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:	1 1 88	
Faci	lity ID: 0041	4

	TAKI I-	TO BE COMIT	DETEDDIT	IIIE SIAI	I E SURVET AGENCT		racinty iD. 00414	
MEDICARE/MEDICAID PROVID (L1) 245419	DER NO.	3. NAME AND AI (L3) TWIN VALI				4. TYPE OF ACTIO		
2.STATE VENDOR OR MEDICAID	NO.	(L4) 208 OPPEG	ARD AVENU	E NORTH	WEST, PO BOX 480	1. Initial 3. Termination	2. Recertification 4. CHOW	
(L2) 546242800		(L5) TWIN VALI	LEY, MN		(L6) 56584	5. Validation 7. On-Site Visit	6. Complaint 9. Other	
5. EFFECTIVE DATE CHANGE OF (L9)	OWNERSHIP	7. PROVIDER/SU	JPPLIER CATEO	GORY 09 ESRD	02 (L7) 13 PTIP 22 CLIA	8. Full Survey Afte		
	5/2016 (L34)	02 SNF/NF/Dual	06 PRTF	10 NF				
8. ACCREDITATION STATUS:	(L10)	03 SNF/NF/Distinct	07 X-Ray	11 ICF/IID	14 CORF D 15 ASC	FISCAL YEAR ENDI	NG DATE: (L35)	
0 Unaccredited 1 TJC	(E10)	04 SNF	08 OPT/SP	12 RHC	16 HOSPICE	09/30		
2 AOA 3 Other		04 5141	00 01 1/51		TO HOST ICE	0,7,00		
11LTC PERIOD OF CERTIFICATION	ON	10.THE FACILITY		AS:				
From (a):		X A. In Complia			And/Or Approved Waivers Of	· .	ents:	
To (b):		~	equirements e Based On:		2. Technical Personnel	6. Scope of S	ervices Limit	
		_			3. 24 Hour RN	7. Medical Di		
12.Total Facility Beds	58 (L18)	1. A	cceptable POC		4. 7-Day RN (Rural SN	<u> </u>		
13.Total Certified Beds	58 (L17)	B. Not in Comp	liance with Progr	ram	5. Life Safety Code	9. Beds/Room	1	
		Requirements	and/or Applied	Waivers:	* Code: A	(L12)		
14. LTC CERTIFIED BED BREAKDO	OWN				15. FACILITY MEETS			
18 SNF 18/19 SNF	19 SNF	ICF	IID		1861 (e) (1) or 1861 (j) (1):	(L15)		
58								
(L37) (L38)	(L39)	(L42)	(L43)					
16. STATE SURVEY AGENCY REM	MARKS (IF APPLICA	ABLE SHOW LTC CA	ANCELLATION	DATE):				
17. SURVEYOR SIGNATURE		Date :			18. STATE SURVEY AGENCY	APPROVAL	Date:	
Rebecca Haberly, HFE I	NEII		06/23/2016	(L19)	Mark Meath, E	Inforcement Special	ist _ 08/09/2016 (L20)	
PA	RT II - TO BE	COMPLETED I	BY HCFA RI	EGIONAI	L OFFICE OR SINGLE S	TATE AGENCY		
19. DETERMINATION OF ELIGIBI			MPLIANCE WITH	H CIVIL	 Statement of Financial Solvency (HCFA-2572) Ownership/Control Interest Disclosure Stmt (HCFA-1513) 			
X 1. Facility is Eligible to	-				3. Both of the Above :			
2. Facility is not Eligibl	(L21)							
22. ORIGINAL DATE	23. LTC AGREE	MENT 24	4. LTC AGREEN	MENT	26. TERMINATION ACTION:		(L30)	
OF PARTICIPATION	BEGINNING	G DATE	ENDING DA	TE	VOLUNTARY 00	INVOLUI	NTARY	
02/01/1987					01-Merger, Closure	05-Fail to	Meet Health/Safety	
(L24)	(L41)		(L25)		02-Dissatisfaction W/ Reimburse	ement 06-Fail to	Meet Agreement	
25. LTC EXTENSION DATE:	27. ALTERNATI	VE SANCTIONS			03-Risk of Involuntary Termination	on OTHER		
		n of Admissions:			04-Other Reason for Withdrawal	<u></u>	er Status Change	
			(L44)			00-Active		
(L27)	B. Rescind St	uspension Date:						
			(L45)					
28. TERMINATION DATE:	29	. INTERMEDIARY	/CARRIER NO.		30. REMARKS			
	03001							
	(L28)			(L31)				
31. RO RECEIPT OF CMS-1539	31 RO RECEIPT OF CMS-1539 32 D							
	32	2. DETERMINATION 06/24/2016						
	(L32)			(L33)	DETERMINATION APPL	ROVAL		



PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

CMS Certification Number (CCN): 245419

August 8, 2016

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

Dear Ms. Schreiner:

The Minnesota Department of Health assists the Centers for Medicare and Medicaid Services (CMS) by surveying skilled nursing facilities and nursing facilities to determine whether they meet the requirements for participation. To participate as a skilled nursing facility in the Medicare program or as a nursing facility in the Medicaid program, a provider must be in substantial compliance with each of the requirements established by the Secretary of Health and Human Services found in 42 CFR part 483, Subpart B.

Based upon your facility being in substantial compliance, we are recommending to CMS that your facility be recertified for participation in the Medicare and Medicaid program.

Effective June 23, 2016 the above facility is certified foror recommended for:

44 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 44 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 Weath

Mark Meath, Enforcement Specialist Program Assurance Unit Licensing and Certification Program Health Regulation Division

Email: mark.meath@state.mn.us

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



PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

July 15, 2016

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

RE: Project Number S5419026

Dear Ms. Schreiner:

On May 18, 2016, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on May 5, 2016. 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 June 24, 2016, the Minnesota Department of Health completed a Post Certification Revisit (PCR) and on June 24, 2016 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 5, 2016. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of June 23, 2016. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on May 5, 2016, effective June 23, 2016 and therefore remedies outlined in our letter to you dated May 18, 2016, will not be imposed.

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

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

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

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist Program Assurance Unit Licensing and Certification Program Health Regulation Division

Email: mark.meath@state.mn.us Telephone: (651) 201-4118

Fax: (651) 215-9697

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA /	MULTIPLE CONSTRUCTION		DATE OF REVISIT	
IDENTIFICATION NUMBER	A. Building			
245419 _{Y1}	B. Wing	Y2	6/24/2016	Y3
NAME OF FACILITY		STREET ADDRESS, CITY, STATE, ZIP CODE		
TWIN VALLEY LIVING CENTER		208 OPPEGARD AVENUE NORTHWEST, PO BOX 480		
		TWIN VALLEY, MN 56584		

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

ITEI		DATE	ITEM			DATE	ITEM			DATE
Y4		Y5	Y4			Y5	Y4			Y5
ID Prefix	F0221	Correction	ID Prefix	F0246		Correction	ID Prefix	F0309		Correction
Reg. #	483.13(a)	Completed	Reg. #	483.15()(1)	Completed	Reg.#	483.25		Completed
LSC		06/03/2016	LSC			06/03/2016	LSC			06/03/2016
ID Prefix	F0329	Correction	ID Prefix	F0371		Correction	ID Prefix			Correction
Reg.#	483.25(I)	Completed	Reg. #	483.35(1	Completed	Reg.#			Completed
LSC		06/03/2016	LSC			06/03/2016	LSC			
ID Prefix		Correction	ID Prefix			Correction	ID Prefix			Correction
Reg. #		Completed	Reg. #			Completed	Reg.#			Completed
LSC			LSC			_	LSC			
ID Prefix		Correction	ID Prefix			Correction	ID Prefix			Correction
Reg.#		Completed	Reg. #			Completed	Reg.#			Completed
LSC			LSC			_	LSC			
ID Prefix		Correction	ID Prefix			Correction	ID Prefix			Correction
Reg.#		Completed	Reg. #			Completed	Reg.#			Completed
LSC			LSC			_	LSC			
REVIEWE STATE AG		REVIEWED BY (INITIALS) LB/mm	DATE 07/13/20	16	SIGNATURE OF S	urveyor 3356	2		DATE 06/2	4/2016
REVIEWE CMS RO	D BY	REVIEWED BY (INITIALS)	DATE		TITLE				DATE	
FOLLOWUP TO SURVEY COMPLETED ON 5/5/2016		CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? YES NO					s 🔲 no			

POST-CERTIFICATION REVISIT REPORT

1 001 OEKHI IOAHOK KEVIOH KEI OKI										
PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION A. Building 01 - MAIN BUILDING 01		DATE OF REVISIT							
245419 _{Y1}	B. Wing	Y2	6/24/2016 _{Y3}							
NAME OF FACILITY		STREET ADDRESS, CITY, STATE, ZIP CODE								
TWIN VALLEY LIVING CENTER		208 OPPEGARD AVENUE NORTHWEST, PO BOX 480								
		TWIN VALLEY, MN 56584								
	es previously reported on the CMS-2567, Staten	and/or Clinical Laboratory Improvement Amendments nent of Deficiencies and Plan of Correction, that have								

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).

ITEI Y4		DATE Y5	ITEM Y4			DATE Y5	ITEM Y4			DATE Y5
ID Prefix		Correction	ID Prefix			Correction	ID Prefix			Correction
Reg.#	NFPA 101	Completed	Reg. #	NFPA 1	01	Completed	Reg.#	NFPA 101		Completed
LSC	K0018	05/11/2016	LSC	K0038		06/10/2016	LSC	K0051		06/23/2016
ID Prefix		Correction	ID Prefix			Correction	ID Prefix			Correction
Reg. #	NFPA 101	Completed	Reg. #	NFPA 1	01	Completed	Reg.#			Completed
LSC	K0067	06/16/2016	LSC	K0146			LSC			
ID Prefix		Correction	ID Prefix			Correction	ID Prefix			Correction
Reg. #		Completed	Reg.#			Completed	Reg.#			Completed
LSC			LSC			_	LSC			
ID Prefix		Correction	ID Prefix			Correction	ID Prefix			Correction
Reg.#		Completed	Reg. #			Completed	Reg.#			Completed
LSC			LSC			_	LSC			
ID Prefix		Correction	ID Prefix			Correction	ID Prefix			Correction
Reg.#		Completed	Reg. #			Completed	Reg.#			Completed
LSC			LSC			_	LSC			
REVIEWE STATE AG		REVIEWED BY (INITIALS) TL/mn	DATE 07/15/20	16	SIGNATURE OF S	URVEYOR	36536		DATE 06/24	/2016
REVIEWE CMS RO	D BY	REVIEWED BY (INITIALS)	DATE		TITLE				DATE	
FOLLOWUP TO SURVEY COMPLETED ON 5/9/2016			CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? YES NO					s 🗆 no		

Form CMS - 2567B (09/92) EF (11/06)

Page 1 of 1

EVENT ID:

TY8822



PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

July 15, 2016

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

Re: Enclosed Reinspection Results - Project Number S5419026

Dear Ms. Schreiner:

On June 24, 2016 survey staff of the Minnesota Department of Health, Licensing and Certification Program completed a reinspection of your facility, to determine correction of orders found on the survey completed on May 5, 2016,, with orders received by you on May 23, 2016. At this time these correction orders were found corrected and are listed on the attached Revisit Report Form.

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

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

Sincerely,

Mark Weath

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

Enclosure(s)

cc: Original - Facility

Licensing and Certification File

STATE FORM: REVISIT REPORT

STATE FORM: REVISIT REPORT									
	MULTIPLE CONSTRUCTION		DATE OF REVISIT						
IDENTIFICATION NUMBER	A. Building								
00414 _{Y1}	B. Wing	Y2	6/24/2016	Y3					
NAME OF FACILITY		STREET ADDRESS, CITY, STATE, ZIP CODE							
TWIN VALLEY LIVING CENTER		208 OPPEGARD AVENUE NORTHWEST, PO BOX 480							
		TWIN VALLEY, MN 56584							
This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such									

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).

ITE	M	DATE	ITEM		DATE	ITEM		DATE
Y4		Y5	Y4		Y5	Y4		Y5
ID Prefix Reg. # LSC	20535 MN Rule 4658.03 Subp. 5 A-D	Correction Completed 06/03/2016	ID Prefix 2083 MN R Reg. # Subp. LSC	ule 4658.0520	Correction Completed 06/03/2016	ID Prefix Reg. # LSC	21015 MN Rule 4658.0610 Subp. 7	Correction Completed 06/03/2016
ID Prefix Reg. # LSC	21535 MN Rule4658.13 Subp.1 ABCD	Correction 15 Completed 06/03/2016	ID Prefix 2181 MN S Subd. LSC	t. Statute 144.651	Correction Completed 06/03/2016	ID Prefix Reg. # LSC		Correction Completed
ID Prefix Reg. # LSC		Correction Completed	ID Prefix Reg. # LSC		Correction Completed	ID Prefix Reg. # LSC		Correction Completed
ID Prefix Reg. # LSC		Correction	ID PrefixReg. #		Correction Completed	ID Prefix Reg. # LSC		Correction
ID Prefix Reg. # LSC		Correction	ID Prefix Reg. # LSC		Correction Completed	ID Prefix Reg. # LSC		Correction Completed
REVIEWE STATE AG REVIEWE CMS RO FOLLOWI 5/5/2016	D BY	REVIEWED BY (INITIALS) LB/mm REVIEWED BY (INITIALS) DMPLETED ON		SIGNATURE OF SU TITLE R ANY UNCORRECTE CTED DEFICIENCIES (33562	. WAS A SUM	IMARY OF	DATE 06/24/2016 DATE YES NO
	Page 1 of 1 EVENT ID: TV0012							

EVENT ID: Page 1 of 1 TY8812

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: TY88 PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY Facility ID: 00414 1. MEDICARE/MEDICAID PROVIDER NO. 3. NAME AND ADDRESS OF FACILITY 4. TYPE OF ACTION: 2 (L8) (L3) TWIN VALLEY LIVING CENTER (L1)245419 1. Initial 2. Recertification (L4) 208 OPPEGARD AVENUE NORTHWEST, PO BOX 480 2.STATE VENDOR OR MEDICAID NO. 4. CHOW 3. Termination (L6) 56584 546242800 (L2)(L5) TWIN VALLEY, MN 5. Validation 6. Complaint 7. On-Site Visit 9. Other 5. EFFECTIVE DATE CHANGE OF OWNERSHIP 7. PROVIDER/SUPPLIER CATEGORY 02 (L7)8. Full Survey After Complaint (L9) 05 HHA 13 PTIP 01 Hospital 09 ESRD 22 CLIA 6. DATE OF SURVEY 05/05/2016 (L34) 02 SNF/NF/Dual 06 PRTE 10 NF 14 CORF FISCAL YEAR ENDING DATE: (L35)8. ACCREDITATION STATUS: 03 SNF/NF/Distinct 07 X-Ray 11 ICF/IID 15 ASC (L10) 12 RHC 16 HOSPICE 09/30 0 Unaccredited 1 TJC 04 SNF 08 OPT/SP 2 AOA 3 Other 11. LTC PERIOD OF CERTIFICATION 10.THE FACILITY IS CERTIFIED AS: A. In Compliance With And/Or Approved Waivers Of The Following Requirements: From (a): ____ 2. Technical Personnel То (b): Program Requirements Scope of Services Limit Compliance Based On: ___ 3. 24 Hour RN Medical Director 4. 7-Day RN (Rural SNF) 1. Acceptable POC 8. Patient Room Size 12. Total Facility Beds 58 (L18) ___ 5. Life Safety Code ___ 9. Beds/Room 13. Total Certified Beds 58 (L17) **X** B. Not in Compliance with Program Requirements and/or Applied Waivers: (L12)14. LTC CERTIFIED BED BREAKDOWN 15. FACILITY MEETS 18 SNF 18/19 SNF 19 SNF ICF IID (L15)1861 (e) (1) or 1861 (j) (1): 58 (L37) (1.38)(L39) (L42)(L43)16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE): 17. SURVEYOR SIGNATURE Date : 18. STATE SURVEY AGENCY APPROVAL Rebecca, Haberle, HFE NEII 06/16/2016 Mark Weath, Enforcement Specialist (L20) PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY 19. DETERMINATION OF ELIGIBILITY 20. COMPLIANCE WITH CIVIL 1. Statement of Financial Solvency (HCFA-2572) Ownership/Control Interest Disclosure Stmt (HCFA-1513) RIGHTS ACT: X 1. Facility is Eligible to Participate 3. Both of the Above: Facility is not Eligible (L21) 22. ORIGINAL DATE 23. LTC AGREEMENT 24. LTC AGREEMENT 26. TERMINATION ACTION: (L30) 00 OF PARTICIPATION BEGINNING DATE ENDING DATE **VOLUNTARY** INVOLUNTARY 02/01/1987 01-Merger, Closure 05-Fail to Meet Health/Safety 02-Dissatisfaction W/ Reimbursement 06-Fail to Meet Agreement (L24)(L41)(L25)03-Risk of Involuntary Termination 25. LTC EXTENSION DATE: 27. ALTERNATIVE SANCTIONS 04-Other Reason for Withdrawal A. Suspension of Admissions: 07-Provider Status Change 00-Active (L44)(L27)B. Rescind Suspension Date: (L45)28. TERMINATION DATE: 29. INTERMEDIARY/CARRIER NO. 30. REMARKS 03001 (L28) (L31)31. RO RECEIPT OF CMS-1539 32. DETERMINATION OF APPROVAL DATE

(L33)

DETERMINATION APPROVAL

(L32)



PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Certified Mail # 7015 0640 0003 5695 0397

May 18, 2016

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

RE: Project Number S5419026

Dear Ms. Schreiner:

On May 5, 2016, 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:

Lyla Burkman, Unit Supervisor Bemidji Survey Team Licensing and Certification Program Health Regulation Division Minnesota Department of Health 705 5th Street Northwest, Suite A Bemidji, Minnesota 56601-2933

Email: Lyla.burkman@state.mn.us

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

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by June 14, 2016, the Department of Health will impose the following remedy:

• State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by June 14, 2016 the following remedy will be imposed:

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

PLAN OF CORRECTION (PoC)

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

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;
- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;
- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;
- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;
- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,
- Include signature of provider and date.

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

- Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));
- Per day civil money penalty (42 CFR 488.430 through 488.444).

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by August 5, 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 November 5, 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 a PoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc idr.cfm

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

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

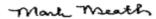
Questions regarding all documents submitted as a response to the Life Safety Code deficiencies (those preceded by a "K" tag), i.e., the plan of correction, request for waivers, should be directed to:

Tom Linhoff, Fire Safety Supervisor
Health Care Fire Inspections
Minnesota Department of Public Safety
State Fire Marshal Division
445 Minnesota Street, Suite 145
St Paul, Minnesota 55101-5145
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 letter.

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

Enclosure

cc: Licensing and Certification File

PRINTED: 05/18/2016 CENTERS FOR MEDICARE & MEDICAID SERVICES FORM APPROVED STATEMENT OF DEFICIENCIES OMB NO. 0938-0391 (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: (X3) DATE SURVEY A. BUILDING COMPLETED 1.1UN 0-8 2016 245419 B. WING NAME OF PROVIDER OR SUPPLIER Minuestoa Department of Health 05/05/2016 STREET ADDRESS, CITY, STATE, ZIP CODE TWIN VALLEY LIVING CENTER 208 OPPEGARD AVENUE NORT WEST, PO BOX 480 TWIN VALLEY, MN 56584 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL PROVIDER'S PLAN OF CORRECTION PRÉFIX PREFIX (X5) COMPLETION REGULATORY OR LSC IDENTIFYING INFORMATION) (EACH CORRECTIVE ACTION SHOULD BE TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) F 000 **INITIAL COMMENTS** F 000 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. 483.13(a) RIGHT TO BE FREE FROM F 221 F 221 F 221: Nursing PHYSICAL RESTRAINTS SS=D The Twin Valley Living Center must The resident has the right to be free from any physical restraints imposed for purposes of ensure the resident's right to be free discipline or convenience, and not required to from any physical restraints imposed treat the resident's medical symptoms. for purposes of discipline or convenience, and not required to This REQUIREMENT is not met as evidenced treat the resident's medical by: Based on observation, interview and document symptom. review, the facility failed to ensure a physical restraint device (lap buddy) was properly applied Based on observation, interview and and used for the least amount of time for 1 of 1 document review, the facility failed resident (R30) observed to utilize a lap buddy to ensure a physical restraint device without ability to independently release. (lap buddy) was properly applied and used for the least amount of Findings include: time for 1 of 1 resident (R30) observed to utilize a lap buddy R30's diagnosis list dated 10/25/12, identified without ability to independently R30's diagnoses as seizures, depression, Alzheimer's disease and myoclonus (a brief release. approved LB. 06/10/16 30RATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE (X6) DATE , deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that er safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days owing 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

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

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Event ID: TY8811

's following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued

Facility ID: 00414

If continuation sheet Page 1 of 21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION			P) MULTIPLE CONSTRUCTION BUILDING			(X3) DATE SURVEY COMPLETED	
	245419	B. WING			05/0	05/2016	
NAME OF PROVIDER OR SUPPLIER TWIN VALLEY LIVING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 208 OPPEGARD AVENUE NORTHWEST, PO TWIN VALLEY, MN 56584				
PRÉFIX (EACH DEFICIENCY I	EMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION)	ID PREFI TAG		TION SHOULD E THE APPROPRI	BE IATE	(X5) COMPLETION DATE	
R30's quarterly Mining 3/29/16, indicated R3 impairment; required transferring, dressing daily utilization of a transferring, dressing daily utilization of a transferring dressing dre	num Data Set (MDS) dated 30 had severe cognitive extensive assist with 3, eating, and toileting; and runk restraint. aint Care Area Assessment indicated R30 utilized a lap on that fits over a resident's rearmrests of the restrict the residents' ability is from the wheelchair) aily. The CAA indicated R30 he lap buddy and R30 used e. In addition, R30 was buddy was there to remind out being assisted. The 30 had jerking spells which for falls and the reason for ers dated 5/22/13, indicated ave a restraint - a lap buddy a wheelchair to enhance	F 2	Resident # 30's lap but removed and discarded improper fit with her was replaced with a nalap buddy which fits at Manufacturer's direct positioning of the lap was added to the policies of Restraint" policies physical restraints, and reviewed with the Quateam on 05/26/2016. All nursing staff were easted the proper application buddy restraint and into medical device can any manner other than was intended. All nursing staff were easted the importance of releases to one's	ed due to wheelchair ew "Skil-Ca ppropriatel ions for pro buddy cush cy book. icy was ecific ing use of d was ality Assura educated or of the lap formed that be applied of for which educated on asing physic low for	nce nce t in it		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245419	B. WING			05	5/05/2016
	PROVIDER OR SUPPLIER	R	STREET ADDRESS, CITY, STATE, ZIP CODE 208 OPPEGARD AVENUE NORTHWEST, PO BOX 480 TWIN VALLEY, MN 56584				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
	for the observation indicated whenever the lap buddy had be on 5/2/16, at 5:09 per dining room, seated assisted to eat by treat (TMA)-A. A lap bud R30's wheelchair. Twith the cut out side placed around the awith the straight side against R30's abdorportion of the lap but (on backwards). R3 place throughout the fed by TMA-A. On 5/2/16, at 5:25 pusually had the lap be the straight side against R30's abdorportion of the lap but (on backwards). R3 place throughout the fed by TMA-B.	Assistive Devices/Restraints period of 3/15/16 - 3/18/16, R30 was up in her wheelchair	F 2	221	Random audits of resident's restraint use will be conducted weekly with findings reviewed with a Quality Assurance team unticompliance is met. Director of Nursing or designee monitor for compliance. 6/3/16 Tammy Courtright Director of Nursing	iI	4/3/14
		m. R30 was observed seated					

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		T .	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		245419	B. WING _	·	O.F	5/05/2016
	PROVIDER OR SUPPLIER	R		30		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL BC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 221	wheelchair. The lap secured to the arm portion of the lap bu	ge 3 secured to the front of her buddy was again observed rests with the contoured ddy faced outward and tight up against R30's	F 22	1		
	(LPN)-A and nursing observed to transfer wheelchair. LPN-A buddy with the cut o and the contoured p	.m. licensed practical nurse gassistant (NA)-B were R30 from R30's bed into the and NA-B secured the lap ut sides around the arm rests ortion of the lap buddy faced aight edged side placed tight domen.				
	in her wheelchair at fed by activity aide (/ secured to the front contoured portion of outwards and the str up against R30' abd	aight edged side placed tight omen. R30's lap buddy throughout the entire time	·			
	observed to remain s the dining room area engaged in activities reading and a game R30's lap buddy rema	m. until 9:40 a.m. R30 was seated in her wheelchair in During this time, R30 was which involved a snack, all coordinated by AA-A. ained in place and secured 0's wheelchair during this		·		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245419	B. WING		05/	/05/2016	
	PROVIDER OR SUPPLIER LLEY LIVING CENTE	R		STREET ADDRESS, CITY, STATE, ZIP CODE 208 OPPEGARD AVENUE NORTHWEST, F TWIN VALLEY, MN 56584		·	
(X4) ID PREFIX TAG				PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE	
F 221	buddy was always a with the contoured outwards and the srestraint faced tight acknowledged the I placed and should I contoured portion of R30's waist. LPN-ER30's restraint should the stated the lap budd meal time. On 5/4/16, at 12:20 confirmed R30 used considered a restraint should be during activities as RN-A verified the mup in her wheelchair RN-A stated the expluddy would be seed on 5/4/16, at 12:58 (DON) confirmed R considered a restraithe lap buddy off an verified R30's lap buremoved when R30 during meal time, at activity group. In activity group.	a.m. LPN-B stated R30's lap secured to R30's wheelchair portion of the restraint faced traight edge portion of the up to R30's abdomen. LPN-B ap buddy was inappropriately have been positioned with the of the restraint faced towards as was unsure of how often the old be released, however, y should be removed during p.m. registered nurse (RN)- Add a lap buddy which was int. RN-A confirmed the removed during meals and long as R30 was participating. ajority of time when R30 was refer the restraint was placed. Dectation was that the lap cured appropriately. p.m. the director of nursing 30's lap buddy was int and that R30 had utilized and on since 2013. The DON auddy should have been was in view of other staff, and when R30 was with an addition, DON confirmed the lap been applied correctly.	F 22	21			
	R30's lap buddy wa	o.m. The DON confirmed s incorrectly applied and ddy was old and staff were					

	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	LE CONSTRUCTION		E SURVEY PLETED
		245419	B. WING	· · · · · · · · · · · · · · · · · · ·	05/	05/2016
	PROVIDER OR SUPPLIER	R		STREET ADDRESS, CITY, STATE, ZIP CODE 208 OPPEGARD AVENUE NORTHWEST, PO TWIN VALLEY, MN 56584		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 221	unable to find the m The Skil-Care lap to directions directed s with the straight edge	anufacture guidelines. p cushions application staff to position the lap buddy ged side faced away from the	F 221			
F 246 SS=D	l <u>^ ^ ^ </u>					
			F 246	F 246: Nursing The Twin Valley Living Center mensure that each resident has the		
				right to reside and receive service in the facility with reasonable accommodations of individual nearly preferences, except when the health or safety of the individual other residents would be	eeds ne	
	by: Based on observation review, the facility fa	T is not met as evidenced on, interview and document iled to provide appropriate or 1 of 2 bariatric residents specialized toileting		endangered.		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILE		LE CONSTRUCTION		E SURVEY IPLETED
		245419	B. WING	i		05/	05/2016
	PROVIDER OR SUPPLIER LLEY LIVING CENTE SUMMARY STA	R TEMENT OF DEFICIENCIES	ID	STREET ADDRESS, CITY, STATE, ZIP CODE 208 OPPEGARD AVENUE NORTHWEST, PO BOX 480 TWIN VALLEY, MN 56584)
PRÉFIX TAG	(EACH DEFICIENC)	/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFI TAG		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 246	equipment. Findings include: R36's admission Mi 12/23/15, indicated morbid obesity and (neuromuscular dis- muscle weakness a cognition, was conti and required extens activities of daily livi Assessment (CAA) was alert and orient urinary tract infectio had the ability to red defecate, but had un bowel. The assessi the ability to transfet the size of his abdor	nimum Data Set (MDS) dated R36 was diagnosed with	F2	246	Based on observation, interview document review, the facility factor provide appropriate medical equipment for 1 of 2 bariatric residents (R36) who required specialized toileting equipment On 05/18/16 the new bariatric commode arrived. R36 was reluted to try it citing various reasons whe could not or did not want to up. Staff had been encouraging to try the new commode since i arrived. On 05/27/16 R36 did agto try the new commode. He state the did not like it because it was uncomfortable and that he coul not sit back far enough. It was a noted that his feet did not touch floor.	ctant thy get him t gree ated	
3	R36's quarterly MDS dated 3/16/16, indicated R36 was occasionally incontinent of bowel and bladder.				On 05/31/16 an Occupational Therapy order was obtained to evaluate toileting needs and		
	indicated R36 was ir bladder. However, t incomplete, and a pl incontinence needs	an to assist R36 with had not been developed nor equipment to accommodate			equipment. He was assessed on day and OT continues to work or accommodating his toileting nee	ı	

	FOF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	PLE CONSTRUCTION	COM		
		245419	B. WING		05	/05/2016	
	PROVIDER OR SUPPLIER	R		STREET ADDRESS, CITY, STATE, ZIP CODE 208 OPPEGARD AVENUE NORTHWEST, PO BOX 480 TWIN VALLEY, MN 56584			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE	
F 246	R36's care plan dathad urge incontiner one staff to utilize the to utilized the bedpare. On 5/3/16, at 10:00 bed pan and urinal however, he preferredefecate, but the coproperly. R36 statewas too small to ac bottom did not fit predefecate/urinate ap the commode "pince"	red 12/27/15, indicated R36 nce and required assistance of the urinal and assist of 1-2 staff an. a.m. R36 stated he utilized a for his toileting needs, red to use a commode to the mode chair did not fit him and the hole in the commode commodate his body and his operly to allow him to propriately. R36 also stated the d" his bottom and was not atted the staff were aware of	F 246	On 06/01/16 the Social Worke contacted the Ombudsman for further guidance. A new Volaro hoyer lift (700# capacity) was also ordered (ar 5/11/16), along with a "sit to s lift (600# capacity — currently oback order and scheduled to a the week of 06/06/16) in the emechanical lift is required for I All nursing staff were educated the importance of reporting recomplaints to the Director of Nursing or Administrator so the accommodations can be made	rived stand" on rrive event a R36. d on ssident		
	chair/commode was room. On 5/4/16, at 8:40 a stated R36 utilized a toileting needs. She urinal or bedpan and	a.m. a bariatric shower sobserved in the west unit tub a.m. nursing assistant (NA)-Da bedpan and urinal for his estated R36 always used the doccasionally had incontinent atted she had never assisted mode.		meet the resident's needs. Nursing staff will continue to w with Occupational Therapy to r R36's toileting needs. Recommendations will be brou to the attention of the Adminis and the Quality Assurance team indicated until compliance is me	vork meet ght trator		
	stated R36 was inco experienced urgence him with placement stated the facility ha	a.m. registered nurse (RN)-B ontinent of urine because he y and required staff to assist of the urinal or bedpan. She d purchased a bariatric modate R36 prior to his		Director of Nursing or designee monitor for compliance. 06/03/16 Tammy Courtright Director of I		4/3/14	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILD			(X3) DATE SURVEY COMPLETED	
		245419	B. WING			05/	05/2016
	PROVIDER OR SUPPLIE				REET ADDRESS, CITY, STATE, ZIP CODE 3 OPPEGARD AVENUE NORTHWEST, PO /IN VALLEY, MN 56584	CODE	
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F 246	admission, howev	page 8 ver, the hole in the commode gh to accommodate his physical ed" him therefore he was not	F2	46			
	use the commode	0 p.m. NA-F stated R36 did not because it pinched him. She ed staff when he needed to use urinal.					
	bowel and bladder completed. She we concerns with the however, the facility the commode to a	p.m. RN-B confirmed R36's r assessment had not been erified R36 had expressed current bariatric commode, ty had not attempted to adapt ccommodate his needs nor had mpt to find an alternative to utilize.					
	R36's bowel and been completed a R36 being admitte commode was purmade aware of the concerns until 5/4/she had placed an	p.m. the administrator verified pladder assessment had not so directed. She stated prior to d into the facility, a bariatric rehased but she had not been a commode pinching R36 or his 16. The administrator stated order for a second bariatric tempt to assist R36 with his					
	policy directed the the pertinent inform	ary Continence and ssment and Management staff to periodically evaluate nation related to a resident					

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	į.	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245419	B. WING		05/05/2016	
	PROVIDER OR SUPPLIER	R	:	STREET ADDRESS, CITY, STATE, ZIP CODE 208 OPPEGARD AVENUE NORTHWEST, I TWIN VALLEY, MN 56584		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE COMPLETION	1
F 246 F 309 SS=D	Needs policy indicated and staff were to as and/or achieving income and well-being. 483.25 PROVIDE CHIGHEST WELL BEET TO THE STATE TO T	y of Life - Accommodation of ted the facility's enjoinment sist the resident in maintain dependent functioning, dignity EARE/SERVICES FOR EING	F 246	F 309: Nursing The Twin Valley Living Center ensure that each resident rec	eives	
	mental, and psychological accordance with the and plan of care.	rdance with the comprehensive assessment or maintain the higher plan of care. physical, mental, and well-being, in accord	necessary care and services to or maintain the highest practi physical, mental, and psychos well-being, in accordance with comprehensive assessment ar	o attain cable ocial n the		
	by: Based on observati			of care. Based on observation, interview document review, the facility to provide appropriate monitors.	ew and failed	
	Findings include:			for 1 of 1 resident (R41) who displayed low blood glucose le	vels.	
		dated 6/7/13, indicated R41's diabetes, dementia and ase.				
		mum Data Set (MDS) dated 41 had severe cognitive				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		E CONSTRUCTION		E SURVEY PLETED
		245419	B. WING	_		05/0	05/2016
	PROVIDER OR SUPPLIER	R	1	2	TREET ADDRESS, CITY, STATE, ZIP CODE 08 OPPEGARD AVENUE NORTHWEST, PO WIN VALLEY, MN 56584		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 309	impairment and red R41's Physician Orstaff to administer to administer to R41's diabetes: -Novolog (insulin) 6 injection into the subreakfast (hold if do-Novolog 50 units Schoesn't eat) -Novolog 40 units Schoesn't eat) -Lantus (insulin) 80 a.m.) -Lantus 60 units Schoesn't eat) -Lantus	ders dated 4/28/16, directed he following medications for 0 units subcutaneously (SQ -bcutaneous tissue) with besn't eat) GQ with noon meal (hold if GQ with evening meal (hold if units SQ every morning (8:00 p.m.) re directed to check R41's four times a day. D.m. licensed practical nurse g assistant (NA)-B were R41 from her room into the A and NA-B were on each side d her front wheeled walker and	F3	809	A "Nursing Care of the Resident Diabetes Mellitus" policy was developed with specific guideling for the intervention of low blood glucose levels, elevated blood glucose levels, when to recheck blood glucose levels and when contact the physician. This policy was reviewed by the Quality Assurance team on 05/26/16. Resident R41's EMAR was adjust to include: "Recheck inhouse glucose reading if blood sugar if or >110 with signs/symptoms of hyperglycemia", with the availational space for rechecks. The RN/LPN's were educated of contents of the new "Nursing Contents o	nes od to cy sted s <70, of obility s. n the	
	grabbed the walker room and into the d R41's care plan dat	NA-E guided R41 out of her					

	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILD		LE CONSTRUCTION		E SURVEY MPLETED
		245419	B. WING			05/	05/2016
	PROVIDER OR SUPPLIER	R	··	2	STREET ADDRESS, CITY, STATE, ZIP CODE 208 OPPEGARD AVENUE NORTHWEST, PO FWIN VALLEY, MN 56584		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 309	levels) related to Ra The care plan direct medications as ordered and when reverse and when reverse a regrand directed a regrand directed staff to symptoms of diabet. R41's A1c (blood te blood glucose levels past 2-3 months) date elevated A1c of 6.5 On 5/5/16, at 10:14 confirmed R41's blood glucose levels past 2-3 months) date elevated A1c of 6.5 On 5/5/16, at 10:14 confirmed R41's blood for the last 30 record lacked docur of these low blood great elevated A1c of 6.5 -4/5/16, at 6:00 a.m4/5/16, at 6:00 a.m4/9/16, at 6:00 a.m4/10/16, at 6:00 a.m4/10/16, at 6:00 a.m4/15/16, at 6:00 a.m4/16/16, at 6:00 a.m4/16/16, at 6:00 a.m4/16/16, at 6:00 a.m. result -4/17/16, at 6:00 a.m. at 4:00 p.m. result = 6/17/16, at 6:00 a.m. result = 6/17/16, at	A1's diagnosis of diabetes. ted staff to administer ered, check blood sugars as needed, hold insulin if R41 als. The plan also indicated ular diet with diabetic features o monitor for signs and cic reaction. st which indicated how well s had been controlled over the ated 3/30/16, indicated an (reference range 4.2-6). a.m. registered nurse (RN)-A and glucose readings listed days and that the medical mentation of a recheck on any plucose readings: blood glucose (BG) result = eciliter (mg/dL) BG result = 70 mg/dL BG result = 66 mg/dL and at mg/dL BG result = 63 mg/dL and see the second of the second of the second becomes a second of the s	F3	809	importance of follow up blood glucose checks for any blood glucose that is out of parameters to ensure the resident's highest practical physical well-being. Random audits of blood glucose monitoring will be conducted monthly and findings reviewed with the Quality Assurance team unticompliance is met. Director of Nursing or designee with monitor for compliance 06/03/16 Tammy Courtright Director of Nursing	o with	4/3/14

	OF CORRECTION	IDENTIFICATION NUMBER:	1		i		ATE SURVEY OMPLETED
		245419	B. WING			0,	5/05/2016
	PROVIDER OR SUPPLIER		•	2	STREET ADDRESS, CITY, STATE, ZIP CODE 208 OPPEGARD AVENUE NORTHWEST, P FWIN VALLEY, MN 56584		
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETION DATE
	-4/19/16, at 4:00 p4/22/16, at 4:00 p4/25/16, at 4:00 p4/28/16, at 6:00 a. at 4:00 p.m. result -4/29/16, at 6:00 a5/2/16, at 4:00 p.m 8:00 p.m. 60 mg/dl -5/3/16, at 4:00 p.m Nursing Home Note physician on 4/28/1 glucose levels had -Morning checks = -11:00 a.m. checks -4:00 p.m. checks = -11:00 a.m. checks -4:00 p.m. checks = The physician indic On 5/5/16, at 9:55 a blood sugar levels w gave R41 a snack a blood sugar after ea On 5/5/16, at 10:02 blood sugar's fluctu expectation for staff sugar reading, the s or some fluids and t and this should be of unable to confirm th orders had been ad	m. BG result = 66 mg/dL m. BG result = 68 mg/dL m. BG result = 64 mg/dL m. BG result = 63 mg/dL and = 56 mg/dL m. BG result = 70 mg/dL m. BG result = 70 mg/dL n. BG result = 59 mg/dL and at n. BG result = 62 mg/dL e dated and signed by the 6, indicated R41's blood been running: 58-168 mg/dL = 64-221 mg/dL = 60-177 mg/dL 49-177 mg/dL ated no changes to be made. a.m. LPN-D stated when R41's were low, the staff usually and should recheck R41's ating it. a.m. RN-A confirmed R41's ated. RN-A stated the if was if R41 had a low blood staff should give R41 a snack ithen recheck the blood sugar documented. RN-A was the last time R41's insulin	F3	809			
		/ blood sugar would be any					

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	LTIPLE CONSTRUCTION DING			E SURVEY MPLETED
		245419	B. WING			05/	05/2016
	PROVIDER OR SUPPLIER	R	STREET ADDRESS, CITY, STATE, ZIP CODE 208 OPPEGARD AVENUE NORTHWEST, PO BOX 480 TWIN VALLEY, MN 56584				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		TION SHOULD THE APPROPE	BE	(X5) COMPLETION DATE
,	value under the nor The DON confirmed identified a snack s resident and then the rechecked and resuconfirmed the facilit diabetes managemed 483.25(I) DRUG REUNNECESSARY DIE Each resident's drug unnecessary drugs. drug when used in eduplicate therapy); of without adequate mindications for its us adverse consequents should be reduced combinations of the Based on a comprel resident, the facility who have not used a given these drugs untherapy is necessary as diagnosed and do record; and resident drugs receive gradus behavioral interventice.	mal range of 80-140 mg/dL. d when a low blood sugar was hould be provided to the he blood sugar level should be alt documented. The DON y did not have a policy on ent. GIMEN IS FREE FROM RUGS g regimen must be free from An unnecessary drug is any excessive dose (including or for excessive duration; or onitoring; or without adequate e; or in the presence of ces which indicate the dose or discontinued; or any reasons above. mensive assessment of a must ensure that residents antipsychotic drugs are not nless antipsychotic drug y to treat a specific condition ocumented in the clinical s who use antipsychotic all dose reductions, and	F3	The Twin Valley Living ensure each resident's must be free from unn drugs. An unnecessary drug when used in exce (including duplicate the excessive duration; or adequate monitoring; cadequate indications for in the presence of advectors and equate which includes should be reduced discontinued; or any coof the reasons above.	drug reginecessary drug is an essive dose erapy); or a without or without or its use; o erse dicate the	men y e for	
I	This REQUIREMEN [*] by:	T is not met as evidenced					

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILD		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245419	B. WING	i		05/	05/2016
	PROVIDER OR SUPPLIER LLEY LIVING CENTE SUMMARY STA		STREET ADDRESS, CITY, STATE, ZIP CODE 208 OPPEGARD AVENUE NORTHWEST, PORTION OF CORRECTION OF CORRE				
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREF TAG		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE RIATE	COMPLÉTION DATE
	review the facility fajustification for the identified for 2 of 2 received a routine of the facility failed to reduction of an anticontraindications of 2 of 2 residents (Redaily antipsychotic reduction attempted Findings Include: R45 was routinely a (antipsychotic) with addition, a trial doso or contraindications adminsitration of the R45's quarterly Min 2/23/16, indicated Fimpairment, require activities of daily living hallucinations or de wandering daily. R4 Care Area Assessmindicated R45 has a physician ordered the the resident become unit, the doses will the attempt to disconting the resident of the second to disconting the second to disconting the resident of the resident	tion, interview and document ailed to ensure the appropriate use of an antipsychotic was residents (R45, R35) who dose of Seroquel. In addition, ensure a tapering dose ipsychotic was attempted or f the reduction documented for 45, R35) who had received a (Seroquel) without a trial dose d. administered Seroquel out appropriate diagnoses. In e reduction was not attempted a documented prior to the e Seroquel (antipsychotic). imum Data Set (MDS) dated R45 had moderate cognitive ad extensive assist with ing, showed no signs of clusions and exhibited to the seroquel for agitation, the nee Seroquel for agitation as es acclimated to the secured one adjusted as able with the company of the secured one adjusted as able with the company of the company of the secured one adjusted as able with the company of the com	F3	329	Based on a comprehensive assessment of a resident, the far must ensure that residents who have not used antipsychotic drug are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record and residents who use antipsychology are gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. Based on observation, interview document review the facility fail to ensure the appropriate justification for the use of an antipsychotic was identified for 2 residents (R45, R35) who recei	rd; notic	
	regimen review forn	armacist monthly medication indicated a recommendation				į	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL [*] A. BUILDI		E CONSTRUCTION		E SURVEY PLETED
		245419	B. WING			05/	05/2016
	PROVIDER OR SUPPLIER	R	STREET ADDRESS, CITY, STATE, ZIP CODE 208 OPPEGARD AVENUE NORTHWEST, PO BOX 4: TWIN VALLEY, MN 56584				_
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F 329	continue the use of consider reducing t	ge 15 he clinical rationale to Seroquel or if appropriate he dosage of this medication. y failed to act on these	F 3	29	a routine dose of Seroquel. In addition, the facility failed to er a tapering dose reduction of an antipsychotic was attempted or contraindications of the reduction documented for 2 of 2 resident	c ion s	
	R45's current physician order dated 5/3/16, indicated R45 was diagnosed with Alzheimer's disease, depression, and dementia and on 10/2/14, Seroquel 50 milligrams (mg) every day for Dementia with agitation was started.				(R45, R35) who had received a daily antipsychotic (Seroquel) without a trial dose reduction attempted. Resident #45's antipsychotic medication (Seroquel) was reviewed		,
	ambulating with a tv	o.m. R45 was observed vo wheeled walker in the main red unit, R45 was counting out			with her primary care physician 05/04/2016, noting current diagnosis for the use of the Seroquel. The physician added t		
		.m. R45 was observed seated dining room eating breakfast. her pancake.			diagnosis of "psychosis" for her Seroquel and decreased the dos to 25mg daily. The order was changed at that time.	sage	
	(LPN)-B stated R45 counted. On 5/4/16, at 11:30 verified antipsychoti appropriate diagnos to be done, however always want to do the country of the country				Resident #35's antipsychotic medication (Seroquel) was reviewith his primary care physician of 05/04/2016, noting current diagnosis for the use of the Seroquel. The physician ordered that the Seroquel be discontinued.	on ed	
	(DON) verified psychave an appropriate	a.m. the director of nursing hotropic medications should diagnosis and Seroquel diagnosis, and dose			and staff to continue to monitor The order was changed at that ti		

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION		TE SURVEY MPLETED
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	PROVIDER OR SUPPLIER ALLEY LIVING CENTE	R		2	STREET ADDRESS, CITY, STATE, ZIP CODE 208 OPPEGARD AVENUE NORTHWEST, PO FWIN VALLEY, MN 56584		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROFILIENCY)	D BE	(X5) COMPLETION DATE
	reductions should he DON stated she wood on 5/4/16, at 12:55 newly obtained physical indicated the diagnosticated the diagnosticated the diagnosticated immediated should be sho	p.m. the DON provided a sician order for R45 which osis for R45's Seroquel was duce the Seroquel from 50 The DON stated this would be diately. dministered Seroquel without es. In addition, a trial dose thempted or contraindications the adminsitration of the diately. cian order dated 5/3/16, of depression and dementia uel 25 mg daily was started nosis of dementia. mum Data Set (MDS) dated 35 had moderate cognitive dextensive assist with eng, showed no signs of ited wandering daily. R35's as Care Area Assessment if ited wandering daily. R35's as Care Area Assessment if ited wandering daily. R35's as Care Area Assessment if ited wandering daily. R35's as Care Area Assessment if ited wandering daily. R35's as Care Area Assessment if ited wandering daily. Ha is a will be resistive to cares,	F3	329	An "Antipsychotic Medication policy was developed that incleappropriate diagnosis for the unantipsychotic medications along with monitoring schedules and gradual dose reduction trials. It policy was reviewed by the Quantum Assurance team on 05/26/2016. The licensed nursing staff were educated on the importance of keeping residents free from	udes ise of g his ality	
		armacist monthly medication indicated on 12/21/15, a					

AND PLAN OF CORRECTION IDENTIFICAT		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		FIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED 05/05/2016	
		245419	B. WING		O£		
NAME OF PROVIDER OR SUPPLIER TWIN VALLEY LIVING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 208 OPPEGARD AVENUE NORTHWEST, PO BOX 480 TWIN VALLEY, MN 56584				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE	
F 329	Continued From page 17 recommendation for the documentation of a clinical rationale for the continued use of the Seroquel or if appropriate, consider reducing this medication. On 5/3/16, at 1:40 p.m. R35 was observed quietly propelling self in his wheelchair towards the common seating area. On 5/4/16, at 7:30 a.m. R35 was observed seated at the table in the dining room eating his breakfast independently. On 5/4/16, at 12:33 p.m. LPN-B stated R35 was just resistive to cares at times, did not have any hallucinations, and no psychotic behaviors. On 5/4/16, at 11:30 a.m. RN-A verified		F 329	attempting to reduce and discontinue medications as appropriate. The new "Antipsychotic Medication Use" policy was reviewed which includes appropriate diagnoses for the use of antipsychotic medications. Random audits of resident's drug regimens will be conducted monthly and findings reviewed with the Quality Assurance team until compliance is met. Director of Nursing or designee will monitor for compliance.			
	appropriate diagnosto be done, however always want to do the control of the contr	a.m. the director of nursing chotropic medications should de diagnosis and Seroquel codiagnosis, and dose e attempted. The DON tive to cares was not an on for the use of antipsychotic ON stated she would look into		06/03/2016 Tammy Courtright Director of Nursing		4/3/14	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
245419		245419	B. WING			05/05/2016	
NAME OF PROVIDER OR SUPPLIER TWIN VALLEY LIVING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 208 OPPEGARD AVENUE NORTHWEST, PO BOX 480 TWIN VALLEY, MN 56584				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			(X5) COMPLETION DATE
F 329 F 371 SS=E	Continued From page 18 directed staff to discontinue the Seroquel and to monitor R35. The DON stated this would be implemented immediately. The facility PSYCHOTROPIC DRUG MONITORING policy, updated 6/1/14, indicated individuals who were prescribed psychotropic medications would be regularly assessed and evaluated for appropriate use. Each individuals drug regiment will be free from unnecessary drug use. 483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions		F 329		F 371: Nursing The Twin Valley Living Center must procure food from sources approved or considered satisfactory by Federal, State, or local authorities; and store, prepare, distribute and serve food under sanitary conditions.		
	by: Based on observat review, the facility fa Room microwave in condition and failed in the East Day Roo	IT is not met as evidenced ion, interview and document ailed to maintain the East Day a clean and sanitary to ensure resident food items or refrigerator were labeled at the potential of affect 41 and these areas.			Based on observation, interview document review, the facility fait to maintain the East Day Room microwave in a clean and sanita condition and failed to ensure resident food items in the East E Room refrigerator were labeled dated. This had the potential to affect 41 residents who utilized these areas.	iled ry Day	

OTATEMEN	T OF DEFICIENCES	- GOVERNOUS GENTANOLO				OMB NO. 0938-039		
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		245419	B. WING	G		05	/05/2016	
NAME OF	PROVIDER OR SUPPLIER			1	STREET ADDRESS, CITY, STATE, ZIP CODE	1 00	100,2010	
TWIN VALLEY LIVING CENTER					208 OPPEGARD AVENUE NORTHWEST, PO BOX 480			
(V4) ID	CUMMARYOTA	TENENT OF DEPARTMENT			TWIN VALLEY, MN 56584			
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F 371	Continued From page 19 On 5/5/16, at 9:27 a.m. the East Day Room kitchenette was reviewed with registered nurse (RN)-A. The microwave was observed to have			371	The East Day Room facility kitchenette was cleaned on			
					05/05/16 which included the		, '	
					microwave and the refrigerator.	Λ11		
	food particles adher	ed to all 4 surfaces of the			unlabeled, undated food items v			
	interior, as well as the interior surface of the door. In addition, the refrigerator had 1 unlabeled, undated container of noodles with vegetables, 1 unlabeled, undated serving sized bowl of soup, 1 unlabeled, undated container of strawberries and cream, 1 unlabeled, undated container of ground meat and 1 undated submarine sandwich. RN-A confirmed the microwave was dirty and the containers of food were unlabeled and/or unmarked. RN-A indicated he did not know how long any of the items had been in the refrigerator or if they were safe to eat.				discarded.	vere		
					A note was placed on the East Da	av		
					Room refrigerator informing staf			
					residents and family, "All food ite			
					placed in this refrigerator must b			
					covered and labeled with the	_	`	
					resident's name and dated. Pleas	se		
					note that any, unlabeled, uncove			
					and outdated food items (after 3	Í		
	On 5/5/16, at 9:48 a.m. nursing assistant (NA)-C stated the cleaning of the kitchenette was the			ļ	days from the date on the contai			
					will be discarded". This informat	- 1		
j	responsibility of the r	the night shift staff. NA-C ad list of night shift duties posted		}	was also placed in the Lutheran	ļ		
	in the utility room on the north hall. An undated list entitled "Night Duties" was observed posted to the interior door of the upper cupboard in the north hall utility room. The list identified Wednesday's duties to include: wash residents' refrigerator in small dining room and clean microwave. NA-C indicated all items in the refrigerator were to be labeled and dated or they were to be thrown out. NA-C confirmed the refrigerator and microwave should have been cleaned the previous night shift.			- 1	Homes June flyer which is mailed			
					out to family members and			
					significant others. An envelope	1		
1					holding a roll of tape and a mark	er		
					were placed on the refrigerator			
				}	ease in labeling food items.			
					A note was placed on the	1		
					microwave, "Please cover food	:'		
				items with wax paper when heat	ing ,			
	On 5/5/16, at 9:55 a.r	n. the director of nursing			Everyone using this microwave is			
	(DON) confirmed items in the refrigerator should have been labeled and dated and the microwave				responsible to wipe up all spills ar			
'	have been labeled and dated and the microwave			- 1	i cabonaine to wihe ah ali ahilia g	mu j		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED			
245419		245419	B. WING			05/05/2016			
NAME OF PROVIDER OR SUPPLIER				8	STREET ADDRESS, CITY, STATE, ZIP CODE	0	0/05/2016		
TWIN VALLEY LIVING CENTER				208 OPPEGARD AVENUE NORTHWEST, PO BOX 480 TWIN VALLEY, MN 56584					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PROVIDER'S PLAN OF CORRECT PREFIX (EACH CORRECTIVE ACTION SHOUTH CROSS-REFERENCED TO THE APPRINCE DEFICIENCY)		RF	(X5) COMPLETION DATE		
F 371	should have been c	leaned. The DON indicated policy regarding the cleaning	F3		splatters immediately". A roll of paper was provided for use. A policy: "Kitchenette Cleaning and developed which includes direct for cleaning which will be done in the dietary staff weekly and provided for cleaning which will be done in the dietary staff weekly and provided for cleaning which will be done in the dietary staff weekly and provided for cleaning staff was educated of the importance of keeping the kitchenette area in a sanitary condition. Random audits of cleanliness of the kitchenette area will be conducted monthly and findings reviewed with the Quality Assurance team until compliance is met. Director of Nursing or designee with monitor for compliance. 06/03/2016 Tammy Courtright Director of Nursing	and cions by ee	4/3/14		

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PRINTED: 06/09/2016 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/GLIA (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A, BUILDING 01 - MAIN BUILDING 01 245419 B. WING 05/09/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 208 OPPEGARD AVENUE NORTHWEST, PO BOX 480 TWIN VALLEY LIVING CENTER TWIN VALLEY, MN 56584 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION ID (X5) COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PRFFIX PRÉFIX CROSS-REFERENCED TO THE APPROPRIATE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) **INITIAL COMMENTS** K 000 APPROVED 7 FIRE SAFETY By Tom Linhoff at 3:07 pm, Jun 16, 2016 THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE Please note we just DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST received these corrections via email from Mark PAGE OF THE CMS-2567 WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC. AN ONSITE REVISIT OF YOUR FACILITY MAY BE leath 4/19/16 CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey Twin Valley Living Center was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR. Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY **DEFICIENCIES (K TAGS) TO:** JUN 1 6 2016 HEALTH CARE FIRE INSPECTIONS STATE FIRE MARSHAL DIVISION MN DEPT. OF PUBLIC SAFET STATE FIRE MARSHAL DIVISION 444 CEDAR STREET, SUITE 145 ST. PAUL, MN 55101-5145, or By e-mail to: 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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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01		(X3) DATE SURVEY COMPLETED		
		245419	B. WING			05/	09/2016
	PROVIDER OR SUPPLIER	R	STREET ADDRESS, CITY, STATE, ZIP CODE 208 OPPEGARD AVENUE NORTHWEST, PO BOX 480 TWIN VALLEY, MN 56584)
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
K 000	DEFICIENCY MUS FOLLOWING INFO 1. A description of v to correct the deficie 2. The actual, or proceed of the correct the deficiency of the correct the deficiency of the actual, or proceed of the correct of the correct of the constructed at six of the constructed at six of the determined to be of the south of the build be of Type II (000) or to the dining room a constructed and was (000) constitution. In addition was construction. In 199 the north of the 196 II (111) construction, addition was added wing of the 1965 but construction. The later the construction of the later the construction. The later the construction of the later the construction. The later the construction of the later the construction. The later the correct the construction of the later the construction. The later the correct the deficiency of the later the correct the deficiency of the later the correct the corr	RRECTION FOR EACH T INCLUDE ALL OF THE DRMATION: what has been, or will be, done ency. possed, completion date. It title of the person ection and monitoring to nace of the deficiency center is a 1-story building. The building was ifferent times. The original aucted in 1965 and was Type II(111) construction. In addition was constructed to ding that was determined to construction. In 1975 additions and a activates were as determined to be Type II in 1981, a sleeping room aucted on the east side of the ermined to be of Type V(111) 2, a dayroom was added to 5 building that is of Type In 1995, a small dining room to the east side of the north ilding that is of Type II(111) test addition was an in 1996 to the south of the	K	000	¥1		

Event ID: TY8821

CENTE	HS FOR MEDICARE	& MEDICAID SERVICES			DIVILLY INC.	0936-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION NG 01 - MAIN BUILDING 01		E SURVEY PLETED
		245419	B. WING		05/	09/2016
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K 000	construction. The becomes. The building is fully accordance with NI Installation of Sprin The facility has a firedetection at smoke open to the corridor automatic fire depart accordance with NI Alarm Code" 1999 smoke detection in Other hazardous are detection that is on accordance with the 2007 edition.	sprinklered throughout in FPA 13 Standard for the kler Systems 1999 edition . e alarm system with smoke barrier doors and in spaces is that is monitored for the remaining the parties of	K 00	00		
K 018 SS=E	census of 54 at the Because the origina meet the construction buildings, this facilit building. The requirement at NOT MET as evided NFPA 101 LIFE SAI Doors protecting correquired enclosures hazardous areas shas those constructe core wood, or capal 20 minutes. Clearar and floor covering is	al building and its additions on type allowed for existing y was surveyed as a single 42 CFR, Subpart 483.70(a) is	K 01	that latched, this was co	ng order mpleted tenance in the ng order. will do	5/11/11

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA (LE CONSTRUCTION	(X3) DATE SURVEY		
	OF CORRECTION	IDENTIFICATION NUMBER:	1 ' '	01 - MAIN BUILDING 01		LETED
		245419	B. WING	05/0	05/09/2016	
,	PROVIDER OR SUPPLIER	R		STREET ADDRESS, CITY, STATE, ZIP CODE 208 OPPEGARD AVENUE NORTHWEST FWIN VALLEY, MN 56584		0,110
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE APP DEFICIENCY)	DULD BE	(X5) COMPLETION DATE
K 018	required to resist the no impediment to the open devices that repushed or pulled are provided with a medoor closed. Dutch permitted. Door framade of steel or othe with 8.2.3.2.1. Rolled CMS regulations in 19.3.6.3 This STANDARD is Based on observate facility failed to main 1 corridor door accessection 19.3.6.3.1. affect the safety of undetermined amounts.	e passage of smoke. There is ne closing of the doors. Hold elease when the door is e permitted. Doors shall be ans suitable for keeping the doors meeting 19.3.6.3.6 are mes shall be labeled and ner materials in compliance or latches are prohibited by all health care facilities. Is not met as evidenced by: ion and staff interview, the natain the smoke resistance of ording to NFPA 101 LSC (00) This deficient practice could 11 of the 54 residents and an unt of staff and visitors, if were allowed to enter the exit	K 018			
SS=E	on 05/09/2016 observealed resident ro This deficient condit Maintenance Direct NFPA 101 LIFE SAF Exit access is arran accessible at all tim 7.1. 19.2.1 This STANDARD is Based on observati	petween 8:45 am to 12:30 pm ervation and staff interview from 717 would not latch. Sion was verified by the present of the pr	K 038	The North exit by the Physica entrance was filled in with cothe slope to make an every surface. The Maintenance Dhis designee with monitor the ensure compliance.	oncrete on n walking pirector or	4/10/11

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A, BUILDING 01 - MAIN BUILDING 01		(X3) DATE SURVEY COMPLETED		
		245419	B. WING_		05/09/2016	
	PROVIDER OR SUPPLIER	R	STREET ADDRESS, CITY, STATE, ZIP CODE 208 OPPEGARD AVENUE NORTHWEST, PO BOX 480 TWIN VALLEY, MN 56584			
(X4) ID PREFIX TAG	X (EACH DEFICIENCY MUST BE PRECEDED BY FULL			PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
K 038	with the egress requested Safety Code (00) sed declicient practice of efficient exiting of 1 visitors. Findings include: On the facility tour to on 05/09/2016 observealed the exit netherapy room has all	ge 4 uirements of NFPA 101 Life ection 7.2.1.3, floor level. This could affect the safe and 3 of the 54 residents, staff and etween 8:45 am to 12:30 pm ervation and staff interview xt to the North physical nuneven walking surface that difference before a ramp or	K 03	8		
SS=F	Maintenance Director NFPA 101 LIFE SAFA A fire alarm system components approvaccordance with NF and NFPA 72, Nation provide effective was building. Fire alarm transmission paths a Initiation of the fire a means and by any realarm, detection device Manual alarm boxes egress near each reboxes in patient sleer required at exits if molocated at all nurse's notification is provide signals. In critical ca	is installed with systems and ed for the purpose in PA 70, National Electric Code nal Fire Alarm Code to rning of fire in any part of the system wiring or other are monitored for integrity. Ilarm system is by manual equired sprinkler system ice, or detection system. are provided in the path of quired exit. Manual alarm eping areas shall not be anual alarm boxes are	K 051	Protection Systems will be here 22 nd to change smoke detected ensure Twin Valley Living Cented compliance with codes. This was monitored by Maintenance Directly ensure compliance.	ors to er is in will be	6/23/14

CENTE	HO FOR MEDICARE	& MEDICAID SERVICES			IVID NO. L	1939-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	LE CONSTRUCTION 101 - MAIN BUILDING 01	(X3) DATE COMP	SURVEY LETED
		245419	B. WING		05/09	9/2016
	PROVIDER OR SUPPLIER	R	2	BOX 480	30	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ITEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-HEFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
K 051	the event of fire. The activates required of records are maintain 18.3.4, 19.3.4, 9.6. This STANDARD is Based on observatifacility failed to instance with NF section 19.3.4.2, 9.1. Fire Alarm Code (98) deficient practice of alarm system to so a fire event which controlled the section 19.3.4.2.	ge 5 If to notify emergency forces in the fire alarm automatically control functions. System ned and readily available. Is not met as evidenced by: ions and staff interview the all the smoke detection in FPA 101 Life Safety Code (00) 6.1.4 and NFPA 72 National 9) section 2-3.6.6.2. This build affect the ability of the aud in a timely manner during build affect all of the 54 determined amount of staff	K 051			
K 067 SS=F	on 05/09/2016 observealed the corridoresident room wings. This deficient condit Maintenance Director NFPA 101 LIFE SAF Heating, ventilating, with the provisions of in accordance with the specifications. 19 19.5.2.2 This STANDARD is Based on record rewas revealed that the	ETY CODE STANDARD and air conditioning comply of section 9.2 and are installed	K 067	Protection Systems will be here Jurto test fire dampers complete documentation. The director Maintenance will monitor yea ensure compliance and that Twin Living Center does not exceed the limit.	with or of rly to Valley	4/16/14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ' '	PLE CONSTRUCTION G 01 - MAIN BUILDING 01	(X3) DATE SURVEY COMPLETED		
		245419	B. WING_		05/09/2016	
	PROVIDER OR SUPPLIER	R		STREET ADDRESS, CITY, STATE, ZIP CODE 208 OPPEGARD AVENUE NORTHWEST, PC TWIN VALLEY, MN 56584	BOX 480)
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / 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
K 067	accordance with Ni deficient practice of another compartme to be ineffective in a negatively effect all undetermined amon	ge 6 FPA 101 (00) 9.3.1. This build allow smoke to enter into ent causing the smoke barrier a fire event and could 54residents and an unt of staff and visitors.	K 06	7		
	on 05/09/2016 reco	petween 8:45 am to 12:30 pm rd review and staff interview noke dampers exceeded the sting interval. They were last).				
SS=F	Maintenance Direct NFPA 101 LIFE SAI The nursing home/requipment shall have power separate and source that will be enhour after loss of the 199. This STANDARD is Based on record refacility failed to obtain atural gas supplier service to the generaccording to NFPA practice could affect residents and an unand visitors.	ce was observed by the or. FETY CODE STANDARD nospice with no life support we an alternate source of lindependent from the normal offective for minimum of 1 1/2 e normal source 3-6. (NFPA so not met as evidenced by: eview and staff interview the in a letter of reliability from the othat ensures uninterupted eator in case of an emergency 110 (99) This deficient the care and safety of all 54 determined amount of staff setween 8:45 am to 12:30 pm	K 146	Twin Valley Living Center obtaletter of reliability was obtaine Community C0-0ps of Lake P. 5/12/2016, see enclosed.	d from	5/12/14

PRINTED: 06/09/2016 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01			(X3) DATE SURVEY COMPLETED	
1		245419	B. WING			05/09/2016	
	PROVIDER OR SUPPLIER	R	STREET ADDRESS, CITY, STATE, ZIP CODE 208 OPPEGARD AVENUE NORTHWEST, PO BOX 480 TWIN VALLEY, MN 56584				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
K 146	revealed there was gas company for th	ord review and staff interview no letter of reliability from the e natural gas generator. ce was observed by the	Kı	46	DEPICIENCI		

Event ID: TY8821

Lake Park Office 14583 Hwy. 10 West P.O. Box 329 Lake Park, MN 56554 Main Office: 218-238-5911 Toll Free: 1-800-992-6671 Fax: 218-238-5435



Detroit Lakes • Lake Park • Mahnomen Twin Valley • Flom Malinomen Office 201 S. Railway St. P.O. Box 398 Malinomen, MN 56557 Main Office: 218-935-2281 Toll Free: 1-888-935-2281 Fax: 218-935-5572

Twin Valley Living Center

May 12, 2016

Reliability of Natural Gas Statement

Natural gas is a very reliable source of energy. It originates in our system at a local town border station located on the north edge of Ada, Minnesota and is transported to the City of Twin Valley on a brand new natural gas transmission system. The system was designed and built in 2015 with extra capacity to support substantial growth to provide a very reliable system well into the future. The likely hood of interruption to the natural gas system is very low because the system is new and the supply of natural gas into neighboring towns that have had natural gas for many years have never been interrupted. The supply to the Community Co-op system comes directly off the Viking Transmission line and we have a supply agreement in place with Viking and also Constellation Energy that guarantees our daily, monthly and annual supply to serve our customers. We also have the Twin Valley Living Center on a non-interruptible service so at no time will we ask them or require them to curb consumption to balance the system load.

Sincerely,

David Blomseth

General Manager

Community Co-ops of Lake Park



PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Certified Mail # 7015 0640 0003 5695 0397

May 18, 2016

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

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5419026

Dear Ms. Schreiner:

The above facility was surveyed on May 2, 2016 through May 5, 2016 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.

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.

Twin Valley Living Center May 18, 2016 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:

Lyla Burkman, Unit Supervisor Bemidji Survey Team Licensing and Certification Program Health Regulation Division Minnesota Department of Health 705 5th Street Northwest, Suite A Bemidji, Minnesota 56601-2933

Email: Lyla.burkman@state.mn.us

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

We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should **immediately contact Lyla Burkman at the phone number or email detailed above**.

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

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

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

Sincerely,

Mark Meath

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

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

Enclosure(s)

innes	ota Department of H	ealth .			· · · · · · · · · · · · · · · · · · ·		ED: 05/18/20 RM APPROVE
'ATEME ID PLAN	NT OF DEFICIENCIES NOF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI	TIPLE CONSTRUC NG: REC	EIVED	(X3) D/	ATE SURVEY DMPLETED
		00414	B. WING	HUN	0 8 2016	, o	<u>5/05/2</u> 016
ME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CIT	Y, STATE, ZIP	Pariment of Health		
VIN VA	ALLEY LIVING CENTE	R 208 OPP TWIN VA	EGARD AN	ENUE NORTH	WEST, PO BOX 4	80	
X4) ID REFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PRI (EACH	OVIDER'S PLAN OF CO I CORRECTIVE ACTIO REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
2 000	Initial Comments		2 000			1.	
	****ATTEI	NTION*****			· .		
	NH LICENSING	CORRECTION ORDER					
1	pursuant to a survey found that the defici herein are not corre not corrected shall be with a schedule of fi the Minnesota Depar						
	corrected requires or requirements of the number and MN Rul When a rule contains comply with any of the lack of compliance. re-inspection with an result in the assessm	ether a violation has been ompliance with all rule provided at the tag e number indicated below. It is several items, failure to be items will be considered below tack of compliance upon y item of multi-part rule will nent of a fine even if the item ing the initial inspection was	·				
t	nat may result from i orders provided that a he Department withir	earing on any assessments non-compliance with these a written request is made to 15 days of receipt of a for non-compliance.					
th co	Department's staff visone following licensing orrections are completed in the bottom of the firith "Laboratory Directions".	: , 2016, surveyors of this ited the above provider and orders were issued. When eted, please sign and date rst page in the line marked itor's or Provider/Supplier		Correction C Tag numbers	Department of Head the State Licens Orders using fedes have been assignated the statutes/rules	sing eral software. aned to	

a Department of Health
ORY PIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE ORM

ini Ductor EXCLUE TY8811

(X6) DATE If continuation sheet 1 of 24

PRINTED: 05/18/2016

FORM APPROVED Minnesota Department of Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: _____ B. WING _ 00414 05/05/2016 NAME OF PROVIDER OR SLIPPLIER STREET ADDRESS CITY STATE 7IP CODE

NAME OF F	PROVIDER OR SUPPLIER STREE	STREET ADDRESS, CITY, STATE, ZIP CODE					
TWIN VA	I I E V I IVING ("ENTER	208 OPPEGARD AVENUE NORTHWEST, PO BOX 480 TWIN VALLEY, MN 56584					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE			
2 000	Initial Comments	2 000					
	****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 to corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.	on					
	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 ite that was violated during the initial inspection was corrected.	l em					
	You may request a hearing on any assessment that may result from non-compliance with these orders provided that a written request is made the Department within 15 days of receipt of a notice of assessment for non-compliance.	9					
	INITIAL COMMENTS: On May 2, 3, 4, and 5, 2016, surveyors of this Department's staff visited the above provider a the following licensing orders were issued. Wh corrections are completed, please sign and dat on the bottom of the first page in the line marke with "Laboratory Director's or Provider/Supplier Representative's signature." Make a copy of	en ed	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.				

Minnesota Department of Health

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

TITLE (X6) DATE Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			A. BOILBING.			
		00414	B. WING	G 05/05		2016
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
TWIN VA	LLEY LIVING CENTE	K	GARD AVEN	NUE NORTHWEST, PO BOX 480 6584		
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE ((X5) COMPLETE DATE
2 000	Continued From page 1		2 000			
	these orders for your records and return the original to the address below: Minnesota Department of Health 705 Fifth Street NW, Suite A, Bemidji, MN 56601-2933 c/o Lyla Burkman, Unit Supervisor			The assigned tag number appears far left column entitled "ID Prefix The state statute/rule number and corresponding text of the state state out of compliance is listed in the "Summary Statement of Deficience column and replaces the "To Compliance is the "To Compliance is the state of Deficience column and replaces the "To Compliance is the state of Deficience column and replaces the state of Deficience is the State of Defi	Tag." I the atute/rule	
				portion of the correction order. To column also includes the findings are in violation of the state statute statement, "This Rule is not met a evidenced by." Following the surfindings are the Suggested Metho Correction and the Time Period Formection.	his s which after the as veyors	
				PLEASE DISREGARD THE HEAD THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES T FEDERAL DEFICIENCIES ONLY WILL APPEAR ON EACH PAGE.	F TO	
				THERE IS NO REQUIREMENT T SUBMIT A PLAN OF CORRECTIONS OF MINNESOTAS STATUTES/RULES.	ON FOR	
2 535	MN Rule 4658.0300 Restraints	0 Subp. 5 A-D Use of	2 535			
	resident placed in a home must also: A. develop a sy restrained resident specified in the writ B. assist the re	restraints. At a minimum, for a a physical restraint, a nursing vstem to ensure that the is monitored at the interval ten order from the physician; esident as often as necessary afety, comfort, exercise, and				

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		00414	B. WING		05/	05/2016
	PROVIDER OR SUPPLIER	208 OPP	DDRESS, CITY, ST PEGARD AVENI LLEY, MN 565	UE NORTHWEST, PO BOX	480	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
2 535	elimination needs; C. provide an of exercise, and elimin minutes during each restraint is employed. D. release their quickly as possible. This MN Requirements by: Based on observation review, the facility for restraint device (lagrand used for the lease resident (R30) observation without ability to incomplete the resident (R30) observation in	opportunity for motion, nation for not less than ten the two-hour period in which a ed; and esident from the restraint as	2 535	DEFICIENCY		
	R30's Physical Res (CAA) dated 3/29/1	traint Care Area Assessment 6, indicated R30 utilized a lap ion that fits over a resident's				

Minnesota Department of Health

STATE FORM 6899 TY8811 If continuation sheet 3 of 24

STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVE COMPLETED	
		00414	B. WING		05/0	5/2016
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE	1 33/3	0,2010
TWIN VA	LLEY LIVING CENTE	R	GARD AVEN	NUE NORTHWEST, PO BOX 480		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
2 535	wheelchair, which of to remove themselves restraint more than was able to remove the restraint as a taimpulsive and the la R30 to not stand with CAA also indicated increased R30's rist the lap buddy. R30's Physician Or an order for R30 to as needed when up R30's physical safe. R30's care plan data potential for falls, directed staff to assaddition, the care puthe lap buddy in platray and that R30 kethe lap buddy. R30's Monitoring of for the observation indicated whenever the lap buddy had be considered whenever the lap b	can restrict the residents' ability wes from the wheelchair) daily. The CAA indicated R30 is the lap buddy and R30 used ble. In addition, R30 was ap buddy was there to remind thout being assisted. The R30 had jerking spells which is for falls and the reason for ders dated 5/22/13, indicated have a restraint - a lap buddy in a wheelchair to enhance ity. Ted 5/21/15, indicated R30 had utilized a lap buddy and sess R30 for restraint use. In lan indicated R30 liked to have and was utilized like a lap new how to apply and remove a sessible period of 3/15/16 - 3/18/16, R30 was up in her wheelchair	2 535			

Minnesota Department of Health

STATE FORM TY8811 If continuation sheet 4 of 24

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00414	B. WING		05/0	5/2016
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE NUE NORTHWEST, PO BOX 480		
TWIN VA	LLEY LIVING CENTE	R	LEY, MN 56			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / 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)	_D BE	(X5) COMPLETE DATE
2 535	Continued From pa	ge 4	2 535			
	against R30's abdo portion of the lap bu (on backwards). R	e of the lap buddy tight up men and the contoured uddy positioned facing outward 30's lap buddy remained in e entire time R30 was being				
	usually had the lap TMA-B confirmed o	o.m. TMA-B stated R30 buddy off during meal times. during the evening meal on uddy had not been removed.				
	wheelchair propelling hallway with the lap	o.m. R30 was seated in her ing herself up and down the buddy placed and positioned portion of the restraint faced				
	in her wheelchair no The lap buddy was wheelchair. The lap secured to the arm portion of the lap bu	a.m. R30 was observed seated ext to the dining room table. secured to the front of her p buddy was again observed rests with the contoured uddy faced outward and tight up against R30's				
	(LPN)-A and nursin observed to transfe wheelchair. LPN-A buddy with the cut of and the contoured p	o.m. licensed practical nurse g assistant (NA)-B were or R30 from R30's bed into the and NA-B secured the lap out sides around the arm rests portion of the lap buddy faced raight edged side placed tight odomen.				

6899

Minnesota Department of Health STATE FORM

	TATEMENT OF DEFICIENCIES ND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		00414	B. WING		05/0	5/2016
	PROVIDER OR SUPPLIER	R 208 OPPE		STATE, ZIP CODE SUE NORTHWEST, PO BOX 480 S584		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 535	On 5/4/16, at 7:03 a in her wheelchair at fed by activity aide secured to the front contoured portion of outwards and the stup against R30' ab remained in position R30 was being fed. On 5/4/16, at 9:05 a observed to remain the dining room are engaged in activitie reading and a game R30's lap buddy rerinappropriately to Ractivity period. On 5/4/16, at 9:45 a buddy was always swith the contoured outwards and the strestraint faced tight acknowledged the I placed and should a contoured portion on R30's waist. LPN-ER30's restraint should a time.	a.m. R30 was observed seated the dining room table being (AA)-B. R30's lap buddy was to five wheelchair with the fithe lap buddy faced traight edged side placed tight domen. R30's lap buddy in throughout the entire time by AA-B. a.m. until 9:40 a.m. R30 was seated in her wheelchair in the a. During this time, R30 was swhich involved a snack, at all coordinated by AA-A. In mained in place and secured (30's wheelchair during this secured to R30's wheelchair portion of the restraint faced traight edge portion of the up to R30's abdomen. LPN-B ap buddy was inappropriately have been positioned with the fithe restraint faced towards as was unsure of how often the all did be released, however, y should be removed during	2 535			
	confirmed R30 use considered a restra	p.m. registered nurse (RN)- A d a lap buddy which was int. RN-A confirmed the removed during meals and				

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	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					E SURVEY PLETED
		00414	B. WING		05/	05/2016
	PROVIDER OR SUPPLIER	208 OPPE		TATE, ZIP CODE IUE NORTHWEST, PO BOX 4 584	80	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
2 535	during activities as RN-A verified the m up in her wheelchai	long as R30 was participating. ajority of time when R30 was ir the restraint was placed. pectation was that the lap	2 535			
	(DON) confirmed R considered a restrathe lap buddy off ar verified R30's lap b removed when R30 during meal time, a activity group. In activity and activity group.	p.m. the director of nursing i30's lap buddy was int and that R30 had utilized and on since 2013. The DON uddy should have been was in view of other staff, and when R30 was with an addition, DON confirmed the lap been applied correctly.				
	R30's lap buddy was stated R30's lap bu	o.m. The DON confirmed as incorrectly applied and ddy was old and staff were nanufacture guidelines.				
	directions directed with the straight ed	op cushions application staff to position the lap buddy ged side faced away from the ntoured side positioned at the				
	would be kept as re	dated] indicated residents estraint free as possible. If a nted, the least restrictive utilized.				
	dated 5/12/03, indic	e Device Assessment Policy cated restraint devices would st quarterly to determine its				

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STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00414	B. WING		05/0	5/2016
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
TWIN VA	LLEY LIVING CENTE	K	GARD AVEN	NUE NORTHWEST, PO BOX 480		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
2 535	Continued From pa	ge 7	2 535			
	continued usefulnes	SS.				
	The director of nurs develop and implen related to restraints provide training for physical restraints.	THOD OF CORRECTION: sing (DON) or designee, could nent policies and procedures . The DON or designee, could all nursing staff related to The quality assessment and ee could perform random mpliance.				
	TIME PERIOD FOR (21) days.	R CORRECTION: Twenty-one				
2 830	MN Rule 4658.0520 Proper Nursing Car	Subp. 1 Adequate and e; General	2 830			
	receive nursing carcustodial care, and individual needs an the comprehensive plan of care as des 4658.0405. A nursi of bed as much as written order from the custodial care.	general. A resident must e and treatment, personal and supervision based on d preferences as identified in resident assessment and scribed in parts 4658.0400 and any home resident must be out possible unless there is a he attending physician that the in in bed or the resident				
	by: Based on observati	ent is not met as evidenced on, interview and document ailed to provide appropriate				

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	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	E CONSTRUCTION		E SURVEY PLETED
		00414	B. WING		05/	05/2016
NAME OF	PROVIDER OR SUPPLIER			TATE, ZIP CODE		
TWIN VA	ALLEY LIVING CENTE	K	EGARD AVEN LLEY, MN 56	IUE NORTHWEST, PO BOX 48 584	30	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETE DATE
2 830	monitoring for 1 of displayed low blood	1 resident (R41) who	2 830			
		dated 6/7/13, indicated R41's diabetes, dementia and ease.				
	4/28/16, indicated F	imum Data Set (MDS) dated R41 had severe cognitive eived daily insulin injections.				
	staff to administer to R41's diabetes: -Novolog (insulin) 6 injection into the subreakfast (hold if do-Novolog 50 units States) -Novolog 40 units States doesn't eat) -Lantus (insulin) 80 a.m.) -Lantus 60 units States	SQ with noon meal (hold if SQ with evening meal (hold if units SQ every morning (8:00 Q every evening (8:00 p.m.) are directed to check R41's				
	(LPN)-A and nursin observed to assist dining room. LPN-	o.m. licensed practical nurse g assistant (NA)-B were R41 from her room into the A and NA-B were on each side d her front wheeled walker and dining area.				

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	EMENT OF DEFICIENCIES PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	E CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		00414	B. WING		05/0	05/2016
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE	•	
TWIN VA	LLEY LIVING CENTE	R	LEY, MN 50	NUE NORTHWEST, PO BOX 480 6584		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
2 830	Continued From pa	ge 9	2 830			
	and encouraged R4 room for a cookie. around R41's waist of R41. With minim	a.m. NA-E entered R41's room 41 to come out to the dining NA-E placed a gait belt and placed the walker in front nal assist, R41 stood up and . NA-E guided R41 out of her lining area.				
	a potential for hype levels) related to Ra The care plan direct medications as ordered and when a was not eating mea R41 received a reg	ted 6/22/13, indicated R41 had rglycemia (high glucose 41's diagnosis of diabetes. Ited staff to administer ered, check blood sugars as needed, hold insulin if R41 als. The plan also indicated ular diet with diabetic features of monitor for signs and tic reaction.				
	blood glucose level past 2-3 months) da	est which indicated how well s had been controlled over the ated 3/30/16, indicated an (reference range 4.2-6).				
	confirmed R41's blo	a.m. registered nurse (RN)-A cod glucose readings listed 0 days and that the medical mentation of a recheck on any glucose readings:				
	52 milligrams per d -4/6/16, at 6:00 a.m -4/7/16, at 6:00 a.m	n. blood glucose (BG) result = eciliter (mg/dL) n. BG result = 70 mg/dL n. BG result = 56 mg/dL n. BG result = 66 mg/dL and at				

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NAME OF PROVIDER OR SUPPLIER TWIN VALLEY LIVING CENTER STREET ADDRESS, CITY, STATE, ZIP CODE 208 OPPEGARD AVENUE NORTHWEST, PO BOX 480 TWIN VALLEY, MN 56584 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X5)	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 208 OPPEGARD AVENUE NORTHWEST, PO BOX 480 TWIN VALLEY LIVING CENTER (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 2 830 Continued From page 10 4:00 p.m. result = 50 mg/dL -4/10/16, at 6:00 a.m. BG result = 63 mg/dL and at 11:00 a.m. result = 56 mg/dL -4/15/16, at 6:00 a.m. BG result = 58 mg/dL -4/16/16, at 6:00 a.m. BG result = 68 mg/dL and at 4:00 p.m. result = 64 mg/dL -4/17/16, at 6:00 a.m. BG result = 60 mg/dL, at 11:00 a.m. result = 64 mg/dL -4/17/16, at 6:00 a.m. BG result = 60 mg/dL, at 11:00 a.m. result = 64 mg/dL -4/18/16, at 6:00 a.m. BG result = 59 mg/dL, and 11:00 a.m. result = 64 mg/dL, and at 4:00 p.m. result 60 mg/dL, and at 4:00 p.m. result = 59 mg/dL, and						
TWIN VALLEY LIVING CENTER 208 OPPEGARD AVENUE NORTHWEST, PO BOX 480 TWIN VALLEY, MN 56584 (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 2 830 Continued From page 10 4:00 p.m. result = 50 mg/dL -4/10/16, at 6:00 a.m. BG result = 63 mg/dL -4/11/16, at 6:00 a.m. BG result = 63 mg/dL -4/16/16, at 6:00 a.m. BG result = 68 mg/dL -4/16/16, at 6:00 a.m. BG result = 68 mg/dL -4/17/16, at 6:00 a.m. BG result = 60 mg/dL -4/17/16, at 6:00 a.m. BG result = 60 mg/dL -4/17/16, at 6:00 a.m. BG result = 60 mg/dL, at 11:00 a.m. result = 64 mg/dL -4/17/16, at 6:00 a.m. BG result = 60 mg/dL, at 11:00 a.m. result = 64 mg/dL -4/18/16, at 6:00 a.m. BG result = 59 mg/dL, and 11:00 a.m. result = 64 mg/dL -4/18/16, at 6:00 a.m. BG result = 59 mg/dL, and		00414	B. WING		05/0	5/2016
TWIN VALLEY, MN 56584 (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 2 830 Continued From page 10 4:00 p.m. result = 50 mg/dL -4/10/16, at 6:00 a.m. BG result = 63 mg/dL -4/15/16, at 6:00 a.m. BG result = 58 mg/dL -4/16/16, at 6:00 a.m. BG result = 68 mg/dL -4/16/16, at 6:00 a.m. BG result = 68 mg/dL and at 4:00 p.m. result = 64 mg/dL -4/17/16, at 6:00 a.m. BG result = 60 mg/dL, at 11:00 a.m. result = 64 mg/dL -4/17/16, at 6:00 a.m. BG result = 60 mg/dL, at 11:00 a.m. result = 64 mg/dL -4/18/16, at 6:00 a.m. BG result = 59 mg/dL, and at 4:00 p.m. result = 64 mg/dL; and at 4:00 p.m. result = 64 mg/dL, and at 6:00 a.m. BG result = 60 mg/dL, at 11:00 a.m. result = 64 mg/dL; and at 4:00 p.m. result = 64 mg/dL, and at 4:00 p.m. result = 64 mg/dL, and at 6:00 a.m. BG result = 59 mg/dL, and	NAME OF PROVIDER OR SUPPLIER		, ,	,		
PRÉFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 2 830 Continued From page 10 4:00 p.m. result = 50 mg/dL -4/10/16, at 6:00 a.m. BG result = 63 mg/dL -4/11/16, at 6:00 a.m. BG result = 58 mg/dL -4/16/16, at 6:00 a.m. BG result = 68 mg/dL at 4:00 p.m. result = 64 mg/dL -4/17/16, at 6:00 a.m. BG result = 68 mg/dL at 4:00 p.m. result = 64 mg/dL -4/17/16, at 6:00 a.m. BG result = 60 mg/dL, at 11:00 a.m. result = 64 mg/dL; and at 4:00 p.m. result = 64 mg/dL; and at 4:00 p.m. result = 64 mg/dL, and at 4:00 p.m. result = 64 mg/dL; and at 4:00 p.m. result = 64 mg/dL, and at 4:00 p.m. result =	TWIN VALLEY LIVING CENTE	IIFK				
4:00 p.m. result = 50 mg/dL -4/10/16, at 6:00 a.m. BG result = 63 mg/dL and at 11:00 a.m. result = 56 mg/dL -4/11/16, at 6:00 a.m. BG result = 63 mg/dL -4/15/16, at 6:00 a.m. BG result = 58 mg/dL -4/16/16, at 6:00 a.m. BG result = 68 mg/dL and at 4:00 p.m. result = 64 mg/dL -4/17/16, at 6:00 a.m. BG result = 60 mg/dL, at 11:00 a.m. result = 64 mg/dL; and at 4:00 p.m. result 60 mg/dL -4/18/16, at 6:00 a.m. BG result = 59 mg/dL, and	PREFIX (EACH DEFICIENC	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO	LD BE	COMPLETE
-4/19/16, at 4:00 p.m. BG result = 66 mg/dL -4/22/16, at 4:00 p.m. BG result = 68 mg/dL -4/25/16, at 4:00 p.m. BG result = 64 mg/dL -4/28/16, at 6:00 a.m. BG result = 63 mg/dL and at 4:00 p.m. result = 56 mg/dL -4/29/16, at 6:00 a.m. BG result = 70 mg/dL -5/2/16, at 4:00 p.m. BG result = 59 mg/dL and at 8:00 p.m. 60 mg/dL -5/3/16, at 4:00 p.m. BG result = 59 mg/dL and at 8:00 p.m. 60 mg/dL -5/3/16, at 4:00 p.m. BG result = 62 mg/dL Nursing Home Note dated and signed by the physician on 4/28/16, indicated R41's blood glucose levels had been running: -Morning checks = 58-168 mg/dL -11:00 a.m. checks = 64-221 mg/dL -4:00 p.m. checks = 64-221 mg/dL -8edtime checks = 49-177 mg/dL The physician indicated no changes to be made. On 5/5/16, at 9:55 a.m. LPN-D stated when R41's blood sugar levels were low, the staff usually gave R41 a snack and should recheck R41's blood sugar after eating it.	4:00 p.m. result = 8 -4/10/16, at 6:00 a. at 11:00 a.m. result -4/11/16, at 6:00 a4/15/16, at 6:00 a4/16/16, at 6:00 a. at 4:00 p.m. result -4/17/16, at 6:00 a. 11:00 a.m. result = result 60 mg/dL -4/18/16, at 6:00 a. at 8:00 p.m. result -4/19/16, at 4:00 p4/22/16, at 4:00 p4/25/16, at 4:00 p4/28/16, at 6:00 a. at 4:00 p.m. result -4/29/16, at 6:00 a. at 4:00 p.m. result -4/29/16, at 4:00 p. 8:00 p.m. 60 mg/dl -5/3/16, at 4:00 p.m. Nursing Home Not physician on 4/28/glucose levels had -Morning checks = -11:00 a.m. checks -4:00 p.m. checks	= 50 mg/dL a.m. BG result = 63 mg/dL and sult = 56 mg/dL a.m. BG result = 63 mg/dL a.m. BG result = 58 mg/dL a.m. BG result = 58 mg/dL a.m. BG result = 68 mg/dL and ult = 64 mg/dL a.m. BG result = 60 mg/dL, at t = 64 mg/dL; and at 4:00 p.m. a.m. BG result = 59 mg/dL, and ult = 49 mg/dL p.m. BG result = 66 mg/dL p.m. BG result = 68 mg/dL p.m. BG result = 63 mg/dL a.m. BG result = 63 mg/dL and ult = 56 mg/dL a.m. BG result = 70 mg/dL b.m. BG result = 59 mg/dL and at /dL b.m. BG result = 59 mg/dL and at /dL b.m. BG result = 59 mg/dL and at /dL b.m. BG result = 59 mg/dL and at /dL b.m. BG result = 59 mg/dL and at /dL b.m. BG result = 59 mg/dL and at /dL b.m. BG result = 62 mg/dL b.m. BG result = 64 mg/dL b.m. BG result = 68 mg/dL b.m. BG result = 68 mg/dL b.m. BG result = 69 mg/dL b.m. BG re	2 830			

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PRINTED: 05/18/2016 FORM APPROVED

Minnesota Department of Health
STATEMENT OF DEFICIENCIES (X1)

_	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ´ COME		(X3) DATE COMP	SURVEY LETED
			A. BUILDING:			
		00414	B. WING		05/0	5/2016
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
TWIN VA	LLEY LIVING CENTE	R	GARD AVEN LEY, MN 50	NUE NORTHWEST, PO BOX 480 6584		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 830	Continued From pa	ige 11	2 830			
	expectation for staf sugar reading, the or some fluids and and this should be	rated. RN-A stated the f was if R41 had a low blood staff should give R41 a snack then recheck the blood sugar documented. RN-A was ne last time R41's insulin dijusted.				
	(DON) verified a lov value under the nor The DON confirme identified a snack s resident and then the rechecked and resident	a.m. the director of nursing w blood sugar would be any rmal range of 80-140 mg/dL. d when a low blood sugar was should be provided to the ne blood sugar level should be ult documented. The DON ty did not have a policy on tent.				
	The director of nurs develop and impler related to the diabe designee, could pro staff related to ensu diabetes mellitus. T	THOD OF CORRECTION: sing (DON) or designee, could ment policies and procedures stes mellitus. The DON or ovide training for all nursing uring the staff understand the quality assessment and ee could perform random mpliance.				
	TIME PERIOD FOR (21) days.	R CORRECTION: Twenty-one				
21015	MN Rule 4658.0610 Requirements- Sa	0 Subp. 7 Dietary Staff nitary conditi	21015			
	Subp. 7. Sanitary	conditions. Sanitary				

6899

Minnesota Department of Health STATE FORM

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00414	B. WING		05/0	5/2016
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
TWIN VA	LLEY LIVING CENTE	·R	LEY, MN 56	IUE NORTHWEST, PO BOX 480 5584		
(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 CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
21015	Continued From pa	nge 12	21015			
		nditions must be maintained in e dietary department at all				
	by: Based on observat review, the facility f Room microwave ii condition and failed in the East Day Roo	ent is not met as evidenced ion, interview and document ailed to maintain the East Day in a clean and sanitary if to ensure resident food items om refrigerator were labeled and the potential of affect 41 ed these areas.				
	Findings include:					
	kitchenette was rev (RN)-A. The micro food particles adhe interior, as well as t In addition, the refr undated container of unlabeled, undated unlabeled, undated cream, 1 unlabeled meat and 1 undated confirmed the micro containers of food of unmarked. RN-A in	a.m. the East Day Room riewed with registered nurse wave was observed to have ared to all 4 surfaces of the the interior surface of the door. igerator had 1 unlabeled, of noodles with vegetables, 1 serving sized bowl of soup, 1 container of strawberries and 1, undated container of ground d submarine sandwich. RN-A owave was dirty and the were unlabeled and/or indicated he did not know how its had been in the refrigerator to eat.				
	stated the cleaning	a.m. nursing assistant (NA)-C of the kitchenette was the night shift staff. NA-C				

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P WING		
B. WING		05/05/2016
PEGARD AVEN	IUE NORTHWEST, PO BOX 480	
ID PREFIX TAG		
to y d e		
nd		
	PPEGARD AVEN VALLEY, MN 56 PREFIX TAG 21015 ed it to	T ADDRESS, CITY, STATE, ZIP CODE PPEGARD AVENUE NORTHWEST, PO BOX 480 VALLEY, MN 56584 D

6899

Minnesota Department of Health STATE FORM

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING:	E CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED	
		00414	B. WING		05/0	05/2016
_	PROVIDER OR SUPPLIER	g 208 OPPE		TATE, ZIP CODE IUE NORTHWEST, PO BOX 480 584		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
21535	Continued From pa	ge 14	21535			
21535	Drug Usage; Gener Subpart 1. Genera	al. A resident's drug regimen	21535			
	must be free from unnecessary drugs. An unnecessary drug is any drug when used: A. in excessive dose, including duplicate drug therapy; B. for excessive duration; C. without adequate indications for its use; or D. in the presence of adverse consequences which indicate the dose should be reduced or discontinued. In addition to the drug regimen review required in part 4658.1310, the nursing home must comply with provisions in the Interpretive Guidelines for Code of Federal Regulations, title 42, section 483.25 (1) found in Appendix P of the State Operations Manual, Guidance to Surveyors for Long-Term Care Facilities, published by the Department of Health and Human Services,					
	Health Care Financ This standard is inc available through th	ing Administration, April 1992. Porporated by reference. It is the Minitex interlibrary loan te Law Library. It is not				
	by: Based on observati review the facility fa justification for the u identified for 2 of 2 received a routine of the facility failed to reduction of an anti contraindications of	ent is not met as evidenced on, interview and document illed to ensure the appropriate use of an antipsychotic was residents (R45, R35) who lose of Seroquel. In addition, ensure a tapering dose psychotic was attempted or the reduction documented for 15, R35) who had received a				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00414	B. WING		05/0	5/2016
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE	•	
TWIN VA	LLEY LIVING CENTE	R	GARD AVEN LEY, MN 56	IUE NORTHWEST, PO BOX 480 5584		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
21535	Continued From pa	ge 15	21535			
	reduction attempted	d.				
	Findings Include:					
	(antipsychotic) with addition, a trial dosor contraindications	administered Seroquel out appropriate diagnoses. In e reduction was not attempted a documented prior to the e Seroquel (antipsychotic).				
	2/23/16, indicated Fimpairment, require activities of daily liv hallucinations or dewandering daily. Racare Area Assessmindicated R45 has I physician ordered the resident becom	imum Data Set (MDS) dated R45 had moderate cognitive ed extensive assist with ing, showed no signs of elusions and exhibited 45's Behavioral Symptoms nent (CAA) dated 9/15/15, nad behaviors of agitation, the he Seroquel for agitation as es acclimated to the secured be adjusted as able with nue.				
	regimen review form dated 12/21/15, and documentation for the continue the use of consider reducing the	narmacist monthly medication m indicated a recommendation d again on 3/29/16, for the clinical rationale to Seroquel or if appropriate he dosage of this medication. y failed to act on these				
	indicated R45 was disease, depression	cian order dated 5/3/16, diagnosed with Alzheimer's n, and dementia and on 50 milligrams (mg) every day				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED	
		00414	B. WING		05/0	5/2016
	208 OPP			STATE, ZIP CODE NUE NORTHWEST, PO BOX 480		
I WIN VA	LLEY LIVING CENTE	TWIN VAL	LEY, MN 56	5584		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / 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	(X5) COMPLETE DATE
21535	Continued From pa	ge 16	21535			
	for Dementia with a	gitation was started.				
	On 5/3/16, at 1:40 p.m. R45 was observed ambulating with a two wheeled walker in the main hallway of the secured unit, R45 was counting out loud.					
	On 5/4/16, at 7:26 a.m. R45 was observed seated in the secured unit dining room eating breakfast. R45 requested another pancake.					
	On 5/4/16, 12:33 p.m. licensed practical nurse (LPN)-B stated R45 just wandered the halls and counted.					
	verified antipsychot appropriate diagnos	a.m. registered nurse (RN)-A ic medications should have an sis and dose reductions were er, the physician does not hat.				
	(DON) verified psychave an appropriate required a psychotic	a.m. the director of nursing chotropic medications should e diagnosis and Seroquel c diagnosis, and dose have been attempted. The buld look into this.				
	newly obtained phy indicated the diagno psychosis and to re	p.m. the DON provided a sician order for R45 which osis for R45's Seroquel was educe the Seroquel from 50 The DON stated this would be diately.				
	R35 was routinely a	administered Seroquel without				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED	
	00414		B. WING		05/0	05/2016
NAME OF	PROVIDER OR SUPPLIER		DRESS, CITY, S	STATE, ZIP CODE		0.2010
IWIN VALLEY LIVING CENTER			GARD AVEN	IUE NORTHWEST, PO BOX 480 5584		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
21535	reduction was not a documented prior to Seroquel. R35's current physicidentified diagnosis and indicated Seroguel.	age 17 ses. In addition, a trial dose attempted or contraindications to the adminsitration of the cian order dated 5/3/16, of depression and dementia quel 25 mg daily was started gnosis of dementia.	21535			
	R35's quarterly Minimum Data Set (MDS) dated 2/16/16, indicated R35 had moderate cognitive impairment, required extensive assist with activities of daily living, showed no signs of psychosis and exhibited wandering daily. R35's Behavioral Symptoms Care Area Assessment (CAA) dated 9/10/15, indicated R35 was started on a antipsychotic to help him be more accepting of help with his activity's of daily living. He is a private person and will be resistive to cares, especially toileting.					
	regimen review form recommendation for clinical rationale for	narmacist monthly medication m indicated on 12/21/15, a or the documentation of a the continued use of the opriate, consider reducing this				
		o.m. R35 was observed quietly s wheelchair towards the rea.				
		a.m. R35 was observed seated ining room eating his				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		00414	B. WING		05/0	5/2016
TWIN VALLEY LIVING CENTER 208 OPPE				STATE, ZIP CODE NUE NORTHWEST, PO BOX 480 5584		
(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
21535	Continued From pa	ge 18	21535			
	breakfast independ	ently.				
	On 5/4/16, at 12:33 p.m. LPN-B stated R35 was just resistive to cares at times, did not have any hallucinations, and no psychotic behaviors.					
	On 5/4/16, at 11:30 a.m. RN-A verified antipsychotic medications should have an appropriate diagnosis and dose reductions were to be done, however, the physician does not always want to do that.					
	On 5/4/16, at 11:38 a.m. the director of nursing (DON) verified psychotropic medications should have an appropriate diagnosis and Seroquel requires a psychotic diagnosis, and dose reductions should be attempted. The DON verified being resistive to cares was not an appropriate indication for the use of antipsychotic medications. The DON stated she would look into R35's medication use.					
	newly obtained phy directed staff to dis-	p.m. the DON provided a sician order for R35 which continue the Seroquel and to OON stated this would be diately.				
	individuals who wer medications would evaluated for appro	OTROPIC DRUG cy, updated 6/1/14, indicated e prescribed psychotropic be regularly assessed and priate use. Each individuals be free from unnecessary drug				
	SUGGESTED MET	HOD OF CORRECTION:				

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		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER		IDENTIFICATION NUMBER:	A. BUILDING:		COMP	LETED
	00414		B. WING		05/0	5/2016
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
T\\/INI \/A	LLEY LIVING CENTE	208 OPPE	GARD AVE	NUE NORTHWEST, PO BOX 480		
I WIIN VA	LLET LIVING CENTE	TWIN VAL	LEY, MN 56	5584		
(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
21535	Continued From pa	ige 19	21535			
	develop and implen related to antipsych designee, could pro The quality assessi	sing (DON) or designee, could ment policies and procedures notic medications. The DON or ovide education to the staff. ment and assurance erform random audits to				
	TIME PERIOD FOR CORRECTION: Twenty-one (21) days.					
21810	MN St. Statute 144 Residents of HC Fa	.651 Subd. 6 Patients & ac.Bill of Rights	21810			
	Subd. 6. Appropriate health care. Patients and residents shall have the right to appropriate medical and personal care based on individual needs. Appropriate care for residents means care designed to enable residents to achieve their highest level of physical and mental functioning. This right is limited where the service is not reimbursable by public or private resources.					
	by: Based on observati review, the facility formedical equipment	ent is not met as evidenced ion, interview and document ailed to provide appropriate for 1 of 2 bariatric residents I specialized toileting				
	Findings include:					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '	E CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		71. 501251110.			
	00414	B. WING		05/0	05/2016
NAME OF PROVIDER OR SUPPLI			STATE, ZIP CODE		
TWIN VALLEY LIVING CEN	IFR	LEY, MN 50	NUE NORTHWEST, PO BOX 480 6584		
PREFIX (EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETE DATE
12/23/15, indical morbid obesity a (neuromuscular muscle weakness cognition, was cand required extactivities of daily Assessment (CA) was alert and or urinary tract infelhad the ability to defecate, but hat bowel. The asset the ability to transtend the size of his all independently replaced properly. R36's quarterly R36 was occast bladder. R36's undated Elindicated R36 with bladder. However incomplete, and incontinence new had any speciality to ileting needs but R36's care planshad urge incontinence.	Minimum Data Set (MDS) dated ed R36 was diagnosed with and myasthenia gravis disease that leads to fluctuating and fatigue), had intact ontinent of bowel and bladder ensive assistance with all living. R36's Urinary Care Area (A) dated 12/23/15, indicated R36 ented and had a history of ctions. The CAA indicated R36 recognize the urge to void and durgency of both bladder and essment also indicated R36 had sfer in and out of bed but due to domen he was unable to ach or see that the urinal was MDS dated 3/16/16, indicated onally incontinent of bowel and er, the assessment was a plan to assist R36 with eds had not been developed nor zed equipment to accommodate een identified. dated 12/27/15, indicated R36 nence and required assistance of the urinal and assist of 1-2 staff	21810			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
			B. WING			7.0040
		00414	b. WING		05/0	5/2016
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
I WIN VALLEY LIVING CENTER			LEY, MN 56	NUE NORTHWEST, PO BOX 480 6584		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
21810	On 5/3/16, at 10:00 bed pan and urinal however, he prefer defecate, but the coproperly. R36 state was too small to ach bottom did not fit prodefecate/urinate apthe commode "pinocomfortable. He state his concern with the Con 5/3/16, at 1:30 produced to accommode was room. On 5/4/16, at 8:40 a stated R36 utilized to	a.m. R36 stated he utilized a for his toileting needs, red to use a commode to ommode chair did not fit him ed the hole in the commode commodate his body and his roperly to allow him to opropriately. R36 also stated thed" his bottom and was not ated the staff were aware of ecommode. b.m. a bariatric shower s observed in the west unit tub a.m. nursing assistant (NA)-D a bedpan and urinal for his e stated R36 always used the ad occasionally had incontinent ated she had never assisted amode. a.m. registered nurse (RN)-B ontinent of urine because he cy and required staff to assist to f the urinal or bedpan. She ad purchased a bariatric amodate R36 prior to his er, the hole in the commode in to accommodate his physical d" him therefore he was not	21810			
		p.m. NA-F stated R36 did not because it pinched him. She				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED	
		00414	B. WING		05/0	5/2016
TWIN VALLEY LIVING CENTER 208 OPPE				STATE, ZIP CODE NUE NORTHWEST, PO BOX 480 5584		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
21810	stated R36 directed the bedpan or the u	staff when he needed to use rinal. o.m. RN-B confirmed R36's	21810			
	completed. She ve concerns with the c however, the facility the commode to ac	assessment had not been rified R36 had expressed urrent bariatric commode, rhad not attempted to adapt commodate his needs nor had not to find an alternative o utilize.				
	On 5/4/16, at 1:10 p.m. the administrator verified R36's bowel and bladder assessment had not been completed as directed. She stated prior to R36 being admitted into the facility, a bariatric commode was purchased but she had not been made aware of the commode pinching R36 or his concerns until 5/4/16. The administrator stated she had placed an order for a second bariatric commode in an attempt to assist R36 with his toileting needs.					
	policy directed the state the pertinent inform	sment and Management staff to periodically evaluate ation related to a resident and assist the resident in				
	Needs policy indica and staff were to as	y of Life - Accommodation of ted the facility's enjoinment sist the resident in maintain dependent functioning, dignity				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				SURVEY LETED		
		00414	B. WING		05/0	5/2016
NAME OF				27ATE 7/D 00DE	03/0	5/2010
	PROVIDER OR SUPPLIER	208 OPPE		STATE, ZIP CODE NUE NORTHWEST, PO BOX 480		
TWIN V	ALLEY LIVING CENTE	K	LEY, MN 56			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
21810	Continued From pa	ge 23	21810			
	SUGGESTED MET The director of nurs develop and implen related to the accor The DON or design all nursing staff rela understand the nee assessment and as perform random au	THOD OF CORRECTION: sing (DON) or designee, could nent policies and procedures nmodation of the residents. ee, could provide training for ted to ensuring the staff ds of the resident. The quality surance committee could dits to ensure compliance. R CORRECTION: Twenty-one				

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