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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: TS2R

Facility ID: 00442

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245373**

2.STATE VENDOR OR MEDICAID NO.
(L2) **537342500**

3. NAME AND ADDRESS OF FACILITY
(L3) **PELICAN VALLEY HEALTH CENTER**
(L4) **211 EAST MILL AVENUE**
(L5) **PELICAN RAPIDS, MN** (L6) **56572**

4. TYPE OF ACTION: 7 (L8)

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **12/01/2015** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

12.Total Facility Beds **36** (L18)

13.Total Certified Beds **36** (L17)

10.THE FACILITY IS CERTIFIED AS:

X A. In Compliance With Program Requirements Compliance Based On:
____1. Acceptable POC

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

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

* Code: **A** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	36			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Christina Martinson, HFE NEII 12/29/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath, Enforcement Specialist 12/29/2015 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
12/01/1986
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30)

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

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

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
00805
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
12/03/2015
(L33)

DETERMINATION APPROVAL

CMS Certification Number (CCN): 245373

December 29, 2015

Ms. Barbara Garrity, Administrator
Pelican Valley Health Center
211 East Mill Avenue
Pelican Rapids, MN 56572-0645

Dear Ms. Garrity:

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 programl.

Effective November 20, 2015 the above facility is certified for:

36 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 36 skilled nursing facility beds.

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

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

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

Sincerely,

Mark Meath

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

Electronically delivered
December 29, 2015

Ms. Barbara Garrity, Administrator
Pelican Valley Health Center
211 East Mill Avenue
Pelican Rapids, Minnesota 56572-0645

RE: Project Number S5373028

Dear Ms. Garrity:

On November 2, 2015, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on October 15, 2015. This survey found the most serious deficiencies to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D), whereby corrections were required.

On December 1, 2015, the Minnesota Department of Health completed a Post Certification Revisit (PCR) to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on October 15, 2015. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of November 20, 2015. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on October 15, 2015, effective Noveberm 20, 2015 and therefore remedies outlined in our letter to you dated November 2, 2015, will not be imposed.

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

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

Sincerely,

Mark Meath

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

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

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

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245373	A. Building B. Wing	12/1/2015

Name of Facility	Street Address, City, State, Zip Code
PELICAN VALLEY HEALTH CENTER	211 EAST MILL AVENUE PELICAN RAPIDS, MN 56572

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

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix F0241 Reg. # 483.15(a) LSC	11/20/2015	ID Prefix F0309 Reg. # 483.25 LSC	11/20/2015	ID Prefix F0431 Reg. # 483.60(b), (d), (e) LSC	11/20/2015
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	GA/mm	12/29/2015	32600	12/01/2015
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on: 10/15/2015

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

Electronically delivered
December 29, 2015

Ms. Barbara Garrity, Administrator
Pelican Valley Health Center
211 East Mill Avenue
Pelican Rapids, Minnesota 56572-0645

Re: Reinspection Results - Project Number S5373028

Dear Ms. Garrity:

On December 1, 2015 survey staff of the Minnesota Department of Health, Licensing and Certification Program completed a reinspection of your facility, to determine correction of orders found on the survey completed on October 15, 2015. At this time these correction orders were found corrected and are listed on the accompanying Revisit Report Form submitted to you electronically.

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

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

Sincerely,

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

Telephone: (651) 201-4118
Fax: (651) 215-9697

AH Form Approved
12/29/2015

State Form: Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
00442	A. Building B. Wing	12/1/2015

Name of Facility	Street Address, City, State, Zip Code
PELICAN VALLEY HEALTH CENTER	211 EAST MILL AVENUE PELICAN RAPIDS, MN 56572

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

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix 20830 Reg. # MN Rule 4658.0520 Subp. 1 LSC	11/20/2015	ID Prefix 21805 Reg. # MN St. Statute 144.651 Subd. 5 LSC	11/20/2015	ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	GA/mm	12/29/2015	32600	12/01/2015
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? YES NO
10/15/2015	

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: TS2R
Facility ID: 00442

1. MEDICARE/MEDICAID PROVIDER NO.
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2. STATE VENDOR OR MEDICAID NO.
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(L3) **PELICAN VALLEY HEALTH CENTER**
(L4) **211 EAST MILL AVENUE**
(L5) **PELICAN RAPIDS, MN** (L6) **56572**

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **10/15/2015** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

12. Total Facility Beds **36** (L18)

13. Total Certified Beds **36** (L17)

10. THE FACILITY IS CERTIFIED AS:

A. In Compliance With Program Requirements Compliance Based On:
____1. Acceptable POC

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	36			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Patricia Bernstetter, HFE NEII 11/18/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath
Enforcement Specialist 12/02/2015 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
12/01/1986
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30)

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

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

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
00805
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

Electronically delivered
November 2, 2015

Ms. Barbara Garrity, Administrator
Pelican Valley Health Center
211 East Mill Avenue
Pelican Rapids, Minnesota 56572-0645

RE: Project Number S5373028

Dear Ms. Garrity:

On October 15, 2015, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs. This survey found the most serious deficiencies in your facility to be isolated deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level D), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

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

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

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

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

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

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

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

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

DEPARTMENT CONTACT

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

Gail Anderson, Unit Supervisor
Fergus Falls Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Email: gail.anderson@state.mn.us

Phone: (218) 332-5140
Fax: (218) 332-5196

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by November 24, 2015, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

- Indicate how the facility plans to monitor its performance to make sure that solutions are

sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;

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

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

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

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by January 15, 2016 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by April 15, 2016 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is

mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

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

Tom Linhoff, Fire Safety Supervisor
Health Care Fire Inspections
Minnesota Department of Public Safety
State Fire Marshal Division
Email: tom.linhoff@state.mn.us

Phone: (651) 430-3012
Fax: (651) 215-0525

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

Sincerely,

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

Telephone: (651) 201-4118
Fax: (651) 215-9697

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245373	A. BUILDING ______ B. WING ______	10/15/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PELICAN VALLEY HEALTH CENTER	**211 EAST MILL AVENUE PELICAN RAPIDS, MN 56572**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS Citation Text for Tag 0000, Regulation FF08 The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. Upon receipt of an acceptable POC an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to provide services with use of a transfer belt in a dignified manner for 1 of 3 residents (R30) who utilized a transfer belt. R30's admission Minimum Data Set (MDS) dated 6/29/15, identified R30 had diagnoses which included dementia, delusions,and psychotic behaviors. The MDS identified R30 had moderate cognitive impairment, required extensive assistance for hygiene, dressing, transfer and locomotion.	F 241	All resident had the potential to be affected. An updated transfer belt policy will be completed and used as education for all direct care nursing department staff, to prevent reoccurrence for all residents. Staff will be educated regarding dignity and gait belt use. This policy will include instructions for removal or prevention of extended periods of transfer belts fastened around residents waists. All nursing department staff will review and sign the updated policy as they work in the	11/20/15

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		11/09/2015

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245373	A. BUILDING ______ B. WING ______	10/15/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PELICAN VALLEY HEALTH CENTER	**211 EAST MILL AVENUE PELICAN RAPIDS, MN 56572**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 241	Continued From page 1 On 10/12/15, at 4:50 p.m. licensed practical nurse (LPN)-A assisted R30 to ambulate with a walker and a cream colored transfer belt fastened around R30's waist. The transfer belt was fastened over R30's street clothes, visible over the clothing. R30 was assisted to ambulate from the residents' room to a reclining chair in the lobby area near the nurses station. R30 was seated in the reclining chair, feet elevated on the foot rest, and a blanket lay across R30's feet and legs. The cream colored transfer belt remained fastened, and visible around R30's waist while he remained seated in the reclining chair with feet elevated. On 10/12/15, during observations from 4:50 p.m. to 5:50 p.m., R30 remained seat in the lobby of the facility, with the cream colored transfer belt fastened, and visible around R30's waist. On 10/12/2015, at 5:50 p.m. R30 was seated in a stationary chair at a table in the dining room, with visitor (V)-A seated next to R30. R30 independently ate the evening meal from 5:50 p.m. to 6:19 p.m., with V-A seated at the table, visiting with R30. R30's cream colored transfer belt remained fastened, visible around R30's waist through out the entire meal. On 10/12/2015, at 6:19 p.m. NA-B assisted R30 to ambulate with the transfer belt and walker, from the dining room to the lobby area near the nurses station. R30 was assisted to sit in the reclining chair. On 10/12/15, at 6:24 p.m. R30 remained seated in the lobby of the facility with the transfer belt, fastened, visible over R30's street clothes.	F 241	nursing department unit. Completion date: 11/20/2015, and ongoing. Nursing will perform audits to ensure proper procedures are being followed in regards to tracking proper gait belt use. Random audits will be done weekly for four weeks and then monthly for three months. The findings of any audits will be presented to the QAPI team for review. Audits will be discontinued at the recommendation of QAPI. The Director of Nursing or her designee will be responsible for correction and monitoring.	

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F 241	Continued From page 2 R30 wore a transfer belt, fastened around R30's waist from 4:50 p.m. to 6:24 p.m. when staff removed the belt at 6:24 p.m. On 10/14/2015, at 9:47 a.m. nursing assistant (NA)-A verified transfer belts were not to be routinely left fastened around residents waists when not in use. NA-A stated "that would be uncomfortable." On 10/14/2015, at 10:13 a.m. NA-B verified R30's transfer belt had remained around R 30's waist for a prolonged period of time the previous evening,10/12/15. NA-B verified the transfer belt had not been removed during the entire evening meal. NA-B indicated it was not the usual facility practice to leave transfer belts on when the residents were not using the belts. On 10/14/2015, at 1:52 p.m. the Director of Nursing (DON) stated transfer belts were to be removed after transfers and the resident was ina safe place. She indicated having the resident wear a transfer belt for a extended period of time, was not dignified. The facility policy dated January 2009, titled Transfer Belt : Use of, did not include instructions for removal or prevention of extended periods of transfer belts fastened around residents waists.	F 241		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical,	F 309		11/20/15

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F 309	Continued From page 3 mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure bruising was assessed, monitored and interventions implemented to prevent further bruising for 1 of 2 residents (R26) reviewed for non- pressure related skin conditions. Findings include: R26 ' s quarterly Minimum Data Set (MDS) dated 7/24/15, listed diagnoses which included dementia, peripheral vascular disease and diabetes. The MDS identified R26 was moderately cognitively impaired and required extensive assistance with activities of daily living which included, hygiene, dressing, toileting and mobility. R26 ' s care plan with a print date of 8/13/15, indicated R26 was on blood thinners and had interventions which included to monitor for bruising, observe for unusual bleeding, adverse effects or report new signs and symptoms to the doctor. On 10/14/15, at 8:21 a.m. R26 was observed to have an oblong bruise on the right side of the abdomen approximately 3 inches in size. The resident ' s right outer elbow area had a bruise approximately 5 inches long and 4 inches at its widest point. On 10/14/15, at 1:42 p.m. R26's right elbow area was observed to have an open area which was dry and around it had various sizes of purple colored bruises tack size or smaller. R26's right	F 309	Resident R26 has expired. All residents have the potential to be affected. When licensed nurses are completing weekly skin checks and any bruising/ecchymotic areas are noted, the information will be addressed in the weekly documentation and added to the wound nurse's binder. Wound nurse will continue to assess and document at least weekly. Any new bruising will continue to be reported, investigated, and added to wound nurse binder for weekly documentation. Updated skin policy to reflect these changes. A random skin check audit will be completed 1x weekly for 4 weeks, and then monthly x3 months to assure compliance with the updated skin policy. QAPI will review and approve updated policy. Completion date 11/20/2015 and ongoing. Education will be provided to all licensed nurses, including the wound nurse. The Director of nursing or her designee will be responsible for correction and monitoring.	

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	245373	A. BUILDING ______ B. WING ______	10/15/2015

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F 309	Continued From page 4 lateral elbow had a bruise which was 4 inches long and 2 ½ inches at its widest point and the inner elbow had a triangle shape area which was deep dull purple in color. In addition, there were 3 deep purple colored bruised areas by R26's right wrist which were tack size. R26 ' s left wrist had a 1 inch circular shaped purple colored bruise and 2 additional purple colored bruises one near the distal part of the arm which was rectangular in shape, 1 inch long and 3/4 wide. Above that area there was an irregular oval shaped bruise, 1 inch long and 1 ½ inch wide. Review of R26's physician orders dated 10/9/15, indicated R26 received Coumadin (blood thinner) 5 milligrams(mgs) on Monday, Wednesday and Friday and 2.5 mgs on Tuesday, Thursday, Saturday and Sunday. Review of R26 ' s skin assessments dated from 8/3/15 to 9/28/15, revealed: - On 9/18/15, had a large bruise on the right antecubital area (region in front of the elbow) and an abrasion which measure 0.5 centimeters (cm) on the top of the scalp. No further documentation of monitoring of the bruising or abrasion were found in R26's record. Review of R26 ' s progress notes dated from 9/16/15 to 10/14/15, revealed the following: -On 9/20/15, resident was noted to have a large bruise on right forearm. Resident fell a few days ago. - On 10/13/15, large bruise to outer aspect of right elbow. Had been with sons, out of the building at medical appointment. No further documentation of bruising was found in the record. On 10/15/15, at 11:17 a.m. the assistant director of nursing (ADON) visualized both of R26's arms, confirmed R26 had multiple bruises and indicated she felt some of the discoloration on the	F 309		

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	245373	A. BUILDING ______ B. WING ______	10/15/2015

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F 309	Continued From page 5 resident's arms could have come from old bruises. ADON stated she felt staff had become immune to it (bruises), was unsure if resident came with them and did not know why documentation of monitoring of the bruising had not been done. . ADON stated the usual facility practice was for license staff to complete weekly skin inspections. ADON stated she would expect documentation on discoloration and bruising weekly when skin inspections were done. On 10/15/15, at 12:18 p.m. the director of nursing (DON) stated she would expect new bruising to be reported, investigated and weekly documentation done. The DON stated bruises need to be addressed, documented weekly and as needed with any changes. DON verified there was no documentation of monitoring of R26's bruises. Review of the facility policy , titled Skin Assessment and Care, revised 7/15, indicated the following: Each resident is to receive the necessary care and services to attain the highest practicable physical, mental, and psychosocial well -being, in accordance with the comprehensive assessment and plan of care related to skin care.	F 309		
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.	F 431		11/20/15

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	245373	A. BUILDING ______ B. WING ______	**10/15/2015**

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F 431	Continued From page 6 Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure expired insulin was not available for use for 1 of 1 residents (R26) with expired insulin during observation of the facility medication cart. Findings include: R26 Minimum Date Set (MDS) dated 7/24/15, identified R26 had diagnoses which included diabetes,and dementia. The MDS identified R26 had severe cognitive impairment, and received	F 431	All residents that receive insulin have the potential to be affected. The insulin pen use policy remains current and will be printed and reviewed with all licensed nursing staff. Audits of insulin pen use and audits of the proper procedure will be completed weekly for four weeks and then monthly for three months. The findings of any audits will presented to the QAPI team for review. Audits will be discontinued at the recommendation of QAPI. Completion date 11/20/2015 and	

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	245373	A. BUILDING ______ B. WING ______	10/15/2015

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F 431	Continued From page 7 daily insulin injections. During observation of the facility medication cart on 10/15/15 at 8:39 a.m., R26's opened, partially used Lantus insulin pen was observed, with an opened dated on the pen, 8/10/15, 66 days prior. Review of R26's record identified a physician order for Lantus insulin, Inject 10 unit subcutaneous every night at bed time for diabetes. Review of R26's October, Medical Administration Record (MAR) identified R26 received 12 units of Lantus insulin on the first and second of October, and received 10 units each evening the sixth through the fourteenth, after R26's return from a hospital stay on 10/6/15. On 10/15/2015, at 9:27 a.m. the director of nursing (DON) verified R26's Lantus insulin pen open date of 8/10/15. The DON indicated R26's Lantus insulin pen should have been discarded 28 days after opening. The DON verified R26 currently utilized the Lantus insulin pen daily and due to the length of time the pen had been in use, the medication was outdated. The undated facility policy titled Policy For Insulin Pen Use identified #7. Dispose of the pen once the pen is empty, or after it has been opened for 28 days, or if it has expired. According to the American Diabetic Association (ADA) Lantus insulin was not to be used greater than 28 days after opening the vile or pen.	F 431	ongoing. The Director of Nursing or her designee is responsible for the correction and monitoring.	

F5373025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245373	A. BUILDING **01 - MAIN BUILDING 01** B. WING ______	**10/22/2015**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PELICAN VALLEY HEALTH CENTER	**211 EAST MILL AVENUE** **PELICAN RAPIDS, MN 56572**

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K 000	INITIAL COMMENTS A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on October 22, 2015. At the time of this survey Pelican Valley Health Center 01 Main Building was found in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. The Pelican Valley Health Center was constructed at 4 different times and is a 1-story building without a basement. In 1951 the original building was built and was determined to be of Type II(111) construction (it is the lower level of the with a clinic building). In 1969 the majority of the building was constructed to the west and north of the clinic building and was determined to be Type II (000) construction. In 1996 a business office/ family room addition was constructed to the north of the 1969 building and was determined to be Type II (111) construction. A connecting link to the assisted living apartment building to the north was constructed in 2002 north of the 1996 addition and was determined to be Type V (111) construction and is separated from the assisted living with 2-hour fire rated barrier. The building is divided into 3 smoke zones with at least 30 minute fire barriers. The building is completely sprinkler protected in accordance with NFPA 13 Standard for the Installation of Sprinkler Systems 1999 edition. The facility has a manual fire alarm system with corridor smoke detection in the 1969 and 1996	K 000		

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

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

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	245373	A. BUILDING **01 - MAIN BUILDING 01** B. WING	**10/22/2015**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 000	Continued From page 1 building in accordance with NFPA 72 "The National Fire Alarm Code" 1999 edition. Additional automatic fire detection is provided in all rooms required by the Minnesota State Fire Code 2007 edition and is monitored for automatic fire department notification. The facility has a capacity of 36 beds and had a census of 27 at the time of the survey.	K 000		

Electronically delivered
November 2, 2015

Ms. Barbara Garrity, Administrator
Pelican Valley Health Center
211 East Mill Avenue
Pelican Rapids, Minnesota 56572-0645

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5373028

Dear Ms. Garrity:

The above facility was surveyed on October 12, 2015 through October 15, 2015 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, Health Regulation 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.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm . The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

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

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

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

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, **you should immediately contact Gail Anderson at (218) 332-5140 or email: gail.anderson@state.mn.us**.

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

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

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

Sincerely,

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

Telephone: (651) 201-4118
Fax: (651) 215-9697

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00442	A. BUILDING: ______ B. WING ______	10/15/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PELICAN VALLEY HEALTH CENTER	**211 EAST MILL AVENUE PELICAN RAPIDS, MN 56572**

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm The State licensing orders are delineated on the attached Minnesota	2 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		11/09/15

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PELICAN VALLEY HEALTH CENTER	211 EAST MILL AVENUE PELICAN RAPIDS, MN 56572

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	Continued From page 1 Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. On 10/12,1013,10/14 and 10/15/15 surveyors of this Department's staff, visited the above provider and the following correction orders are issued. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed. Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. 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.	2 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00442	A. BUILDING: ______ B. WING ______	10/15/2015

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2 000	Continued From page 2 THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure bruising was assessed, monitored and interventions implemented to prevent further bruising for 1 of 2 residents (R26) reviewed for non- pressure related skin conditions. Findings include: R26 ' s quarterly Minimum Data Set (MDS) dated 7/24/15, listed diagnoses which included dementia, peripheral vascular disease and diabetes. The MDS identified R26 was moderately cognitively impaired and required extensive assistance with activities of daily living which included, hygiene, dressing, toileting and	2 830	Corrected.	11/20/15

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2 830	Continued From page 3 mobility. R26 ' s care plan with a print date of 8/13/15, indicated R26 was on blood thinners and had interventions which included to monitor for bruising, observe for unusual bleeding, adverse effects or report new signs and symptoms to the doctor. On 10/14/15, at 8:21 a.m. R26 was observed to have an oblong bruise on the right side of the abdomen approximately 3 inches in size. The resident ' s right outer elbow area had a bruise approximately 5 inches long and 4 inches at its widest point. On 10/14/15, at 1:42 p.m. R26's right elbow area was observed to have an open area which was dry and around it had various sizes of purple colored bruises tack size or smaller. R26's right lateral elbow had a bruise which was 4 inches long and 2 ½ inches at its widest point and the inner elbow had a triangle shape area which was deep dull purple in color. In addition, there were 3 deep purple colored bruised areas by R26's right wrist which were tack size. R26 ' s left wrist had a 1 inch circular shaped purple colored bruise and 2 additional purple colored bruises one near the distal part of the arm which was rectangular in shape, 1 inch long and 3/4 wide. Above that area there was an irregular oval shaped bruise, 1 inch long and 1 ½ inch wide. Review of R26's physician orders dated 10/9/15, indicated R26 received Coumadin (blood thinner) 5 milligrams(mgs) on Monday, Wednesday and Friday and 2.5 mgs on Tuesday, Thursday, Saturday and Sunday. Review of R26 ' s skin assessments dated from 8/3/15 to 9/28/15, revealed: - On 9/18/15, had a large bruise on the right antecubital area (region in front of the elbow) and an abrasion which measure 0.5 centimeters (cm) on the top of the scalp. No further documentation	2 830		

Minnesota Department of Health

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2 830	Continued From page 4 of monitoring of the bruising or abrasion were found in R26's record. Review of R26 ' s progress notes dated from 9/16/15 to 10/14/15, revealed the following: -On 9/20/15, resident was noted to have a large bruise on right forearm. Resident fell a few days ago. - On 10/13/15, large bruise to outer aspect of right elbow. Had been with sons, out of the building at medical appointment. No further documentation of bruising was found in the record. On 10/15/15, at 11:17 a.m. the assistant director of nursing (ADON) visualized both of R26's arms, confirmed R26 had multiple bruises and indicated she felt some of the discoloration on the resident's arms could have come from old bruises. ADON stated she felt staff had become immune to it (bruises), was unsure if resident came with them and did not know why documentation of monitoring of the bruising had not been done. . ADON stated the usual facility practice was for license staff to complete weekly skin inspections. ADON stated she would expect documentation on discoloration and bruising weekly when skin inspections were done. On 10/15/15, at 12:18 p.m. the director of nursing (DON) stated she would expect new bruising to be reported, investigated and weekly documentation done. The DON stated bruises need to be addressed, documented weekly and as needed with any changes. DON verified there was no documentation of monitoring of R26's bruises. Review of the facility policy , titled Skin Assessment and Care, revised 7/15, indicated the following: Each resident is to receive the necessary care and services to attain the highest practicable physical, mental, and psychosocial well -being, in accordance with the	2 830		

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2 830	Continued From page 5 comprehensive assessment and plan of care related to skin care. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee could educate all licensed staff on the need to monitor non-pressure skin conditions on residents. The director of nursing could develop a system for evaluating and monitoring consistent implementation of these policies and the results of these audits being brought to the facility's Quality Assurance Committee for review. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	2 830		
21805	MN St. Statute 144.651 Subd. 5 Patients & Residents of HC Fac.Bill of Rights Subd. 5. Courteous treatment. Patients and residents have the right to be treated with courtesy and respect for their individuality by employees of or persons providing service in a health care facility. This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to provide services with use of a transfer belt in a dignified manner for 1 of 3 residents (R30) who utilized a transfer belt. R30's admission Minimum Data Set (MDS) dated 6/29/15, identified R30 had diagnoses which included dementia, delusions,and psychotic	21805	Corrected.	11/20/15

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21805	Continued From page 6	21805		

Continued From page 6

behaviors. The MDS identified R30 had moderate cognitive impairment, required extensive assistance for hygiene, dressing, transfer and locomotion.

On 10/12/15, at 4:50 p.m. licensed practical nurse (LPN)-A assisted R30 to ambulate with a walker and a cream colored transfer belt fastened around R30's waist. The transfer belt was fastened over R30's street clothes, visible over the clothing. R30 was assisted to ambulate from the residents' room to a reclining chair in the lobby area near the nurses station. R30 was seated in the reclining chair, feet elevated on the foot rest, and a blanket lay across R30's feet and legs. The cream colored transfer belt remained fastened, and visible around R30's waist while he remained seated in the reclining chair with feet elevated.

On 10/12/15, during observations from 4:50 p.m. to 5:50 p.m., R30 remained seat in the lobby of the facility, with the cream colored transfer belt fastened, and visible around R30's waist.

On 10/12/2015, at 5:50 p.m. R30 was seated in a stationary chair at a table in the dining room, with visitor (V)-A seated next to R30. R30 independently ate the evening meal from 5:50 p.m. to 6:19 p.m., with V-A seated at the table, visiting with R30. R30's cream colored transfer belt remained fastened, visible around R30's waist through out the entire meal.

On 10/12/2015, at 6:19 p.m. NA-B assisted R30 to ambulate with the transfer belt and walker, from the dining room to the lobby area near the nurses station. R30 was assisted to sit in the reclining chair.

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On 10/12/15, at 6:24 p.m. R30 remained seated in the lobby of the facility with the transfer belt, fastened, visible over R30's street clothes.

R30 wore a transfer belt, fastened around R30's waist from 4:50 p.m. to 6:24 p.m. when staff removed the belt at 6:24 p.m.

On 10/14/2015, at 9:47 a.m. nursing assistant (NA)-A verified transfer belts were not to be routinely left fastened around residents waists when not in use. NA-A stated "that would be uncomfortable."

On 10/14/2015, at 10:13 a.m. NA-B verified R30's transfer belt had remained around R 30's waist for a prolonged period of time the previous evening,10/12/15. NA-B verified the transfer belt had not been removed during the entire evening meal. NA-B indicated it was not the usual facility practice to leave transfer belts on when the residents were not using the belts.

On 10/14/2015, at 1:52 p.m. the Director of Nursing (DON) stated transfer belts were to be removed after transfers and the resident was ina safe place. She indicated having the resident wear a transfer belt for a extended period of time, was not dignified.

The facility policy dated January 2009, titled Transfer Belt : Use of, did not include instructions for removal or prevention of extended periods of transfer belts fastened around residents waists.

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21805	Continued From page 8 SUGGESTED METHOD OF CORRECTION: The director of nursing or designee, could review/revise policies and procedures related to the provision of dignified resident care and services. Employees could be re-educated on these policies. A system for evaluating and monitoring consistent implementation of these policies could be developed, with the results of these audits being brought to the facility's Quality Assurance Committee for review. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21805		