulation guidelines unless in the best interest of the resident to which there was supporting documentation.	F 329		
F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure the consulting pharmacist	F 428	Twin Valley Living Center must ensure the drug regimen of each resident be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and this report must be acted upon. Based on interview and document review, the facility failed to ensure the consulting pharmacist identified the lack of adequate monitoring and indications for the use of an antipsychotic medication (Risperdal) for 1 of 5 residents whose drug regiment was reviewed.	

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F 428	Continued From page 15 identified the lack of adequate monitoring and indications for the use of an antipsychotic medication (Risperdal) for 1 of 5 residents (R57) whose drug regiment was reviewed. Findings include: R57's psychologist note dated 6/14/13, indicated R57 was diagnosed with delirium and confusion while recently in the hospital. R57's physician's order dated 6/17/13, indicated R57 received Risperdal 0.5 milligrams (mg) every evening and 0.25 mg every morning for dementia with behaviors such as striking out with cares. R57's quarterly Minimum Data Set (MDS) dated 2/27/14, indicated R57's diagnoses included psychotic disorder, dementia and depression. The MDS also indicated R57 was cognitively intact and had no mood or behavior symptoms. R57's physician's progress note dated 8/14/13, indicated R57 was transferred out of the facility's secured memory unit. R57's physician's orders dated 9/25/13, indicated R57's morning dose of Risperdal was discontinued. R57's physician's orders dated 10/23/13, indicated Risperdal was decreased to 0.25 mg every evening. R57's physician's orders dated 12/4/13, indicated Risperdal was discontinued. R57's nurses notes dated 12/8/13, indicated after the Risperdal was discontinued on 12/4/13, R57 had no signs/symptoms of psychosis (impaired	F 428	Discussion with the consultant pharmacist was held regarding this citation. This residents medications have been reviewed by the consultant pharmacist on 05/20/2014 and recommendations reported to the Director of Nursing, RN's, Administrator, and the Physician. This resident's antipsychotic medication (Risperdal) was reviewed with her primary care physician on 05/21/2014 and the physician wrote orders to "Change Risperdal 0.25mg orally to every other day x 2 weeks, then discontinue". The order was change at that time. The consulting pharmacist will review the drug regimen of each resident at least monthly and report any irregularities to the DON and supervising RN's to share with the attending physician. The supervising RN's will ensure the recommendations of the consulting pharmacist will be addressed they the appropriate prescriber or attending physician.	

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F 428	Continued From page 16 contact with reality) noted. The note also indicated R57 did become anxious when worried about her children driving in bad weather and her first care conference meeting. R57's nurses noted dated 12/12/13, at 10:50 a.m. indicated R57 had complaints of chest pain and had received 3 nitroglycerin tablets (used to treat episodes of chest pain) with relief noted. At 2:16 p.m. R57's family reported R57 seemed more anxious and confused, thinking today was church, nervousness and worried about not receiving her bath due to not feeling well. R57's nurses notes dated 12/13/13, at 1:37 p.m. indicated registered nurse (RN)-A spoke with R57's physician on the phone and reported R57's increased anxiety, episode of chest pain and increased confusion yesterday. RN-A documented she had informed R57's physician the Risperdal was discontinued on 12/4/13. The note also indicated the physician restarted the R57's Risperdal at 0.25 mg everyday for dementia with psychosis. On 12/20/13, the consulting pharmacist documented R57's Risperdal was stopped but then restarted 2 weeks later. On 5/13/14, at 12:59 p.m. R57 was observed doing a puzzle in her room. At 1:00 p.m. licensed practical nurse (LPN)-A stated R57 was admitted to the memory care unit and stated now R57 was more oriented than a lot of the other residents. On 5/14/14, at 8:33 a.m. R57 was observed in her room working on a puzzle. R57 stated she just had some nervousness and no anxious	F 428	Random audits of resident's drug regimens will be conducted monthly and findings reviewed with the Quality Assurance team until compliance is met. Director of Nursing or designee will monitor for compliance.	6/9/14

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F 428	Continued From page 17 feelings. R57 also stated she was mentally pretty clear but would forget for a few seconds or minutes.. At 10:49 a.m. nursing assistant (NA)-A stated R57 would attempt to self transfer once and a while. NA-A stated she had not noticed any confusion. At 12:04 p.m. RN-B stated the only behavior of R57 that was tracked was attempts at self transfers. RN-B further stated there was no documentation to support the restart of the Risperdal. RN-B stated she would have had the NA's report hallucinations and increased confusion prior to restarting. On 5/15/14, at 8:17 a.m. the consulting pharmacist was interviewed via phone. The pharmacist stated another pharmacist had done R57's December 2013, review for her. The pharmacist stated her impression was that R57 had delirium while in the hospital and she wanted the Risperdal discontinued. The pharmacist stated she would need to see more specific behaviors other than to monitor attempts at self transfers to justify the use of the Risperdal. The pharmacist stated when she did the January 2014, review she did not review the explanation for the restart of Risperdal. The pharmacist also stated R57 was having more nervousness and that an increase in Remeron (antidepressant) would be more appropriate for those symptoms, and not the use of Risperdal. On 5/15/14, at 9:28 a.m. RN-A stated she did not see any documentation of R57 having hallucinations. RN-A verified on 12/13/13, she had notified R57's physician regarding the chest	F 428		

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F 428	Continued From page 18 pain and increased nervousness and also informed the physician that R57's Risperdal was recently discontinued. RN-A stated she would have wanted the NA's to track hallucinations or paranoia to justify the Risperdal use. RN-A verified there was not adequate documentation to justify the restart of the Risperdal. The Psychotropic Drug Monitoring policy dated 7/18/01, indicated the use of unnecessary medications would not be used outside regulation guidelines unless in the best interest of the resident to which there was supporting documentation.	F 428		
F 431 SS=F	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.	F 431	The Twin Valley Living Center must ensure drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions and the expiration date when applicable. Based on observation and interview, the facility failed to ensure there were no expired medications available for use in the emergency medication supply box. This had the potential to affect all 58 residents residing in the facility.	

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F 431	Continued From page 19 The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure there were no expired medications available for use in the emergency medication supply box. This had the potential to affect all 58 residents residing in the facility. Findings include: On 5/14/14, at 11:01 a.m. the medication room located on the 500/600/700 wings was reviewed with licensed practical nurse LPN-C. At 11:06 a.m. in the emergency medication supply box three expired medications were observed. -Mephyton (a medication to treat vitamin K deficiency or clotting problems) 5 milligram (mg) tablets (14) expired on 3/14. -Prednisone (a steroid medication used to treat inflammation) 5 mg tablets (12) expired on 4/14. -Ondansetron (a medication to treat nausea and vomiting) tablets (5) expired on 4/14. On 5/15/14, at 9:17 a.m. the director of nursing (DON) stated there was no policy to address how often the medications in the emergency supply	F 431	The expired medications were replaced by pharmacy on 05/14/2014. The emergency kit was checked at that time to make sure all remaining medications were within the appropriate expirations dates. The emergency kit was also monitored for completeness and to ensure that no expired medications were present on 05/28/2014 by the Director of Nursing and the Consultant Pharmacist. The Consultant Pharmacist and the Director of Nursing will complete monthly audits of the emergency kit for expiration dates and completeness of the log sheet (See attachment A). The audits will be brought to the Quality Assurance team until compliance is met. Director of Nursing or designee will monitor for compliance.	6/9/14

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F 431	Continued From page 20 box were checked for expiration dates. The DON stated it was her responsibility to check the box monthly. The DON stated she had missed checking for the expired medications the beginning of April.	F 431		
F 492 SS=F	483.75(b) COMPLY WITH FEDERAL/STATE/LOCAL LAWS/PROF STD The facility must operate and provide services in compliance with all applicable Federal, State, and local laws, regulations, and codes, and with accepted professional standards and principles that apply to professionals providing services in such a facility. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to ensure the supplemental nursing service agency (SNSA) utilized by the facility was properly registered with the Minnesota commissioner as required. This had the potential to affect all 58 who resided in the facility. Findings include: On 5/12/14, during the entrance conference, the Administrator indicated the facility utilized Prostat HealthCare LLC, located in Fargo, North Dakota as a supplemental nursing staff agency. Upon verification of the SNSA registration, it was found that the agency was not registered with the Minnesota commissioner. The administrator provided a highlighted schedule identifying the pool nursing staff hired by the facility. The list included one licensed practical nurse (LPN-B), and four nursing assistants (NA-C, NA-D, NA-E,	F 492	Twin Valley Living Center must operate and provide services in compliance with all applicable Federal, State, and local laws, regulation, and codes, and with accepted professional standards and principals that apply to professionals providing services in our facility. Based on interview and document review the facility failed to ensure the supplemental nursing service agency (SNSA) was properly registered with The Minnesota commissioner as required. This had the potential to affect all 58 residents who reside in the facility. On 5/14/2014 the Director of Nursing immediately removed all supplemental nursing service employees from the schedule.	

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F 492	Continued From page 21 NA-F). On 5/14/14, at 12:59 p.m. the Administrator verified the SNSA company was not on the Minnesota registry, and provided a print out of the currently registered (SNSA) companies in the state of Minnesota and confirmed Prostat was not on the registry. On 5/15/14, at 8:26 a.m. during an interview with the director of nursing (DON), who stated prior to hiring the above identified staff, she had not verified if Prostat HealthCare LLC was properly registered on the Minnesota registry. On 5/15/14, at 11:30 a.m. the administrator stated, "we do not have a policy regarding the use of SNSA's for hiring staff. "	F 492	A policy was developed for use of Supplemental Nursing Service Agencies, (see attachment). The Administrator or her designee will randomly audit the SNSA registry to ensure compliance.	4/9/14

Attachment A

Emergency Box Log Sheet

Date	Seal # Removed	Emergency Box Activity – Record name of resident and medication taken from the supply box	Pharmacy Notification Date	Seal # Applied	Staff Member Signature

Attachment B

Mandatory

For RN's/LPN's

Inservice

Psychotropic medications and indications for use

(Presented by Nicole Kruger, consultant pharmacist)

Wednesday June 25th 1pm and 3pm in East dining room

Attachment C

Dining Room Wheelchair Placement

Resident	Date	Meal	Noted Concern	Action	Initial

Signature: ________________

Signature: ________________

Signatuer: ________________

Signature: ________________

Twin Valley Living Center Policy for Supplemental Nursing Service Agency Employees

Prior to hiring a contracted employee through a Supplemental Nursing Agency the following items must be completed and on file:

- Full Name
- Date of Birth
- Criminal Back Ground Study
- OIG Exclusion Listing
- License or Registry Certificate
- SNSA (Supplemental Nursing Service Agency) listed as registered on the MN Department of Health website
- Completed In-service Education Requirements
- Employee Evaluation
- Mantoux screening
- Onsite Orientation

Date Created: 6/5/14 SKS

Reviewed by QA: _____

Twin Valley Living Center
Preadmission Screening and Resident Review
PASRR Policy

The preadmission screening identifies the person's need for NF level of care through screening of a person's health status, independence in activities of daily living, and the availability of supports and services that could meet the person's needs either in a Nursing Facility or in the community. The Preadmission Screening is conducted by The Minnesota Board on Aging and the Senior Linkage Line.

Level I screening identifies whether the applicant may have a serious mental illness. A level I screening must be completed for all referrals independent of and prior to Nursing Facility admission. If the Level I screening indicates the person may have a serious mental illness, a Level II evaluation and determination must be conducted prior to admission.

Level II Screening- is implemented to determine if a person has a mental illness and must be conducted by the county where the person physically resides. If a primary or secondary diagnosis exists, the screening also determines if the person is covered by regulation under OBRA. This evaluation must be based upon current diagnostic and functional assessment.

No person will be admitted to Twin Valley Living Center unless the Preadmission Screening and Resident Review (PASRR) has been completed and been determined appropriate for placement and to determine if they meet level of care and/or require specialized services for mental health care.

Date Created: 6-5-14 SAS
Reviewed by QA: _____

Twin Valley Living Center Care Plan Policy and Procedure

Policy: It is the policy of Twin Valley Living Center to provide an integrated plan of care for each resident in order to identify individual needs for service and program. A written plan of care will be developed for each resident in coordination with all services and individuals involved in the care of the resident.

Procedure

Admission: The Social Service Department in coordination with nursing will determine if the admission profile is appropriate for admission. They will notify each department of admission.

Each department will perform interviews, review charting, and perform assessment to complete the RAI process and formulate a plan of care with measurable time limited goals which address the individual resident's needs, desires, and approaches towards reaching those goals.

Initial Care Conference:

- The initial care conference is scheduled for each new resident within 21 days following admission.
- Each department head and/or representative will be present.
- The care plan is reviewed by all present at the conference.
- Everyone attending the Resident Care Conference including; residents, resident's family, staff or other participants will sign the care plan.
- Each department head will have the responsibility to see that their portion of the individual's plan in implemented.
- A Vulnerable Adult Abuse/Neglect Plan will be formulated for each resident according to the Vulnerable Adult Plan of the facility.
- A discharge plan will be formulated for each resident and addressed on the Plan of Care.

Record

The master plan of care is placed in the Care Plan book at the nurse's station on the unit where the resident resides.

Each individual resident plan of care shall contain.

- Name of Resident
- Date of initial conference
- Problems or needs of the resident
- Short term goals for each problem or need
- The approaches used to attain the goals

- The department responsible for implementing these approaches The long term goals developed for the resident
- A discharge plan or statement
- 30 day review and revisions If necessary
- The quarterly conference review dates and revisions in the plan of care.

Each plan of care will be implemented by all services. Individuals within each service will be assigned responsibilities in the care of the resident.

The RN Care Coordinator is responsible for the coordinating the development, monitoring the implementation and coordinating the reviews of each resident's plan of care.

30 Day Reviews

- The Registered Nurse, the Activities/Rehab Director, Social Service Director, and Food Service Supervisor who reviews the problems, needs, goals, and approaches for which they are responsible to do 30 day reviews.
- The reviews are documented on the last pages of the Resident Care Plan.
- When changes in the plan occur, each department head has the authority to make revisions necessary to the plan of care. Each change must by dated and signed.

Quarterly Review Conference

- Quarterly review conference will be held within 92 days of the previous conference for review and/or revision as needed by all services involved in the care of the resident.
- The resident and family or other representative will review timely invitation to the conference and be encouraged to attend all Care Conferences.
- All personnel attending the Resident Care Conference shall sign their name on the last pages of the care plan at each care conference (facility staff, resident, family, and any other participants).
- Each Department Head will have the responsibility to see their portion of the individual's plan of care is implemented.

Revision Date: 6-5-14

Adopted by QA: _____

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245419	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**05/14/2014**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TWIN VALLEY LIVING CENTER	**208 OPPEGARD AVENUE NORTHWEST, PO BOX 480 TWIN VALLEY, MN 56584**

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K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety. At the time of this survey Twin Valley Living Center was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K TAGS) TO: HEALTH CARE FIRE INSPECTIONS STATE FIRE MARSHAL DIVISION 444 CEDAR STREET, SUITE 145 ST. PAUL, MN 55101-5145, or By e-mail to:	K 000	POC ok TS 6-9-14 RECEIVED JUN - 9 2014 MN DEPT. OF PUBLIC SAFETY STATE FIRE MARSHAL DIVISION	

Exit: 5-15-14 DC: 6-24-14

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Shari Schreiner	Executive Director	4/8/14

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

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K 000	Continued From page 1 Marian.Whitney@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency Twin Valley Living Center is a 1-story building without a basement. The building was constructed at six different times. The original building was constructed in 1965 and was determined to be of Type II(111) construction. In 1969, a dining room addition was constructed to the south of the building that was determined to be of Type II(000) construction. In 1975 additions to the dining room and a activates were constructed and was determined to be Type II (000) constitution. In 1981, a sleeping room addition was constructed on the east side of the facility that was determined to be of Type V(111) construction. In 1992, a dayroom was added to the north of the 1965 building that is of Type II(111) construction. In 1995, a small dining room addition was added to the east side of the north wing of the 1965 building that is of Type II(111) construction. The latest addition was an administration wing in 1996 to the south of the 1981 addition, which is of Type V(111) construction. The building is divided into 9 smoke zones.	K 000		

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K 000	Continued From page 2 The building is fully sprinklered throughout in accordance with NFPA 13 Standard for the Installation of Sprinkler Systems 1999 edition . The facility has a fire alarm system with smoke detection at smoke barrier doors and in spaces open to the corridors that is monitored for automatic fire department notification in accordance with NFPA 72 "The National Fire Alarm Code" 1999 edition with single station smoke detection in all resident sleeping rooms Other hazardous areas have automatic fire detection that is on the fire alarm system in accordance with the Minnesota State Fire Code 2007 edition. The facility has a capacity of 58 beds and had a census of 58 at the time of the survey. Because the original building and its additions meet the construction type allowed for existing buildings, this facility was surveyed as a single building.	K 000		
K 056 SS=D	The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by: NFPA 101 LIFE SAFETY CODE STANDARD If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler	K 056	Twin Valley Living Center ordered spare sprinkler heads that were missing and had on hand by 5/2014. If for some reason a spare sprinkler head is used it will be replaced to ensure there are enough heads in storage to use as needed. This will be monitored by the Maintenance Director to ensure compliance.	4/9/14

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K 056	Continued From page 3 systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5 This STANDARD is not met as evidenced by: Based on observations and staff interview, it was found that the automatic sprinkler system is not installed and maintained in accordance with NFPA 13 the Standard for the Installation of Sprinkler Systems (99), Section 3-2.9. The failure to maintain the sprinkler system in compliance with NFPA 13 (99) could allow system being place out of service causing a decrease in the fire protection system capability in the event of an emergency that would affect 58 of 58 residents, visitors and staff of the facility. Findings include: On facility tour between 10:00 AM to 2:00 PM on 05/14/2014, observations reveled that the spare sprinkler head box located next to the main sprinkler riser assemble was not equipped with a full and complete compliment of spare heads that includes every type and style of sprinkler heads that are being used in the facility. The observed missing spare sprinkler heads were the fire sprinkler heads that were found in the Memory Care Dining Room, the Freezer/Refrigerator located in the Kitchen, older side wall heads and the heads that are located in the PT room located by the locked Memory Care Unit. This was confirmed by the Director of	K 056		

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K 056	Continued From page 4 Maintenance.	K 056		

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7011 2000 0002 5143 4936

May 23, 2014

Ms. Shari Schreiner, Administrator
Twin Valley Living Center
208 Oppegard Avenue Northwest, PO Box 480
Twin Valley, Minnesota 56584

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5419024

Dear Ms. Schreiner:

The above facility was surveyed on May 12, 2014 through May 15, 2014 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health, Compliance Monitoring Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

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

The State licensing orders are delineated on the attached Minnesota Department of Health order form (attached). The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute after the statement, "This Rule is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

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

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

When all orders are corrected, the order form should be signed and returned to this office at:

Lyla Burkman, Unit Supervisor
Minnesota Department of Health
705 5th Street Northwest, Suite A
Bemidji, Minnesota 56601-2933

Phone: (218) 308-2104
Fax: (218) 308-2122

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 Lyla Burkman at: (218) 308-2104.

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

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

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

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Division of Compliance Monitoring
P.O. Box 64900
St. Paul, Minnesota 55164-0900
Telephone: (651) 201-4118 Fax: (651) 215-9697
Email: mark.meath@state.mn.us

Enclosure(s)

cc: Original - Facility
Licensing and Certification File 5419s14lic.rtf