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.
(L1) **245419**
2.STATE VENDOR OR MEDICAID NO.
(L2) **546242800**

3. NAME AND ADDRESS OF FACILITY
(L3) **TWIN VALLEY LIVING CENTER**
(L4) **208 OPPEGARD AVENUE NORTHWEST, PO BOX 480**
(L5) **TWIN VALLEY, MN** (L6) **56584**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **05/05/2016** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY **02** (L7)

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

12.Total Facility Beds **58** (L18)
13.Total Certified Beds **58** (L17)

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

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

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

* Code: **A** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	58			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Rebecca Haberly, HFE NEII 06/23/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath, Enforcement Specialist 08/09/2016 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
02/01/1987
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal
INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
06/24/2016
(L33)

DETERMINATION APPROVAL

MDH
Minnesota Department of Health

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 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

MDH
Minnesota Department of Health

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

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
245419 Y1	A. Building 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).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0221	Correction	ID Prefix F0246	Correction	ID Prefix F0309	Correction
Reg. # 483.13(a)	Completed	Reg. # 483.15(e)(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(l)	Completed	Reg. # 483.35(i)	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	

REVIEWED BY STATE AGENCY	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
[X]	LB/mm	07/13/2016	33562	06/24/2016
REVIEWED BY CMS RO [ ]	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

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
245419 Y1	A. Building 01 - MAIN BUILDING 01 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).

ITEM 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 101	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 101	Completed	Reg. #	Completed
LSC K0067	06/16/2016	LSC K0146	05/12/2016	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	

REVIEWED BY STATE AGENCY	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
☒	TL/mm	07/15/2016	36536	06/24/2016
REVIEWED BY CMS RO ☐	**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

MDH
Minnesota Department of Health

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 Meath

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

Enclosure(s)

cc: Original - Facility
Licensing and Certification File

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
00414 Y1	A. Building 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 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).

ITEM Y4		DATE Y5	ITEM Y4		DATE Y5	ITEM Y4		DATE Y5
ID Prefix	20535	Correction	ID Prefix	20830	Correction	ID Prefix	21015	Correction
Reg. #	MN Rule 4658.0300 Subp. 5 A-D	Completed	Reg. #	MN Rule 4658.0520 Subp. 1	Completed	Reg. #	MN Rule 4658.0610 Subp. 7	Completed
LSC		06/03/2016	LSC		06/03/2016	LSC		06/03/2016
ID Prefix	21535	Correction	ID Prefix	21810	Correction	ID Prefix		Correction
Reg. #	MN Rule4658.1315 Subp.1 ABCD	Completed	Reg. #	MN St. Statute 144.651 Subd. 6	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		

REVIEWED BY STATE AGENCY	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
☒	LB/mm	07/15/2016	33562	06/24/2016
REVIEWED BY CMS RO ☐	**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

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.
(L1) **245419**

2.STATE VENDOR OR MEDICAID NO.
(L2) **546242800**

3. NAME AND ADDRESS OF FACILITY
(L3) **TWIN VALLEY LIVING CENTER**
(L4) **208 OPPEGARD AVENUE NORTHWEST, PO BOX 480**
(L5) **TWIN VALLEY, MN** (L6) **56584**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **05/05/2016** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

12.Total Facility Beds **58** (L18)

13.Total Certified Beds **58** (L17)

10.THE FACILITY IS CERTIFIED AS:

A. In Compliance With Program Requirements Compliance Based On:
___1. Acceptable POC

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	58			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Rebecca, Haberle, HFE NEII 06/16/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath, Enforcement Specialist 06/24/2016 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
02/01/1987
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal
INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

MDH
Minnesota Department of Health

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:

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

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

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

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

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

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

DEPARTMENT CONTACT

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

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

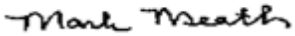
Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245419	A. BUILDING _____ B. WING _____	05/05/2016

RECEIVED
JUN 08 2016
Minnesota Department of Health
Regulation

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. Upon receipt of an acceptable POC an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 221 SS=D	483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure a physical restraint device (lap buddy) was properly applied and used for the least amount of time for 1 of 1 resident (R30) observed to utilize a lap buddy without ability to independently release. Findings include: R30's diagnosis list dated 10/25/12, identified R30's diagnoses as seizures, depression, Alzheimer's disease and myoclonus (a brief	F 221	F 221: Nursing The Twin Valley Living Center must ensure the resident's right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptom. Based on observation, interview and document review, the facility failed to ensure a physical restraint device (lap buddy) was properly applied and used for the least amount of time for 1 of 1 resident (R30) observed to utilize a lap buddy without ability to independently release. approved LB. 06/10/16	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Dani Johnson, Executive Director		6/3/16

/ 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 '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 gram participation.

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F 221	Continued From page 1 involuntary twitching of a muscle or group of muscles). R30's quarterly Minimum Data Set (MDS) dated 3/29/16, indicated R30 had severe cognitive impairment; required extensive assist with transferring, dressing, eating, and toileting; and daily utilization of a trunk restraint. R30's Physical Restraint Care Area Assessment (CAA) dated 3/29/16, indicated R30 utilized a lap buddy (a thick cushion that fits over a resident's lap and secured to the armrests of the wheelchair, which can restrict the residents' ability to remove themselves from the wheelchair) restraint more than daily. The CAA indicated R30 was able to remove the lap buddy and R30 used the restraint as a table. In addition, R30 was impulsive and the lap buddy was there to remind R30 to not stand without being assisted. The CAA also indicated R30 had jerking spells which increased R30's risk for falls and the reason for the lap buddy. R30's Physician Orders dated 5/22/13, indicated an order for R30 to have a restraint - a lap buddy as needed when up in a wheelchair to enhance R30's physical safety. R30's care plan dated 5/21/15, indicated R30 had a potential for falls, utilized a lap buddy and directed staff to assess R30 for restraint use. In addition, the care plan indicated R30 liked to have the lap buddy in place and was utilized like a lap tray and that R30 knew how to apply and remove	F 221	Resident # 30's lap buddy was removed and discarded due to improper fit with her wheelchair. It was replaced with a new "Skil-Care" lap buddy which fits appropriately. Manufacturer's directions for proper positioning of the lap buddy cushion was added to the policy book. "Use of Restraint" policy was updated to include specific directions for minimizing use of physical restraints, and was reviewed with the Quality Assurance team on 05/26/2016. All nursing staff were educated on the proper application of the lap buddy restraint and informed that no medical device can be applied in any manner other than for which it was intended. All nursing staff were educated on the importance of releasing physical restraints in order to allow for normal access to one's body.	

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F 221	Continued From page 2 the lap buddy. R30's Monitoring of Assistive Devices/Restraints for the observation period of 3/15/16 - 3/18/16, indicated whenever R30 was up in her wheelchair the lap buddy had been applied. On 5/2/16, at 5:09 p.m. R30 was observed in the dining room, seated in a wheelchair being assisted to eat by trained medication aide (TMA)-A. A lap buddy was secured to the front of R30's wheelchair. The lap buddy was positioned with the cut out sides of the lap buddy securely placed around the arm rests of the wheelchair with the straight side of the lap buddy tight up against R30's abdomen and the contoured portion of the lap buddy positioned facing outward (on backwards). R30's lap buddy remained in place throughout the entire time R30 was being fed by TMA-A. On 5/2/16, at 5:25 p.m. TMA-B stated R30 usually had the lap buddy off during meal times. TMA-B confirmed during the evening meal on 5/2/16, R30's lab buddy had not been removed. on 5/2/16, at 7:01 p.m. R30 was seated in her wheelchair propelling herself up and down the hallway with the lap buddy placed and positioned with the contoured portion of the restraint faced outward. On 5/3/16, at 8:27 a.m. R30 was observed seated in her wheelchair next to the dining room table.	F 221	Random audits of resident's restraint use will be conducted weekly with findings reviewed with the Quality Assurance team until compliance is met. Director of Nursing or designee will monitor for compliance. 6/3/16 Tammy Courtright Director of Nursing	4/3/14

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F 221	Continued From page 3 The lap buddy was secured to the front of her wheelchair. The lap buddy was again observed secured to the arm rests with the contoured portion of the lap buddy faced outward and straight edged side tight up against R30's abdomen. On 5/3/16, at 2:52 p.m. licensed practical nurse (LPN)-A and nursing assistant (NA)-B were observed to transfer R30 from R30's bed into the wheelchair. LPN-A and NA-B secured the lap buddy with the cut out sides around the arm rests and the contoured portion of the lap buddy faced outward and the straight edged side placed tight up against R30's abdomen. On 5/4/16, at 7:03 a.m. R30 was observed seated in her wheelchair at the dining room table being fed by activity aide (AA)-B. R30's lap buddy was secured to the front of the wheelchair with the contoured portion of the lap buddy faced outwards and the straight edged side placed tight up against R30' abdomen. R30's lap buddy remained in position throughout the entire time R30 was being fed by AA-B. On 5/4/16, at 9:05 a.m. until 9:40 a.m. R30 was observed to remain seated in her wheelchair in the dining room area. During this time, R30 was engaged in activities which involved a snack, reading and a game all coordinated by AA-A. R30's lap buddy remained in place and secured inappropriately to R30's wheelchair during this activity period.	F 221		

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F 221	Continued From page 4 On 5/4/16, at 9:45 a.m. LPN-B stated R30's lap buddy was always secured to R30's wheelchair with the contoured portion of the restraint faced outwards and the straight edge portion of the restraint faced tight up to R30's abdomen. LPN-B acknowledged the lap buddy was inappropriately placed and should have been positioned with the contoured portion of the restraint faced towards R30's waist. LPN-B was unsure of how often the R30's restraint should be released, however, stated the lap buddy should be removed during meal time. On 5/4/16, at 12:20 p.m. registered nurse (RN)- A confirmed R30 used a lap buddy which was considered a restraint. RN-A confirmed the restraint should be removed during meals and during activities as long as R30 was participating. RN-A verified the majority of time when R30 was up in her wheelchair the restraint was placed. RN-A stated the expectation was that the lap buddy would be secured appropriately. On 5/4/16, at 12:58 p.m. the director of nursing (DON) confirmed R30's lap buddy was considered a restraint and that R30 had utilized the lap buddy off and on since 2013. The DON verified R30's lap buddy should have been removed when R30 was in view of other staff, during meal time, and when R30 was with an activity group. In addition, DON confirmed the lap buddy should have been applied correctly. On 5/4/16, at 1:34 p.m. The DON confirmed R30's lap buddy was incorrectly applied and stated R30's lap buddy was old and staff were	F 221		

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F 221	Continued From page 5 unable to find the manufacture guidelines. The Skil-Care lap top cushions application directions directed staff to position the lap buddy with the straight edged side faced away from the resident and the contoured side positioned at the resident's waist. Restraint Policy [undated] indicated residents would be kept as restraint free as possible. If a restraint was warranted, the least restrictive restraint would be utilized. Restraint/Supportive Device Assessment Policy dated 5/12/03, indicated restraint devices would be assessed at least quarterly to determine its continued usefulness.	F 221		
F 246 SS=D	483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide appropriate medical equipment for 1 of 2 bariatric residents (R36) who required specialized toileting	F 246	F 246: Nursing The Twin Valley Living Center must ensure that each resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered.	

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F 246	Continued From page 6 equipment. Findings include: R36's admission Minimum Data Set (MDS) dated 12/23/15, indicated R36 was diagnosed with morbid obesity and myasthenia gravis (neuromuscular disease that leads to fluctuating muscle weakness and fatigue), had intact cognition, was continent of bowel and bladder and required extensive assistance with all activities of daily living. R36's Urinary Care Area Assessment (CAA) dated 12/23/15, indicated R36 was alert and oriented and had a history of urinary tract infections. The CAA indicated R36 had the ability to recognize the urge to void and defecate, but had urgency of both bladder and bowel. The assessment also indicated R36 had the ability to transfer in and out of bed but due to the size of his abdomen he was unable to independently reach or see that the urinal was placed properly. R36's quarterly MDS dated 3/16/16, indicated R36 was occasionally incontinent of bowel and bladder. R36's undated Bowel and Bladder assessment indicated R36 was incontinent of bowel and bladder. However, the assessment was incomplete, and a plan to assist R36 with incontinence needs had not been developed nor had any specialized equipment to accommodate toileting needs been identified.	F 246	Based on observation, interview and document review, the facility failed to 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 reluctant to try it citing various reasons why he could not or did not want to get up. Staff had been encouraging him to try the new commode since it arrived. On 05/27/16 R36 did agree to try the new commode. He stated he did not like it because it was uncomfortable and that he could not sit back far enough. It was also noted that his feet did not touch the floor. On 05/31/16 an Occupational Therapy order was obtained to evaluate toileting needs and equipment. He was assessed on that day and OT continues to work on accommodating his toileting needs.	

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F 246	Continued From page 7 R36's care plan dated 12/27/15, indicated R36 had urge incontinence and required assistance of one staff to utilize the urinal and assist of 1-2 staff to utilized the bedpan. On 5/3/16, at 10:00 a.m. R36 stated he utilized a bed pan and urinal for his toileting needs, however, he preferred to use a commode to defecate, but the commode chair did not fit him properly. R36 stated the hole in the commode was too small to accommodate his body and his bottom did not fit properly to allow him to defecate/urinate appropriately. R36 also stated the commode "pinched" his bottom and was not comfortable. He stated the staff were aware of his concern with the commode. On 5/3/16, at 1:30 p.m. a bariatric shower chair/commode was observed in the west unit tub room. On 5/4/16, at 8:40 a.m. nursing assistant (NA)-D stated R36 utilized a bedpan and urinal for his toileting needs. She stated R36 always used the urinal or bedpan and occasionally had incontinent episodes. NA-D stated she had never assisted R36 to use the commode. On 5/4/16, at 11:40 a.m. registered nurse (RN)-B stated R36 was incontinent of urine because he experienced urgency and required staff to assist him with placement of the urinal or bedpan. She stated the facility had purchased a bariatric commode to accommodate R36 prior to his	F 246	On 06/01/16 the Social Worker contacted the Ombudsman for further guidance. A new Volaro hoyer lift (700# capacity) was also ordered (arrived 5/11/16), along with a "sit to stand" lift (600# capacity – currently on back order and scheduled to arrive the week of 06/06/16) in the event a mechanical lift is required for R36. All nursing staff were educated on the importance of reporting resident complaints to the Director of Nursing or Administrator so that accommodations can be made to meet the resident's needs. Nursing staff will continue to work with Occupational Therapy to meet R36's toileting needs. Recommendations will be brought to the attention of the Administrator and the Quality Assurance team as indicated until compliance is met. Director of Nursing or designee will monitor for compliance. 06/03/16 Tammy Courtright Director of Nursing	4/3/16

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F 246	Continued From page 8 admission, however, the hole in the commode was not big enough to accommodate his physical needs as it "pinched" him therefore he was not utilizing it. On 5/4/16, at 12:50 p.m. NA-F stated R36 did not use the commode because it pinched him. She stated R36 directed staff when he needed to use the bedpan or the urinal. On 5/4/16, at 1:05 p.m. RN-B confirmed R36's bowel and bladder assessment had not been completed. She verified R36 had expressed concerns with the current bariatric commode, however, the facility had not attempted to adapt the commode to accommodate his needs nor had they made an attempt to find an alternative commode for R36 to 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. The undated Urinary Continence and Incontinence Assessment and Management policy directed the staff to periodically evaluate the pertinent information related to a resident urinary incontinence and assist the resident in	F 246		

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F 246	Continued From page 9 maintain continence. The The undated Quality of Life - Accommodation of Needs policy indicated the facility's enjoinment and staff were to assist the resident in maintain and/or achieving independent functioning, dignity and well-being.	F 246		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide appropriate monitoring for 1 of 1 resident (R41) who displayed low blood glucose levels. Findings include: R41's diagnosis list dated 6/7/13, indicated R41's diagnoses included diabetes, dementia and coronary artery disease. R41's quarterly Minimum Data Set (MDS) dated 4/28/16, indicated R41 had severe cognitive	F309	F 309: Nursing The Twin Valley Living Center must ensure that each resident receives and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Based on observation, interview and document review, the facility failed to provide appropriate monitoring for 1 of 1 resident (R41) who displayed low blood glucose levels.	

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F 309	Continued From page 10 impairment and received daily insulin injections. R41's Physician Orders dated 4/28/16, directed staff to administer the following medications for R41's diabetes: -Novolog (insulin) 60 units subcutaneously (SQ - injection into the subcutaneous tissue) with breakfast (hold if doesn't eat) -Novolog 50 units SQ with noon meal (hold if doesn't eat) -Novolog 40 units SQ with evening meal (hold if doesn't eat) -Lantus (insulin) 80 units SQ every morning (8:00 a.m.) -Lantus 60 units SQ every evening (8:00 p.m.) In addition, staff were directed to check R41's blood glucose levels four times a day. On 5/3/16, at 3:40 p.m. licensed practical nurse (LPN)-A and nursing assistant (NA)-B were observed to assist R41 from her room into the dining room. LPN-A and NA-B were on each side of R41 as R41 used her front wheeled walker and ambulated into the dining area. On 5/4/16, at 9:12 a.m. NA-E entered R41's room and encouraged R41 to come out to the dining room for a cookie. NA-E placed a gait belt around R41's waist and placed the walker in front of R41. With minimal assist, R41 stood up and grabbed the walker. NA-E guided R41 out of her room and into the dining area. R41's care plan dated 6/22/13, indicated R41 had a potential for hyperglycemia (high glucose	F 309	A "Nursing Care of the Resident with Diabetes Mellitus" policy was developed with specific guidelines for the intervention of low blood glucose levels, elevated blood glucose levels, when to recheck blood glucose levels and when to contact the physician. This policy was reviewed by the Quality Assurance team on 05/26/16. Resident R41's EMAR was adjusted to include: "Recheck inhouse glucose reading if blood sugar is <70, or >110 with signs/symptoms of hyperglycemia", with the availability of additional space for rechecks. The RN/LPN's were educated on the contents of the new "Nursing Care of the Resident with Diabetes Mellitus" policy along with the	

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	245419	A. BUILDING _____ B. WING _____	05/05/2016

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TWIN VALLEY LIVING CENTER	208 OPPEGARD AVENUE NORTHWEST, PO BOX 480 TWIN VALLEY, MN 56584

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F 309	Continued From page 11 levels) related to R41's diagnosis of diabetes. The care plan directed staff to administer medications as ordered, check blood sugars as ordered and when needed, hold insulin if R41 was not eating meals. The plan also indicated R41 received a regular diet with diabetic features and directed staff to monitor for signs and symptoms of diabetic reaction. R41's A1c (blood test which indicated how well blood glucose levels had been controlled over the past 2-3 months) dated 3/30/16, indicated an elevated A1c of 6.5 (reference range 4.2-6). On 5/5/16, at 10:14 a.m. registered nurse (RN)-A confirmed R41's blood glucose readings listed below for the last 30 days and that the medical record lacked documentation of a recheck on any of these low blood glucose readings: -4/5/16, at 6:00 a.m. blood glucose (BG) result = 52 milligrams per deciliter (mg/dL) -4/6/16, at 6:00 a.m. BG result = 70 mg/dL -4/7/16, at 6:00 a.m. BG result = 56 mg/dL -4/9/16, at 6:00 a.m. BG result = 66 mg/dL and at 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 at 8:00 p.m. result = 49 mg/dL	F 309	importance of follow up blood glucose checks for any blood glucose level 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 until compliance is met. Director of Nursing or designee will monitor for compliance 06/03/16 Tammy Courtright Director of Nursing	6/3/16

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F 309	Continued From page 12 -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 = 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 = 60-177 mg/dL -Bedtime 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. On 5/5/16, at 10:02 a.m. RN-A confirmed R41's blood sugar's fluctuated. RN-A stated the expectation for staff was if R41 had a low blood sugar reading, the staff should give R41 a snack or some fluids and then recheck the blood sugar and this should be documented. RN-A was unable to confirm the last time R41's insulin orders had been adjusted. On 5/5/16, at 11:00 a.m. the director of nursing (DON) verified a low blood sugar would be any	F 309		

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F 309	Continued From page 13 value under the normal range of 80-140 mg/dL. The DON confirmed when a low blood sugar was identified a snack should be provided to the resident and then the blood sugar level should be rechecked and result documented. The DON confirmed the facility did not have a policy on diabetes management.	F 309		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs 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 antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by:	F 32[illegible]	F 329: Nursing The Twin Valley Living Center must ensure each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.	

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F 329	Continued From page 14 Based on observation, interview and document review the facility failed to ensure the appropriate justification for the use of an antipsychotic was identified for 2 of 2 residents (R45, R35) who received a routine dose of Seroquel. In addition, the facility failed to ensure a tapering dose reduction of an antipsychotic was attempted or contraindications of the reduction documented for 2 of 2 residents (R45, R35) who had received a daily antipsychotic (Seroquel) without a trial dose reduction attempted. Findings Include: R45 was routinely administered Seroquel (antipsychotic) without appropriate diagnoses. In addition, a trial dose reduction was not attempted or contraindications documented prior to the adminsitration of the Seroquel (antipsychotic). R45's quarterly Minimum Data Set (MDS) dated 2/23/16, indicated R45 had moderate cognitive impairment, required extensive assist with activities of daily living, showed no signs of hallucinations or delusions and exhibited wandering daily. R45's Behavioral Symptoms Care Area Assessment (CAA) dated 9/15/15, indicated R45 has had behaviors of agitation, the physician ordered the Seroquel for agitation as the resident becomes acclimated to the secured unit, the doses will be adjusted as able with attempt to discontinue. R45's consultant pharmacist monthly medication regimen review form indicated a recommendation dated 12/21/15, and again on 3/29/16, for	F 329	Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs 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 antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. Based on observation, interview and document review the facility failed to ensure the appropriate justification for the use of an antipsychotic was identified for 2 of 2 residents (R45, R35) who received	

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F 329	Continued From page 15 documentation for the clinical rationale to continue the use of Seroquel or if appropriate consider reducing the dosage of this medication. However, the facility failed to act on these recommendations. 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. 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. On 5/4/16, at 11:30 a.m. registered nurse (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 required a psychotic diagnosis, and dose	F 329	a routine dose of Seroquel. In addition, the facility failed to ensure a tapering dose reduction of an antipsychotic was attempted or contraindications of the reduction documented for 2 of 2 residents (R45, R35) who had received a daily antipsychotic (Seroquel) without a trial dose reduction attempted. Resident #45's antipsychotic medication (Seroquel) was reviewed with her primary care physician on 05/04/2016, noting current diagnosis for the use of the Seroquel. The physician added the diagnosis of "psychosis" for her Seroquel and decreased the dosage to 25mg daily. The order was changed at that time. Resident #35's antipsychotic medication (Seroquel) was reviewed with his primary care physician on 05/04/2016, noting current diagnosis for the use of the Seroquel. The physician ordered that the Seroquel be discontinued and staff to continue to monitor. The order was changed at that time.	

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F 329	Continued From page 16 reductions should have been attempted. The DON stated she would look into this. On 5/4/16, at 12:55 p.m. the DON provided a newly obtained physician order for R45 which indicated the diagnosis for R45's Seroquel was psychosis and to reduce the Seroquel from 50 mg to 25 mg daily. The DON stated this would be implemented immediately. R35 was routinely administered Seroquel without appropriate diagnoses. In addition, a trial dose reduction was not attempted or contraindications documented prior to the adminsitration of the Seroquel. R35's current physician order dated 5/3/16, identified diagnosis of depression and dementia and indicated Seroquel 25 mg daily was started 7/30/15, for the diagnosis of dementia. 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. R35's consultant pharmacist monthly medication regimen review form indicated on 12/21/15, a	F 329	An "Antipsychotic Medication Use" policy was developed that includes appropriate diagnosis for the use of antipsychotic medications along with monitoring schedules and gradual dose reduction trials. This policy was reviewed by the Quality Assurance team on 05/26/2016. The licensed nursing staff were educated on the importance of keeping residents free from	

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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 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. On 5/4/16, at 12:55 p.m. the DON provided a newly obtained physician order for R35 which	F 329	unnecessary medications and 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. 06/03/2016 Tammy Courtright Director of Nursing	6/3/16

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F 329	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.	F 329		
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to maintain the East Day Room microwave in a clean and sanitary condition and failed to ensure resident food items in the East Day Room refrigerator were labeled and dated. This had the potential of affect 41 residents who utilized these areas. Findings include:	F 371	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. Based on observation, interview and document review, the facility failed to maintain the East Day Room microwave in a clean and sanitary condition and failed to ensure resident food items in the East Day Room refrigerator were labeled and dated. This had the potential to affect 41 residents who utilized these areas.	

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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 food particles adhered to all 4 surfaces of the 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. On 5/5/16, at 9:48 a.m. nursing assistant (NA)-C stated the cleaning of the kitchenette was the responsibility of the night shift staff. NA-C indicated they had list of night shift duties posted 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. On 5/5/16, at 9:55 a.m. the director of nursing (DON) confirmed items in the refrigerator should have been labeled and dated and the microwave	F 371	The East Day Room facility kitchenette was cleaned on 05/05/16 which included the microwave and the refrigerator. All unlabeled, undated food items were discarded. A note was placed on the East Day Room refrigerator informing staff, residents and family, "All food items placed in this refrigerator must be covered and labeled with the resident's name and dated. Please note that any, unlabeled, uncovered and outdated food items (after 3 days from the date on the container) will be discarded". This information was also placed in the Lutheran Homes June flyer which is mailed out to family members and significant others. An envelope holding a roll of tape and a marker were placed on the refrigerator for ease in labeling food items. A note was placed on the microwave, "Please cover food items with wax paper when heating. Everyone using this microwave is responsible to wipe up all spills and	

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F 371	Continued From page 20 should have been cleaned. The DON indicated she did not have a policy regarding the cleaning of facility kitchenettes.	F 371	splatters immediately". A roll of wax paper was provided for use. A policy: "Kitchenette Cleaning and Temperature Monitoring" was developed which includes directions for cleaning which will be done by the dietary staff weekly and prn. This policy was reviewed with the Quality Assurance team on 05/26/2016. The nursing staff was educated on 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 will monitor for compliance. 06/03/2016 Tammy Courtright Director of Nursing	6/3/16

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

F5419025

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

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K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN 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 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: HEALTH CARE FIRE INSPECTIONS STATE FIRE MARSHAL DIVISION 444 CEDAR STREET, SUITE 145 ST. PAUL, MN 55101-5145, or By e-mail to:	K 000	APPROVED Thomas Linhoff By Tom Linhoff at 3:07 pm, Jun 16, 2016 Please note we just received these corrections via email from Mark Meath 6/19/16 SHS RECEIVED JUN 16 2016 MN DEPT. OF PUBLIC SAFETY STATE FIRE MARSHAL DIVISION	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Traci Schweer | TITLE: Executive Director | (X6) DATE: 6-13-16

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245419	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	05/09/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	Continued From page 1 Marian.Whitney@state.mn.us and Angela.Kappenman@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency Twin Valley Living Center is a 1-story building without a basement. The building was constructed at six different times. The original building was constructed in 1965 and was determined to be of Type II(111) construction. In 1969, a dining room addition was constructed to the south of the building that was determined to be of Type II(000) construction. In 1975 additions to the dining room and a activates were constructed and was determined to be Type II (000) constitution. In 1981, a sleeping room addition was constructed on the east side of the facility that was determined to be of Type V(111) construction. In 1992, a dayroom was added to the north of the 1965 building that is of Type II(111) construction. In 1995, a small dining room addition was added to the east side of the north wing of the 1965 building that is of Type II(111) construction. The latest addition was an administration wing in 1996 to the south of the 1981 addition, which is of Type V(111)	K 000		

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K 000	Continued From page 2 construction. The building is divided into 9 smoke zones. The building is fully sprinklered throughout in accordance with NFPA 13 Standard for the Installation of Sprinkler Systems 1999 edition . The facility has a fire alarm system with smoke detection at smoke barrier doors and in spaces open to the corridors that is monitored for automatic fire department notification in accordance with NFPA 72 "The National Fire Alarm Code" 1999 edition with single station smoke detection in all resident sleeping rooms Other hazardous areas have automatic fire detection that is on the fire alarm system in accordance with the Minnesota State Fire Code 2007 edition. The facility has a capacity of 58 beds and had a census of 54 at the time of the survey. Because the original building and its additions meet the construction type allowed for existing buildings, this facility was surveyed as a single building. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 018 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas shall be substantial doors, such as those constructed of 13/4 inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Clearance between bottom of door and floor covering is not exceeding 1 inch. Doors in fully sprinklered smoke compartments are only	K 018	The door in room 717 was oiled, repaired to be in good working order that latched, this was completed 5/11/2016. The maintenance department checked all doors in the building to ensure proper working order. The Maintenance Director will do random audits to ensure compliance.	5/11/16

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	245419	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**05/09/2016**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 018	Continued From page 3 required to resist the passage of smoke. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Doors shall be provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.2.3.2.1. Roller latches are prohibited by CMS regulations in all health care facilities. 19.3.6.3 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain the smoke resistance of 1 corridor door according to NFPA 101 LSC (00) section 19.3.6.3.1. This deficient practice could affect the safety of 11 of the 54 residents and an undetermined amount of staff and visitors, if smoke from a fire were allowed to enter the exit access corridors making it untenable. Findings include: On the facility tour between 8:45 am to 12:30 pm on 05/09/2016 observation and staff interview revealed resident room 717 would not latch. This deficient condition was verified by the Maintenance Director	K 018		
K 038 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1 This STANDARD is not met as evidenced by: Based on observation and staff interview the facility failed to maintain 1 exits in accordance	K 038	The North exit by the Physical Therapy entrance was filled in with concrete on the slope to make an even walking surface. The Maintenance Director or his designee with monitor this area to ensure compliance.	4/10/16

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K 038	Continued From page 4 with the egress requirements of NFPA 101 Life Safety Code (00) section 7.2.1.3, floor level. This deficient practice could affect the safe and efficient exiting of 13 of the 54 residents, staff and visitors. Findings include: On the facility tour between 8:45 am to 12:30 pm on 05/09/2016 observation and staff interview revealed the exit next to the North physical therapy room has an uneven walking surface that exceeds the height difference before a ramp or bevel is needed. This deficient condition was verified by the Maintenance Director	K 038		
K 051 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system is installed with systems and components approved for the purpose in accordance with NFPA 70, National Electric Code and NFPA 72, National Fire Alarm Code to provide effective warning of fire in any part of the building. Fire alarm system wiring or other transmission paths are monitored for integrity. Initiation of the fire alarm system is by manual means and by any required sprinkler system alarm, detection device, or detection system. Manual alarm boxes are provided in the path of egress near each required exit. Manual alarm boxes in patient sleeping areas shall not be required at exits if manual alarm boxes are located at all nurse's stations. Occupant notification is provided by audible and visual signals. In critical care areas, visual alarms are sufficient. The fire alarm system transmits the	K 051	Protection Systems will be here June 22nd to change smoke detectors to ensure Twin Valley Living Center is in compliance with codes. This will be monitored by Maintenance Director to ensure compliance.	6/23/16

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	245419	A. BUILDING 01 - MAIN BUILDING 01 B. WING	05/09/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 051	Continued From page 5 alarm automatically to notify emergency forces in the event of fire. The fire alarm automatically activates required control functions. System records are maintained and readily available. 18.3.4, 19.3.4, 9.6 This STANDARD is not met as evidenced by: Based on observations and staff interview the facility failed to install the smoke detection in accordance with NFPA 101 Life Safety Code (00) section 19.3.4.2, 9.6.1.4 and NFPA 72 National Fire Alarm Code (99) section 2-3.6.6.2. This deficient practice could affect the ability of the alarm system to sound in a timely manner during a fire event which could affect all of the 54 residents and an undetermined amount of staff and visitors. Findings include: On the facility tour between 8:45 am to 12:30 pm on 05/09/2016 observation and staff interview revealed the corridor smoke detectors in all the resident room wings exceeds 30 feet apart. This deficient condition was verified by the Maintenance Director.	K 051		
K 067 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Heating, ventilating, and air conditioning comply with the provisions of section 9.2 and are installed in accordance with the manufacturer's specifications. 19.5.2.1, 9.2, NFPA 90A, 19.5.2.2 This STANDARD is not met as evidenced by: Based on record review and staff interview it was revealed that the facility failed to provide documentation of the fire damper testing in	K 067	Protection Systems will be here June 15th to test fire dampers complete with documentation. The director of Maintenance will monitor yearly to ensure compliance and that Twin Valley Living Center does not exceed the 4 year limit.	4/16/16

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K 067	Continued From page 6 accordance with NFPA 101 (00) 9.3.1. This deficient practice could allow smoke to enter into another compartment causing the smoke barrier to be ineffective in a fire event and could negatively effect all 54residents and an undetermined amount of staff and visitors. Findings Include: On the facility tour between 8:45 am to 12:30 pm on 05/09/2016 record review and staff interview revealed the fire/smoke dampers exceeded the maximum 4 year testing interval. They were last tested on 6/12/2010. The deficient practice was observed by the Maintenance Director.	K 067		
K 146 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD The nursing home/hospice with no life support equipment shall have an alternate source of power separate and independent from the normal source that will be effective for minimum of 1 1/2 hour after loss of the normal source 3-6. (NFPA 99) This STANDARD is not met as evidenced by: Based on record review and staff interview the facility failed to obtain a letter of reliability from the natural gas supplier that ensures uninterupted service to the generator in case of an emergency according to NFPA 110 (99) This deficient practice could affect the care and safety of all 54 residents and an undetermined amount of staff and visitors. On the facility tour between 8:45 am to 12:30 pm	K 146	Twin Valley Living Center obtained a letter of reliability was obtained from Community CO-Ops of Lake Park on 5/12/2016, see enclosed.	5/12/16

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

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K 146	Continued From page 7 on 05/09/2016 record review and staff interview revealed there was no letter of reliability from the gas company for the natural gas generator. The deficient practice was observed by the Maintenance Director.	K 146		

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

COMMUNITY CO-OP

Detroit Lakes • Lake Park • Mahnomen
Twin Valley • Flom

Mahnomen Office
201 S. Railway St.
P.O. Box 398
Mahnomen, 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

David Blomseth
General Manager
Community Co-ops of Lake Park

MDH
Minnesota Department of Health

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 only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the deficiency within the established time frame is required. The “suggested method of correction” is for your information and assistance only.

The State licensing orders are delineated on the attached Minnesota Department of Health order form (attached). The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

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

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

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

When all orders are corrected, the order form should be signed and returned to this office at:

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)

'ATEMENT OF DEFICIENCIES ID PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00414	A. BUILDING: RECEIVED B. WING JUN 0 8 2016	05/05/2016

ME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VIN VALLEY LIVING CENTER	208 OPPEGARD AVENUE NORTHWEST, PO BOX 480 TWIN VALLEY, MN 56584

Minnesota Department of Health
Bemidji

X4) ID REFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On May 2, 3, 4, and 5, 2016, surveyors of this Department's staff visited the above provider and the following licensing orders were issued. When corrections are completed, please sign and date on the bottom of the first page in the line marked with "Laboratory Director's or Provider/Supplier Representative's signature." Make a copy of	2 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.	

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2 000	Continued From page 1 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	2 000	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 which are in violation of the state statute after the statement, "This Rule is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	
2 535	MN Rule 4658.0300 Subp. 5 A-D Use of Restraints Subp. 5. Physical restraints. At a minimum, for a resident placed in a physical restraint, a nursing home must also: A. develop a system to ensure that the restrained resident is monitored at the interval specified in the written order from the physician; B. assist the resident as often as necessary for the resident's safety, comfort, exercise, and	2 535		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00414	A. BUILDING: _____ B. WING _____	05/05/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 535	Continued From page 2 elimination needs; C. provide an opportunity for motion, exercise, and elimination for not less than ten minutes during each two-hour period in which a restraint is employed; and D. release the resident from the restraint as quickly as possible. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure a physical restraint device (lap buddy) was properly applied and used for the least amount of time for 1 of 1 resident (R30) observed to utilize a lap buddy without ability to independently release. Findings include: R30's diagnosis list dated 10/25/12, identified R30's diagnoses as seizures, depression, Alzheimer's disease and myoclonus (a brief involuntary twitching of a muscle or group of muscles). R30's quarterly Minimum Data Set (MDS) dated 3/29/16, indicated R30 had severe cognitive impairment; required extensive assist with transferring, dressing, eating, and toileting; and daily utilization of a trunk restraint. R30's Physical Restraint Care Area Assessment (CAA) dated 3/29/16, indicated R30 utilized a lap buddy (a thick cushion that fits over a resident's lap and secured to the armrests of the	2 535		

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2 535	Continued From page 3 wheelchair, which can restrict the residents' ability to remove themselves from the wheelchair) restraint more than daily. The CAA indicated R30 was able to remove the lap buddy and R30 used the restraint as a table. In addition, R30 was impulsive and the lap buddy was there to remind R30 to not stand without being assisted. The CAA also indicated R30 had jerking spells which increased R30's risk for falls and the reason for the lap buddy. R30's Physician Orders dated 5/22/13, indicated an order for R30 to have a restraint - a lap buddy as needed when up in a wheelchair to enhance R30's physical safety. R30's care plan dated 5/21/15, indicated R30 had a potential for falls, utilized a lap buddy and directed staff to assess R30 for restraint use. In addition, the care plan indicated R30 liked to have the lap buddy in place and was utilized like a lap tray and that R30 knew how to apply and remove the lap buddy. R30's Monitoring of Assistive Devices/Restraints for the observation period of 3/15/16 - 3/18/16, indicated whenever R30 was up in her wheelchair the lap buddy had been applied. On 5/2/16, at 5:09 p.m. R30 was observed in the dining room, seated in a wheelchair being assisted to eat by trained medication aide (TMA)-A. A lap buddy was secured to the front of R30's wheelchair. The lap buddy was positioned with the cut out sides of the lap buddy securely placed around the arm rests of the wheelchair	2 535		

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2 535	Continued From page 4 with the straight side of the lap buddy tight up against R30's abdomen and the contoured portion of the lap buddy positioned facing outward (on backwards). R30's lap buddy remained in place throughout the entire time R30 was being fed by TMA-A. On 5/2/16, at 5:25 p.m. TMA-B stated R30 usually had the lap buddy off during meal times. TMA-B confirmed during the evening meal on 5/2/16, R30's lab buddy had not been removed. on 5/2/16, at 7:01 p.m. R30 was seated in her wheelchair propelling herself up and down the hallway with the lap buddy placed and positioned with the contoured portion of the restraint faced outward. On 5/3/16, at 8:27 a.m. R30 was observed seated in her wheelchair next to the dining room table. The lap buddy was secured to the front of her wheelchair. The lap buddy was again observed secured to the arm rests with the contoured portion of the lap buddy faced outward and straight edged side tight up against R30's abdomen. On 5/3/16, at 2:52 p.m. licensed practical nurse (LPN)-A and nursing assistant (NA)-B were observed to transfer R30 from R30's bed into the wheelchair. LPN-A and NA-B secured the lap buddy with the cut out sides around the arm rests and the contoured portion of the lap buddy faced outward and the straight edged side placed tight up against R30's abdomen.	2 535		

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2 535	Continued From page 5 On 5/4/16, at 7:03 a.m. R30 was observed seated in her wheelchair at the dining room table being fed by activity aide (AA)-B. R30's lap buddy was secured to the front of the wheelchair with the contoured portion of the lap buddy faced outwards and the straight edged side placed tight up against R30' abdomen. R30's lap buddy remained in position throughout the entire time R30 was being fed by AA-B. On 5/4/16, at 9:05 a.m. until 9:40 a.m. R30 was observed to remain seated in her wheelchair in the dining room area. During this time, R30 was engaged in activities which involved a snack, reading and a game all coordinated by AA-A. R30's lap buddy remained in place and secured inappropriately to R30's wheelchair during this activity period. On 5/4/16, at 9:45 a.m. LPN-B stated R30's lap buddy was always secured to R30's wheelchair with the contoured portion of the restraint faced outwards and the straight edge portion of the restraint faced tight up to R30's abdomen. LPN-B acknowledged the lap buddy was inappropriately placed and should have been positioned with the contoured portion of the restraint faced towards R30's waist. LPN-B was unsure of how often the R30's restraint should be released, however, stated the lap buddy should be removed during meal time. On 5/4/16, at 12:20 p.m. registered nurse (RN)- A confirmed R30 used a lap buddy which was considered a restraint. RN-A confirmed the restraint should be removed during meals and	2 535		

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2 535	Continued From page 6 during activities as long as R30 was participating. RN-A verified the majority of time when R30 was up in her wheelchair the restraint was placed. RN-A stated the expectation was that the lap buddy would be secured appropriately. On 5/4/16, at 12:58 p.m. the director of nursing (DON) confirmed R30's lap buddy was considered a restraint and that R30 had utilized the lap buddy off and on since 2013. The DON verified R30's lap buddy should have been removed when R30 was in view of other staff, during meal time, and when R30 was with an activity group. In addition, DON confirmed the lap buddy should have been applied correctly. On 5/4/16, at 1:34 p.m. The DON confirmed R30's lap buddy was incorrectly applied and stated R30's lap buddy was old and staff were unable to find the manufacture guidelines. The Skil-Care lap top cushions application directions directed staff to position the lap buddy with the straight edged side faced away from the resident and the contoured side positioned at the resident's waist. Restraint Policy [undated] indicated residents would be kept as restraint free as possible. If a restraint was warranted, the least restrictive restraint would be utilized. Restraint/Supportive Device Assessment Policy dated 5/12/03, indicated restraint devices would be assessed at least quarterly to determine its	2 535		

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2 535	Continued From page 7 continued usefulness. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee, could develop and implement policies and procedures related to restraints. The DON or designee, could provide training for all nursing staff related to physical restraints. The quality assessment and assurance committee could perform random audits to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 535		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide appropriate	2 830		

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2 830	Continued From page 8 monitoring for 1 of 1 resident (R41) who displayed low blood glucose levels. Findings include: R41's diagnosis list dated 6/7/13, indicated R41's diagnoses included diabetes, dementia and coronary artery disease. R41's quarterly Minimum Data Set (MDS) dated 4/28/16, indicated R41 had severe cognitive impairment and received daily insulin injections. R41's Physician Orders dated 4/28/16, directed staff to administer the following medications for R41's diabetes: -Novolog (insulin) 60 units subcutaneously (SQ - injection into the subcutaneous tissue) with breakfast (hold if doesn't eat) -Novolog 50 units SQ with noon meal (hold if doesn't eat) -Novolog 40 units SQ with evening meal (hold if doesn't eat) -Lantus (insulin) 80 units SQ every morning (8:00 a.m.) -Lantus 60 units SQ every evening (8:00 p.m.) In addition, staff were directed to check R41's blood glucose levels four times a day. On 5/3/16, at 3:40 p.m. licensed practical nurse (LPN)-A and nursing assistant (NA)-B were observed to assist R41 from her room into the dining room. LPN-A and NA-B were on each side of R41 as R41 used her front wheeled walker and ambulated into the dining area.	2 830		

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2 830	Continued From page 9 On 5/4/16, at 9:12 a.m. NA-E entered R41's room and encouraged R41 to come out to the dining room for a cookie. NA-E placed a gait belt around R41's waist and placed the walker in front of R41. With minimal assist, R41 stood up and grabbed the walker. NA-E guided R41 out of her room and into the dining area. R41's care plan dated 6/22/13, indicated R41 had a potential for hyperglycemia (high glucose levels) related to R41's diagnosis of diabetes. The care plan directed staff to administer medications as ordered, check blood sugars as ordered and when needed, hold insulin if R41 was not eating meals. The plan also indicated R41 received a regular diet with diabetic features and directed staff to monitor for signs and symptoms of diabetic reaction. R41's A1c (blood test which indicated how well blood glucose levels had been controlled over the past 2-3 months) dated 3/30/16, indicated an elevated A1c of 6.5 (reference range 4.2-6). On 5/5/16, at 10:14 a.m. registered nurse (RN)-A confirmed R41's blood glucose readings listed below for the last 30 days and that the medical record lacked documentation of a recheck on any of these low blood glucose readings: -4/5/16, at 6:00 a.m. blood glucose (BG) result = 52 milligrams per deciliter (mg/dL) -4/6/16, at 6:00 a.m. BG result = 70 mg/dL -4/7/16, at 6:00 a.m. BG result = 56 mg/dL -4/9/16, at 6:00 a.m. BG result = 66 mg/dL and at	2 830		

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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 -4/11/16, 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 at 8:00 p.m. result = 49 mg/dL -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 = 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 = 60-177 mg/dL -Bedtime 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. On 5/5/16, at 10:02 a.m. RN-A confirmed R41's	2 830		

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2 830	Continued From page 11 blood sugar's fluctuated. RN-A stated the expectation for staff was if R41 had a low blood sugar reading, the staff should give R41 a snack or some fluids and then recheck the blood sugar and this should be documented. RN-A was unable to confirm the last time R41's insulin orders had been adjusted. On 5/5/16, at 11:00 a.m. the director of nursing (DON) verified a low blood sugar would be any value under the normal range of 80-140 mg/dL. The DON confirmed when a low blood sugar was identified a snack should be provided to the resident and then the blood sugar level should be rechecked and result documented. The DON confirmed the facility did not have a policy on diabetes management. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee, could develop and implement policies and procedures related to the diabetes mellitus. The DON or designee, could provide training for all nursing staff related to ensuring the staff understand diabetes mellitus. The quality assessment and assurance committee could perform random audits to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 830		
21015	MN Rule 4658.0610 Subp. 7 Dietary Staff Requirements- Sanitary conditi Subp. 7. Sanitary conditions. Sanitary	21015		

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21015	Continued From page 12 procedures and conditions must be maintained in the operation of the dietary department at all times. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to maintain the East Day Room microwave in a clean and sanitary condition and failed to ensure resident food items in the East Day Room refrigerator were labeled and dated. This had the potential of affect 41 residents who utilized these areas. Findings include: 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 food particles adhered to all 4 surfaces of the 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. On 5/5/16, at 9:48 a.m. nursing assistant (NA)-C stated the cleaning of the kitchenette was the responsibility of the night shift staff. NA-C	21015		

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21015	Continued From page 13 indicated they had list of night shift duties posted 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. On 5/5/16, at 9:55 a.m. the director of nursing (DON) confirmed items in the refrigerator should have been labeled and dated and the microwave should have been cleaned. The DON indicated she did not have a policy regarding the cleaning of facility kitchenettes. SUGGESTED METHOD OF CORRECTION: The dietary director and/or the director of nursing (DON), could develop and implement policies and procedures related to the cleanliness of kitchenette areas outside of the main kitchen. The DON or designee could provide educations to the staff. The quality assessment and assurance committee could perform random audits to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21015		

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21535	Continued From page 14	21535		
21535	MN Rule4658.1315 Subp.1 ABCD Unnecessary Drug Usage; General Subpart 1. General. A resident's drug regimen 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 Financing Administration, April 1992. This standard is incorporated by reference. It is available through the Minitex interlibrary loan system and the State Law Library. It is not subject to frequent change. This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure the appropriate justification for the use of an antipsychotic was identified for 2 of 2 residents (R45, R35) who received a routine dose of Seroquel. In addition, the facility failed to ensure a tapering dose reduction of an antipsychotic was attempted or contraindications of the reduction documented for 2 of 2 residents (R45, R35) who had received a daily antipsychotic (Seroquel) without a trial dose	21535		

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21535	Continued From page 15 reduction attempted. Findings Include: R45 was routinely administered Seroquel (antipsychotic) without appropriate diagnoses. In addition, a trial dose reduction was not attempted or contraindications documented prior to the adminsitration of the Seroquel (antipsychotic). R45's quarterly Minimum Data Set (MDS) dated 2/23/16, indicated R45 had moderate cognitive impairment, required extensive assist with activities of daily living, showed no signs of hallucinations or delusions and exhibited wandering daily. R45's Behavioral Symptoms Care Area Assessment (CAA) dated 9/15/15, indicated R45 has had behaviors of agitation, the physician ordered the Seroquel for agitation as the resident becomes acclimated to the secured unit, the doses will be adjusted as able with attempt to discontinue. R45's consultant pharmacist monthly medication regimen review form indicated a recommendation dated 12/21/15, and again on 3/29/16, for documentation for the clinical rationale to continue the use of Seroquel or if appropriate consider reducing the dosage of this medication. However, the facility failed to act on these recommendations. 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	21535		

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21535	Continued From page 16 for Dementia with agitation 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. On 5/4/16, at 11:30 a.m. registered nurse (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 required a psychotic diagnosis, and dose reductions should have been attempted. The DON stated she would look into this. On 5/4/16, at 12:55 p.m. the DON provided a newly obtained physician order for R45 which indicated the diagnosis for R45's Seroquel was psychosis and to reduce the Seroquel from 50 mg to 25 mg daily. The DON stated this would be implemented immediately. R35 was routinely administered Seroquel without	21535		

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21535	Continued From page 17 appropriate diagnoses. In addition, a trial dose reduction was not attempted or contraindications documented prior to the adminsitration of the Seroquel. R35's current physician order dated 5/3/16, identified diagnosis of depression and dementia and indicated Seroquel 25 mg daily was started 7/30/15, for the diagnosis of dementia. 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. R35's consultant pharmacist monthly medication regimen review form indicated on 12/21/15, a 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	21535		

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21535	Continued From page 18 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 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. On 5/4/16, at 12:55 p.m. the DON provided a newly obtained physician order for R35 which 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. SUGGESTED METHOD OF CORRECTION:	21535		

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21535	Continued From page 19 The director of nursing (DON) or designee, could develop and implement policies and procedures related to antipsychotic medications. The DON or designee, could provide education to the staff . The quality assessment and assurance committee could perform random audits to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21535		
21810	MN St. Statute 144.651 Subd. 6 Patients & Residents of HC Fac.Bill of Rights 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. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide appropriate medical equipment for 1 of 2 bariatric residents (R36) who required specialized toileting equipment. Findings include:	21810		

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21810	Continued From page 20 R36's admission Minimum Data Set (MDS) dated 12/23/15, indicated R36 was diagnosed with morbid obesity and myasthenia gravis (neuromuscular disease that leads to fluctuating muscle weakness and fatigue), had intact cognition, was continent of bowel and bladder and required extensive assistance with all activities of daily living. R36's Urinary Care Area Assessment (CAA) dated 12/23/15, indicated R36 was alert and oriented and had a history of urinary tract infections. The CAA indicated R36 had the ability to recognize the urge to void and defecate, but had urgency of both bladder and bowel. The assessment also indicated R36 had the ability to transfer in and out of bed but due to the size of his abdomen he was unable to independently reach or see that the urinal was placed properly. R36's quarterly MDS dated 3/16/16, indicated R36 was occasionally incontinent of bowel and bladder. R36's undated Bowel and Bladder assessment indicated R36 was incontinent of bowel and bladder. However, the assessment was incomplete, and a plan to assist R36 with incontinence needs had not been developed nor had any specialized equipment to accommodate toileting needs been identified. R36's care plan dated 12/27/15, indicated R36 had urge incontinence and required assistance of one staff to utilize the urinal and assist of 1-2 staff to utilized the bedpan.	21810		

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21810	Continued From page 21 On 5/3/16, at 10:00 a.m. R36 stated he utilized a bed pan and urinal for his toileting needs, however, he preferred to use a commode to defecate, but the commode chair did not fit him properly. R36 stated the hole in the commode was too small to accommodate his body and his bottom did not fit properly to allow him to defecate/urinate appropriately. R36 also stated the commode "pinched" his bottom and was not comfortable. He stated the staff were aware of his concern with the commode. On 5/3/16, at 1:30 p.m. a bariatric shower chair/commode was observed in the west unit tub room. On 5/4/16, at 8:40 a.m. nursing assistant (NA)-D stated R36 utilized a bedpan and urinal for his toileting needs. She stated R36 always used the urinal or bedpan and occasionally had incontinent episodes. NA-D stated she had never assisted R36 to use the commode. On 5/4/16, at 11:40 a.m. registered nurse (RN)-B stated R36 was incontinent of urine because he experienced urgency and required staff to assist him with placement of the urinal or bedpan. She stated the facility had purchased a bariatric commode to accommodate R36 prior to his admission, however, the hole in the commode was not big enough to accommodate his physical needs as it "pinched" him therefore he was not utilizing it. On 5/4/16, at 12:50 p.m. NA-F stated R36 did not use the commode because it pinched him. She	21810		

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21810	Continued From page 22 stated R36 directed staff when he needed to use the bedpan or the urinal. On 5/4/16, at 1:05 p.m. RN-B confirmed R36's bowel and bladder assessment had not been completed. She verified R36 had expressed concerns with the current bariatric commode, however, the facility had not attempted to adapt the commode to accommodate his needs nor had they made an attempt to find an alternative commode for R36 to 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. The undated Urinary Continence and Incontinence Assessment and Management policy directed the staff to periodically evaluate the pertinent information related to a resident urinary incontinence and assist the resident in maintain continence. The The undated Quality of Life - Accommodation of Needs policy indicated the facility's enjoinment and staff were to assist the resident in maintain and/or achieving independent functioning, dignity and well-being.	21810		

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21810	Continued From page 23 SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee, could develop and implement policies and procedures related to the accommodation of the residents. The DON or designee, could provide training for all nursing staff related to ensuring the staff understand the needs of the resident. The quality assessment and assurance committee could perform random audits to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21810		