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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: RUUO

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00121

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245442**
2.STATE VENDOR OR MEDICAID NO.
(L2) **046545300**

3. NAME AND ADDRESS OF FACILITY
(L3) **SPRING VALLEY CARE CENTER**
(L4) **800 MEMORIAL DRIVE**
(L5) **SPRING VALLEY, MN** (L6) **55975**

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 **10/21/2013** (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 **50** (L18)

13.Total Certified Beds **50** (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
	50			
(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):

See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Gary Schroeder, Deputy State Fire Marshall 08/14/2013 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 05/21/2014 (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
03/01/1987
(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
07/30/2013
(L33)

DETERMINATION APPROVAL

C&T REMARKS - CMS 1539 FORM **STATE AGENCY REMARKS**

CCN: 24-5442

A follow up of the Life Safety Code deficiency KTAG 0038 from the standard survey, completed on May 31, 2013 was completed. It was recommended for a temporary waiver with a date of completion of September 30, 2013 and was completed and found corrected on October 21, 2013.

Refer to the CMS 2567b for results of this revisit.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

February 28, 2014

Ms. Penny Solberg, Administrator
Spring Valley Care Center
800 Memorial Drive
Spring Valley, Minnesota 55975

RE: Project Number F5442021

Dear Ms. Solberg:

On June 7, 2013 we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on May 31, 2013. 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 August 14, 2013 we notified you that based on our follow-up visit completed on July 15, 2013 we determined that your facility had corrected the deficiencies issued pursuant to our standard survey, effective

On August 14th, we also informed you that your request for a temporary waiver involving the Life Safety Code deficiency cited at K38, including the date of completion of September 30, 2013 had been approved.

A follow-up of the remaining Life Safety Code deficiency cited at K38 was completed on October 21, 2013 and the deficiency was found to be corrected as of September 30, 2013. Enclosed is a copy of the Post Certification Revisit Form (CMS-2567B) from this visit.

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

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Telephone: (651) 201-4112
Fax: (651) 215-9697

cc: Licensing and Certification File

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
245442	A. Building B. Wing 01 - MAIN BUILDING 01	10/21/2013

Name of Facility	Street Address, City, State, Zip Code
SPRING VALLEY CARE CENTER	800 MEMORIAL DRIVE SPRING VALLEY, MN 55975

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

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix Reg. # NFPA 101 LSC K0038	09/30/2013	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		ID Prefix Reg. # LSC	

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	PS/kfd	02/28/2014	25822	10/21/2013
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
5/28/2013	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINSTRATION

FORM APPROVED
OMB No. 0938-0391

SURVEY TEAM COMPOSITION AND WORKLOAD REPORT

Provider/Supplier Number	Provider/Supplier Name
245442	SPRING VALLEY CARE CENTER

Type of Survey (select all that apply):

D					

A Complaint Investigation
B Dumping Investigation
C Federal Monitoring
D Follow-up Visit
E Initial Certification
F Inspection of Care
G Validation
H Life safety Code
I Recertification
J Sanction/Hearing
K State License
L Chow

Extent of Survey (Select all that apply):

A					

A Routine/Standard (all providers/suppliers)
B Extended Survey (HHA or long term care facility)
C Partial Extended Survey (HHA)
D Other Survey

SURVEY TEAM AND WORKLOAD DATA

Please enter the workload information for each surveyor. Use the surveyor's information number.

Surveyor Id Number (A)	First Date Arrived (B)	Last Date Departed (C)	Pre-Survey Preparation Hours (D)	On-Site Hours 12am-8am (E)	On-Site Hours 8am-6pm (F)	On-Site Hours 6pm-12am (G)	Travel Hours (H)	Off-Site Report Preparation Hours (I)
1. Team Leader 25822	10/21/13	10/21/13	0.50	0.00	0.00	0.00	0.00	0.50
2.								
3.								
4.								
5.								
6.								
7.								
8.								
9.								
10.								

Total Supervisory Review Hours ..... 0.00 .25

Total Clerical/Data Entry Hours.....

Was Statement of Deficiencies given to the provider on-site at completion of the survey? ..... .25

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: RUUO

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00121

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245442**
2.STATE VENDOR OR MEDICAID NO.
(L2) **046545300**

3. NAME AND ADDRESS OF FACILITY
(L3) **SPRING VALLEY CARE CENTER**
(L4) **800 MEMORIAL DRIVE**
(L5) **SPRING VALLEY, MN** (L6) **55975**

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 (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 **50** (L18)

13.Total Certified Beds **50** (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

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
	50			
(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):

See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Gary Nederhoff, Unit Supervisor 08/14/2013 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Colleen B. Leach, Program Specialist 12/20/13 (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
03/01/1987
(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
07/30/2013
(L33)

DETERMINATION APPROVAL

C&T REMARKS - CMS 1539 FORM **STATE AGENCY REMARKS**

CCN: 24-5442

Post Certification Revisit by review of the facility's plan of correction, to verify that the facility has achieved and maintained compliance with Federal Certification Regulations. Please refer to the CMS 2567B. Effective July 3, 2013, the facility is certified for 50 skilled nursing facility beds.

The facility's request for a temporary waiver with a completion date of September 30, 2013 has been approved.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Medicare Provider # 24-5442 December 20, 2013

Ms. Penny Solberg, Administrator
Spring Valley Care Center
800 Memorial Drive
Spring Valley, Minnesota 55975

Dear Ms. Solberg:

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 July 3, 2013, the above facility is certified for:

50 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 50 skilled nursing facility beds.

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

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

Please contact me if you have any questions.

Sincerely,

Colleen Leach

Colleen B. Leach, Program Specialist
Program Assurance Unit, Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
P.O. Box 64900, St. Paul, MN 55164-0900
Telephone #: (651)201-4117 Fax #: (651)215-9697

cc: Licensing and Certification File

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

August 14, 2013

Ms. Penny Solberg, Administrator
Spring Valley Care Center
800 Memorial Drive
Spring Valley, Minnesota 55975

RE: Project Number S5442024

Dear Ms. Solberg:

On June 7, 2013, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on May 31, 2013. 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 15, 2013, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on July 5, 2013 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 31, 2013. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of July 3, 2013. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on May 31, 2013, effective July 3, 2013 and therefore remedies outlined in our letter to you dated June 7, 2013, will not be imposed.

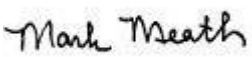
Correction of the Life Safety Code deficiency cited under K38 at the time of the May 31, 2013 standard survey, has not yet been verified. Your plan of correction for this deficiency, including your request for a temporary waiver with a date of completion of September 30, 2013, has been approved.

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, Program Specialist
Program Assurance Unit
Licensing and Certification Program
Division of Compliance Monitoring
85 East Seventh Place, Suite 220
P.O. Box 64970
St. Paul, MN 55164-0970
Telephone: (651) 201-4118 Fax: (651) 281-9697

Enclosure

cc: Licensing and Certification File 5442r13.rtf

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
245442	A. Building B. Wing	7/15/2013

Name of Facility	Street Address, City, State, Zip Code
SPRING VALLEY CARE CENTER	800 MEMORIAL DRIVE SPRING VALLEY, MN 55975

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

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix **F0156** Reg. # **483.10(b)(5) - (10), 483.10(b)(1)** LSC	**06/10/2013**	ID Prefix **F0282** Reg. # **483.20(k)(3)(ii)** LSC	**06/30/2013**	ID Prefix **F0309** Reg. # **483.25** LSC	**06/12/2013**
ID Prefix **F0312** Reg. # **483.25(a)(3)** LSC	**06/30/2013**	ID Prefix **F0327** Reg. # **483.25(j)** LSC	**06/11/2013**	ID Prefix **F0371** Reg. # **483.35(i)** LSC	**06/19/2013**
ID Prefix **F0441** Reg. # **483.65** LSC	**06/10/2013**	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 State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	MM/GPN	08/14/2013	25822	07/15/2013
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
5/31/2013			

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
245442	A. Building / B. Wing: **01 - MAIN BUILDING 01**	7/5/2013

Name of Facility	Street Address, City, State, Zip Code
SPRING VALLEY CARE CENTER	800 MEMORIAL DRIVE SPRING VALLEY, MN 55975

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

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix Reg. # **NFPA 101** LSC K0029	**07/03/2013**	ID Prefix Reg. # **NFPA 101** LSC K0050	**07/03/2013**	ID Prefix Reg. # **NFPA 101** LSC K0144	**07/03/2013**
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 State Agency	**Reviewed By** MM/PS	**Date:** 08/14/2013	**Signature of Surveyor:** 25822	**Date:** 07/05/2013
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**
Followup to Survey Completed on: 5/28/2013		**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: RUUO

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00121

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245442**
2.STATE VENDOR OR MEDICAID NO.
(L2) **046545300**

3. NAME AND ADDRESS OF FACILITY
(L3) **SPRING VALLEY CARE CENTER**
(L4) **800 MEMORIAL DRIVE**
(L5) **SPRING VALLEY, MN** (L6) **55975**

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 **05/31/2013** (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 **50** (L18)

13.Total Certified Beds **50** (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
	50			
(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):

At the time of the Standard survey, the facility was not in compliance with Federal certification regulations. Please refer to the CMS 2567 for both health and life safety code along with the facility's plan of correction. Documentation in support of the facility's request for a temporary waiver of K38 is being forwarded to CMS for approval. Post Certification Revisit to follow.

17. SURVEYOR SIGNATURE Date :
Lee Marietta, HFE NEII 06/18/2013 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Colleen B. Leach, Program Specialist 07/26/2013 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
03/01/1987
(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 7/30/2013 ML

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 3854

June 7, 2013

Ms. Penny Solberg, Administrator
Spring Valley Care Center
800 Memorial Drive
Spring Valley, Minnesota 55975

RE: Project Number S5442024

Dear Ms. Solberg:

On May 31, 2013, 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:

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

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

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

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

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

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

DEPARTMENT CONTACT

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

Gary Nederhoff
Minnesota Department of Health
18 Wood Lake Drive Southeast
Rochester, Minnesota 55904

Telephone: (507) 206-2731

Fax: (507) 206-2711

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by July 10, 2013, 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 July 10, 2013 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 31, 2013 (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 December 1, 2013 (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:

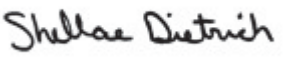
Mr. Patrick Sheehan, Supervisor
Health Care Fire Inspections
State Fire Marshal Division
444 Cedar Street, Suite 145
St. Paul, Minnesota 55101-5145

Telephone: (651) 201-7205

Fax: (651) 215-0541

Feel free to contact me if you have questions.

Sincerely,



Shellae Dietrich, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: (651) 201-4106 Fax: (651) 215-9697

Enclosure

cc: Licensing and Certification File 5442s13.rtf

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245442	A. BUILDING _____ JUN 17 2013 B. WING _____ MN Dept of Health Rochester	05/31/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING VALLEY CARE CENTER	800 MEMORIAL DRIVE SPRING VALLEY, MN 55975

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD 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 156 SS=D	483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing. The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and	F 156	SEE Attached form	6-10-13

6-18-13 SPN

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

[signature] RN. P.O.N. — 6-13-13

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. SPN

DRAFT PLAN OF CORRECTION 6/3/13

F156 The facility must inform the resident both orally and in writing in a language that he resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility.....

What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?	The power of attorney will be sent a reimbursement check along with the letter of explanation. Letter and check were dated June 4th 2013.
How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?	Residents who would be at potential risk are those who are here and were here for a short term stay or require skilled rehab (Managed Care) where a notice of coverage would need to be issued. Record review will be conducted, to ensure the same clerical error was not duplicated elsewhere. Audit of records were performed on 6/5/2013 with no further deficiencies noted.
What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?	The "Notice of Medicare Non-Coverage" was reviewed; a line was added to include "todays date" in the "additional information (optional) area". A 3 check system was also put into place, as well as a cross departmental communication pathway. Will be ingrained into everyday practice. All of these interventions were put into place on 6/7/2013
How the facility plans to monitor its performance to make sure that solutions are sustained? 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.	After the first month of implementation of new communication pathway and 3 check systems, DON will review the "denial" forms. A meeting will be held with parties involved to evaluate the system and need for any changes (July 2, 2013). If there are no needed changes, then this practice will be done quarterly and reported to the QA team members.
Who is responsible for this plan of correction?	The Director of Nursing or designee will be responsible for compliance. Date of Correction: 6/10/2013 and ongoing through QA

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245442	A. BUILDING _____ B. WING _____ JUN 17 2013 MN Dept of Health Rochester	05/31/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING VALLEY CARE CENTER	800 MEMORIAL DRIVE SPRING VALLEY, MN 55975

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 156	Continued From page 1 inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section. The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate. The facility must furnish a written description of legal rights which includes: A description of the manner of protecting personal funds, under paragraph (c) of this section; A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels. A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and	F 156		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245442	JUN 17 2013 A. BUILDING ~~MN Dept of Health~~ Rochester B. WING	05/31/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 156	Continued From page 2 misappropriation of resident property in the facility, and non-compliance with the advance directives requirements. The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care. The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits. This REQUIREMENT is not met as evidenced by: During interview and document review the facility had failed to provide the proper liability notices in a timely manner for 1 of 3 residents (R56) reviewed for liability notices and beneficiary appeal rights review. Findings include: R56 received the proper notice of potential liability for the non-covered stay but had not been given 48 hours before the services were denied. R56 was not provided the Skilled Nursing Facility Advanced Beneficiary Notice or Denial Letter which advises residents they are no longer eligible for Medicare services within 48 hours of discontinuing Medicare services. R56 was given notice on 1/10/13, Medicare services would end 1/10/13. There was no evidence the 48 hour	F 156		

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 156	Continued From page 3 notice requirement had been waived either. During interview on 5/31/13, at 10:31 a.m. the assistant director or nursing (ADON) indicated R56 had an acute change in status and was discontinued from therapy and Medicare services were discontinued. At 10:39 a.m. ADON indicated should have observed and continued with skilled nursing so the 48 hour notice was given. During interview on 5/31/13, at 10:40 a.m. the director of nursing indicated there was no policy just followed the regulation. The director or nursing indicated R56 was very complex, he was on therapy and then therapy was put on hold and discontinued due to an acute decline.	F 156		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure the written care plan was followed for personal grooming assistance, related to clean eye glasses for 1 of 3 residents (R58) reviewed in the sample for activities of daily living. Findings include: R58 was observed on 5/28/13, 5/29/13 and 5/30/13 to be wearing eye glasses that had smeared and speckled spots on the lenses.	F 282	See attached forms	6-30-13

DRAFT PLAN OF CORRECTION 6/3/2013

F 282

§483.20(k)(3)(ii) Be provided by qualified persons in accordance with each resident's written plan of care.

What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?	For resident (R58) The written care plan was reviewed and more specifically individualized. The aide Kardex was updated to reflect care plan on 6/5/2013.
How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?	Residents who are at risk are those who wear corrective lenses and any future admissions who wear corrective lenses. Review the at risk populations care plans to ensure care plans are more specifically individualized; if any changes to the care plans aide Kardex will be updated. Record review and corrections were completed on 6/8/2013.
What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?	Language will be changed in the PCC care planning library so that specific entry is required. A target question will be added to the admission assessment and required scheduled assessments under vision that would automatically generate an intervention in the care plan. This was completed on 6/6/2013.
How the facility plans to monitor its performance to make sure that solutions are sustained? 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.	With the update to the assessment and automatic triggers to the care plan will assist in the sustainability. Any new care plans that are generated for persons at risk with corrective lenses will be reviewed by the DON for one month; then quarterly at time of care conference. An initial random audit of adherence to the care plan will be done prior to June 30 to ensure compliance with the care plans initiated; then quarterly for quality assurance and followed by QA team.
Who is responsible for this plan of correction?	The Director of Nursing or designee will be responsible for compliance. Date of Correction: 6/30/2012 (time for audit)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245442	A. BUILDING _____ B. WING _____ JUN 17 2013 MN Dept of Health Rochester	05/31/2013

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F 282	Continued From page 4 Upon document review R58 had a diagnosis of Dementia. The care plan dated 3/20/12 identified R58 as having an, "ADL [activity of daily living] self care performance deficit R/T (related to) dementia, confusion" and interventions included: "Vision: [R58] requires use of corrective lenses for proper vision. Ensure [R58's] glasses are clean and well fitting." During an interview at 10:50 a.m. on 5/30/13 nursing assistant (NA)-D stated nursing assistants were to clean eye glasses for residents in the morning as a part of getting a resident ready for the day. During an interview at 10:58 a.m. on 5/30/13 licensed practical nurse (LPN)-A stated R58's glasses could use a wipe off and stated the lenses appeared dusty. The LPN than proceed to clean R58's eye glasses. LPN verified R58's eye glasses were not clean per the plan of care.	F 282		
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. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to identify purple colored	F 309	See attached forms	6/12/13

DRAFT PLAN OF CORRECTION 6/3/2013

F 309

§483.25 Quality of care

The facility must ensure that –Each resident must receive and the facility must provide the necessary care and the services to attain or maintain the highest practicable physical, mental and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.

What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?	New skin assessment was completed on 6/6/13 to specifically indicate resident has "purple spots r/t etiology of diagnosis and old age". Care plan was updated to include specific skin integrity focus of the same.
How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?	Residents who are at risk are those who have the same skin appearances (or other baseline skin appearances that when on first appearance appear to be something else; such as a prominent birth mark or gross pigmentation changes) and those that are at risk for developing the same as it pertains to medical risk factors other than old age. Record review was completed on 6/12/13 on those that have medical risk factors or those that are known to have the same skin spots. corresponding care plans were updated along with the Kardex was completed on 6/12/13.
What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?	On admission skin assessment and subsequent scheduled skin assessments, new questions were added to the admission screener on 6/7/2013 to identify this type of skin or "different" markings. If indicated by the answers given; a care plan focus will be automatically generated. Pathway was developed to hand off information to ensure staff is aware of any abnormal normal skin conditions. Pathway, explanation of skin conditions, monitoring, schedule of assessments, and reporting were all discussed at the mandatory staff meeting held on 6/11/13.
How the facility plans to monitor its performance to make sure that solutions are sustained? 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	Interventions will sustain themselves because of integration from the mandatory skin assessments to the care plan. For the first 4 weeks, DON will review any new skin assessments, communication pathway, and care plan to ensure both are completed correctly. The care plans and skin assessments will be compared and reviewed quarterly at care conference time to identify any discrepancies; it is found that monitoring systems or pathways are deficient will make immediate changes and provide education/direction/instruction for ongoing quality assurance and followed by the QA team.

integrated into the quality assurance system.	
Who is responsible for this plan of correction?	The Director of Nursing or designee will be responsible for compliance. Date of Correction: 6/12/13

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245442	A. BUILDING _____ B. WING _____ JUN 17 2013 MN Dept of Health Rochester	05/31/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING VALLEY CARE CENTER	800 MEMORIAL DRIVE SPRING VALLEY, MN 55975

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 5 skin areas for 1 of 3 residents (R36) reviewed for non-pressure related skin conditions. Findings include: R36 was observed at 2:09 p.m. on 5/28/13 with purple skin areas on the back side of the left wrist and back side of the right hand with no documentation of these being found until the staff were informed of them by surveyor on 5/29/13. Upon document review R36 had diagnoses of Alzheimer ' s disease, mineral deficiency and acute post hemorrhagic anemia. R36 had a quarterly Minimum Data Set completed on 5/19/13 and this assessment revealed R36 had long and short term memory problems and severely impaired decision making skills for daily living. Upon review of May ' s 2013 nursing progress notes there was no documentation in regards to the purple skin areas located on the left wrist or right hand. R36 ' s care plan dated 3/7/13 identified R36 as having "tendency to bruise very easily R/T (related to) anemia and mineral deficiency" and interventions included: "Implement temporary bruising care plan if bruising occurs. Monitor bruises daily and document weekly. If bruises increase notify MD [medical doctor]/NP [nurse practitioner]. Notify physician if increase bruising occurs. Use caution when going through doorways, leaning against hard objects. Use lotion as needed for dry and frail skin." During an interview at 2:31 p.m. on 5/29/13 registered nurse (RN)- A stated the bruises on R36's right hand and left wrist were new today as they were not identified during the skin check R36 received on bath night the previous evening. RN-A stated when bruises were identified staff were to alert the nurse. Then the nurse was to	F 309		

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F 309	Continued From page 6 initiate a temporary care plan for skin integrity. RN-A verified R36's bruises were brought to her attention by the director of nursing on 5/29/13. RN- A stated she then assessed the bruises on R36's hands and planned to complete measurements of the bruising and initiate a temporary care plan for skin integrity. After RN-A completed the skin impaired temporary care plan on 5/29/13 it was noted that RN-A had identified R36 had an "Alteration in skin integrity due to injury suspected bumped hand on wall/bed rail. Resident was unable to say where the bruise came from. As evidenced by bruise. Bruising location: R [right] hand 1 cm [centimeters] x 1.2 cm. R FA [forearm] 0.4 cm x 0.8 cm. L [left] wrist 1 cm x 0.7 cm. Interventions: Measure and chart bruises description weekly. Nursing check bruising daily chart if changes noted and notify MD [medical doctor] and charge nurse." During an interview at 11:57 a.m. on 5/30/13 the director of nurses (DON) stated her expectation was for staff to be observing for bruising when they assisted residents with their cares and on bath day to inspect skin. The DON stated staff was to alert the nurse when a bruise was identified and then the nurse was to implement a temporary skin impaired care plan and monitor the bruising. During an interview on at 10:20 a.m. on 5/31/13 the DON stated she did not expect nursing assistants to report new skin bruising/discoloration areas for R36's as the skin areas were due to Coumadin (possible side effect is the increase in bruising potential) and	F 309		

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F 309	Continued From page 7 hyperlipidemia. The DON also said that the purple areas on R36 ' s skin are anticipated and they come and go. During the review of Procedure for bruise monitoring dated May 2013, it read: " 1) On admission assess residents risk for bruising based off medications, co-morbidities, and general skin condition. Care plan risk for bruising. 2) If resident is admitted with a bruise or develops a bruise a temporary care plan "skin impaired". For duration of bruise. 3) Nursing monitors the bruising according to the designed care plan. A line in the TAR [treatment record] will be added to prompt the nurse to check. Nurses will initial in the space indicating they assess/evaluated the bruise. If there is a worsening change a progress note is required. 4) The Care Coordinator assess the bruise once weekly and writes a progress note or use the skin tracking form in point click care until resolved."	F 309		
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure each resident received grooming assistance as necessary,	F 312	See attachment	6/30/13

DRAFT PLAN OF CORRECTION 6/3/2013

F 312

§483.25(a)(3) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.

What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?	For resident (R58) The written care plan was reviewed and more specifically individualized for fit his need. The aide Kardex was updated to reflect care plan on 6/5/2013.
How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?	Residents who are at risk are those who wear corrective lenses and any future admissions who wear corrective lenses. Review/assess the at risk populations and care plans to ensure care plans are more specifically individualized; if any changes to the care plans aide Kardex will be updated. Record review and corrections were completed on 6/8/2013.
What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?	Language will be changed in the PCC care planning library so that specific entry is required. A target question will be added to the admission assessment and required scheduled assessments under vision assessment that would automatically generate an intervention in the care plan. This was completed on 6/6/2013.
How the facility plans to monitor its performance to make sure that solutions are sustained? 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.	With the update to the assessment and automatic triggers to the care plan will assist in the sustainability. Any new care plans that are generated for persons at risk with corrective lenses will be reviewed by the DON for one month; then quarterly at time of care conference. An initial random audit of adherence to the care plan will be done prior to June 30 to ensure compliance with the care plans initiated; then quarterly for quality assurance and followed by the QA team.
Who is responsible for this plan of correction?	The Director of Nursing or designee will be responsible for compliance. Date of Correction: 6/30/2013 (time for audit)

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F 312	Continued From page 8 related to clean eye glasses for 1 of 3 residents (R58) reviewed in the sample for activities of daily living. Findings Include: R58 was observed at 3:22 p.m. on 5/28/13, at 10:46 a.m. on 5/29/13 and 7:54 a.m. on 5/30/13 to be wearing eyeglasses that had visible debris smeared and speckled spots on the lenses. Upon document review R58 had a diagnosis of Dementia. The care plan dated 3/20/12 identified R58 as having an, "ADL (activity of daily living) self-care performance deficit R/T (related to) dementia, confusion "and interventions included: "Vision: [R58] requires use of corrective lenses for proper vision. Ensure [R58' s] glasses are clean and well fitting." During an interview at 10:50 a.m. on 5/30/13 nursing assistant (NA)-D stated nursing assistants were to clean eye glasses for residents in the morning as a part of getting a resident ready for the day. During an interview at 10:58 a.m. on 5/30/13 licensed practical nurse (LPN)-A verified R5's eye glasses were not clean. LPN-A stated R58' s glasses could use a wipe off and stated the lenses appeared dusty. The LPN than proceed to clean R58's eye glasses. During an interview at 12:03 p.m. on 5/30/13 the director of nurses (DON) stated her expectation was if a resident' s glasses were noted to be dirty by staff, they should ask the resident if they can clean their glasses. The DON stated she would expect staff to be checking residents' glasses and	F 312		

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F 312	Continued From page 9 offering assistance as needed. The DON stated the facility did not have a policy that addressed activity of daily living assistance provided to residents.	F 312		
F 327 SS=D	483.25(j) SUFFICIENT FLUID TO MAINTAIN HYDRATION The facility must provide each resident with sufficient fluid intake to maintain proper hydration and health. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure critical fluid restriction intake monitoring due to kidney failure and dialysis treatment for 1 of 1 resident (R45) reviewed with fluid restriction. Findings include: R45, who had a physician ordered fluid restriction of 1500 cc (cubic centimeters) per day, lacked daily (24 hour) monitoring of fluid intake. R45 was admitted 2/27/13, with diagnosis that included end stage renal disease. The facility identified R45 on the admission Minimum Data Set (MDS), an assessment dated 3/6/13, to require extensive assistance of two staff for activities of daily living, had moderate cognitive impairment, received therapeutic diet, and received dialysis. Document review of the nutrition status care area assessment (CAA) notes dated 3/6/13, revealed	F 327	See attachment	6/11/13

DRAFT PLAN OF CORRECTION 6/3/2013

F 327

§483.25(j) Hydration

The facility must ensure that –The facility must provide each resident with sufficient fluid intake to maintain proper hydration

What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?	For resident (R45) record review was performed by RN to assess fluid balance. Pathway was changed for fluid monitoring on 6/5/2013. Fluid monitoring sheet was changed to include check area for RN assessment of fluid intake. Fluid intake monitoring was added to RN check list to prompt/remind on 6/5/2013. Nursing staff was instructed on how to record fluid monitoring on 6/4-6/6/2013.
How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?	Residents who are at risk are those who are on fluid restrictions/fluid monitoring. Pathway was changed for fluid monitoring on 6/5/13. Record review was performed on those with fluid restrictions; to ensure the same practice was not duplicated elsewhere this was completed on 6/9/2013. The same approach will be used as above.
What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?	Pathway was changed for fluid monitoring. Fluid monitoring sheet was changed to include check area for RN assessment of fluid intake 6/5/13. Fluid intake monitoring was added to RN check list to prompt/remind 6/5/13. Nursing staff was instructed on how to record fluid monitoring. In addition, pictures were taken of the cup sizes with corresponding cc's that will be distributed to staff during staff meeting on 6/11/13; and be available to view at nursing stations to ensure accuracy.
How the facility plans to monitor its performance to make sure that solutions are sustained? 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.	All new staff will receive the cup size in cc's monitoring sheet during the orientation process. Because of the new forms and checklist the practice will be ingrained into daily routine tasks making itself self-sustaining. DON will review check list and progress notes weekly for 4 weeks to ensure system if being followed making correction as needed, the system will then be reviewed quarterly for quality assurance and followed by the QA team.
Who is responsible for this plan of correction?	The Director of Nursing or designee will be responsible for compliance.

	Date of Correction: 6/11/13

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F 327	Continued From page 10 R45 received "1500" cc fluid restriction diet and understood the diet restrictions. Document review of physician orders dated 5/13, revealed orders for 1500 milliliter/centimeters fluid restriction with a start date of 2/27/13. Document review of the facility nutrition review dated 3/6/13, 4/30/13, and 5/27/13, revealed R45 received dialysis, was on a " 1500" cc fluid restriction, was offered 360 cc fluids with meals, accepted diet, and was compliant with diet restrictions. Document review of the facility resident care plan initiated 3/4/13, revealed R45 at risk for " hypovolemic" (decreased blood volume) related to loss of appetite and fluid restrictions. Interventions included measure all sources of fluid intake. Care plan initiated 5/27/13; revealed R45 had nutrition problem or potential nutritional problem related to renal diet with 1500 milliliter fluid restriction. Interventions included " 1500 " cc fluid restriction and watch for signs and symptoms of dehydration. During interview on 5/29/13, at 11:50 a.m., licensed practical nurse (LPN)-A identified the facility monitored fluids on the fluid monitoring form which was located in the medication administration record. During interview on 5/29/13, at 11:55 a.m., assistant director of nursing (ADON) also identified the facility monitored fluids for residents was located on the fluid monitoring form located in the medication administration record. Document review of the facility fluid monitoring	F 327		

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F 327	Continued From page 11 form located in the medication administration record revealed the following: From 3/1/13 to 3/31/13, revealed 19 out of 31 days lacked complete fluid entries and no 24 hour totals were monitored. From 4/1/13 to 4/30/13, revealed 22 out of 30 days lacked complete fluid entries and no 24 hour totals were monitored. From 5/1/13 to 5/28/13, revealed 24 out of 28 days lacked complete fluid entries and no 24 hour totals were monitored. During interview on 5/29/13, at 1150 a.m., LPN-A verified the facility lacked consistent monitoring of fluid intake and lack of monitoring 24 hour fluid intake totals. During interview on 5/29/13, at 11:55 a.m., ADON stated the facility expected the night nurse to monitor 24 hour fluid intake totals. She stated the facility process was for nursing to complete the intake for each meal. She stated the monitoring was done by nursing looking at the intake numbers. ADON verified the facility lacked consistent monitoring of fluids and lacked 24 hour daily fluid intake totals. During interview on 5/29/13, at 1:25 p.m., ADON verified the 24 hour monitoring was the only intake monitoring the facility used. During observations on 5/29/13, at 12:00 p.m., R45 ate all of lunch which consisted of lettuce salad, soup, ice cream, small glass juice, and drank approximately ¼ large glass of water. During interview at that time, nursing assistant -E (NA-E) stated R45 ' s fluid intake for lunch was 400 cc.	F 327		

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F 327	Continued From page 12 During interview on 5/29/13, at 12:12 p.m., certified dietary manager (CDM) stated dietary allowed 1080 cc fluids a day for meals. CDM stated nursing monitored fluid intake in the dining room and monitored what nursing provided on the floor. During interview on 5/30/13, at 8:30 a.m., registered dietician (RD) stated she expected nursing to monitor fluid intake due to 1500 cc fluid restriction. RD stated R45 was compliant with diet. During interview of 5/30/13, at 2:25 p.m., LPN-B stated R45 was on fluid restriction and received 240 cc water at bedside each shift. However, these fluids if consumed would exceed the 1500 cc per day limit. During interview on 5/30/13, at 2:30 p.m., R45 stated he was aware of fluid restriction and stated he received dialysis three times a week. Observations at that time revealed 240 cc glass of water at bedside. During interview on 5/31/13, at 8:20 a.m., CDM verified dietary allowed 1080 cc fluids provided by dietary per day. Nursing was allowed 420 cc fluids per day for a total of 1500 cc per day. CDM verified he was not aware that nursing provided 240 cc three times a day. CDM verified that if all fluids provided were consumed, the 24 hour total would exceed physician ordered 1500 cc fluid restriction by 300 cc per day. CDM verified the lack of written plan that included the amount of fluids provided by dietary and the amount of fluids provided by nursing. CDM stated on dialysis days, three times a week, dietary provided 360 cc	F 327		

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F 327	Continued From page 13 fluids to consume before R45 left the facility or consume while at dialysis. CDM stated he expected nursing to monitor the fluids consumed on dialysis days. CDM verified the facility lacked consistent monitoring of fluid intake and lacked of monitoring of 24 hour fluid intake totals. During interview on 5/31/13, at 10:20 a.m., director of nursing (DON) stated she expected fluid intake entered into the facility computer program by the nursing assistants. DON stated she expected nursing to enter fluid intake on the fluid monitoring sheets located in the medication administration record. DON stated she expected the charge nurse/care coordinator to monitor 24 hour fluid intake.	F 327		
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure clean dishes were stored dry to maintain sanitary conditions. This practice had the potential to affect 45 of 45 residents who resided in the facility.	F 371	See attachment	6/19/13

DRAFT PLAN OF CORRECTION (date when was corrected)

F (371)

483.35(i)(2) Store, prepare, distribute, and serve food under sanitary condition....

What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?	A rack will be used for drying dishes before they are put away. Once the items are dry they then will be put away on a separate storage rack or into the proper bins or draws.
How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?	Deficiency had the potential to effect all of the residents future and present. Dishes will be checked by manager and cooks when manager is not here to ensure all dishes are thoroughly dry and put away correctly throughout the day.
What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?	A new rack was purchased and assembled for storage area and the previous rack that was here will be used as a drying rack.
How the facility plans to monitor its performance to make sure that solutions are sustained? 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.	Existing staff will be instructed on how to use the rack by the dish area for drying purposes and once the items are dry they, then can be put away to the proper storage area according to policy and procedure. A training program/ in service for proper handling of dishes will be signed to ensure everyone knows what to do on June 19th. Procedure will be a part of new employee orientation. Dietary manager or designee will perform audits once weekly for the first 4 weeks to ensure compliance of procedure and to identify any further training or instruction of policy/procedure. Then quarterly audits will be performed and brought before QA committee with results.
Who is responsible for this plan of correction?	The Dietary Manager Jesse Arnold CDM CFPP Date of Correction: June 19th 2013

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F 371	Continued From page 14 Findings include: At 8:26 a.m. on 5/29/13, during a kitchen tour with the certified dietary manager (CDM) three clear plastic pitchers, two syrup pitchers and a serving tray were observed to be stored wet. The three clear plastic pitchers were placed on a shelf upside down, with water droplets covering the inside of the pitchers. The two syrup pitchers had their lids tightened, water droplets covering the inside of them and were stored in a metal container on a shelf. One serving tray in a stack of serving stays was also noted to be wet. At 8:35 a.m. on 5/29/13 the CDM stated his expectation was items were not to be stored until they were fully dried. The CDM stated when items were taken through the dishwasher they were to be fully dried prior to placing them in the designated storage area. The CDM verified the three water pitchers, two syrup pitchers and one serving tray were wet when placed in their designated storage area in the kitchen. The CDM stated the facility did not have any drying racks and stated when the items are taken through the dishwasher the kitchen staff needed to wait for items to dry. Review of the DISHWASHING POLICY dated January 2004, indicated, " All items must be air-dried. No moisture can be found on any stacked items. Pots, pans and utensils will be air-dried before being stored or will be stored in a self-draining position on suitably located hooks constructed of corrosion resistant material. Whenever applicable, stored containers and utensils would be covered or inverted."	F 371		

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F 371	Continued From page 15 At 1:46 p.m. on 5/30/13 the CDM verified staff failed to follow the facility policy to ensure all items were air dried prior to being placed in their storage area in the kitchen.	F 371		
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens	F 441	See attachment	6/10/13

DRAFT PLAN OF CORRECTION 6/10/13

F 441

Statute number §483.65 Infection Control Program

The facility must establish an infection control program under which it –

(1) Investigates, controls, and prevents infections in the facility;

(2) Decides what procedures, such as isolation, should be applied to an individual resident; and

(3) Maintains a record of incidents and corrective actions related to

What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?	Staff members were immediately informed of deficient practice of storing ice scoop in the ice bin during water pass. Dietary provided separate container for the ice scoop to be stored in when not being used to pass ice.
How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?	All current residents were potentially affected by the deficient practice. Infections and transmission of infections will continue to be monitored by Infection Control Coordinator or designee and continue to investigate potential root cause of infections.
What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?	Random audits of the ice pass will be completed weekly for 4 weeks, and then at least Quarterly thereafter by the Infection Control Coordinator or designee to ensure ice scoops are stored appropriately when not in use. Target focus will be added to the new employee orientation checklist to be completed by the ICC. The check list was updated on 6.10.13.
How the facility plans to monitor its performance to make sure that solutions are sustained? Develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its	Ice Storage policy will be reviewed and staff will be instructed on appropriate storage of the ice scoop when ice scoop is not in use. This will be presented at the next mandatory staff meeting (6/11/13). Infection Control Coordinator (or designee) will complete audits on ice pass weekly for 4 weeks to ensure understanding and compliance making corrections as needed. Then audit at least Quarterly thereafter to monitor compliance and need for additional instruction. Findings, as well as any corrective action, continued instruction, or needed changes will be reported to the Quality Assurance Committee.

effectiveness. The plan of correction is integrated into the quality assurance system.	
Who is responsible for this plan of correction?	The Infection Control Coordinator or designee will be responsible for compliance. Date of Correction: 6/10/13

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245442	A. BUILDING _____ B. WING _____ JUN 17 2013	05/31/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING VALLEY CARE CENTER	800 MEMORIAL DRIVE SPRING VALLEY, MN 55975

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 16 Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to distribute ice water in a sanitary manner during 1 of 1 water pass observed. This had the potential to affect 22 of 22 residents on Western Trail hallway. Findings include: The soiled scoop used to fill resident mugs with ice water was left in the ice bucket between uses. During observation on 5/28/13, at 2:05 p.m. nursing assistants (NA)-A & B were observed serving ice water from two white buckets with lids to the residents who lived on the Western Trail hallway. NA-A lifted up the lid on one of the containers which contained two metal scoops and ice inside of the container. The NA-A had gloves on and filled a mug with ice and water, re-covered ice bucket and opened the door with the gloved hand and went into the resident's room gathered the used mugs from the room and without changing the soiled gloves proceed to take the scoop out of the ice bucket and fill a sanitized mug. NA-A continued to wear the soiled gloves during the serving of water to the residents on the Western Trail hallway. NA-B was observed to wear soiled gloves in the same manner that NA-A had done. During interview on 5/28/13, at 2:12 p.m. NA -A indicated their process consisted of keeping the	F 441		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245442	A. BUILDING _____ B. WING _____ JUN 17 2013 MN Dept of Health Rochester	05/31/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING VALLEY CARE CENTER	800 MEMORIAL DRIVE SPRING VALLEY, MN 55975

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 17 ice scoops in the ice bucket but made sure that the lids were covered between residents. During interview on 5/28/13, at 2:14 p.m. the assistant director of nursing confirmed ice scoops were to be kept separate from the ice bucket and verified the scoop/s had been in the ice buckets. During interview on 5/30/13, at 7:28 a.m. the director of nursing indicated they would expect a separate container next to the ice bucket but should not be in with the ice. During review of Ice Machine and Ice Storage Chests policy dated December 2010, directed staff to keep the ice scoop on a clean, hard surface when not in use.	F 441		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245442	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**05/28/2013**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING VALLEY CARE CENTER	**800 MEMORIAL DRIVE** **SPRING VALLEY, MN 55975**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATION 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 Spring Valley Care 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 445 Minnesota St., Suite 145 St Paul, MN 55101-5145, or	K 000	RECEIVED JUN 17 2013 MN DEPT OF PUBLIC SAFETY STATE FIRE MARSHAL DIVISION See attch's for POC's POC ok w/ TW for K35 PS 6-20-13	

DC: 07.10.2013

Exit: 05.31.2013

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

CEO | 6.14.13

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
	245442	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**05/28/2013**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING VALLEY CARE CENTER	**800 MEMORIAL DRIVE** **SPRING VALLEY, MN 55975**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	Continued From page 1 By email to: Barbara.Lundberg@state.mn.us and 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. The Spring Valley Care Center is a 1-story building with a partial basement. The building was constructed in 1975 and was determined to be of Type II(111) construction. The building is fully fire sprinkler protected. The facility has a fire alarm system with full corridor smoke detection and spaces open to the corridor, that is monitored for automatic fire department notification. The facility has a licensed capacity of 50 beds and had a census of 45 at the time of the survey. The requirement at 42 CFR Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 029 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD	K 029		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245442	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**05/28/2013**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING VALLEY CARE CENTER	**800 MEMORIAL DRIVE** **SPRING VALLEY, MN 55975**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 029	Continued From page 2 One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain smoke-resisting partitions and doors in accordance with the following requirements of 2000 NFPA 101, Section 19.3.2.1. The deficient practice could affect 30 out of 45 residents. Findings include: On facility tour between 1:00 PM and 3:30 PM on 05/28/2013, observation revealed that the following was found: 1. IT/record storage (over 50 sq ft) no door closer 2. Kitchen storage room (over 50 sq ft) no door closer 3. Textile care clean storage (over 50 sq ft) does not positively latch 4. Soiled linen room by dining room no door closer	K 029		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245442	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**05/28/2013**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING VALLEY CARE CENTER	**800 MEMORIAL DRIVE** **SPRING VALLEY, MN 55975**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 029	Continued From page 3 These deficient practices were confirmed by the Facility Maintenance Director at the time of discovery.	K 029		
K 038 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1 This STANDARD is not met as evidenced by: Based on observation, the facility failed to provide means of egress in accordance with the following requirements of 2000 NFPA 101, Section 19.2., 7.1.6.2 and 7.2.1.4.5. The deficient practice could affect all 45 residents. Findings include: On facility tour between 1:00 PM and 3:30 PM on 05/28/2013, observation revealed, that the following was found: 1. South and West exit discharge has a change in elevation of more than 1/2 inch from door thresh hold to concrete sidewalk 2. West exit discharge door takes more than 50 lbs of force to open These deficient practices were confirmed by the Facility Maintenance Director at the time of discovery.	K 038	Temporary Waiver request.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245442	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**05/28/2013**

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K 050 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2 This STANDARD is not met as evidenced by: Based on documentation review and staff interview, the facility failed to assure fire drills were conducted once per shift per quarter for all staff under varying times and conditions as required by 2000 NFPA 101, Section 19.7.1.2. This deficient practice could affect all 45 residents. Findings include: On facility tour between 1:00 PM and 3:30 PM on 05/28/2013, the review of the fire drill documentation for the past 9 months (August 2012 to April 2013) revealed the drills for the the following shifts were completed but did not sufficiently vary the times that the drills were conducted: Days: 1039, 1312 and 1020 hours Evening: 1422, 1405 and 1505 hours Night: 2240, 2305 and 2220 hours	K 050		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245442	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**05/28/2013**

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K 050	Continued From page 5 This deficient practice was confirmed by the Facility Maintenance Director at the time of discovery.	K 050		
K 144 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1. This STANDARD is not met as evidenced by: Based on documentation review and staff interview, the facility failed to test the emergency generator in accordance with the requirements of 2000 NFPA 101 - 9.1.3 and 1999 NFPA 110 Chapter 6-4.1. The deficient practice could affect all 45 residents. Findings include: On facility tour between 1:00 PM and 3:30 PM on 05/28/2013, the documentation review of the weekly inspection and monthly run logs (August 2012 to May 2013) for the diesel emergency generator revealed that the following was found: 1. The weekly operational inspections were missed for the weeks of 10/1, 10/8, 10/22, 10/29, 11/5, 11/12,11/19, 12/3, 12/10, 12/17, 12/24 and 12/31/2012. 1/6, 1/21,1/28, 2/18, 2/25, 3/4, 3/11, 3/25, 4/1, 4/8, 4/15, 4/22, 5/6 and 5/13/2013	K 144		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245442	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**05/28/2013**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING VALLEY CARE CENTER	**800 MEMORIAL DRIVE** **SPRING VALLEY, MN 55975**

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K 144	Continued From page 6 2. No documentation for monthly 30% load run as follows: September 2012 through November 2012 This deficient practice was confirmed by the Facility Maintenance Director at the time of discovery. *TEAM COMPOSITION* Gary Schroeder, Life Safety Code Spc.	K 144		

DRAFT PLAN OF CORRECTION 6/3/2013

K029 Hazardous Areas/existing

1. IT/record storage (over 50 sq ft) no door closer
2. Kitchen storage room no door closer
3. Textile care clean storage does not have a positive latch
4. Soiled linen room by dining room no door closer

What corrective action(s) have been or will be accomplished to correct this deficiency.	Door closers added to IT/record storage; kitchen storage; soiled linen room by dining room. Positive latch added to the textile care clean storage door.
The Actual/Proposed Completion Date	By 7.3.13
The Name/Title of person responsible for the correction and monitoring to prevent a reoccurrence of the deficiency.	William Hale, Facilities Director

24-5442

DRAFT PLAN OF CORRECTION 6/3/2013

K38 Exit Access readily accessible
South and West exit discharge has a drop of more than ½ inch
South Door takes more than 50 lbs of force to open

What corrective action(s) have been or will be accomplished to correct this deficiency.	South and west exit discharge will be corrected to no more than a ½ inch drop. A temporary Waiver to allow for additional time to complete has been requested. South door will be adjusted to open with no more than 50# of force.
The Actual/Proposed Completion Date	By 7.3.13 For the South Door Adjustment to open with no more than 50# By 9.30.13 For the Correction in the discharge drop of the south and west exits.
The Name/Title of person responsible for the correction and monitoring to prevent a reoccurrence of the deficiency.	William Hale, Facilities Director

24-5442

DRAFT PLAN OF CORRECTION 6/3/2013

K50 Fire Drills

Fire Drills were conducted, but did not vary the conditions:

What corrective action(s) have been or will be accomplished to correct this deficiency.	Fire drills will be conducted with the vary in conditions as required. There will be a 1.5 hour variance in the times of the drills per shift per quarter.
The Actual/Proposed Completion Date	By 7.3.13
The Name/Title of person responsible for the correction and monitoring to prevent a reoccurrence of the deficiency.	William Hale, Facilities Director

DRAFT PLAN OF CORRECTION 6/3/2013

K144 Generator Testing

1. No documentation for weekly emergency generator inspection.
2. No documentation for monthly emergency generator 30% load run.

What corrective action(s) have been or will be accomplished to correct this deficiency.	Documentation will be done weekly to reflect weekly generator inspection. Documentation will be done monthly to reflect the monthly generator 30% load run.
The Actual/Proposed Completion Date	By 7.3.13
The Name/Title of person responsible for the correction and monitoring to prevent a reoccurrence of the deficiency.	William Hale, Facilities Director

24- 5442

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7011 2000 0002 5143 3854

June 7, 2013

Ms. Penny Solberg, Administrator
Spring Valley Care Center
800 Memorial Drive
Spring Valley, Minnesota 55975

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5442024

Dear Ms. Solberg:

The above facility was surveyed on May 28, 2013 through May 31, 2013 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.

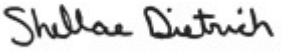
When all orders are corrected, the order form should be signed and returned to this office at Minnesota Department of Health, 18 Wood Lake Drive Southeast, Rochester, Minnesota 55904. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact me.

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

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

Please feel free to call me with any questions.

Sincerely,



Shellae Dietrich, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: (651) 201-4106 Fax: (651) 215-9697

Enclosure(s)

cc: Original - Facility
Licensing and Certification File

5442s13lic.rtf

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00121	A. BUILDING: _____ B. WING _____	05/31/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING VALLEY CARE CENTER	800 MEMORIAL DRIVE SPRING VALLEY, MN 55975

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On May 28, 29, 30, and 31, 2013, surveyors of this Department's staff visited the above provider and the following licensing orders were issued. When corrections are completed, please sign and date, make a copy of these orders and return the original to the Minnesota Department of Health, Division of Compliance Monitoring, Licensing and	2 000	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.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00121	A. BUILDING: _____ B. WING _____	05/31/2013

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2 000	Continued From page 1 Certification Program; 18 Wood Lake Drive SE, Rochester, MN 55904.	2 000	The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	
2 565	MN Rule 4658.0405 Subp. 3 Comprehensive Plan of Care; Use Subp. 3. Use. A comprehensive plan of care must be used by all personnel involved in the care of the resident. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure the written care plan was followed for personal grooming	2 565		

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	00121	A. BUILDING: _____ B. WING _____	05/31/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING VALLEY CARE CENTER	800 MEMORIAL DRIVE SPRING VALLEY, MN 55975

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 565	Continued From page 2 assistance, related to clean eye glasses for 1 of 3 residents (R58) reviewed in the sample for activities of daily living. Findings Include: R58 was observed on 5/28/13, 5/29/13 and 5/30/13 to be wearing eye glasses that had smeared and speckled spots on the lenses. Upon document review R58 had a diagnosis of Dementia. The care plan dated 3/20/12 identified R58 as having an, " ADL [activity of daily living] self care performance deficit R/T (related to) dementia, confusion " and interventions included: "Vision: [R58] requires use of corrective lenses for proper vision. Ensure [R58's] glasses are clean and well fitting." During an interview at 10:50 a.m. on 5/30/13 nursing assistant (NA)-D stated nursing assistants were to clean eye glasses for residents in the morning as a part of getting a resident ready for the day. During an interview at 10:58 a.m. on 5/30/13 licensed practical nurse (LPN)-A stated R58's glasses could use a wipe off and stated the lenses appeared dusty. The LPN than proceed to clean R58's eye glasses. LPN verified R58's eye glasses were not clean per the plan of care. SUGGESTED METHOD OF CORRECTION: The director of nursing could develop policies and procedures to ensure staff provided care according to the written plan of care. The director of nursing could educate staff and develop a monitoring system to ensure staff are providing care as directed by the written plan of care. TIME PERIOD FOR CORRECTION: Twenty-one	2 565		

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2 565	Continued From page 3 (21) days.	2 565		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to identify purple colored skin areas for 1 of 3 residents (R36) reviewed for non-pressure related skin conditions. Findings include: R36 was observed at 2:09 p.m. on 5/28/13 with purple skin areas on the back side of the left wrist and back side of the right hand with no documentation of these being found until the staff were informed of them by surveyor on 5/29/13. Upon document review R36 had diagnoses of Alzheimer ' s disease, mineral deficiency and acute post hemorrhagic anemia. R36 had a quarterly Minimum Data Set completed on 5/19/13 and this assessment revealed R36 had long and short term memory problems and severely impaired decision making skills for daily	2 830		

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2 830	Continued From page 4 living. Upon review of May ' s 2013 nursing progress notes there was no documentation in regards to the purple skin areas located on the left wrist or right hand. R36 ' s care plan dated 3/7/13 identified R36 as having "tendency to bruise very easily R/T (related to) anemia and mineral deficiency" and interventions included: "Implement temporary bruising care plan if bruising occurs. Monitor bruises daily and document weekly. If bruises increase notify MD [medical doctor]/NP [nurse practitioner]. Notify physician if increase bruising occurs. Use caution when going through doorways, leaning against hard objects. Use lotion as needed for dry and frail skin." During an interview at 2:31 p.m. on 5/29/13 registered nurse (RN)- A stated the bruises on R36's right hand and left wrist were new today as they were not identified during the skin check R36 received on bath night the previous evening. RN-A stated when bruises were identified staff were to alert the nurse. Then the nurse was to initiate a temporary care plan for skin integrity. RN-A verified R36's bruises were brought to her attention by the director of nursing on 5/29/13. RN- A stated she then assessed the bruises on R36's hands and planned to complete measurements of the bruising and initiate a temporary care plan for skin integrity. After RN-A completed the skin impaired temporary care plan on 5/29/13 it was noted that RN-A had identified R36 had an "Alteration in skin integrity due to injury suspected bumped hand on wall/bed rail. Resident was unable to say where the bruise came from. As evidenced by bruise. Bruising location: R [right] hand 1 cm [centimeters] x 1.2 cm. R FA [forearm] 0.4 cm x 0.8 cm. L [left] wrist 1 cm x 0.7 cm. Interventions: Measure and chart bruises description weekly.	2 830		

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2 830	Continued From page 5 Nursing check bruising daily chart if changes noted and notify MD [medical doctor] and charge nurse." During an interview at 11:57 a.m. on 5/30/13 the director of nurses (DON) stated her expectation was for staff to be observing for bruising when they assisted residents with their cares and on bath day to inspect skin. The DON stated staff was to alert the nurse when a bruise was identified and then the nurse was to implement a temporary skin impaired care plan and monitor the bruising. During an interview on at 10:20 a.m. on 5/31/13 the DON stated she did not expect nursing assistants to report new skin bruising/discoloration areas for R36's as the skin areas were due to Coumadin (possible side effect is the increase in bruising potential) and hyperlipidemia. The DON also said that the purple areas on R36 ' s skin are anticipated and they come and go. During the review of Procedure for bruise monitoring dated May 2013, it read: " 1) On admission assess residents risk for bruising based off medications, co-morbidities, and general skin condition. Care plan risk for bruising. 2) If resident is admitted with a bruise or develops a bruise a temporary care plan "skin impaired". For duration of bruise. 3) Nursing monitors the bruising according to the designed care plan. A line in the TAR [treatment record] will be added to prompt the nurse to check. Nurses will initial in the space indicating they assess/evaluated the bruise. If there is a worsening change a progress note is required.	2 830		

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2 830	Continued From page 6 4) The Care Coordinator assess the bruise once weekly and writes a progress note or use the skin tracking form in point click care until resolved." SUGGESTED METHOD OF CORRECTION: The director of nursing or her designee could develop policies and procedures to ensure residents consistently were provided appropriate interventions. The director of nursing or her designee could educate all appropriate staff on these policies and procedures. The director of nursing or her designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 830		
2 920	MN Rule 4658.0525 Subp. 6 B Rehab - ADLs Subp. 6. Activities of daily living. Based on the comprehensive resident assessment, a nursing home must ensure that: B. a resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure each resident received grooming assistance as necessary, related to clean eye glasses for 1 of 3 residents (R58) reviewed in the sample for activities of daily living. Findings Include: R58 was observed at 3:22 p.m. on 5/28/13, at 10:46 a.m. on 5/29/13 and 7:54 a.m. on 5/30/13 to be wearing eyeglasses that	2 920		

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2 920	Continued From page 7 had visible debris smeared and speckled spots on the lenses. Upon document review R58 had a diagnosis of Dementia. The care plan dated 3/20/12 identified R58 as having an, "ADL (activity of daily living) self-care performance deficit R/T (related to) dementia, confusion "and interventions included: "Vision: [R58] requires use of corrective lenses for proper vision. Ensure [R58' s] glasses are clean and well fitting." During an interview at 10:50 a.m. on 5/30/13 nursing assistant (NA)-D stated nursing assistants were to clean eye glasses for residents in the morning as a part of getting a resident ready for the day. During an interview at 10:58 a.m. on 5/30/13 licensed practical nurse (LPN)-A verified R5's eye glasses were not clean. LPN-A stated R58' s glasses could use a wipe off and stated the lenses appeared dusty. The LPN than proceed to clean R58's eye glasses. During an interview at 12:03 p.m. on 5/30/13 the director of nurses (DON) stated her expectation was if a resident' s glasses were noted to be dirty by staff, they should ask the resident if they can clean their glasses. The DON stated she would expect staff to be checking residents' glasses and offering assistance as needed. The DON stated the facility did not have a policy that addressed activity of daily living assistance provided to residents. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee(s) could review and revise policies and procedures related to ensuring residents received the necessary	2 920		

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2 920	Continued From page 8 assistance with activities of daily living. The director of nursing or designee (s)could develop a system to educate staff and develop a monitoring system to ensure staff provided necessary assistance with activities of daily living. TIME PERIOD FOR CORRECTION: Twenty-One (21) days.	2 920		
2 940	MN Rule 4658.0525 Subp. 9 Rehab - Hydration Subp. 9. Hydration. Residents must be offered and receive adequate water and other fluids to maintain proper hydration and health, unless fluids are restricted. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure critical fluid restriction intake monitoring due to kidney failure and dialysis treatment for 1 of 1 resident (R45) reviewed with fluid restriction. Findings include: R45, who had a physician ordered fluid restriction of 1500 cc (cubic centimeters) per day, lacked daily (24 hour) monitoring of fluid intake. R45 was admitted 2/27/13, with diagnosis that included end stage renal disease. The facility identified R45 on the admission Minimum Data Set (MDS), an assessment dated 3/6/13, to require extensive assistance of two staff for activities of daily living, had moderate cognitive impairment, received therapeutic diet, and received dialysis.	2 940		

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2 940	Continued From page 9 Document review of the nutrition status care area assessment (CAA) notes dated 3/6/13, revealed R45 received "1500" cc fluid restriction diet and understood the diet restrictions. Document review of physician orders dated 5/13, revealed orders for 1500 milliliter/centimeters fluid restriction with a start date of 2/27/13. Document review of the facility nutrition review dated 3/6/13, 4/30/13, and 5/27/13, revealed R45 received dialysis, was on a " 1500" cc fluid restriction, was offered 360 cc fluids with meals, accepted diet, and was compliant with diet restrictions. Document review of the facility resident care plan initiated 3/4/13, revealed R45 at risk for " hypovolemic" (decreased blood volume) related to loss of appetite and fluid restrictions. Interventions included measure all sources of fluid intake. Care plan initiated 5/27/13; revealed R45 had nutrition problem or potential nutritional problem related to renal diet with 1500 milliliter fluid restriction. Interventions included " 1500 " cc fluid restriction and watch for signs and symptoms of dehydration. During interview on 5/29/13, at 11:50 a.m., licensed practical nurse (LPN)-A identified the facility monitored fluids on the fluid monitoring form which was located in the medication administration record. During interview on 5/29/13, at 11:55 a.m., assistant director of nursing (ADON) also identified the facility monitored fluids for residents was located on the fluid monitoring form located in the medication administration record.	2 940		

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2 940	Continued From page 10 Document review of the facility fluid monitoring form located in the medication administration record revealed the following: From 3/1/13 to 3/31/13, revealed 19 out of 31 days lacked complete fluid entries and no 24 hour totals were monitored. From 4/1/13 to 4/30/13, revealed 22 out of 30 days lacked complete fluid entries and no 24 hour totals were monitored. From 5/1/13 to 5/28/13, revealed 24 out of 28 days lacked complete fluid entries and no 24 hour totals were monitored. During interview on 5/29/13, at 1150 a.m., LPN-A verified the facility lacked consistent monitoring of fluid intake and lack of monitoring 24 hour fluid intake totals. During interview on 5/29/13, at 11:55 a.m., ADON stated the facility expected the night nurse to monitor 24 hour fluid intake totals. She stated the facility process was for nursing to complete the intake for each meal. She stated the monitoring was done by nursing looking at the intake numbers. ADON verified the facility lacked consistent monitoring of fluids and lacked 24 hour daily fluid intake totals. During interview on 5/29/13, at 1:25 p.m., ADON verified the 24 hour monitoring was the only intake monitoring the facility used. During observations on 5/29/13, at 12:00 p.m., R45 ate all of lunch which consisted of lettuce salad, soup, ice cream, small glass juice, and drank approximately ¼ large glass of water. During interview at that time, nursing assistant -E (NA-E) stated R45 ' s fluid intake for lunch was 400 cc. During interview on 5/29/13, at 12:12 p.m.,	2 940		

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2 940	Continued From page 11 certified dietary manager (CDM) stated dietary allowed 1080 cc fluids a day for meals. CDM stated nursing monitored fluid intake in the dining room and monitored what nursing provided on the floor. During interview on 5/30/13, at 8:30 a.m., registered dietician (RD) stated she expected nursing to monitor fluid intake due to 1500 cc fluid restriction. RD stated R45 was compliant with diet. During interview of 5/30/13, at 2:25 p.m., LPN-B stated R45 was on fluid restriction and received 240 cc water at bedside each shift. However, these fluids if consumed would exceed the 1500 cc per day limit. During interview on 5/30/13, at 2:30 p.m., R45 stated he was aware of fluid restriction and stated he received dialysis three times a week. Observations at that time revealed 240 cc glass of water at bedside. During interview on 5/31/13, at 8:20 a.m., CDM verified dietary allowed 1080 cc fluids provided by dietary per day. Nursing was allowed 420 cc fluids per day for a total of 1500 cc per day. CDM verified he was not aware that nursing provided 240 cc three times a day. CDM verified that if all fluids provided were consumed, the 24 hour total would exceed physician ordered 1500 cc fluid restriction by 300 cc per day. CDM verified the lack of written plan that included the amount of fluids provided by dietary and the amount of fluids provided by nursing. CDM stated on dialysis days, three times a week, dietary provided 360 cc fluids to consume before R45 left the facility or consume while at dialysis. CDM stated he expected nursing to monitor the fluids consumed	2 940		

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2 940	Continued From page 12 on dialysis days. CDM verified the facility lacked consistent monitoring of fluid intake and lacked of monitoring of 24 hour fluid intake totals. During interview on 5/31/13, at 10:20 a.m., director of nursing (DON) stated she expected fluid intake entered into the facility computer program by the nursing assistants. DON stated she expected nursing to enter fluid intake on the fluid monitoring sheets located in the medication administration record. DON stated she expected the charge nurse/care coordinator to monitor 24 hour fluid intake. SUGGESTED METHOD FOR CORRECTION: The director of nursing could review and revise policies and procedures for monitoring fluid intake for residents at risk for dehydration. The director of nursing could develop a system to monitor fluid intake for residents with fluid restriction. The director of nursing could educate staff and monitor TIME PERIOD FOR CORRECTION: Twenty one (21) days.	2 940		
21165	MN Rule 4658.0675 Subp. 7 Mechanical Cleaning and Sanitizing;Air drying Subp. 7. Air drying. Dishes and utensils must be air dried before being stored or must be stored in a self-draining position. Properly racked sanitized dishes and utensils may complete air drying in proper storage places, if available. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure clean dishes were stored dry to maintain sanitary conditions.	21165		

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21165	Continued From page 13 This practice had the potential to affect 45 of 45 residents who resided in the facility. Findings include: At 8:26 a.m. on 5/29/13, during a kitchen tour with the certified dietary manager (CDM) three clear plastic pitchers, two syrup pitchers and a serving tray were observed to be stored wet. The three clear plastic pitchers were placed on a shelf upside down, with water droplets covering the inside of the pitchers. The two syrup pitchers had their lids tightened, water droplets covering the inside of them and were stored in a metal container on a shelf. One serving tray in a stack of serving stays was also noted to be wet. At 8:35 a.m. on 5/29/13 the CDM stated his expectation was items were not to be stored until they were fully dried. The CDM stated when items were taken through the dishwasher they were to be fully dried prior to placing them in the designated storage area. The CDM verified the three water pitchers, two syrup pitchers and one serving tray were wet when placed in their designated storage area in the kitchen. The CDM stated the facility did not have any drying racks and stated when the items are taken through the dishwasher the kitchen staff needed to wait for items to dry. Review of the DISHWASHING POLICY dated January 2004, indicated, " All items must be air-dried. No moisture can be found on any stacked items. Pots, pans and utensils will be air-dried before being stored or will be stored in a self-draining position on suitably located hooks constructed of corrosion resistant material. Whenever applicable, stored containers and utensils would be covered or inverted."	21165		

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21165	Continued From page 14 At 1:46 p.m. on 5/30/13 the CDM verified staff failed to follow the facility policy to ensure all items were air dried prior to being placed in their storage area in the kitchen. SUGGESTED METHOD FOR CORRECTION: The administrator with the director of food service could review and revise dishwashing policies and procedures to assure that equipment is sanitized and properly stored, educate the employees and monitor the sanitation of the utensils and equipment on a periodic basis. SUGGESTED METHOD FOR CORRECTION: The director of dietary or designee(s) could review and revise policies and procedures regarding proper drying of dishes. The director of dietary or designee (s) could provide training for all appropriate staff on these policies and procedures. The director of dietary or designee (s) could monitor to assure clean dishes were stored dry. TIME PERIOD FOR CORRECTION: Seven (7) days.	21165		
21375	MN Rule 4658.0800 Subp. 1 Infection Control; Program Subpart 1. Infection control program. A nursing home must establish and maintain an infection control program designed to provide a safe and sanitary environment. This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to distribute ice water in a	21375		

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SPRING VALLEY CARE CENTER	800 MEMORIAL DRIVE SPRING VALLEY, MN 55975

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21375	Continued From page 15 sanitary manner during 1 of 1 water pass observed. This had the potential to affect 22 of 22 residents on Western Trail hallway. Findings include: The soiled scoop used to fill resident mugs with ice water was left in the ice bucket between uses. During observation on 5/28/13, at 2:05 p.m. nursing assistants (NA)-A & B were observed serving ice water from two white buckets with lids to the residents who lived on the Western Trail hallway. NA-A lifted up the lid on one of the containers which contained two metal scoops and ice inside of the container. The NA-A had gloves on and filled a mug with ice and water, re-covered ice bucket and opened the door with the gloved hand and went into the resident's room gathered the used mugs from the room and without changing the soiled gloves proceed to take the scoop out of the ice bucket and fill a sanitized mug. NA-A continued to wear the soiled gloves during the serving of water to the residents on the Western Trail hallway. NA-B was observed to wear soiled gloves in the same manner that NA-A had done. During interview on 5/28/13, at 2:12 p.m. NA -A indicated their process consisted of keeping the ice scoops in the ice bucket but made sure that the lids were covered between residents. During interview on 5/28/13, at 2:14 p.m. the assistant director of nursing confirmed ice scoops were to be kept separate from the ice bucket and verified the scoop/s had been in the ice buckets. During interview on 5/30/13, at 7:28 a.m. the director of nursing indicated they would expect a separate container next to the ice bucket but should not be in with the ice.	21375		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00121	A. BUILDING: _____ B. WING _____	05/31/2013

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21375	Continued From page 16 During review of Ice Machine and Ice Storage Chests policy dated December 2010, directed staff to keep the ice scoop on a clean, hard surface when not in use. Suggested Method of Correction: The director of nursing could review policies and procedures to ensure proper infection control techniques are followed during fresh water pass. The director of nursing could educate staff on infection control techniques. The director of nursing could monitor staff compliance. Time Period for Correction: Twenty one (21) days.	21375		
21805	MN St. Statute 144.651 Subd. 5 Patients & Residents of HC Fac.Bill of Rights Subd. 5. Courteous treatment. Patients and residents have the right to be treated with courtesy and respect for their individuality by employees of or persons providing service in a health care facility. This MN Requirement is not met as evidenced by: During interview and document review the facility had failed to provide the proper liability notices in a timely manner for 1 of 3 residents (R56) reviewed for liability notices and beneficiary appeal rights review. Findings include: R56 received the proper notice of potential liability for the non-covered stay but had not been given 48 hours before the services were denied.	21805		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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21805	Continued From page 17 R56 was not provided the Skilled Nursing Facility Advanced Beneficiary Notice or Denial Letter which advises residents they are no longer eligible for Medicare services within 48 hours of discontinuing Medicare services. R56 was given notice on 1/10/13, Medicare services would end 1/10/13. There was no evidence the 48 hour notice requirement had been waived either. During interview on 5/31/13, at 10:31 a.m. the assistant director or nursing (ADON) indicated R56 had an acute change in status and was discontinued from therapy and Medicare services were discontinued. At 10:39 a.m. ADON indicated should have observed and continued with skilled nursing so the 48 hour notice was given. During interview on 5/31/13, at 10:40 a.m. the director of nursing indicated there was no policy just followed the regulation. The director or nursing indicated R56 was very complex, he was on therapy and then therapy was put on hold and discontinued due to an acute decline. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee could develop policies and procedures to ensure residents received the appropriate medicare denial letter and non-coverage forms timely. The director of nursing or designee could educate all appropriate staff members on the processes. The director of nursing or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-One (21) Days.	21805		