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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: QWIO

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00336

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245416**

2.STATE VENDOR OR MEDICAID NO.
(L2) **804242000**

3. NAME AND ADDRESS OF FACILITY
(L3) **MINNESOTA VALLEY HLTH CTR-LONG**
(L4) **621 SOUTH 4TH STREET**
(L5) **LE SUEUR, MN** (L6) **56058**

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 **11/09/2015** (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 **55** (L18)

13.Total Certified Beds **55** (L17)

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	55			
(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 :
Gayle Lantto, Unit Supervisor 01/05/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath, Enforcement Specialist 01/05/2016 (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
11/24/2015
(L33)

DETERMINATION APPROVAL

MDH
Minnesota
Department
of Health

CMS Certification Number (CCN): 245416

January 5, 2016

Ms. Luann Linn, Administrator
Minnesota Valley Hlth Center -Long
621 South 4th Street
Le Sueur, Minnesota 56058

Dear Ms. Linn:

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 October 7, 2015 the above facility is certified for:

55 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 55 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 eNotice.

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Email: mark.meath@state.mn.us

Minnesota Department of Health

Electronically delivered
November 30, 2015

Ms. Luann Linn, Administrator
Minnesota Valley Health Center-Long
621 South 4th Street
Le Sueur, Minnesota 56058

RE: Project Number S5416025

Dear Ms. Linn:

On September 29, 2015, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on September 24, 2015. This survey found the most serious deficiencies to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D), whereby corrections were required.

On November 9, 2015, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on November 18, 2015 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 September 24, 2015. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of October 7, 2015. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on September 24, 2015, effective October 7, 2015 and therefore remedies outlined in our letter to you dated September 29, 2015, will not be imposed.

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

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

Sincerely,

Mark Meath

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

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
245416	A. Building B. Wing	11/9/2015

Name of Facility	Street Address, City, State, Zip Code
MINNESOTA VALLEY HLTH CTR-LONG	621 SOUTH 4TH STREET LE SUEUR, MN 56058

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 **F0279** Reg. # **483.20(d), 483.20(k)(1)** LSC	Correction Completed **10/07/2015**	ID Prefix **F0281** Reg. # **483.20(k)(3)(i)** LSC	Correction Completed **10/07/2015**	ID Prefix **F0314** Reg. # **483.25(c)** LSC	Correction Completed **10/07/2015**
ID Prefix **F0431** Reg. # **483.60(b), (d), (e)** LSC	Correction Completed **10/07/2015**	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	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	GL/mm	11/30/2015	15507	11/09/2015
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
9/24/2015			

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D.C. 20503.

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245416	A. Building B. Wing **01 - MAIN BUILDING 01**	11/18/2015

Name of Facility	Street Address, City, State, Zip Code
MINNESOTA VALLEY HLTH CTR-LONG	621 SOUTH 4TH STREET LE SUEUR, MN 56058

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 Reg. # **NFPA 101** LSC K0154	**09/23/2015**	ID Prefix Reg. # **NFPA 101** LSC K0155	**09/23/2015**	ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	TL/mm	11/30/2015	34764	11/18/2015
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
9/23/2015	

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL ID: QWIO

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY Facility ID: 00336

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(L1) **245416**

2.STATE VENDOR OR MEDICAID NO.
(L2) **804242000**

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(L3) **MINNESOTA VALLEY HLTH CTR-LONG**
(L4) **621 SOUTH 4TH STREET**
(L5) **LE SUEUR, MN** (L6) **56058**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **09/24/2015** (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 **55** (L18)

13.Total Certified Beds **55** (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
	55			
(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 :
Shawn Soucek, HPR SWS 10/13/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath
Enforcement Specialist 11/24/2015 (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
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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
Posted 11/24/2015 Co.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
11/24/2015
(L33)

DETERMINATION APPROVAL

MINNESOTA
MDH
DEPARTMENT OF HEALTH
Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered
September 29, 2015

Ms. Luann Linn, Administrator
Minnesota Valley Health Center-Long
621 South 4th Street
Le Sueur, Minnesota 56058

RE: Project Number S5416025

Dear Ms. Linn:

On September 24, 2015, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs. This survey found the most serious deficiencies in your facility to be isolated deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level D), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

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

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

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

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

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

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

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

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

DEPARTMENT CONTACT

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

Gayle Lantto, Unit Supervisor
Metro D Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Email: gayle.lantto@state.mn.us
Phone: (651) 201-3794 Fax: (651) 215-9697

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 November 3, 2015, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

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

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

- Submit electronically to acknowledge your receipt of the electronic 2567, your review and your ePoC submission.

The state agency may, in lieu of a revisit, determine correction and compliance by accepting the facility's ePoC if the ePoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as

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

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by December 24, 2015 (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 March 24, 2016 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

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

Mr. Gary Schroeder, Interim Supervisor
Health Care Fire Inspections
State Fire Marshal Division
Email: gary.schroeder@state.mn.us
Telephone: (651) 201-7205 Fax: (651) 215-0525

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

Sincerely,

Mark Meath

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245416	A. BUILDING _____ B. WING _____	09/24/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MINNESOTA VALLEY HLTH CTR-LONG	621 SOUTH 4TH STREET LE SUEUR, MN 56058

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 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		10/7/15

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

Electronically Signed | 10/09/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245416	A. BUILDING _____ B. WING _____	09/24/2015

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MINNESOTA VALLEY HLTH CTR-LONG	621 SOUTH 4TH STREET LE SUEUR, MN 56058

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F 279	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to develop care plan interventions to minimize the risk of pressure sore development for 1 of 1 resident (R66) who developed a pressure ulcer during his stay at the facility. Findings include: R66 developed a pressure ulcer within 30 days of admission to the facility, and care plan interventions were lacking directing staff in measures that would have minimized the resident's risk for pressure ulcer development. R66 was admitted to the facility on 6/24/15, after a motor vehicle accident (MVA) and expired on 8/29/15. R66's Physician Orders dated 6/29/15, indicated R66 was on Lasix (a medication to reduce edema) 40 milligrams two times a day for edema in his lower extremities. R66's admission Minimum Data Set (MDS) dated 7/1/15, indicated R66 required extensive assistance of two staff for transfers, bed mobility, dressing and toileting. R66's admission active diagnoses were limited to anxiety disorder, hypertension and diabetes mellitus. R66's MDS admission skin assessment indicated the resident was at risk for pressure ulcers, however, pressure ulcers were not present at that time. R66's care plan dated 7/7/15, indicated an alteration in skin integrity as evidenced by the presence of bruising, abrasion, blisters or open wounds related to recent MVA, edema, and metastatic prostate cancer. R66's goal was to be free from skin breakdown by keeping skin clean	F 279	R66 was reviewed for this survey, but expired prior to survey. We are unable to correct any issues with R66 but will ensure well-being of all current and future residents. Our facility¿s policy is to complete resident care plans within 7 days of admission assessment completion. We will continue to do the following skin tools upon admission: skin snaps Q shift X 4 and weekly X 4; tissue tolerance and Braden skin assessment. An individualized care plan will be developed with appropriate interventions to reduce the risk of skin breakdown and ensure skin integrity of all residents. This was reviewed at the nurses meeting on October 7, 2015. DON will monitor care plans and report findings to quality council.	

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F 279	Continued From page 2	F 279		

and dry, nursing assistants were to observe for skin breakdown an report to nurses, encourage good nutrition, and to treat skin issues as directed on the electronic medication administration record (eMAR). On 7/22/15 a stage 2 pressure ulcer was discovered on R66's heel.

During an interview on 9/23/15, at approximately 2:00 p.m. LPN-A and LPN-B both stated R66's had a lot of edema (edema is abnormal accumulation of fluid beneath the skin) that went from his torso area down to his legs. LPN-B explained that she believed all the fluid from R66's edema went down to his heel which made the heel open into a pressure ulcer. LPN-B confirmed no interventions had been developed nor did she provide any special measures to minimize pressure ulcer development. LPN-B said "standard nursing" interventions such as lying in bed to take the pressure off his legs was provided, but no specialized interventions were provided until after therapy recommended a PRAFO boot on 7/23/15.

During on interview on 9/23/15, a RN-A verified R66's had a lot of edema to his legs and did develop a stage 2 pressure ulcer on his right heel. RN-A explained that skin checks were done by the nursing assistants (NAs) daily and during bathing times, and the nurses relied on the NAs to inform them of new skin issues. However, skin assessments were only completed annually by nurses. RN-A confirmed that no interventions had been initiated for minimize R66's risk for pressure ulcer development. When asked what specific interventions had been care planned to minimize R66's risk for pressure ulcer development, RN-A replied, "What can I say? If it wasn't documented then it wasn't done."

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F 279	Continued From page 3 The facility's policy and procedure titled Skin Integrity undated, indicated for nursing to complete a skin integrity section of the admission packet and complete a Skin Snapshot weekly x 4 (for four weeks).	F 279		
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to administer a medication as guidelines recommended for 1 of 5 residents (R25) reviewed for medication administration. Findings include: R25's medications were dispensed on 9/22/15, at 9:15 a.m. by a licensed practical nurse (LPN)-C. LPN-C dispensed two tablets of Tylenol ES 500 milligrams (mg) (for pain), one tablet of Lexapro 5 mg (for depression), one capsule of Namenda XR 28 mg (to enhance memory), one tablet of Prilosec 20 mg (for gastroesophageal reflux), one tablet of probiotic (for digestive health), one tablet of levothyroxine 100 micrograms (for high blood pressure). The cassette of Prilosec medication was labeled "Take 30 minutes before a meal". LPN-C indicated that the cassette had come from pharmacy and that pharmacy had placed the medication instruction label on the cassette. LPN-C also measured Miralax powder 17 grams	F 281	Our facility has consulted with our pharmacist who has done further research in regards to Prilosec. In collaboration with our pharmacist we have concluded Prilosec should be given prior to a meal but with not specific time frame. Prilosec insert states that it may be given with meals, and can also be opened and sprinkled on food if needed. The pharmacist has informed us that the label from the pharmacy is a suggestion not an absolute time limit. Our facility has taken measures to remove the 30 minute recommendation by simplifying the orders to state ¿give prior to a meal¿. This was also discussed in the mandatory nurses meeting that was held on October 7, 2015. Unit Managers will continue to monitor the orders and will report to the DON. This will be done in conjunction with the pharmacist who will also monitor the orders and report findings to quality council.	10/7/15

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F 281	Continued From page 4	F 281		

(gm) of powder and one package of uti stat into a glass of liquid.

At 9:23 a.m. LPN-C stated that R25 was eating her breakfast now and that resident preferred her medications with her meals because of nausea.

At 9:26 a.m. LPN-C entered the eating area where R25 was seated at the table eating her breakfast. One 1/2 slice of toast was observed on R25's plate before her and all of R25's scrambled eggs and the other 1/2 of toast were observed to already have been eaten. LPN-C then proceeded to administer R25's medications to her, two pills at a time on a spoon until all medications were given.

R25's quarterly Minimum Data Set (MDS) dated 6/23/15, indicated R25's cognition was moderately impaired, she had a diagnosis of dementia, but did not reject care.

The following day at 12:07 p.m. LPN-B reported R25 became "pretty confused." She explained that R25 was not woken up for morning medications, but took them with breakfast, two pills at a time.

A nurse practitioner (NP)-A who was present on the unit then stated she would have expected Prilosec be administered before meals, and for to follow pharmacy instructions to take 30 minutes before a meal. A NP note on 5/11/15, revealed R25's "daughter was wondering if she could have something for GERD [gastroesophageal reflux disease] as she used to take omeprazole [for Prilosec] some time ago, and once in a while she does complain to her family of some heartburn type of symptoms."

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F 281	Continued From page 5 At 12:35 p.m. registered nurse (RN)-A stated her understanding was that the medication Prilosec should have been given on an empty stomach, 30 minutes before eating. RN-A stated, "I can certainly change the time on the order" and proceeded to change the time of administration on the computer physician order from 6:00 a.m. to 7:30 a.m. and added special instructions to "Give 30 min before bkfst [breakfast] on empty stomach." RN-A indicated these special instructions would then show up on the resident's electronic medication administration record (eMAR) for the nurse to see when administering medications. R25's care plan dated 4/15/15, directed staff to follow physician orders for medications. The 9/15, MAR indicated on 9/15/15, that Prilosec was "Administered late at 12:25 by [LPN-C] Comment: given at lunch when res [resident] wanted". On 9/16/15, it was again noted the medication was administered late by LPN-B, without comment as to why. On 9/22/15, at 2:33 p.m. the director of nursing stated that nurses when administering medications should primarily go by the physician's order as well as the pharmacy recommendations. On 9/23/15, at 3:28 p.m. the consulting pharmacist (CP)-A stated via a telephone interview that Prilosec had to be given 30 minutes before a meal on an empty stomach. It was recommended it be administered in that manner, as it was absorbed into the system better on an empty stomach. CP-A also stated that administering Prilosec at the same time of a meal was not the correct way to administer the	F 281		

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F 281	Continued From page 6 medication.	F 281		
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to ensure interventions were in place to reduce the risk of pressure ulcer development for 1 of 2 residents (R66) reviewed for pressure ulcers. Findings include: R66 developed a pressure ulcer within 30 days of admission to the facility. R66 was admitted to the facility on 6/24/15, after a motor vehicle accident (MVA) and expired on 8/29/15. R66's Physician Orders dated 6/29/15, indicated R66 was on Lasix (a medication to reduce edema) 40 milligrams two times a day for edema in his lower extremities. R66's admission Minimum Data Set (MDS) dated 7/1/15, indicated R66 required extensive assistance of two staff for transfers, bed mobility, dressing and toileting. R66's admission active diagnoses were limited to	F 314	R66 was reviewed for this survey, but expired prior to survey. We are unable to correct any issues with R66 but will ensure well-being of all current and future residents. We will continue to do the following skin tools upon admission: skin snaps Q shift X 4 and weekly X 4; tissue tolerance and Braden skin assessment. Also will continue to do Braden quarterly as per policy and skin snap annually. If new skin issues arise the provider will be notified, a skin alteration tool, and a new Braden will be completed. Our skin alteration tool has pictures so nurses can indicate where the wound is located and also includes documentation regarding wound size, depth, color, drainage and interventions. We have also taken steps to add skin to our weekly charting template for all nurses to complete to observe skin on each resident in this	10/7/15

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F 314	Continued From page 7 anxiety disorder, hypertension and diabetes mellitus. R66's MDS admission skin assessment indicated the resident was at risk for pressure ulcers, however, pressure ulcers were not present at that time. However, a subsequent assessment dated 8/18/15, indicated one stage 2 pressure ulcer developed on the resident's right heel on 7/22/15, fewer than 30 days after admission to the facility. R66's care plan dated 7/7/15, indicated an alteration in skin integrity as evidenced by the presence of bruising, abrasion, blisters or open wounds related to recent MVA. Also indicated edema related to metastatic prostate cancer. R66's goal was to be free from skin breakdown with staff to provide interventions to observe for evidence of skin breakdown during cares and update nurse for evaluation and treatment. The care plan was updated on 7/23/15, after the stage 2 pressure ulcer was discovered. Staff was directed to utilize a PRAFO boot (specialized pressure reducing boot) to right foot and to keep heel off loaded when in bed and when up in wheelchair. R66's care plan, however, did not direct staff to use preventative interventions to minimize the risk of pressure ulcers at the time of admission, nor after a nurse documented R66 had red feet/legs, edema and a blister that opened on his heel on 7/15/15. Progress notes were as follows: 1) R66's admission progress note dated 6/24/15, did not reflect any concerns relating to pressure ulcers to R66's heels nor any indication of edema. 2) On 7/15/15, from registered nurse (RN)-B noted R66's "had red feet and legs with 2+	F 314	facility. Nurses were instructed during the mandatory nurses meeting on October 7, 2015 of this change and were also instructed to notify the Unit Managers of any skin issues. Every Thursday we will meet to discuss skin issues during our Medicare Touch Base Meetings. Unit Managers will continue to monitor skin on a quarterly basis unless indicated sooner. DON will monitor and audit skin charting, and assessments and will report findings to quality council.	

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F 314	Continued From page 8	F 314		

edema." (pitting edema is abnormal accumulation of fluid beneath the skin when pressed in a dent is left in the skin, depending on the time it take the dent to fill back in is measured in stages from 1+ to 4+ the greater the number the more edema noted.)

3) On 7/16/15, from licensed practical nurse (LPN)-C noted R66's "blister on right heel popped and had a small open area. Writer cleaned with wound cleaner an applied mepiplex [sic]."

4) On 7/22/15, LPN-B noted "Therapy placed Mepilex on open area on heel, will see if therapy can start a wound care plan." A follow up note one half hour later noted "Therapy is unable to do wound care on residents unless wound is greater than 30 day old. Will update nurse practitioner on rounds and see if we should start a different treatment." However, evidence was lacking to show the NP had been updated. The following day LPN-B noted "Therapy also looking for a boot for [R66's] right foot that will keep pressure off of site."

R66's Treatment Administration History (TAH) for the month of July 2015, indicated on 7/25/15, a treatment order was started for staff to clean right heel with wound cleanser, cover with 4 x 4 and wrap with Kerlex, heel protector on while in bed. R66's TAH directed staff to observed skin weekly on Wednesdays and document on skin observation sheet with a start date of 7/1/15.

R66's Skin Snapshot sheets lacked any information related to the development of a stage 2 pressure ulcer. R66's skin was assessed on the following dates 6/24, 6/25, 7/1, 7/8, 7/15, 7/22, and 8/24/15. Skin alterations were noted as

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follows: On 6/25/15, 3+ edema to both arms and lower body; on 7/15/15, coccyx area red; and on 8/24/15, red area on heel and bottom.

During an interview on 9/23/15, at approximately 2:00 p.m. LPN-A and LPN-B both stated R66's had a lot of edema that went from his torso area down to his legs. LPN-B explained that she believed all the fluid from R66's edema went down to his heel which made the heel open into a pressure ulcer. LPN-B confirmed no interventions had been developed nor did she provide any special measures to minimize pressure ulcer development. LPN-B said "standard nursing" interventions such as lying in bed to take the pressure off his legs was provided, but no specialized interventions were provided until after therapy recommended a PRAFO boot on 7/23/15.

During on interview on 9/23/15, a RN-A verified R66's had a lot of edema to his legs and did develop a stage 2 pressure ulcer on his right heel. RN-A explained that skin checks were done by the nursing assistants (NAs) daily and during bathing times, and the nurses relied on the NAs to inform them of new skin issues. However, skin assessments were only completed annually by nurses. RN-A confirmed that no interventions had been initiated for minimize R66's risk for pressure ulcer development. When asked what specific interventions had been care planned to minimize R66's risk for pressure ulcer development, RN-A replied, "What can I say? If it wasn't documented then it wasn't done."

The facility's policy and procedure titled Skin Integrity undated, indicated for nursing to complete a skin integrity section of the admission

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F 314	Continued From page 10 packet and complete a Skin Snapshot weekly x 4 (for four weeks).	F 314		
F 431 SS=D	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. 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.	F 431		10/7/15

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F 431	Continued From page 11 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure expired medication for 1 of 1 resident (R52) was removed from 1 of 2 carts reviewed for medication storage. Findings include: R52's Advair medication (inhaler) was stored in the medication cart for use on 9/21/15, at 1:46 p.m. The medication was had been opened and seven doses remained, however, the medication had not been labeled when opened. A licensed practical nurse (LPN)-C stated, "Usually we mark the date on the hard part of the inhaler when we take it out of the box and start using it." LPN-C verified that R52's Advair had not been dated when opened, but that it and had been delivered by the pharmacy on 8/10/15, with 60 doses. LPN-C also stated that R52 received one puff of the inhaler twice daily, and was re-ordered approximately a week prior to needing a new supply. LPN-C further stated that she did not know when R52's Advair was opened, as the date was missing. LPN-C then stated, "I should probably lock this and start using a new one. I will open up a new Advair and will date it today." In addition LPN-C stated she would report the issue to the nurse manager. LPN-C then referred to the new Advair manufacturer's instructions that read, "Safely throw away Advair Diskus in the trash 1 month after you open the foil pouch or when the counter reads 0, whichever comes first." LPN-C stated, "We are trained to follow the medication insert that comes with the Advair either that or the Omnicare Inhaled Medication Administration Sheet."	F 431	LPN determined that an Advair for resident R52 was not dated when opened and then immediately removed it and placed it in our locked expired medication disposal storage. LPN immediately opened a new one, dated it, and used it for the resident. The staff were immediately reminded to place a date on the Advair when opening so as to determine the expiration date of 30 days after opening. A mandatory education meeting was set up for October 7, 2015 to review the policies and procedures regarding expired and discontinued medications. The Primary Nurse for each unit, or HIM, will audit their medication carts biweekly to ensure medications are dated, and to identify medications about to expire which will be reported to the DON. Our Pharmacy Consultant was notified and will continue to do the quarterly medication review and report to Quality Council. Audit findings will be monitored by DON or designee and evaluated by Quality Council.	

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F 431	Continued From page 12 On 9/23/15, at 7:06 a.m. LPN-B stated, "When I first take an Advair out of the box to use it, I date it on the inhaler. I think it is good for 30 days." Early afternoon at 12:26 p.m. a nurse practitioner (NP)-A stated that R52 had diagnoses of chronic obstructive pulmonary disease and congestive heart failure and received oxygen. NP-A also stated that Advair was to be thrown away 30 days after opening because of decreasing effectiveness. R52 had a physician order for Advair Diskus 250-50 mcg/dose; amt [amount] 1 puff; inhalation Twice a day" R52's care plan indicated she was at risk for disease related to breathing difficulties. A physician visit dated 8/5/15, indicated R52 had end-stage COPD [chronic obstructive pulmonary disease] with chronic respiratory failure. She is using oxygen...." The director of nursing on 9/22/15, at 2:30 p.m. stated that the pharmacy provided information as to how to administer Advair. The medication was good for 30 days after opening, and staff referred to the manufacture's insert and "are expected to date the Advair when opening." The following day the consulting pharmacist (CP)-A was interviewed via telephone at 3:28 p.m. He stated Advair was only good for 30 days and should be thrown out 30 days after opening because of decreased effectiveness. The 5/26/09, Omnicare Inhaled Medication Administration Guide indicated "Advair Diskus instructs Use by Discard 1 month after opening	F 431		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245416	A. BUILDING _____ B. WING _____	09/24/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MINNESOTA VALLEY HLTH CTR-LONG	621 SOUTH 4TH STREET LE SUEUR, MN 56058

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F 431	Continued From page 13 foil pouch or after the indicator reads '0' whichever comes first."	F 431		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245416	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**09/23/2015**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MINNESOTA VALLEY HLTH CTR-LONG	**621 SOUTH 4TH STREET** **LE SUEUR, MN 56058**

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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 ON-SITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety - State Fire Marshal Division. At the time of this survey, Minnesota Valley Memorial Hospital C & NC 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 445 Minnesota St., Suite 145	K 000	EPOC	

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

Electronically Signed — 10/09/2015

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245416	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**09/23/2015**

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K 000	Continued From page 1 St Paul, MN 55101-5145, or By email to: Marian.Whitney@state.mn.us and Angela.Kappenman@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. Minnesota Valley Memorial Hospital C & NC is a 1-story building with a partial basement. The building was constructed at 2 different times. The original building was constructed in 1967 and was determined to be of Type II(111) construction. In 1996, addition was constructed to the East Wing that was determined to be of Type II(111) construction. Because the original building and the 1 addition are of the same type of construction allowed for existing buildings, the facility was surveyed as one building. The facility is fully sprinklered. The facility has a fire alarm system with smoke detection in resident rooms, corridors and spaces open to the corridors that is monitored for automatic fire department notification.	K 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245416	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**09/23/2015**

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MINNESOTA VALLEY HLTH CTR-LONG	**621 SOUTH 4TH STREET** **LE SUEUR, MN 56058**

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K 000	Continued From page 2 The facility has a capacity of 55 beds and had a census of 43 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 154 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Where a required automatic sprinkler system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction is notified, and the building is evacuated or an approved fire watch system is provided for all parties left unprotected by the shutdown until the sprinkler system has been returned to service. 9.7.6.1	K 154		9/23/15
	This STANDARD is not met as evidenced by: Where a required automatic sprinkler system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction is notified, and the building is evacuated or an approved fire watch system is provided for all parties left unprotected by the shutdown until the sprinkler system has been returned to service. 9.7.6.1 On facility tour between 9:00 AM and 12:00 PM on 09/23/2015, observation and documentation reviewed revealed that there was not a single plan for the out of service plan for the fire sprinkler system. This deficient practice was confirmed by the		Our Director of Facilities has completed a separate plan for the sprinkler system being out of service for more than 4 hours in a 24 hour period.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245416	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**09/23/2015**

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K 154	Continued From page 3 Facility Maintenance Director (RL) at the time of discovery.	K 154		
K 155 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Where a required fire alarm system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction is notified, and the building is evacuated or an approved fire watch is provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service. 9.6.1.8 This STANDARD is not met as evidenced by: Where a required fire alarm system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction is notified, and the building is evacuated or an approved fire watch is provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service. 9.6.1.8 On facility tour between 9:00 AM and 12:00 PM on 09/23/2015, observation and documentation reviewed revealed that there was not a single plan for the out of service plan for the fire alarm system. This deficient practice was confirmed by the Facility Maintenance Director (RL) at the time of discovery.	K 155	Our Director of Facilities has completed a separate plan for the fire alarm system being out of service for more than 4 hours in a 24 hour period.	9/23/15