DEPARTMENT OF HEALTH	AND HUMA	N SERVICES			CENTERS FOR MEI	DICARE & MEDICAID SERVICES
					AND TRANSMITTAL	ID: RUUO
	PART I -	TO BE COMPI	LETED BY T	THE STA	TE SURVEY AGENCY	Facility ID: 00121
1. MEDICARE/MEDICAID PROVIDEI (L1) 245442	R NO.	3. NAME AND AL (L3) SPRING VA	LLEY CARE			4. TYPE OF ACTION: <u>2 (</u> L8) 1. Initial 2. Recertification
2.STATE VENDOR OR MEDICAID NO (L2) 046545300	Э.	(L4) 800 MEMOI (L5) SPRING VA			(L6) 55975	3. Termination 4. CHOW 5. Validation 6. Complaint 7. On Site Visit 0. Other
5. EFFECTIVE DATE CHANGE OF O (L9)	WNERSHIP	7. PROVIDER/SU 01 Hospital	IPPLIER CATEG 05 HHA	ORY 09 ESRD	<u>02</u> (L7) 13 PTIP 22 CLIA	7. On-Site Visit 9. Other 8. Full Survey After Complaint
 6. DATE OF SURVEY 10/21/2 8. ACCREDITATION STATUS: 0 Unaccredited 1 TJC 2 AOA 3 Other 	2013 (L34) (L10)	02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	06 PRTF 07 X-Ray 08 OPT/SP	10 NF 11 ICF/III 12 RHC	14 CORF D 15 ASC 16 HOSPICE	FISCAL YEAR ENDING DATE: (L35) 09/30
11LTC PERIOD OF CERTIFICATION		10.THE FACILITY	IS CERTIFIED	AS:		
From (a):		X A. In Complia	nce With		And/Or Approved Waivers Of	The Following Requirements:
To (b) :			equirements e Based On:		2. Technical Personnel	
12. Total Facility Beds	50 (L18)	1	cceptable POC		 3. 24 Hour RN 4. 7-Day RN (Rural SN 5. Life Safety Code 	 7. Medical Director WF) 8. Patient Room Size 9. Beds/Room
13. Total Certified Beds	50 (L17)		pliance with Prog ents and/or Appli		* Code: A*	(L12)
14. LTC CERTIFIED BED BREAKDOW	VN	·			15. FACILITY MEETS	
18 SNF 18/19 SNF 50	19 SNF	ICF	IID		1861 (e) (1) or 1861 (j) (1):	(L15)
(L37) (L38)	(L39)	(L42)	(L43)			
16. STATE SURVEY AGENCY REMA	RKS (IF APPLICA	ABLE SHOW LTC CA	NCELLATION I	DATE):		
See Attached Remarks						
17. SURVEYOR SIGNATURE		Date :			18. STATE SURVEY AGENCY	APPROVAL Date:
Gary Schroeder, Deputy Sta	ate Fire Marsl	hall 0	8/14/2013	(L19)	Kamala Fiske-Downing, F	Enforcement Specialist 05/21/2014 (L20)
PAR	T II - TO BE	COMPLETED I	BY HCFA RE	GIONA	L OFFICE OR SINGLE S	TATE AGENCY
 DETERMINATION OF ELIGIBILI X 1. Facility is Eligible to Pa 			IPLIANCE WITH ITS ACT:	H CIVIL		ncial Solvency (HCFA-2572) ol Interest Disclosure Stmt (HCFA-1513)
2. Facility is not Eligible	(L21)				5. 2011 0. 110 100	
22. ORIGINAL DATE	23. LTC AGREE	MENT 24	4. LTC AGREEM	1ENT	26. TERMINATION ACTION	: (L30)
OF PARTICIPATION	BEGINNINC	J DATE	ENDING DAT	ГЕ	<u>VOLUNTARY</u> 00	INVOLUNTARY
03/01/1987					01-Merger, Closure	05-Fail to Meet Health/Safety
(L24)	(L41)		(L25)		02-Dissatisfaction W/ Reimburs	
25. LTC EXTENSION DATE:	27. ALTERNATI				03-Risk of Involuntary Terminatio 04-Other Reason for Withdrawal	OTHER
	A. Suspension	n of Admissions:	(L44)		04-Other Reason for Windrawar	07-Provider Status Change 00-Active
(L27)	B. Rescind St	uspension Date:	(L44)			
			(L45)			
28. TERMINATION DATE:	29	. INTERMEDIARY/	CARRIER NO.		30. REMARKS	
		03001				
	(L28)			(L31)		
31. RO RECEIPT OF CMS-1539	32	2. DETERMINATION	OF APPROVAL	DATE		
	(L32)	07/30/2013		(L33)	DETERMINATION APP	ROVAL

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

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.



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,

Kumalu 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

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 245442	(Y2) Multiple Construction A. Building B. Wing 01 - MA	(Y3) Date of Revisit 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	(Y4) Item	(Y5)	Date	(Y4) Item	(Y5)	Date
ID Prefix		Correction Completed 09/30/2013	ID Prefix		Correction Completed	ID Prefix		Correction Completed
	NFPA 101 K0038		Reg. # LSC			Reg. # _ LSC _		
Reg. #		Correction Completed	Reg. #		Correction Completed	Dec. #		Correction Completed
ID Prefix Reg. # LSC		Correction Completed			Correction Completed	Reg. #		Correction Completed
ID Prefix Reg. # LSC		Correction Completed			Correction Completed			Correction Completed
Reg. #			Rea. #			D //		
Reviewed E	3y Reviewed	Ву	Date:	Signature of Sur	vevor:		Date:	
State Agen		kfd	02/28/2014		258	2.2.		10/21/2013
	3y Reviewed		Date:	Signature of Sur			Date:	
Followup t	o Survey Completed or 5/28/2013	1:		Check for any Uncor Uncorrected Defic				NO

SURVEY TEAM COMPOSITION AND WORKLOAD REPORT

Public reporting burden 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 Office of Financial Management, HCFA, P.O. Box 26684, Baltimore, MD 21207; or to the Office of Management and Budget, Paperwork Reduction Project(0838-0583), Washington, D.C. 20503.

Provider/Supplier Number	Provider/Supplier Name
245442	SPRING VALLEY CARE CENTER
Type of Survey (select all that ap	pply): A Complaint Investigation E Initial Certification I Recertification B Dumping Investigation F Inspection of Care J Sanction/Hearing C Federal Monitoring G Validation K State License
	D Follow-up Visit H Life safety Code L Chow
Extent of Survey (Select all that	apply):
	A Routine/Standard (all providers/suppliers)
A	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.

L1			-		-				
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)	
Team Leader 1. 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.									T

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 HUMA	N SERVICES			CENTERS FOR MI	EDICARE & MEDICAID SERVICES		
					AND TRANSMITTAL	ID: RUUO		
	PART	I - TO BE COMP	LETED BY T	'HE STA'	TE SURVEY AGENCY	Facility ID: 00121		
1. MEDICARE/MEDICAID (L1) 245442 2.STATE VENDOR OR MEI		3. NAME AND AI (L3) SPRING VA (L4) 800 MEMO	LLEY CARE C			4. TYPE OF ACTION: <u>7 (</u> L8) 1. Initial 2. Recertification		
(L2) 046545300	JCAD NO.	(L5) SPRING VA			(L6) 55975	3. Termination 4. CHOW 5. Validation 6. Complaint 7. On Site Visit 0. Other		
5. EFFECTIVE DATE CHA (L9)	NGE OF OWNERSHIP	7. PROVIDER/SU 01 Hospital	PPLIER CATEGO	RY 09 ESRD	(L7) 13 PTIP 22 CLIA	7. On-Site Visit 9. Other 8. Full Survey After Complaint		
 DATE OF SURVEY ACCREDITATION STAT 0 Unaccredited 2 AOA 	(L34) FUS:(L10) 1 TJC 3 Other	02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	06 PRTF 07 X-Ray 08 OPT/SP	10 NF 11 ICF/IID 12 RHC	14 CORF 15 ASC 16 HOSPICE	FISCAL YEAR ENDING DATE: (L35) 09/30		
11LTC PERIOD OF CERT	FICATION	10.THE FACILITY	IS CERTIFIED AS	S:				
From (a):		A. In Complia	nce With		And/Or Approved Waivers Of Th	e Following Requirements:		
To (b):			Requirements nce Based On:		2. Technical Personnel 3. 24 Hour RN	6. Scope of Services Limit		
12.Total Facility Beds	50 (L18)		Acceptable POC			 7. Medical Director 8. Patient Room Size 9. Beds/Room 		
13.Total Certified Beds	50 (L17)		mpliance with Prog ents and/or Applied		* Code: A *	(L12)		
14. LTC CERTIFIED BED	BREAKDOWN				15. FACILITY MEETS			
18 SNF	18/19 SNF 19 SNF 50	ICF	IID		1861 (e) (1) or 1861 (j) (1):	(L15)		
(L37)	(L38) (L39)	(L42)	(L43)					
16. STATE SURVEY AGE	NCY REMARKS (IF APPLICAB	LE SHOW LTC CANC	ELLATION DATE):				
See Attached Remar	ks							
17. SURVEYOR SIGNATU	RE	Date :			18. STATE SURVEY AGENCY A	APPROVAL Date:		
Gary Nederho	ff, Unit Superviso	r 08/14/2013		(L19)	Colleen B. Leach, Program Specialist 12/20/13			
	PART II - TO B	E COMPLETED	BY HCFA RI	EGIONA	L OFFICE OR SINGLE ST			
19. DETERMINATION OF1. Facility is2. Facility is	ELIGIBILITY Eligible to Participate	20. COM	MPLIANCE WITH GHTS ACT:		 21. 1. Statement of Financial Solvency (HCFA-2572) 2. Ownership/Control Interest Disclosure Stmt (HCFA-1513) 3. Both of the Above : 			
2. Facility is	(L21)							
22. ORIGINAL DATE	23. LTC AGREE	MENT 2	4. LTC AGREEM	IENT	26. TERMINATION ACTION:	(L30)		
OF PARTICIPATION 03/01/1987	BEGINNIN	G DATE	ENDING DAT	Έ	VOLUNTARY 00 01-Merger, Closure 0	INVOLUNTARY 05-Fail to Meet Health/Safety		
(L24)	(L41)		(L25)		02-Dissatisfaction W/ Reimburseme	oo run to moor rigitoment		
25. LTC EXTENSION DA	TE: 27. ALTERNAT	IVE SANCTIONS			03-Risk of Involuntary Termination	OTHER		
	A. Suspensi	on of Admissions:			04-Other Reason for Withdrawal	07-Provider Status Change		
	(L27) B. Rescind S	spension Date:	(L44)			00-Active		
			(L45)					
28. TERMINATION DATE	: 2	9. INTERMEDIARY/	CARRIER NO.		30. REMARKS			
		03001						
	(L28)			(L31)				
31. RO RECEIPT OF CMS-	1539	2. DETERMINATION	OF APPROVAL D	ATE				
	(L32)	07/30/2013		(L33)	DETERMINATION APPR	OVAL		

DETERMINATION APPROVAL

DEPARTMENT OF HEALTH AND	HUMAN SERVICES	CENTERS FOR MEDICARE & MEDICAID SERVICES				
	MEDICARE/MEDICAID CERTIFICATION AND T	TRANSMITTAL	ID: RUUO			
	PART I - TO BE COMPLETED BY THE STATE SU	RVEY AGENCY	Facility ID: 00121			
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.



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 Jeach

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



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 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.

Spring Valley Care Center August 14, 2013 Page 2

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

Sincerely,

Mark Meath

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

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 245442	(Y2) Multiple Construction A. Building B. Wing		(Y3) Date of Revisit 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	()	(5) Date	(Y4)	ltem		(Y5)	Date	(Y4)	ltem		(Y5) I	Date
		Correction					Correction					Correction
		Completed					Completed					Completed
ID Prefix	F0156	06/10/2013		ID Prefix	F0282		06/30/2013		ID Prefix	F0309		06/12/2013
Reg. #	483.10(b)(5) - (10), 483.1	0(b)(1)		•	483.20(k)(3)(ii)				Reg. #	483.25		
LSC				LSC					LSC			-
								+-				
		Correction					Correction					Correction
		Completed					Completed					Completed
ID Prefix	F0312	06/30/2013		ID Prefix	F0327		06/11/2013		ID Prefix	F0371		06/19/2013
	483.25(a)(3)				483.25(j)					483.35(i)		_
LSC				LSC					LSC			-
		Correction					Correction					Correction
ID Drofiv	50444	Completed 06/10/2013		ID Drofiv			Completed		ID Brofiv			Completed
ID Prefix	F0441	06/10/2013		ID Prefix			-		ID Pleix			_
-	483.65			Reg. #					Reg. #			_
LSC				LSC				<u> </u>	LSC			-
		Correction					Correction					Correction
ID Prefix		Completed		ID Prefix			Completed		ID Prefix			Completed
Reg. # LSC				Reg. #					Reg. #			-
				200				+-	200	-		_
		Correction					Correction					Correction
		Completed					Completed					Completed
ID Prefix				ID Prefix					ID Prefix			
Reg. #				Reg. #								
LSC				LSC					LSC			_
								+				
Reviewed By	Reviewe	d By	Dat	te:	Signature of	Surve	vor:				Date:	
State Agenc	MM/G	-	08	8/14/20		258					07/15	/2013
Reviewed By	/ Reviewe	d By	Dat	te:	Signature of	Surve	yor:				Date:	
CMS RO												
Followup to	Survey Completed on:				Check f	or anv	Uncorrected F	eficie	encies. Was	a Summary of	I	
-	5/31/2013					-				to the Facility?	YES	NO
											-	

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 245442	A. Building	01 - MAIN BUILDING 01				
Name	of Facility			Street Address, City, State, Zip Code			
SP	RING 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	(Y4) Item	(Y5)	Date	(Y4) Item	(Y5)	Date
		Correction			Correction				Correction
		Completed			Completed				Completed
ID Prefix		07/03/2013	ID Prefix		07/03/2013	ID Prefix			07/03/2013
•	NFPA 101	-	-	NFPA 101		-	NFPA 101		_
LSC	K0029		LSC	K0050		LSC	K0144		_
		Correction			Correction				Correction
ID Prefix		Completed			Completed				Completed
		-							_
Reg. # LSC			Reg. #			Reg. #			_
			LSC						_
		Correction			Correction				Correction
		Completed			Completed				Completed
ID Prefix			ID Prefix			ID Prefix			
Reg. #			Reg. #			Reg. #			
LSC		-							_
		Correction			Correction				Correction
		Completed			Completed				Completed
ID Prefix		-	ID Prefix			ID Prefix			_
Reg. #		-	Reg. #			Reg. #			
LSC			LSC			LSC			_
		o "			o "				o "
		Correction			Correction				Correction
ID Prefix		Completed	ID Prefix		Completed	ID Prefix			Completed
Reg. #			Reg. #						
LSC						LSC			_
Reviewed By	Reviewed	Ву	Date:	Signature of Surve	yor:	1		Date:	
State Agency	MM/PS		08/14/20	13 258	22			07/05	/2013
Reviewed By	Reviewed	Ву	Date:	Signature of Surve	yor:			Date:	
CMS RO									
Followup to	Survey Completed on:			Check for any	Uncorrected De	eficiencies. Was	a Summary of		
	5/28/2013			-		(CMS-2567) Sent	-	YES	NO

DEPARTMENT OF HEAD	LTH AND HUMAN	SERVICES			CENTERS FOR MI	EDICARE & MEDICAID SERVICES
	MEDIC	CARE/MEDICA	ID CERTIFIC	ATION	AND TRANSMITTAL	ID: RUUO
	PART I	- TO BE COMP	LETED BY T	HE STA	TE SURVEY AGENCY	Facility ID: 00121
1. MEDICARE/MEDICAID PROV (L1) 245442	VIDER NO.	3. NAME AND AL (L3) SPRING VA	LLEY CARE C			 TYPE OF ACTION: <u>2</u> (L8) Initial 2. Recertification
2.STATE VENDOR OR MEDICAIL	D NO.	(L4) 800 MEMOI			a o 55055	3. Termination 4. CHOW
(L2) 046545300		(L5) SPRING VA	LLEY, MN		(L6) 55975	5. Validation 6. Complaint 7. On-Site Visit 9. Other
5. EFFECTIVE DATE CHANGE ((L9)	OF OWNERSHIP	7. PROVIDER/SU 01 Hospital	PPLIER CATEGO	RY 09 ESRD	<u>_02</u> . (L7) 13 PTIP 22 CLIA	8. Full Survey After Complaint
6. DATE OF SURVEY	05/31/2013 (L34)	02 SNF/NF/Dual	06 PRTF	10 NF	14 CORF	
8. ACCREDITATION STATUS:	(L10)	03 SNF/NF/Distinct	07 X-Ray	11 ICF/IID	15 ASC	FISCAL YEAR ENDING DATE: (L35)
0 Unaccredited 1 TJ 2 AOA 3 Ot		04 SNF	08 OPT/SP	12 RHC	16 HOSPICE	09/30
11LTC PERIOD OF CERTIFICAT	TION	10.THE FACILITY	IS CERTIFIED AS	S:		I
From (a):		A. In Complia	nce With		And/Or Approved Waivers Of Th	e Following Requirements:
To (b):			Requirements ice Based On:		2. Technical Personnel	6. Scope of Services Limit
12.Total Facility Beds	50 (L18)	-	Acceptable POC		3. 24 Hour RN 4. 7-Day RN (Rural SNF	7. Medical Director 8. Patient Room Size
	30 ()				5. Life Safety Code	9. Beds/Room
13.Total Certified Beds	50 (L17)		mpliance with Prog ents and/or Applied		* Code: B	(L12)
14. LTC CERTIFIED BED BREAK	KDOWN	1			15. FACILITY MEETS	
18 SNF 18/19 S	SNF 19 SNF	ICF	IID		1861 (e) (1) or 1861 (j) (1):	(L15)
50)					
(L37) (L38	3) (L39)	(L42)	(L43)			
	g with the facility's p	olan of correction	n. Documenta		18. STATE SURVEY AGENCY A	
Lee Marietta, HFE NI	EII		06/18/2013	(L19)	Colleen B. Leach, Prog	gram Specialist 07/26/2013
	PART II - TO BE	COMPLETED	BY HCFA RI	EGIONA	L OFFICE OR SINGLE ST	
19. DETERMINATION OF ELIGI	BILITY		MPLIANCE WITH GHTS ACT:	CIVIL		cial Solvency (HCFA-2572) I Interest Disclosure Stmt (HCFA-1513)
1. Facility is Eligible	e to Participate				3. Both of the Above	
2. Facility is not El	igible (L21)					
22. ORIGINAL DATE	23. LTC AGREEM	IENT 2	4. LTC AGREEM	IENT	26. TERMINATION ACTION:	(L30)
OF PARTICIPATION 03/01/1987	BEGINNING	DATE	ENDING DAT	E	VOLUNTARY 00 01-Merger, Closure 0	
(L24)	(L41)		(L25)		02-Dissatisfaction W/ Reimburseme	nt 06-Fail to Meet Agreement
25. LTC EXTENSION DATE:	27. ALTERNATI	VE SANCTIONS			03-Risk of Involuntary Termination	OTHER
	A. Suspension	n of Admissions:			04-Other Reason for Withdrawal	07-Provider Status Change
(L27)) B. Rescind Sus	mension Date:	(L44)			00-Active
	D. Resente bus	pension Dute.	(L45)			
28. TERMINATION DATE:	29	. INTERMEDIARY/	CARRIER NO.		30. REMARKS	
		03001				
	(L28)	55001		(L31)	Posted 7/30/20	13 ML
31. RO RECEIPT OF CMS-1539	32	. DETERMINATION	OF APPROVAL D	ATE		
	(L32)			(L33)	DETERMINATION APPR	OVAL



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;

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

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

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

DEPARTMENT CONTACT

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

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

Spring Valley Care Center June 7, 2013 Page 4

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.

Spring Valley Care Center June 7, 2013 Page 5

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: <u>http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm</u>

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

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

Spring Valley Care Center June 7, 2013 Page 6

Feel free to contact me if you have questions.

Sincerely,

Shellae Dietrich

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

SUMMARY STATEMENT OF DEFICIENCIES

(EACH DEFICIENCY MUST BE PRECEDED BY FULL

REGULATORY OR LSC IDENTIFYING INFORMATION)

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

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

483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF

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

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

RIGHTS, RULES, SERVICES, CHARGES

be used as verification of compliance.

STATEMENT OF DEFICIENCIES

NAME OF PROVIDER OR SUPPLIER

SPRING VALLEY CARE CENTER

INITIAL COMMENTS

your verification.

writing.

AND PLAN OF CORRECTION

(X4) ID

PREFIX

TAG

F 000

F 156

SS=D

(X1) PROVIDER/SUPPLIER/CLIA

IDENTIFICATION NUMBER:

245442

(X2) MULTIPLE CONSTRUCTION

A. BUILDING _

B. WING

1D

PREFIX

TAG

F 000

F 156

	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		
LABOF	ATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
	LAND RN. P.O. N.		6-13-12
other s followi days f	efficiency statement ending with an asterisk (*) denotes a deficiency which the institution r safeguards provide sufficient protection to the patients. (See instructions.) Except for nur ing the date of survey whether or not a plan of correction is provided. For nursing homes ollowing the date these documents are made available to the facility. If deficiencies are of m participation.	sing homes, the findings stated al , the above findings and plans of c	correction are disclosable 90 days

MN Dept of Health

PROVIDER'S PLAN OF CORRECTION

(EACH CORRECTIVE ACTION SHOULD BE

CROSS-REFERENCED TO THE APPROPRIATE

DEFICIENCY)

SEG Attached your

STREET ADDRESS, CITY, STATE, ZIP CODE

SPRING VALLEY, MN 55975

800 MEMORIAL DRIVE

PRINTED: 06/07/2013

FORM APPROVED

05/31/2013

(X5) COMPLETION DATE

6-10-13

6-13-12

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

PRINTED:	06/07/2013
FORM	APPROVED
OMB NO	0038-0301

STATEMEN	OF OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUILI	(X2) MULTIPLE CONSTRUCTION JUN 1 7 2013			(X3) DATE SURVEY COMPLETED	
		245442	B. WING	i	MN Dept of Health Rochester	05/	31/2013	
	ROVIDER OR SUPPLIER	'ER		8	REET ADDRESS, CITY, STATE, ZIP CODE 300 MEMORIAL DRIVE SPRING VALLEY, MN 55975			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 156	inform each resider the items and servi- (i)(A) and (B) of this The facility must inf at the time of admis the resident's stay, facility and of charg including any charg under Medicare or I The facility must fur legal rights which in A description of the personal funds, und section; A description of the for establishing elig the right to request 1924(c) which deter non-exempt resourd institutionalization a spouse an equitable cannot be considered toward the cost of the medical care in his down to Medicaid e A posting of names numbers of all perti- groups such as the agency, the State lie ombudsman progra advocacy network, unit; and a statement complaint with the State state in the statement of the statement of the statement of the statement of the statement of the statement of the statement of the ombudsman program of the statement of the state	nt when changes are made to ces specified in paragraphs (5) a section. Form each resident before, or ssion, and periodically during of services available in the les for those services, es for services not covered by the facility's per diem rate. Thish a written description of neludes: manner of protecting der paragraph (c) of this requirements and procedures ibility for Medicaid, including an assessment under section rmines the extent of a couple's ces at the time of and attributes to the community e share of resources which ed available for payment he institutionalized spouse's or her process of spending	F	156				

Facility ID: 00121

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245442		TIPLE CONSTRUCTION / 2013 NG MN Dept of Health Rochester	(X3) DATE SURVEY COMPLETED	
	245442	D. WING		05/	/31/2013
SPRING VALLEY CARE CEN	ſER		STREET ADDRESS, CITY, STATE, ZIP CODE 800 MEMORIAL DRIVE SPRING VALLEY, MN 55975		
PREFIX (EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	DBE	(X5) COMPLETION DATE
facility, and non-con- directives requirem The facility must inti- name, specialty, and physician responsite The facility must pro- written information, applicants for admis- information about h Medicare and Medi- receive refunds for such benefits. This REQUIREMEN- by: During interview and had failed to provide a timely manner for reviewed for liability appeal rights review Findings include: R of potential liability fi had not been given were denied. R56 was not provide Advanced Beneficia which advises residu eligible for Medicare discontinuing Medic notice on 1/10/13, M	Tresident property in the mpliance with the advance ents. Form each resident of the dway of contacting the oble for his or her care. Cominently display in the facility and provide to residents and ssion oral and written ow to apply for and use caid benefits, and how to previous payments covered by NT is not met as evidenced and document review the facility a the proper liability notices in 1 of 3 residents (R56) notices and beneficiary	F 15	56		

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PRINTED:	06/07/2013
FORM	APPROVED
OMD NO	0000 0001

CENTER	13 FUR MEDIUARE	& MEDICAID SERVICES				JUD NO.	0900-0091
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILC				E SURVEY IPLETED
		245442	B. WING		<u>JUN 1 7 2013</u>	05/	31/2013
none et service p	ROVIDER OR SUPPLIER	ER		8	REET ADDRESS, DIMOSTATE ZINCODE 00 MEMORIAL DRIVE Inster 19 PRING VALLEY, MN 55975		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	IX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 156 F 282 SS=D	During interview on assistant director of R56 had an acute of discontinued from t were discontinued, should have observen nursing so the 48 h During interview on director of nursing i just followed the reg nursing indicated R on therapy and ther discontinued due to 483.20(k)(3)(ii) SEF PERSONS/PER C/ The services provide must be provided b accordance with ea care. This REQUIREMEN by: Based on observat review, the facility for plan was followed for assistance, related residents (R58) rev activities of daily livit Findings Include: R 5/29/13 and 5/30/13	had been waived either. 5/31/13, at 10:31 a.m. the r nursing (ADON) indicated shange in status and was herapy and Medicare services At 10:39 a.m. ADON indicated red and continued with skilled our notice was given. 5/31/13, at 10:40 a.m. the ndicated there was no policy gulation. The director or 56 was very complex, he was in therapy was put on hold and an acute decline. RVICES BY QUALIFIED ARE PLAN led or arranged by the facility y qualified persons in ch resident's written plan of NT is not met as evidenced ion, interview and document ailed to ensure the written care or personal grooming to clean eye glasses for 1 of 3 iewed in the sample for		282	see attached form		6-30-1.3
FORM CMS-25	lenses. 67(02-99) Previous Versions	Obsolete Event ID: RUU01	1	Fac	ility ID: 00121 If continu	ation sheel	Page 4 of 18

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? How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? 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.	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. 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. 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. 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)

TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) DATE F 282 Continued From page 4 F 282 F 282 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			HAND HUMAN SERVICES					FORM	: 06/07/2013 APPROVED . 0938-0391
NAME OF PROVIDER OR SUPPLIER Indexedual						UN 1	7 2013	(X3) DAT COM	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 900 MEMORIAL DRIVE SPRING VALLEY CARE CENTER PARING VALLEY CARE CENTER STREET ADDRESS, CITY, STATE, ZIP CODE 900 MEMORIAL DRIVE SPRING VALLEY, MN 55975 PAREIX (EACH DEFICIENCY MUST EFFECEEDE BY PLL RECULATORY OR LSC IDENTIFYING INFORMATION) D PREFIX PACK D PREFIX (EACH DEFICIENCY PACK			245442	B. WINC)	MN Dept Roch	of Health ester	05/	31/2013
With Preserver Submer Statement of Deficiencies of Public Received by Public Received and Served Interventions Interviewed Biologic Received by Public Received and Public Received by Public Received Biologic Received Bio			ſER	•		REET ADDRESS, CITY, STATE, ZIP (800 MEMORIAL DRIVE			***
Upon document review R56 had a diagnosis of Dementia. The care plan dated 3/20/12 (dentified R58 as having an, "ADL lactivity 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 309 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	PREFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREF	ц IX	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TH	ON SHOULD	BE	(X5) COMPLETION DATE
Dementia. The care plan dated 3/20/12 identified R58 as having an, "ADL [activity of dally living] self care performance deficit RT. (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 ficensed practical nurse (LPN)-A stated R58's glasses were tod clean per the plan of care. F 309 483.25 PROVIDE CARE/SERVICES FOR SIS=D HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicale 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	F 282	Continued From pa	ige 4	F	282				
Based on observation, interview and document	0. The second	Dementia. The care R58 as having an, self care performan dementia, confusion "Vision: [R58] requi for proper vision. En clean and well fitting During an interview nursing assistant (N assistants were to c in the morning as a ready for the day. During an interview licensed practical nu glasses could use a lenses appeared du clean R58's eye gla glasses were not cle 483.25 PROVIDE C HIGHEST WELL BE Each resident must provide the necessa or maintain the high mental, and psycho accordance with the and plan of care.	e plan dated 3/20/12 identified "ADL [activity of daily living] nee deficit R/T (related to) n" and interventions included res use of corrective lenses nsure [R58's] glasses are g." at 10:50 a.m. on 5/30/13 VA)-D stated nursing clean eye glasses for resident part of getting a resident at 10:58 a.m. on 5/30/13 urse (LPN)-A stated R58's a wipe off and stated the listy. The LPN than proceed to sses. LPN verified R58's eye ean per the plan of care. CARE/SERVICES FOR EING receive and the facility must ary care and services to attain hest practicable physical, social well-being, in a comprehensive assessment	s F 3	809	see attached fo	zna		&/12/13
FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: RUUO11 Facility ID: 00121 If continuation sheet Page 5 o		review, the facility fa	ailed to identify purple colored						

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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

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PRINTED: 06/07/2013 FORM APPROVED OMB NO. 0938-0391

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	and the second second second	(X2) MULTIPLE CONSTRUCTION A. BUILDING JUN 1 7 2013		(X3) DATE SURVEY COMPLETED	
		245442	B. WING	i	MN Dopt of Health	05/	/31/2013
	PROVIDER OR SUPPLIER	ER		80	REET ADDRESS, CITY, STATE, ZIP CODE 100 MEMORIAL DRIVE SPRING VALLEY, MN 55975		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
3	skin areas for 1 of 3 non-pressure relate Findings include: R on 5/28/13 with purp side of the left wrist hand with no docum until the staff were in on 5/29/13. Upon document rev Alzheimer 's diseas acute post hemorrha quarterly Minimum D 5/19/13 and this ass long and short term severely impaired de living. Upon review of progress notes there regards to the purple left wrist or right han R36 's care plan da having "tendency to (related to) anemia a interventions include bruising care plan if bruises daily and do increase notify MD [in practitioner]. Notify p occurs. Use caution doorways, leaning an lotion as needed for During an interview a registered nurse (RN R36's right hand and they were not identifi received on bath nig RN-A stated when bi	a residents (R36) reviewed for d skin conditions. 36 was observed at 2:09 p.m. ole skin areas on the back and back side of the right nentation of these being found nformed of them by surveyor iew R36 had diagnoses of e, mineral deficiency and agic anemia. R36 had a Data Set completed on ressment revealed R36 had memory problems and ecision making skills for daily of May ' s 2013 nursing e was no documentation in e skin areas located on the id. ted 3/7/13 identified R36 as bruise very easily R/T and mineral deficiency" and ed: "Implement temporary bruising occurs. Monitor cument weekly. If bruises medical doctor]/NP [nurse ohysician if increase bruising when going through gainst hard objects. Use	F	309			

Facility ID: 00121

If continuation sheet Page 6 of 18

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PRINTED:	06/07/2013
FORM	APPROVED
OMB NO	0038-0391

CENTERS FOR MEDICARE & MEDICARD SERVICES						1	0000 0001
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION JUNE 7 7 2013			(X3) DATE SURVEY COMPLETED		
		245442	B. WING		MN Dept of Health Bochester	05/	31/2013
NAME OF P	ROVIDER OR SUPPLIER				EET ADDRESS, CITY, STATE, ZIP CODE		
SPRING	VALLEY CARE CENT	TER			00 MEMORIAL DRIVE PRING VALLEY, MN 55975		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 309	RN-A verified R36's attention by the dire RN- A stated she til R36's hands and p measurements of til temporary care pla After RN-A comple temporary care pla RN-A had identified integrity due to injuin wall/bed rail. Resid the bruise came from Bruising location: F [centimeters] x 1.2 0.8 cm. L [left] wris Measure and chart Nursing check brui noted and notify Mi nurse." During an interview director of nurses (was for staff to be they assisted resid bath day to inspect was to alert the num identified and then temporary skin imp the bruising. During an interview the DON stated sh assistants to report bruising/discolorati areas were due to	 care plan for skin integrity. s bruises were brought to herector of nursing on 5/29/13. nen assessed the bruises on lanned to complete he bruising and initiate a n for skin integrity. ted the skin impaired n on 5/29/13 it was noted that d R36 had an "Alteration in skin ry suspected bumped hand on ent was unable to say where bm. As evidenced by bruise. R [right] hand 1 cm cm. R FA [forearm] 0.4 cm x t 1 cm x 0.7 cm. Interventions: bruises description weekly. sing daily chart if changes D [medical doctor] and charge / at 11:57 a.m. on 5/30/13 the DON) stated her expectation observing for bruising when ents with their cares and on skin. The DON stated staff rse when a bruise was to implement a baired care plan and monitor / on at 10:20 a.m. on 5/31/13 e did not expect nursing 	F	309			

FORM CMS-2567(02-99) Previous Versions Obsolete

Facility ID: 00121

If continuation sheet Page 7 of 18

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PRINTED: 06/07/2013 FORM APPROVED OMB NO 0938-0391

CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 09). 0938-0391
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING 7 2013			(X3) DATE SURVEY COMPLETED	
		245442	B. WING	i	MN Dopt of U	05	/31/2013
	PROVIDER OR SUPPLIER	ER		8	REET ADDRESS, CITY, STATE, ZIP CODE 300 MEMORIAL DRIVE SPRING VALLEY, MN 55975		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ULD BE COMPLETIC	
F 312 SS=D	hyperlipidemia. The purple areas on R3 they come and go. During the review o monitoring dated M " 1) On admission a bruising based off n and general skin co bruising. 2) If resident is adma a bruise a temporar For duration of bruis 3) Nursing monitors designed care plan. record] will be adder check. Nurses will in they assess/evaluat worsening change a 4) The Care Coordin weekly and writes a tracking form in poir 483.25(a)(3) ADL C. DEPENDENT RESI A resident who is un daily living receives maintain good nutrit and oral hygiene. This REQUIREMEN by: Based on observation review, the facility far	DON also said that the 6's skin are anticipated and f Procedure for bruise ay 2013, it read: assess residents risk for nedications, co-morbidities, ndition. Care plan risk for itted with a bruise or develops y care plan "skin impaired". se. the bruising according to the A line in the TAR [treatment d to prompt the nurse to nitial in the space indicating ed the bruise. If there is a progress note is required. nator assess the bruise once progress note or use the skin at click care until resolved." ARE PROVIDED FOR		309	see attackment		¢/30/13

Facility ID: 00121

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

PRINTED:	06/07/2013
FORM	APPROVED
OND NO	1000 0001

STATEMENT OF CERCISENCIS (x1) PROVIDERSUPPLENCIAN (x2) PROVIDER OF SUPPLENCIAN (x3) DATE SUPPLENCIAN MARE OF PROVIDER OR SUPPLENCIAN 245442 B. WINS JUN 1 7 2013 (x3) DATE SUPPLENCIAN SPRING VALLEY CARE CENTER STRUET ADDRESS, CITY, STATEMENT OF DEFICIENCIES MARE OF PROVIDER VALLEY CARE CENTER SUMMARY STATEMENT OF DEFICIENCIES PROVIDER PLAN OF CORRECTIVE (x2) OF CORRECTIVE MARE OF REAL OF VIEWS OF REAL OF DEFICIENCIES SUMMARY STATEMENT OF DEFICIENCIES PROVIDER PLAN OF CORRECTIVE (x2) OF CORRECTIVE More Than Structure SUMMARY STATEMENT OF DEFICIENCIES PROVIDER PLAN OF CORRECTIVE (x2) OF CORRECTIVE (x2) OF CORRECTIVE Mining STRUEY VIEWS OF REAL OF CORRECTIVE CONTRIBUTION (x2) OF CORRECTIVE (x3) OF CORRECTIVE (x4) OF CORRECTIVE<	CENTER	15 FUR MEDICARE	& MEDICAID SERVICES					. 0938-0391
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STA ^{HE} Brobaddeem Bool MEMORIAL DRIVE SPRING VALLEY CARE CENTER PARING VALLEY CARE CENTER STREET ADDRESS, CITY, STA ^{HE} Brobaddeem Bool MEMORIAL DRIVE Sector DEPCREVENUES are proceeding of your REGULATORY OR LSC IDENTIFYING INFORMATION In prefer Prefer REGULATORY OR LSC IDENTIFYING INFORMATION In prefer Prefer REGULATORY OR LSC IDENTIFYING INFORMATION In prefer Prefer REGULATORY OR LSC IDENTIFYING INFORMATION In prefer Prefer Prefer TAG PROVIDER OF DATA OF CORRECTION (RSA) reviewed in the sample for activities of daily living. Prefer Failed to clean eye glasses for 1 of 3 residents (RS5) reviewed in the sample for activities of daily living. F 312 F 312 Findings Include: R58 was observed at 3:22 p.m. on 5/22/13, at 10:46 a.m. on 5/29/13 and 7:54 a.m. on 5/22/13 and 22/012 identified R58 as having an, "ADL (activity of daily living) self-care performance deficit R/T (related to) dementa, conclusion "and Interventions Included: "Vision: [R58] requires use of corrective lenses for proper vision. Ensure [R58] s glasses are clean and well filling." During an interview at 10:50 a.m. on 5/30/13 licensed practical nurse (LPN)-A verified R5's eye glasses out 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 diffy by staff, they should ask the resident if they can defan their glasses. The DON stated she would						G	COMPLETED	
SPRING VALLEY CARE CENTER SPRING VALLEY, MN 55975 PMD Construction SUMMARY STATEMENT OF DEFICIENCIES RECOULTORY WIST BE RECEIPED BY PULL RECOULTORY OR LSC IDENTIFYING INFORMATION PROVIDER'S PLAN OF CORRECTION (CROSS-REFERENCE NOT THE APPROPRIATE DEFICIENCY) COMPLETION (CROSS-REFERENCE NOT SHOULD BE CROSS-REFERENCE NOT SHOULD BE CROSS-REFERENCE NOT THE APPROPRIATE DEFICIENCY) COMPLETION (CROSS-REFERENCE NOT THE APPROPRIATE DEFICIENCY) COMPLETION (CROSS-REFEREN			245442	B. WING		JUN 1 7 201) ₀₅ ,	/31/2013
SPRING VALLEY CARE CENTER SPRING VALLEY, MN 55975 PMD Construction SUMMARY STATEMENT OF DEFICIENCIES RECOULTORY WIST BE RECEIPED BY PULL RECOULTORY OR LSC IDENTIFYING INFORMATION PROVIDER'S PLAN OF CORRECTION (CROSS-REFERENCE NOT THE APPROPRIATE DEFICIENCY) COMPLETION (CROSS-REFERENCE NOT SHOULD BE CROSS-REFERENCE NOT SHOULD BE CROSS-REFERENCE NOT THE APPROPRIATE DEFICIENCY) COMPLETION (CROSS-REFERENCE NOT THE APPROPRIATE DEFICIENCY) COMPLETION (CROSS-REFEREN	NAME OF P	ROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, DECODE alth		
 PRÉRY TAG REACH CORRECTIVE ACTION SHOLLO BE EQUILATORY OR LIS LIDENTIFYING INFORMATION) PRÉRY TAG 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 7:64 a.m. on 5/28/13, at 10:46 a.m. on 5/29/13 and 7:64 a.m. on 5/28/13, at 10:46 a.m. on 5/29/13 and 7:64 a.m. on 5/28/13, at 10:46 a.m. on 5/29/13 and 7:64 a.m. on 5/28/17, at 10:46 a.m. on 5/20/12 identified R58 as having an, "ADL (activity of daily living) self-care performance deficit RT/ (related to) dementia. The care plan dated 3/20/12 identified R58 as having an, "ADL (activity of daily living) self-care performance deficit RT/ (related to) dementia. The care plan dated 3/20/13 identified R58 as having an, "ADL (activity of daily living) self-care performance deficit RT/ (related to) dementia. The care plan dated 3/20/13 identified R58 as having an, "ADL (activity of daily living) self-care performance deficit RT/ (related to) dementia and well fitting." During an interview at 10:50 a.m. on 5/30/13 nursing assistant (NA)-D stated hursing assistants were to clean LPN-A verified R5's eye 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 10:50 p.m. on 5/30/13 the director of nurses (DON) stated her expectation was if a resident's glasses were noted to be diriy by staff, they should ask the resident if they can clean their glasses. The DCN stated her expectation 	SPRING	VALLEY CARE CENT	ER					
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 5/30/13, 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 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 scul use a wipe of 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 she would	PREFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	PREF		(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO	D BE	COMPLETION
	F 312	related to clean eye (R58) reviewed in the living. Findings Include: R on 5/28/13, at 10:46 a.m. on 5/30/13 to the had visible debris st on the lenses. Upon document rev Dementia. The care R58 as having an, self-care performant dementia, confusion "Vision: [R58] requis for proper vision. Er clean and well fitting During an interview nursing assistant (N assistants were to co in the morning as a ready for the day. During an interview licensed practical ne glasses were not cle glasses could use a lenses appeared du clean R58's eye gla During an interview director of nurses (I was if a resident's g by staff, they should clean their glasses.	 glasses for 1 of 3 residents ne sample for activities of daily 58 was observed at 3:22 p.m. 58 was observed at 3:22 p.m. 58 was observed at 3:22 p.m. 59 a.m. on 5/29/13 and 7:54 59 wearing eyeglasses that meared and speckled spots we R58 had a diagnosis of a plan dated 3/20/12 identified "ADL (activity of daily living) ince deficit R/T (related to) n "and interventions included: res use of corrective lenses insure [R58' s] glasses are g." at 10:50 a.m. on 5/30/13 IA)-D stated nursing idean eye glasses for residents part of getting a resident at 10:58 a.m. on 5/30/13 urse (LPN)-A verified R5's eye an. LPN-A stated R58' s wipe off and stated the isty. The LPN than proceed to sses. at 12:03 p.m. on 5/30/13 the DON) stated her expectation glasses were noted to be dirty I ask the resident if they can The DON stated she would 	F	31:	2		

		H AND HUMAN SERVICES	~		ON	FORM	06/07/2013 APPROVED 0938-0391
	FOF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILD	LTIPI DING			E SURVEY PLETED
		245442	B. WING	I	Rochester	05/:	31/2013
NAME OF P	ROVIDER OR SUPPLIER	• • • • • • • • • • • • • • • • • • •			REET ADDRESS, CITY, STATE, ZIP CODE		
SPRING	VALLEY CARE CEN	ΓER		10	000 MEMORIAL DRIVE SPRING VALLEY, MN 55975		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 312	offering assistance the facility did not h	age 9 as needed. The DON stated have a policy that addressed g assistance provided to		312	see attachment		6/11/13
F 327 SS=D	483.25(j) SUFFICI HYDRATION	ENT FLUID TO MAINTAIN	FS	327	See and the		
		ovide each resident with e to maintain proper hydration					
	by: Based on observa review, the facility f restriction intake m	NT is not met as evidenced tion, interview and document alled to ensure critical fluid onitoring due to kidney failure ent for 1 of 1 resident (R45) restriction.					
	Findings include:						1007
	of 1500 cc (cubic c	ysician ordered fluid restriction entimeters) per day, lacked nitoring of fluid intake.					
	R45 was admitted : included end stage	2/27/13, with diagnosis that renal disease.					
	Minimum Data Set 3/6/13, to require estaff for activities of	d R45 on the admission (MDS), an assessment dated xtensive assistance of two f daily living, had moderate nt, received therapeutic diet, is.					
		f the nutrition status care area notes dated 3/6/13, revealed		2			
FORM CMS-25	67(02-99) Previous Versions	Obsolete Event ID: RUUO1	1	Fac	ility ID: 00121 If continuation	n sheet F	Page 10 of 18

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

DEPARTMENT OF HEALTH AND HUMAN SERVICES OCHITES

PRINTED:	06/07/2013
FORM	APPROVED
OMB NO	1028-0301

CENTE	HS FOR MEDICARE	& MEDICAID SERVICES				0	WR NO.	0938-0391
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUILI	TIPLE CONSTR	JUN 17 20	13		E SURVEY PLETED
		245442	B, WING		MN Dept of HealU Rochester		05/3	31/2013
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDR	ESS, CITY, STATE, ZIP	CODE		
SPRING	VALLEY CARE CENT	ER			RIAL DRIVE ALLEY, MN 55975			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	X (E/	PROVIDER'S PLAN OF (ACH CORRECTIVE ACTI SS-REFERENCED TO T DEFICIENC'	ION SHOULD HE APPROPI	8E	(X5) COMPLETION DATE
	understood the diet Document review of revealed orders for fluid restriction with Document review of dated 3/6/13, 4/30/1 received dialysis, w restriction, was offe accepted diet, and w restrictions. Document review of initiated 3/4/13, reve hypovolemic" (decre to loss of appetite a Interventions includ fluid intake. Care p R45 had nutrition pr problem related to r fluid restriction. Inte cc fluid restriction an symptoms of dehyd During interview on licensed practical nu facility monitored fluid form which was loca administration recor 5/29/13, at 11:55 a. nursing (ADON) also monitored fluids for fluid monitoring form administration recor Document review of	0" cc fluid restriction diet and restrictions. f physician orders dated 5/13, 1500 milliliter/centimeters a start date of 2/27/13. f the facility nutrition review 13, and 5/27/13, revealed R45 as on a " 1500" cc fluid red 360 cc fluids with meals, was compliant with diet f the facility resident care plan ealed R45 at risk for " eased blood volume) related nd fluid restrictions. ed measure all sources of lan initiated 5/27/13; revealed roblem or potential nutritional enal diet with 1500 milliliter erventions included " 1500" nd watch for signs and ration. 5/29/13, at 11:50 a.m., urse (LPN)-A identified the ids on the fluid monitoring ated in the medication d. During interview on m., assistant director of o identified the facility residents was located on the n located in the medication d.		327				
ORM CMS-256	37(02-99) Previous Versions	Obsolete Event ID: RUUO1	1	Facility ID: 0012	1	If continuation	on sheet P	Page 11 of 18

FORM CMS-2567(02-99) Previous Versions Obsolete

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STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION JUN 1 7 2013				(X3) DATE SURVEY COMPLETED	
		245442	B, WING		MN Dept of Health Rochoster	05/	31/2013	
	PROVIDER OR SUPPLIER	ĒR		8	REET ADDRESS, CITY, STATE, ZIP CODE 100 MEMORIAL DRIVE SPRING VALLEY, MN 55975			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE	
F 327	form located in the record revealed the From 3/1/13 to 3/31 days lacked complet totals were monitor From 4/1/13 to 4/30 days lacked complet totals were monitor From 5/1/13 to 5/28 days lacked complet totals were monitor During interview on verified the facility I fluid intake and lack intake totals. During interview on stated the facility en monitor 24 hour flui facility process was intake for each mea was done by nursim numbers. ADON v consistent monitorii daily fluid intake tot 5/29/13, at 1:25 p.n monitoring was the facility used. During observations R45 ate all of lunch salad, soup, ice cre drank approximatel During interview at	medication administration following: 1/13, revealed 19 out of 31 ete fluid entries and no 24 hour ed. 0/13, revealed 22 out of 30 ete fluid entries and no 24 hour ed. 8/13, revealed 24 out of 28 ete fluid entries and no 24 hour	F	327				

		AND HUMAN SERVICES	-			FORM): 06/07/2013 1 APPROVED): 0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD				TE SURVEY MPLETED
		245442	B. WING		JUN 1 7 2013	05	/31/2013
NAME OF P	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY OF STATES ZIR CODE		
SPRING	VALLEY CARE CENT	ER			SPRING VALLEY, MN 55975		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	DBE	(X5) COMPLETION DATE
F 327	Continued From page	ge 12	F3	327		A.M.A. 535 (14)	
	During interview on certified dietary mar allowed 1080 cc flui stated nursing moni	5/29/13, at 12:12 p.m., nager (CDM) stated dietary ds a day for meals. CDM tored fluid intake in the dining d what nursing provided on the					
	registered dietician (nursing to monitor fl	5/30/13, at 8:30 a.m., (RD) stated she expected uid intake due to 1500 cc fluid ed R45 was compliant with					
	stated R45 was on f 240 cc water at beds	5/30/13, at 2:25 p.m., LPN-B luid restriction and received side each shift. However, med would exceed the 1500					
	stated he was aware he received dialysis	5/30/13, at 2:30 p.m., R45 e of fluid restriction and stated three times a week. time revealed 240 cc glass					
	verified dietary allow dietary per day. Nur fluids per day for a to verified he was not a 240 cc three times a fluids provided were would exceed physic restriction by 300 cc lack of written plan the fluids provided by die provided by nursing.	5/31/13, at 8:20 a.m., CDM red 1080 cc fluids provided by sing was allowed 420 cc otal of 1500 cc per day. CDM ware that nursing provided day. CDM verified that if all consumed, the 24 hour total sian ordered 1500 cc fluid per day. CDM verified the nat included the amount of etary and the amount of fluids CDM stated on dialysis veek, dietary provided 360 cc					

FORM CMS-2567(02-99) Previous Versions Obsolete

Facility ID: 00121

If continuation sheet Page 13 of 18

		AND HUMAN SERVICES	2000			FOR	ED: 06/07/2013 M APPROVED O. 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUIL		IPLE CONSTRUCTION	C	ATE SURVEY OMPLETED
		245442	B. WING			JUN 1 7 2013	5/31/2013
NAME OF P	ROVIDER OR SUPPLIER			s	TREET ADDRESS, CITY, STATE,	ZIP CBBE of Health Rochester	
SPRING	VALLEY CARE CENT	ER			SPRING VALLEY, MN 559	975	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAC	۶IX	PROVIDER'S PLAN (EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	ACTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLETION DATE
F 327 F 371 SS=F	fluids to consume b consume while at d expected nursing to on dialysis days. Cl consistent monitorin monitoring of 24 ho During interview on director of nursing of fluid intake entered program by the nurs if administration reco the charge nurse/ca hour fluid intake. 483.35(i) FOOD PF STORE/PREPARE The facility must - (1) Procure food fro considered satisfact authorities; and (2) Store, prepare, under sanitary cond This REQUIREMEN by: Based on observal review, the facility f were stored dry to a This practice had th residents who reside	before R45 left the facility or ialysis. CDM stated he ormonitor the fluids consumed DM verified the facility lacked ing of fluid intake and lacked of our fluid intake totals. 5/31/13, at 10:20 a.m., (DON) stated she expected into the facility computer sing assistants. DON stated ing to enter fluid intake on the bets located in the medication rd, DON stated she expected are coordinator to monitor 24 ROCURE, /SERVE - SANITARY orm sources approved or story by Federal, State or local distribute and serve food ditions NT is not met as evidenced tion, interview, and document ailed to ensure clean dishes maintain sanitary conditions. he potential to affect 45 of 45 led in the facility.	F		1 Sec attac		6/19/13
FORM CMS-2	567(02-99) Previous Versions	Obsolete Event ID: RUUO	11		Facility ID: 00121	If continuation sh	eet Page 14 of 18

×.

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 19 th 2013

PRINTED:	06/07/2013
FORM	APPROVED
OMB NO	0038-0301

STATEMEN	CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			LTIPLE CONSTRU	UCTION	<u> </u>	(X3) DATE SURVEY COMPLETED	
, ind i din c		245442	A. BUILO	I	JUN 17		05/:	31/2013
	ROVIDER OR SUPPLIER	TER		800 MEMOF	AND DEPLOTE ESS, CITY, STATE OF RIAL DRIVE ALLEY, MN 55975		=	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	IX (EA	PROVIDER'S PLAN OF ACH CORRECTIVE ACT SS-REFERENCED TO T DEFICIENC	ION SHOULD	BE	(X5) COMPLETION DATE
F 371	the certified dietary plastic pitchers, twi tray were observed clear plastic pitche upside down, with inside of the pitche their lids tightened, inside of them and container on a she of serving stays wa At 8:35 a.m. on 5/2 expectation was ite they were fully drie were taken through be fully dried prior designated storage three water pitcher serving tray were w designated storage stated the facility d and stated when th dishwasher the kito items to dry. Review of the DISH January 2004, india air-dried. No moist stacked items. Pot air-dried before bei self-draining positio constructed of corr Whenever applicat	29/13, during a kitchen tour with manager (CDM) three clear o syrup pitchers and a serving I to be stored wet. The three rs were placed on a shelf water droplets covering the rs. The two syrup pitchers had water droplets covering the were stored in a metal If. One serving tray in a stack as also noted to be wet. 29/13 the CDM stated his ems were not to be stored until d. The CDM stated when items in the dishwasher they were to to placing them in the e area. The CDM verified the s, two syrup pitchers and one wet when placed in their e area in the kitchen. The CDM id not have any drying racks the items are taken through the chen staff needed to wait for HWASHING POLICY dated cated, " All items must be ure can be found on any s, pans and utensils will be ing stored or will be stored in a on on suitably located hooks osion resistant material. obe, stored containers and oovered or inverted."		371	.1	If continuati	on sheet f	Page 15 of 18

F 371 Continued From page 15 F 371 At 1:46 p.m. on 5/30/13 the CDM verified staff failed to follow the facility policy to ensure all because and prior to be be received in their F 371	CENTER	AS FOR MEDICARE	A MEDICAID SERVICES	I		Constraint an association	0920-0391
MARE OF PROVIDER OR SUPPLIER 24042 In Note SPRING VALLEY CARE CENTER STREET ADDRESS MUMORIAL DRIVE D03/31/2013 COULD PREFIX EACH DEPORTORY MUST STATEMENT OF DEFICIENCIES (EACH DEPORTORY MUST BE PRECEDED BY FULL READ DEPORTORY OR LEG IDENTIFYING INFORMATION) D PREFIX PREFIX (EACH CONTECTION AND ESTIMATION) D PREFIX PREFIX PREFIX D PREFIX D				1	3		
SPRING VALLEY CARE CENTER Both MCMAIL DRIVE PMING VALLEY, MIN 55975 BOMMARY STATEMENT OF DEFINICIONS PROVIDENS FULLEY, MIN 55975 PMING VALLEY, MIN 55975 PROVIDENS FULLEY, MIN 55975 PROVIDENS FULLEY, MIN 55975 PMING VALLEY, MIN 55975 PROVIDENS FULLEY, MIN 55975 PROVIDENS FULLEY, MIN 55975 F 371 Continued From page 15 PROVIDENS FULLEY, MIN 55975 PROVIDENS FULLEY, MIN 55975 F 371 Continued From page 15 F 371 PROVIDENS FULLEY, MIN 55975 F 441 483.65 INFECTION CONTROL, PREVENT F 441 SS-EE SPREAD, LINENS F 441 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. F 441 (a) Infection Control Program Thre facility, Control Program Individual resident; and Contrelity must resident hereisions from direct contad with residents o			245442	CAME AN OWNER OF MALE		05/	31/2013
CMD D ENMMARY STATEMENT OF DEFICIENCIES RECOULD TORY OR LSC DENTIFYING INFORMATION PREVIDE RECORDER OF WILL RECOULD TORY OR LSC DENTIFYING INFORMATION PREVIDE RECORDER OF AN OF CORRECTIVE ACCORDENTIFY AND STATEMENT OF DEFICIENCY COMPLETION CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY COMPLETION CROSS-REFERENCED DEFICIENCY			ſER		800 MEMORIAL DRIVE		
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 dired prior to being placed in their storage area in the kitchen. F 441 F 441 483.66 INFECTION CONTROL, PREVENT SS-EE FREAD, 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. F 441 Sece attlacc.Moment (a) Infection Control Program The facility must establish an infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; F 441 Sece attlacc.Moment (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. (c) Preventing Spread of Infection to prevent the spread of infection to their food, if direct contact will ransmit the disease. (3) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact will ransmit 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.	PREFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO	D BE	COMPLETION
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 with resident contact for which hand washing is indicated by accepted professional practice.	F 441	At 1:46 p.m. on 5/3 failed to follow the i items were air dried storage area in the 483.65 INFECTION	0/13 the CDM verified staff facility policy to ensure all d prior to being placed in their kitchen. N CONTROL, PREVENT				¢/10/1_
 (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 with residents or their food, if direct contact with resident contact for which hands after each direct resident contact for which hand washing is indicated by accepted professional practice. 		Infection Control Pr safe, sanitary and o to help prevent the of disease and infe (a) Infection Contro The facility must es	rogram designed to provide a comfortable environment and development and transmission ction. I Program stablish an Infection Control				
 (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. 		 Investigates, co in the facility; Decides what pi should be applied to (3) Maintains a reco 	ntrols, and prevents infections rocedures, such as isolation, o an individual resident; and ord of incidents and corrective				
(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.		 When the Infect determines that a r prevent the spread isolate the resident The facility mus communicable dise from direct contact 	tion Control Program esident needs isolation to of infection, the facility must , t prohibit employees with a ease or infected skin lesions with residents or their food, if				
(C) Linens		(3) The facility mus hands after each di hand washing is ind professional practic	t require staff to wash their irect resident contact for which dicated by accepted				
ORM CMS-2567(02-99) Previous Versions Obsolete Event ID: RUUO11 Facility ID: 00121 If continuation sheet Page 16 of 1		(c) Linens					

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

PRINTED:	06/07/2013
FORM	APPROVED
OMP NO	0000 0001

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED	
		245442	B. WING	JUN 1 7 2013	05/31/201	13	
	PROVIDER OR SUPPLIER	ſER	8	REET ADDRESS, CIPPES PATE OF CODE 00 MEMORIAL DRIVE PSION PRING VALLEY, MN 55975			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPL	(5) LETION (TE	
F 441	Personnel must ha transport linens so infection.	ndle, store, process and as to prevent the spread of	F 441				
	by: Based on observat review the facility fa sanitary manner du	NT is not met as evidenced ion, interview and document iled to distribute ice water in a ring 1 of 1 water pass the potential to affect 22 of 22 rn Trail hallway.					
	resident mugs with bucket between use During observation nursing assistants (serving ice water fro to the residents who hallway. NA-A lifted	he soiled scoop used to fill ice water was left in the ice es. on 5/28/13, at 2:05 p.m. NA)-A & B were observed om two white buckets with lids o lived on the Western Trail up the lid on one of the ntained two metal scoops and					
	ice inside of the con on and filled a mug ice bucket and oper hand and went into the used mugs from changing the soiled scoop out of the ice mug. NA-A continue during the serving of Western Trail hallwa	tainer. The NA-A had gloves with ice and water, re-covered led the door with the gloved the resident's room gathered the room and without gloves proceed to take the bucket and fill a sanitized d to wear the soiled gloves f water to the residents on the ay. NA-B was observed to in the same manner that NA-A					
		5/28/13, at 2:12 p.m. NA -A ss consisted of keeping the					
RM CMS-256	7(02-99) Previous Versions (Dbsolete Event ID: RUUO t	í Facili	ity ID: 00121 If continuati	on sheet Page 17	of 18	

Facility ID: 00121

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION JUN 1 7 2013			
		245442	B, WING _	MN Dept of Health Rochestor	05/	/31/2013
	PROVIDER OR SUPPLIER	ſER	S	STREET ADDRESS, CITY, STATE, ZIP CODE 800 MEMORIAL DRIVE SPRING VALLEY, MN 55975	1 00,	01/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 441	ice scoops in the ic the lids were covered During interview on assistant director of were to be kept sep verified the scoop/s During interview on director of nursing in separate container should not be in with During review of Ice Chests policy dated	e bucket but made sure that ed between residents. 5/28/13, at 2:14 p.m. the f nursing confirmed ice scoops parate from the ice bucket and had been in the ice buckets. 5/30/13, at 7:28 a.m. the ndicated they would expect a next to the ice bucket but h the ice. Machine and Ice Storage December 2010, directed scoop on a clean, hard	F 44			
RM CMS-256	7(02-99) Previous Versions C	Obsolete Event ID: RUUO11	Fa	cility ID: 00121 If continuation	n sheet Pa	age 18 of 18

PRINTED: 06/07/2013 FORM APPROVED OMB NO: 0938-0391

STATEMEN	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL		(X3) DATE SURVEY
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILD	DING 01 - MAIN BUILDING 01	COMPLETED
		245442	B. WING		05/28/2013
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 800 MEMORIAL DRIVE	
SPRING	VALLEY CARE CENT	ER		SPRING VALLEY, MN 55975	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		D BE COMPLÉTION
K 000	INITIAL COMMENT	rs	К	000	
DC: 07.10, 2013	ALLEGATION OF O DEPARTMENT'S A SIGNATURE AT TH PAGE OF THE CM USED AS VERIFIC UPON RECEIPT O AN ONSITE REVIS BE CONDUCTED SUBSTANTIAL CO REGULATION HAS	OC WILL SERVE AS YOUR COMPLIANCE UPON THE ACCEPTANCE. YOUR HE BOTTOM OF THE FIRST IS-2567 FORM WILL BE ATION OF COMPLIANCE. F AN ACCEPTABLE POC, SIT OF YOUR FACILITY MAY TO VALIDATE THAT MPLIANCE WITH THE S BEEN ATTAINED IN ITH YOUR VERIFICATION.		DIE GEIV JUN 17 2013 MA DEVIT OF PUBLIC SU STATE MARCHAE DI See attach's for DIC ok	POC's
ExIT: 05.31.2013	Minnesota Departm time of this survey S found not in substa requirements for pa Medicare/Medicaid 483.70(a), Life Safe edition of National F (NFPA) Standard 1 Chapter 19 Existing PLEASE RETURN CORRECTION FOI DEFICIENCIES (K-TAGS) TO: Health Care Fire Ins State Fire Marshal 445 Minnesota St., St Paul, MN 55101-	at 42 CFR, Subpart ety from Fire, and the 2000 Fire Protection Association 01, Life Safety Code (LSC), 9 Health Care. THE PLAN OF R THE FIRE SAFETY spections Division Suite 145 -5145, or		POC 0K W/TW for K38 19 6-20-13	
		ERISUPPLIER REPRESENTATIVE'S SIG	NATURE	TITLE	(X6) DATE 6.14.13
Any deficience	watatament anding with	an athriak (*) donatan a dafisionay whi	ch tha ins	stitution may be excused from correcting providing	it is determined that

F5442021

Any deficiency statement ending with an esterisk (*) 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:						E SURVEY PLETED	
		245442	B. WING	B. WING		05/28/2013	
NAME OF PROVIDER OR SUPPLIER SPRING VALLEY CARE CENTER			800 MEMORI	SS, CITY, STATE, ZIP CODE AL DRIVE LLEY, MN 55975			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	IX (EAC	ROVIDER'S PLAN OF CORRECTIO CH CORRECTIVE ACTION SHOULD S-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
K 000	DEFICIENCY MUS FOLLOWING INFO 1. A description of to correct the defici 2. The actual, or pr 3. The name and/or responsible for corre prevent a reoccurre The Spring Valley (building with a part constructed in 1975 Type II(111) constr The building is fully facility has a fire all smoke detection ar that is monitored for notification. The facility has a lio and had a census of The requirement at NOT MET as evide	 @state.mn.us and tate.mn.us RRECTION FOR EACH ST INCLUDE ALL OF THE DRMATION: what has been, or will be, done ency. oposed, completion date. r title of the person rection and monitoring to ence of the deficiency. Care Center is a 1-story ial basement. The building was 5 and was determined to be of uction. fire sprinkler protected. The arm system with full corridor nd spaces open to the corridor, or automatic fire department censed capacity of 50 beds of 45 at the time of the survey. : 42 CFR Subpart 483.70(a) is enced by: 					
K 029 SS=F	NFPA 101 LIFE SA	S Obsolete Event ID: RUU02)29 Facility ID: 00121	If continu	ation she	et Page 2 of 7

STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	10 III III III III III III III III III I		LE CONSTRUCTION 3 01 - MAIN BUILDING 01	(X3) DATE SURVEY COMPLETED	
		245442	B. WING			05/2	28/2013
	ROVIDER OR SUPPLIER	ER		8	REET ADDRESS, CITY, STATE, ZIP CODE 800 MEMORIAL DRIVE SPRING VALLEY, MN 55975		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
K 029	Continued From pa One hour fire rated fire-rated doors) or extinguishing syste and/or 19.3.5.4 pro the approved autom option is used, the other spaces by sm doors. Doors are s field-applied protect 48 inches from the permitted. 19.3.2 This STANDARD i Based on observat facility failed to mai partitions and doors following requireme Section 19.3.2.1. T affect 30 out of 45 m Findings include: On facility tour betw 05/28/2013, observ following was found	rge 2 construction (with ³ / ₄ hour an approved automatic fire m in accordance with 8.4.1 tects hazardous areas. When natic fire extinguishing system areas are separated from noke resisting partitions and elf-closing and non-rated or tive plates that do not exceed bottom of the door are 2.1 s not met as evidenced by: tion and staff interview, the ntain smoke-resisting s in accordance with the ents of 2000 NFPA 101, The deficient practice could residents.	K	029			
	closer 2. Kitchen storage closer 3. Textile care clea not positively latch	room (over 50 sq ft) no door an storage (over 50 sq ft) does n by dining room no door					

FORM CMS-2567(02-99) Previous Versions Obsolete

Facility ID: 00121

If continuation sheet Page 3 of 7

AND PLAN OF CORRECTION		1 '	IPLE CONSTRUCTION IG 01 - MAIN BUILDING 01	(X3) DAT	E SURVEY	
		245442	B. WING		05/	28/2013
	PROVIDER OR SUPPLIER	TER	s	TREET ADDRESS, CITY, STATE, ZIP CODE 800 MEMORIAL DRIVE SPRING VALLEY, MN 55975		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPR(DEFICIENCY)	LD BE	(X5) COMPLETION DATE
K 029	Continued From pa	age 3	K 02	9		
K 038 SS=F	Facility Maintenand discovery. NFPA 101 LIFE SA Exit access is arran	actices were confirmed by the ce Director at the time of AFETY CODE STANDARD nged so that exits are readily nes in accordance with section	K 03	8 Temporary Waiver req	lest.	
	Based on observa provide means of e following requireme	is not met as evidenced by: tion, the facility failed to gress in accordance with the ents of 2000 NFPA 101, 5.2 and 7.2.1.4.5. The deficient of all 45 residents.				
	Findings include: On facility tour bety	veen 1:00 PM and 3:30 PM on				
	05/28/2013, observ following was found	ation revealed, that the				
		t exit discharge has a change e than 1/2 inch from door rete sidewalk				
	2. West exit dischause of force to open	arge door takes more than 50				
		ctices were confirmed by the e Director at the time of				
ORM CMS-25	67(02-99) Previous Versions	Obsolete Event ID: RUUO2	!1 F	Facility ID: 00121 If conti	nuation shee	et Page 4 of 7

ULIVILI	101 OT MEDIOATE				0	10101	0000 0001
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	• •	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01			E SURVEY PLETED
		245442	B, WING			05/2	28/2013
	NAME OF PROVIDER OR SUPPLIER SPRING VALLEY CARE CENTER			STREET ADDRESS, CITY, ST 800 MEMORIAL DRIVE SPRING VALLEY, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFERENC	PLAN OF CORRECTION TIVE ACTION SHOULD CED TO THE APPROPP FICIENCY)	BE	(X5) COMPLETION DATE
K 050 SS=F	Fire drills are held a varying conditions, The staff is familiar that drills are part of Responsibility for p assigned only to co qualified to exercise conducted between announcement may alarms. 19.7.1.2 This STANDARD i Based on docume interview, the facilit were conducted on staff under varying required by 2000 N This deficient pract residents. Findings include: On facility tour betw 05/28/2013, the rev documentation for 2012 to April 2013) following shifts were	is not met as evidenced by: ntation review and staff y failed to assure fire drills ce per shift per quarter for all times and conditions as FPA 101, Section 19.7.1.2. ice could affect all 45 veen 1:00 PM and 3:30 PM on view of the fire drill the past 9 months (August revealed the drills for the the e completed but did not times that the drills were	KO				
FORM CMS.25	67(02-99) Previous Versions	Obsolete Event ID: RUUO2	21	Facility ID: 00121	If continue	ation shee	t Page 5 of 7
1 01101 01010-20				adding to. OUTET	n conditua	2001 2166	a aye ovi/

PRINTED: 06/07/2013 FORM APPROVED OMB NO. 0938-0391

ULNILI	101 UN NILDIGANL	A MEDIORID OLIVIOLO				no no.	0000 0001
	F OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01			(X3) DATE SURVEY COMPLETED	
		245442	B. WING			05/2	28/2013
	NAME OF PROVIDER OR SUPPLIER SPRING VALLEY CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP 800 MEMORIAL DRIVE SPRING VALLEY, MN 55975	CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		ON SHOULD E	BE	(X5) COMPLETION DATE
K 050	This deficient pract	age 5 lice was confirmed by the ce Director at the time of	КC	950			
K 144 SS=F	NFPA 101 LIFE SA Generators are ins	FETY CODE STANDARD pected weekly and exercised ninutes per month in FPA 99. 3.4.4.1.	K 1	44			
	Based on docume interview, the facilit generator in accord 2000 NFPA 101 - 9 Chapter 6-4.1. The all 45 residents. Findings include;	is not met as evidenced by: ntation review and staff y failed to test the emergency lance with the requirements of 0.1.3 and 1999 NFPA 110 deficient practice could affect					
	05/28/2013, the do weekly inspection a 2012 to May 2013) generator revealed 1. The weekly oper missed for the wee 11/5, 11/12,11/19, 12/31/2012. 1/6, 1/	veen 1:00 PM and 3:30 PM on cumentation review of the and monthly run logs (August for the diesel emergency that the following was found: ational inspections were ks of 10/1, 10/8, 10/22, 10/29, 12/3, 12/10, 12/17, 12/24 and /21,1/28, 2/18, 2/25, 3/4, 3/11, , 4/22, 5/6 and 5/13/2013					
FORM CMS-25	67(02-99) Previous Versions	Obsolete Event ID: RUU02	21	Facility ID: 00121	If continua	tion shee	t Page 6 of 7

PRINTED:	06/07/2013
FORM	APPROVED
OMB NO.	0938-0391

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				3) DATE SURVEY COMPLETED	
		245442	B, WING			05/28/2013	
	ROVIDER OR SUPPLIER	ĒR		8	REET ADDRESS, CITY, STATE, ZIP CODE 00 MEMORIAL DRIVE SPRING VALLEY, MN 55975		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
К 144	as follows: Septem 2012 This deficient pract Facility Maintenanc discovery. *TEAM COMPOSIT	on for monthly 30% load run aber 2012 through November ice was confirmed by the e Director at the time of	K	144			
FORM CMS-25	67(02-99) Previous Versions	Obsolete Event ID: RUUO2	1	Fac	cility ID: 00121 If continue	ation shee	et Page 7 of 7

- K029 Hazardous Areas/existing
 - 1. IT/record storage (over 50 sq ft) no door closer
 - 2. Kitchen storage room no door closer
 - Textile care clean storage does not have a positive latch
 Soiled linen room by dining room no door closer

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

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	South and west exit discharge will be corrected to no more than a ½ inch drop. A temporary Waiver				
will be accomplished to correct this	to allow for additional time to complete has been requested.				
deficiency.	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	William Hale, Facilities Director				
prevent a reoccurrence of the					
deficiency.					

K50 Fire Drills

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

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

K144 Generator Testing

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

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



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

Spring Valley Care Center June 7, 2013 Page 2

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

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

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

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

Minnesc	ta Department of He	ealth					
	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NU		. ,		(X3) DATE COMPI	
		00121		B. WING		05/3	1/2013
NAME OF F	ROVIDER OR SUPPLIER		STREET AD	DRESS, CITY,	STATE, ZIP CODE		.,_•.•
SPRING	VALLEY CARE CEN	TER		/EMORIAL DRIVE NG VALLEY, MN 55975			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIE Y MUST BE PRECEDED BY SC IDENTIFYING INFORM	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 000	2 000 Initial Comments			2 000			
	*****ATTE	NTION*****					
	NH LICENSING	CORRECTION ORE)ER				
	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.						
Minnesota D	this Department's s and the following liv When corrections a date, make a copy original to the Minn	TS: , and 31, 2013, surve staff visited the above censing orders were are completed, please of these orders and i lesota Department of ance Monitoring, Lice	e provider issued. e sign and return the Health,		Minnesota Department of Health i documenting the State Licensing Correction Orders using federal so Tag numbers have been assigned Minnesota state statutes/rules for Homes.	oftware. I to	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

6899

TITLE

(X6) DATE

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NU				(X3) DATE COMP	SURVEY LETED
		00121		B. WING		05/3	1/2013
NAME OF P	ROVIDER OR SUPPLIER				STATE, ZIP CODE		
SPRING	VALLEY CARE CENT	rer		IORIAL DRIN VALLEY, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIE Y MUST BE PRECEDED BY .SC IDENTIFYING INFORM	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETE DATE
2 000	Continued From pa Certification Progra Rochester, MN 559	am; 18 Wood Lake Di	rive SE,	2 000	The assigned tag number app far left column entitled "ID Pre The state statute/rule out of co listed in the "Summary Statem Deficiencies" column and repli Comply" portion of the correct This column also includes the which are in violation of the sta after the statement, "This Rule as evidence by." Following the findings are the Suggested Me Correction and Time period fo PLEASE DISREGARD THE H THE FOURTH COLUMN WHI STATES, "PROVIDER'S PLAI CORRECTION." THIS APPLI FEDERAL DEFICIENCIES ON WILL APPEAR ON EACH PAU THERE IS NO REQUIREMEN SUBMIT A PLAN OF CORRE VIOLATIONS OF MINNESOT STATUTES/RULES.	efix Tag." ompliance is lent of aces the "To ion order. findings ate statute is not met surveyors ethod of r Correction. EADING OF CH N OF ES TO NLY. THIS GE. IT TO CTION FOR	
2 565	MN Rule 4658.040 Plan of Care; Use	5 Subp. 3 Comprehe	nsive	2 565			
		omprehensive plan o I personnel involved i t.					
	by: Based on observat review, the facility f	ent is not met as evi ion, interview and do failed to ensure the w for personal grooming	cument rritten care				

STATE FORM

RUUO11

If continuation sheet 2 of 18

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPF IDENTIFICATION		A. BUILDING:	CONSTRUCTION		E SURVEY PLETED
		00121		B. WING		05/31/201	
IAME OF P	ROVIDER OR SUPPLIER				TATE, ZIP CODE -		
SPRING	VALLEY CARE CENT	ER		ORIAL DRIVE VALLEY, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENC MUST BE PRECEDED SC IDENTIFYING INFOR	BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETI DATE
2 565	Continued From page 2			2 565			
	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."						
	nursing assistant (Nassistants were to c	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.					
	licensed practical n glasses could use a lenses appeared du clean R58's eye gla	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.					
	The director of nurs procedures to ensu according to the wr of nursing could ed monitoring system	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						

	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPL IDENTIFICATION N		. ,	CONSTRUCTION		E SURVEY PLETED
		00121		B. WING		05/3	31/2013
AME OF F	PROVIDER OR SUPPLIER			DRESS, CITY, ST			
PRING	VALLEY CARE CENT	ER		ORIAL DRIVE VALLEY, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCII MUST BE PRECEDED B' SC IDENTIFYING INFORM	Y FULL	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 565	Continued From pa	ge 3		2 565			
	(21) days.						
2 830	2 830 MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General			2 830			
	Subpart 1. Care in receive nursing car custodial care, and individual needs an the comprehensive plan of care as des 4658.0405. A nurs of bed as much as written order from t resident must rema prefers to remain in	supervision based of d preferences as ide resident assessme scribed in parts 4658 ing home resident n possible unless the he attending physici in in bed or the resi	rsonal and on entified in nt and 3.0400 and nust be out re is a an that the				
		on, interview and do ailed to identify purp 3 residents (R36) re	ocument le colored				
	Findings include: F on 5/28/13 with pur side of the left wrist hand with no docun until the staff were on 5/29/13. Upon document rev Alzheimer 's diseas	ple skin areas on th and back side of th nentation of these b informed of them by view R36 had diagno	e back e right eing found surveyor oses of				
	acute post hemorrh quarterly Minimum 5/19/13 and this as long and short term	agic anemia. R36 I Data Set completed sessment revealed	nad a l on R36 had and				

Vinneso	ota Department of He	ealth				FORM	APPROVE
STATEME	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPL IDENTIFICATION N		(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION		E SURVEY PLETED
		00121		B. WING		- 05/31/20	
IAME OF F	PROVIDER OR SUPPLIER	•	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
SPRING	VALLEY CARE CENT	ER		MORIAL DRIVE VALLEY, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENC / MUST BE PRECEDED B SC IDENTIFYING INFORM	Y FULL	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
2 830	Continued From page 4			2 830			
	living. Upon review progress notes ther regards to the purp left wrist or right ha R36 's care plan da having "tendency to (related to) anemia interventions includ bruising care plan it bruises daily and do increase notify MD practitioner]. Notify occurs. Use caution doorways, leaning a lotion as needed for During an interview registered nurse (R R36's right hand an they were not identific received on bath nit RN-A stated when I were to alert the nu initiate a temporary RN-A verified R36's attention by the dire RN- A stated she th R36's hands and pl measurements of th temporary care plan After RN-A complet temporary care plan RN-A had identified integrity due to injun wall/bed rail. Reside the bruise came fro Bruising location: R [centimeters] x 1.2	re was no documen le skin areas locate nd. ated 3/7/13 identifie b bruise very easily and mineral deficie led: "Implement tem f bruising occurs. M ocument weekly. If [medical doctor]/NF physician if increas n when going throug against hard objects r dry and frail skin." r at 2:31 p.m. on 5/2 N)- A stated the bru d left wrist were ne ified during the skin ght the previous ev bruises were identif rse. Then the nurse r are plan for skin i s bruises were broug ector of nursing on sh hen assessed the bru anned to complete he bruising and initi n for skin integrity. ted the skin impaire n on 5/29/13 it was d R36 had an "Altera ry suspected bump ent was unable to so m. As evidenced by R [right] hand 1 cm	tation in ad on the ad R36 as R/T ency" and porary lonitor bruises P [nurse e bruising gh s. Use 29/13 uises on w today as check R36 ening. Tied staff e was to ntegrity. ght to her 5/29/13. ruises on ate a ad noted that ation in skin ed hand on ay where y bruise.	n			

Minneso	ta Department of He	alth					(ITROVED
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NU			E CONSTRUCTION	(X3) DATE COMPI	SURVEY LETED
		00121		B. WING		05/3	1/2013
NAME OF P	ROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, S	STATE, ZIP CODE		.,
SPRING	VALLEY CARE CENT	ER		ORIAL DRIV /ALLEY, MN			
(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 SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 830	Continued From pa	ge 5		2 830			
	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 o monitoring dated M	f Procedure for bruis ay 2013, it read:	e				
	 " 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. 						

Minneso	ta Department of He	alth				i oran,	
	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NU				(X3) DATE COMP	SURVEY LETED
		00121		B. WING		05/3	1/2013
NAME OF P	ROVIDER OR SUPPLIER	1	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
SPRING	VALLEY CARE CENT	ER		ORIAL DRIV /ALLEY, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIE / MUST BE PRECEDED BY SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROINDEFICIENCY)	D BE	(X5) COMPLETE DATE
2 830	Continued From page 6			2 830			
	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."						
	The director of nurs develop policies an residents consisten interventions. The designee could edu these policies and p nursing or her desig systems to ensure	THOD OF CORRECT sing or her designee d procedures to ensu- tly were provided app director of nursing or licate all appropriate s procedures. The dire- gnee could develop n ongoing compliance.	could ure propriate her staff on ctor of nonitoring				
2 920	MN Rule 4658.052	5 Subp. 6 B Rehab -	ADLs	2 920			
	comprehensive res home must ensure B. a resident who activities of daily liv	is unable to carry ou ing receives the nece n good nutrition, groo	nursing It essary				
	by: Based on observati review, the facility f received grooming related to clean eye (R58) reviewed in t living.	ent is not met as evi ion, interview and dou ailed to ensure each assistance as neces glasses for 1 of 3 re he sample for activition 58 was observed at 3	cument resident sary, esidents es of daily				
Miner and a D	on 5/28/13, at 10:4	6 a.m. on 5/29/13 and be wearing eyeglasse	d 7:54				

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLI IDENTIFICATION NU		A. BUILDING:	CONSTRUCTION	(X3) DATE SURV COMPLETED	
		00121		B. WING		05/3	31/2013
	PROVIDER OR SUPPLIER	ER	800 MEN	IORIAL DRIVE VALLEY, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIE MUST BE PRECEDED BY SC IDENTIFYING INFORM	/ FULL	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLE DATE
2 920	had visible debris s on the lenses. Upon document rev Dementia. The care R58 as having an, self-care performar dementia, confusion "Vision: [R58] requi for proper vision. En clean and well fitting During an interview nursing assistant (N assistants were to c in the morning as a ready for the day. During an interview licensed practical n glasses were not cl glasses could use a lenses appeared du clean R58's eye gla During an interview director of nurses (I was if a resident's by staff, they should clean their glasses. expect staff to be cl offering assistance the facility did not h	view R58 had a diag e plan dated 3/20/12 "ADL (activity of dai nce deficit R/T (relate n "and interventions res use of corrective nsure [R58' s] glasse g." at 10:50 a.m. on 5/3 (A)-D stated nursing clean eye glasses fo part of getting a res at 10:58 a.m. on 5/3 urse (LPN)-A verifie ean. LPN-A stated Fa wipe off and stated usty. The LPN than p	nosis of identified ly living) ed to) s included: e lenses es are 30/13 r residents 30/13 d R5's eye R58' s I the proceed to 30/13 the pectation to be dirty they can be would lasses and N stated dressed				
	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						

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPF IDENTIFICATION			CONSTRUCTION		E SURVEY PLETED
		00121		B. WING			31/2013
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PRING	VALLEY CARE CENT	ER		IORIAL DRIVE VALLEY, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIEN MUST BE PRECEDED SC IDENTIFYING INFOF	BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 920	Continued From page 8			2 920			
	assistance with act director of nursing of system to educate a system to ensure si assistance with act TIME PERIOD FOR Twenty-One (21) da	or designee (s)cou staff and develop a taff provided neces ivities of daily living R CORRECTION:	Id develop a a monitoring ssary				
2 940	MN Rule 4658.052	5 Subp. 9 Rehab -	Hydration	2 940			
	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 Requireme by: Based on observati review, the facility fa restriction intake m and dialysis treatme reviewed with fluid	on, interview and on ailed to ensure crit onitoring due to kind ent for 1 of 1 reside	document ical fluid dney failure				
	Findings include:						
	of 1500 cc (cubic c	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.						

Minneso	ota Department of He	alth				T OT WIT	
	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NU				(X3) DATE COMPI	SURVEY LETED
		00121		B. WING		05/3	1/2013
NAME OF P	ROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, S	STATE, ZIP CODE	-	
SPRING	VALLEY CARE CENT	ER		ORIAL DRIV /ALLEY, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROINDEFICIENCY)	D BE	(X5) COMPLETE DATE
2 940	Continued From pa	ige 9		2 940			
	Document review of assessment (CAA) R45 received "150 understood the diet Document review of revealed orders for fluid restriction with Document review of dated 3/6/13, 4/30/ received dialysis, w restriction, was offe accepted diet, and restrictions. Document review of initiated 3/4/13, rev hypovolemic" (decr to loss of appetite a Interventions includ fluid intake. Care p R45 had nutrition p problem related to a fluid restriction. Inte cc fluid restriction a symptoms of dehyce During interview on licensed practical n facility monitored fluid form which was loc administration reco	of the nutrition status of notes dated 3/6/13, r 0" cc fluid restriction t restrictions. of physician orders da 1500 milliliter/centim a start date of 2/27/1 of the facility nutrition 13, and 5/27/13, reve /as on a " 1500" cc fl ered 360 cc fluids with was compliant with d of the facility resident ealed R45 at risk for reased blood volume) and fluid restrictions. ded measure all source olan initiated 5/27/13; roblem or potential nu- renal diet with 1500 n erventions included '	revealed diet and ated 5/13, neters 13. review ealed R45 luid h meals, liet care plan ") related ces of revealed utritional milliliter " 1500 " nd m., ed the itoring on on				
	nursing (ADON) als monitored fluids for	so identified the facilit residents was locate m located in the medi	ty ed on the				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 00121			A. BUILDING: _	CONSTRUCTION		E SURVEY PLETED	
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			DDRESS, CITY, S IORIAL DRIVE VALLEY, MN	E			
PREFIX (EACH DEFICIEN			SUMMARY STATEMENT OF DEFICIENCIES ID EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX		PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
form located in the record revealed to From 3/1/13 to 3/ days lacked comp totals were monito From 4/1/13 to 4/ days lacked comp totals were monito From 5/1/13 to 5/ days lacked comp totals were monito During interview of verified the facility fluid intake and la intake totals. During interview of stated the facility monitor 24 hour for facility process we intake for each me was done by nurse numbers. ADON consistent monito daily fluid intake to 5/29/13, at 1:25 pp monitoring was the facility used. During observation R45 ate all of lune salad, soup, ice of drank approximation During interview as (NA-E) stated R4 400 cc.	of the facility fluid mo e medication administ the following: 31/13, revealed 19 out blete fluid entries and bred. 30/13, revealed 22 out blete fluid entries and bred. 28/13, revealed 24 out blete fluid entries and	tration t of 31 no 24 hour it of 30 no 24 hour it of 28 no 24 hour m., LPN-A onitoring of our fluid .m., ADON rse to e stated the onitoring ke cked ed 24 hour w on e 24 hour ing the 00 p.m., lettuce ce, and vater. sistant -E nch was					

TATEMEN	ta Department of He	(X1) PROVIDER/SUPPL IDENTIFICATION N			CONSTRUCTION		E SURVEY PLETED
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		IORIAL DRIVE VALLEY, MN					
(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 (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLE DATE	
2 940	Continued From pa	ge 11		2 940			
	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 epartment of Health						

Minnesc	ta Department of He	ealth					
	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NU				(X3) DATE COMP	SURVEY LETED
		00121		B. WING			1/2013
NAME OF F	ROVIDER OR SUPPLIER	00121	STREET AD	DRESS, CITY, S	STATE, ZIP CODE	00/0	1/2010
			ORIAL DRIV /ALLEY, MN	E			
(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 CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 940	Continued From pa	ige 12		2 940			
	consistent monitori	DM verified the facilit ng of fluid intake and our 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.						
	The director of nurs policies and procect for residents at risk of nursing could de intake for residents	THOD FOR CORREC sing could review and lures for monitoring f for dehydration. The velop a system to mo s with fluid restriction could educate staff	l revise luid intake e director onitor fluid . The				
	TIME PERIOD FOR (21) days.	R CORRECTION: T	wenty one				
21165	⁶⁵ MN Rule 4658.0675 Subp. 7 Mechanical Cleaning and Sanitizing;Air drying			21165			
	air dried before bei a self-draining posi	. Dishes and utensils ng stored or must be tion. Properly racked may complete air d ces, if available.	stored in sanitized				
	by: Based on observati review, the facility f	ent is not met as evi ion, interview, and do ailed to ensure clean	cument dishes				
Minnesota D	epartment of Health	maintain sanitary con	uluons.				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIE AND PLAN OF CORRECTION IDENTIFICATION NU				CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
	00121			B. WING		05/	31/2013
NAME OF P	ROVIDER OR SUPPLIER			DDRESS, CITY, S			
SPRING	VALLEY CARE CENT	ER		IORIAL DRIVE VALLEY, MN			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ENCY MUST BE PRECEDED BY FULL PREFIX		PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
21165	Continued From pa	ge 13		21165			
	This practice had th residents who resid		45 of 45				
	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						
	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."						

Minnesc	ta Department of He	ealth						
	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NU		. ,		(X3) DATE COMP	SURVEY LETED	
		00121		B. WING		05/3	1/2013	
NAME OF F	ROVIDER OR SUPPLIER	L	STREET AD	DRESS, CITY, S	STATE, ZIP CODE	1 00/0		
			ORIAL DRIV /ALLEY, MN					
(X4) ID PREFIX TAG				ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ECTIVE ACTION SHOULD BE COMPLET ENCED TO THE APPROPRIATE DATE		
21165	Continued From pa	age 14		21165				
	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.							
21375	MN Rule 4658.0800 Subp. 1 Infection Control; Program			21375				
	home must establis	on control program. Ash and maintain an in signed to provide a sont.	fection					
	by: Based on observat	ent is not met as evi ion, interview and do ailed to distribute ice	cument					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIE IDENTIFICATION NUL				(X2) MULTIPLE CONSTRUCTION A. BUILDING:		E SURVEY PLETED	
		00121	STREET A	DDRESS, CITY, S		05/	31/2013
		IORIAL DRIVE VALLEY, MN					
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE	
21375	Continued From pa	ige 15		21375			
		ring 1 of 1 water pas the potential to affe ern 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.						
	director of nursing i	5/30/13, at 7:28 a.n ndicated they would next to the ice buck	expect a				

Minnesota Department of Health							
	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NU				(X3) DATE SURVEY COMPLETED	
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NAME OF F	ROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
			ORIAL DRIV /ALLEY, MN	E			
(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 CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRC DEFICIENCY)	LD BE	(X5) COMPLETE DATE
21375	Continued From pa	age 16		21375			
	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 Co days.	rrection: Twenty one	e (21)				
21805	MN St. Statute 144 Residents of HC Fa	.651 Subd. 5 Patients ac.Bill of Rights	s &	21805			
	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.						
	by: During interview an had failed to provid a timely manner for	ent is not met as evi ad document review the le the proper liability r r 1 of 3 residents (R5 y notices and benefic w.	he facility notices in 6)				
	Findings include:						
l'anna 1	for the non-covered	roper notice of poten d stay but had not be e services were denie	en given				

Minneso	ta Department of He	ealth					
	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NU				(X3) DATE COMP	
		00121		B. WING		05/3	1/2013
NAME OF P	ROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
			ORIAL DRIV /ALLEY, MN				
(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 SHOUL CROSS-REFERENCED TO THE APPROIN DEFICIENCY)	D BE	(X5) COMPLETE DATE
21805	Continued From part R56 was not provid Advanced Beneficia which advises resid eligible for Medicard discontinuing Media notice on 1/10/13, I 1/10/13. There was notice requirement During interview on assistant director o R56 had an acute of discontinued from t were discontinued. should have observe nursing so the 48 h During interview on director of nursing i just followed the res nursing indicated R on therapy and there discontinued due to SUGGESTED MET director of nursing of policies and proceous received the approp and non-coverage for nursing or designed staff members on the nursing or designed systems to ensure	led the Skilled Nursin ary Notice or Denial L dents they are no long e services within 48 f care services. R56 w Medicare services wo a no evidence the 48 had been waived eith to 5/31/13, at 10:31 a.r r nursing (ADON) ind change in status and therapy and Medicare At 10:39 a.m. ADON ved and continued wir our notice was given to 5/31/13, at 10:40 a.r indicated there was n gulation. The director t56 was very complex n therapy was put on	g Facility Letter ger nours of as given build end hour ner. m. the licated was e services l indicated th skilled m. the to policy or k, he was hold and FION: The velop ents al letter rector of opropriate irector of toring	21805	DEFICIENCY)		
dinnessts D	epartment of Health						