DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY	ID: VRKS Facility ID: 00286
1. MEDICARE/MEDICAID PROVIDER NO. 3. NAME AND ADDRESS OF FACILITY 4. TYPE 0 (L1) 245566 (L3) VALLEY VIEW HEALTHCARE & REHAB 1. Initial 2.STATE VENDOR OR MEDICAID NO. (L4) 510 EAST CEDAR STREET 3. Termin (L2) 844240100 (L5) HOUSTON, MN (L6) 55943 5. Valida 7. On-Si 7. On-Si	ination 4. CHOW ation 6. Complaint
5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9) 7. PROVIDER/SUPPLIER CATEGORY 02 (L7) 8. Full S 6. DATE OF SURVEY 11/04/2013 (L34) 02 SNF/NF/Dual 06 PRTF 10 NF 14 CORF 8. ACCREDITATION STATUS: (L10) 03 SNF/NF/Distinct 07 X-Ray 11 ICF/IID 15 ASC	Survey After Complaint EAR ENDING DATE: (L35) 9/30
11. LTC PERIOD OF CERTIFICATION From (a): X A. In Compliance With And/Or Approved Waivers Of The Following To (b): Program Requirements _ 2. Technical Personnel _ 6. St Compliance Based On: _ 3. 24 Hour RN _ 7. M 12. Total Facility Beds _ 45 (L18) 1. Acceptable POC _ 4. 7-Day RN (Rural SNF) _ 8. P	Requirements: Scope of Services Limit Medical Director Patient Room Size Beds/Room
14. LTC CERTIFIED BED BREAKDOWN 15. FACILITY MEETS 18 SNF 18/19 SNF 19 SNF 10 SNF	(L15) S form 2567B.
17. SURVEYOR SIGNATURE Date: 18. STATE SURVEY AGENCY APPROVAL Gary Nederhoff, Unit Supervisor 11/07/2013 Kamala Fiske-Downing, Enforcement	Date:
PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGE	(L20)
19. DETERMINATION OF ELIGIBILITY X 1. Facility is Eligible to Participate 20. COMPLIANCE WITH CIVIL RIGHTS ACT: 21. 1. Statement of Financial Solvency (22. Ownership/Control Interest Discletion in the Above in t	(HCFA-2572)
07/01/1991 (L24) (L41) (L25) 25. LTC EXTENSION DATE: 27. ALTERNATIVE SANCTIONS A. Suspension of Admissions: (L44) (L37) (L37) (L37) (L37) (L38) (L41) 01-Merger, Closure 02-Dissatisfaction W/ Reimbursement 03-Risk of Involuntary Termination 04-Other Reason for Withdrawal	(L30) INVOLUNTARY 05-Fail to Meet Health/Safety 06-Fail to Meet Agreement OTHER 07-Provider Status Change 00-Active
B. Rescind Suspension Date: (L45) 28. TERMINATION DATE: 29. INTERMEDIARY/CARRIER NO. 30. REMARKS	
03001 (L28) (L28) (L31) 31. RO RECEIPT OF CMS-1539 32. DETERMINATION OF APPROVAL DATE	

(L33)

DETERMINATION APPROVAL

09/30/2013

(L32)



Protecting, Maintaining and Improving the Health of Minnesotans

Medicare Provider # 245566

June 16, 2014

Mr.. Brian Reindl, Administrator Valley View Healthcare & Rehab 510 East Cedar Street Houston, Minnesota 55943

Dear Mr. Reindl:

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 September 7, 2013 the above facility is certified for or recommended for:

45 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 45 skilled nursing facility beds located in rooms.

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

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

Please contact me if you have any questions.

Sincerely,

Kamala Fiske-Downing, Program Specialist Licensing and Certification Program

Division of Compliance Monitoring

Kumalu Fiske Downing

Minnesota Department of Health

Telephone: (651) 201-4112 Fax: (651) 215-9697

Licensing and Certification File cc:



Protecting, Maintaining and Improving the Health of Minnesotans

November 7, 2013

Ms. Deborah Barnes, Administrator Valley View Healthcare & Rehab 510 East Cedar Street Houston, Minnesota 55943

RE: Project Number S5566024

Dear Ms. Barnes:

On August 26, 2013, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on August 15, 2013. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required.

On November 4, 2013, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on October 26, 2013 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on August 15, 2013. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of September 7, 2013. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on August 15, 2013, effective September 7, 2013 and therefore remedies outlined in our letter to you dated August 26, 2013, 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.

Sincerely,

Anne Kleppe, Program Specialist

Dire Klegge

Licensing and Certification Program **Division of Compliance Monitoring** Minnesota Department of Health

Telephone: (651) 201-4124

Fax: (651) 215-9697

Enclosure

cc: Licensing and Certification File

Form Approved OMB NO. 0938-0390

Post-Certification Revisit Report

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

(Y1)	Provider / Supplier / CLIA / Identification Number 245566	(Y2) Multiple Construction A. Building B. Wing		(Y3) Date of Revisit 11/4/2013
Name	e of Facility		Street Address, City, State, Zip Code	
VALLEY VIEW HEALTHCARE & REHAB		3	510 EAST CEDAR STREET HOUSTON, MN 55943	

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

(Y4) Item	(Y5) Date	(Y4) Item	(Y:	5) Date	(Y4)	Item	(Y5)	Date
ID Prefix	F0322	Correction Completed 09/03/2013	ID Prefix	F0425	Correction Completed 09/03/2013		ID Prefix		Correction Completed
Reg. # LSC	483.25(g)(2)	 	Reg. # LSC	483.60(a),(b)	 		Reg. #		_
ID Prefix Reg. # LSC		Correction Completed	ID Prefix Reg. # LSC		Correction Completed		ID Prefix Reg. # LSC		Correction Completed
ID Prefix Reg. # LSC		Correction Completed	Reg. #		Correction Completed		ID Prefix Reg. # LSC		Correction Completed
ID Prefix Reg. # LSC			Reg. #		Correction Completed		ID Prefix Reg. # LSC		Correction Completed
Reg. #			Reg. #				ID Prefix Reg. # LSC		
Reviewed E	CN/A	-	Date: 11/07/201	Signature of S	urveyor:		10160	Date: 11/0	04/2013
Reviewed E	By Review	red By	Date:	Signature of S	urveyor:			Date:	
Followup t	o Survey Completed 8/15/2013	on:					ies. Was a Summary 67) Sent to the Facili		NO

Form Approved OMB NO. 0938-0390

Post-Certification Revisit Report

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

(Y1)	Provider / Supplier / CLIA / Identification Number 245566	(Y2) Multiple Con A. Building B. Wing	LEY VIEW NURSING HOME	(Y3) Date of Revisit 9/26/2013
Nam	e of Facility		Street Address, City, State, Zip Code	
VA	LLEY VIEW HEALTHCARE & REHAE	3	510 EAST CEDAR STREET HOUSTON, MN 55943	

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

(Y4) Item	(Y5)) Date	(Y4) Item	(Y5)	Date	(Y4)	Item	(Y5)	Date
ID Prefix		Correction Completed 09/07/2013	ID Prefix		Correction Completed 08/19/2013		ID Prefix		Correction Completed
•	NFPA 101	-	•	NFPA 101			Reg. #		
LSC	K0045		LSC	K0050			LSC		_
		Correction Completed			Correction Completed				Correction Completed
ID Prefix		-	ID Prefix				ID Prefix		
Reg. #			Reg. #				Reg. #		
LSC			LSC				LSC		
ID Prefix		Correction Completed	ID Prefix		Correction Completed		ID Prefix		Correction Completed
Reg. #		-	Reg. #		-		D "		
ID Prefix Reg. # LSC		Correction Completed	ID Prefix		Correction Completed		ID Prefix		Correction Completed
Reg. #			Reg. #				ID Prefix Reg. # LSC		
Reviewed E	∣ PS/AK	I By	Date: 11/07/20	Signature of Sur	veyor:	25	5822	Date: 09/2	26/2013
	By Reviewed	I By	Date:	Signature of Sur	veyor:			Date:	
Followup t	o Survey Completed or 8/14/2013	n:		Check for any Unco					NO

Form Approved OMB NO. 0938-0390

Post-Certification Revisit Report

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

(Y1) Provider / Supplier / CLIA / Identification Number 245566	(Y2) Multiple Co A. Building B. Wing	1 ADDITION	(Y3) Date of Revisit 9/26/2013
Name of Facility	·	Street Address, City, State, Zip Code	
VALLEY VIEW HEALTHCAR	E & REHAB	510 EAST CEDAR STREET	
		HOUSTON MN 55943	

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

(Y4) Item	(Y:	5) Date	(Y4) Item	(Y5)	Date	(Y4)	Item	(Y 5)	Date
ID Prefix		Correction Completed 08/19/2013	ID Prefix		Correction Completed		ID Prefix			Correction Completed
	NFPA 101									_
•	K0050	_	LSC				LSC			_
ID Prefix Reg. # LSC		Correction Completed	ID Prefix Reg. # LSC		Correction Completed		ID Prefix Reg. # LSC			Correction Completed
ID Prefix Reg. # LSC		Correction Completed 	Reg. #		Correction Completed		ID Prefix Reg. # LSC			Correction Completed —
ID Prefix Reg. # LSC		Correction Completed	Reg. #		Correction Completed		ID Prefix Reg. # LSC			Correction Completed
Reg. #			Reg. #				ID Prefix Reg. # LSC			
Reviewed E	DC/AK	-	Date: 11/07/2013	Signature of Sur	veyor:		25822		Date: 09/26/	/2013
	By Reviewe	d By	Date:	Signature of Sur	veyor:				Date:	
Followup t	o Survey Completed o	n:		Check for any Uncor Uncorrected Defic					YES	NO

CENTERS FOR MEDICARE & MEDICAID SERVICES

ID: VRKS

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

PART	I - TO BE COMPLETED I	BY THE STAT	TE SURVEY AGENCY	Facility ID: 00286
MEDICARE/MEDICAID PROVIDER NO. (L1)	(L1) 245566 (L3) VALLEY VIEW HEALTHCARE & REHAB 2.STATE VENDOR OR MEDICAID NO. (L4) 510 EAST CEDAR STREET (L2) 844240100 (L5) HOUSTON, MN (L6) 55943			
5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9)	7. PROVIDER/SUPPLIER CAT 01 Hospital 05 HHA	09 ESRD	02 (L7) 13 PTIP 22 CLIA	7. On-Site Visit 9. Other 8. Full Survey After Complaint
6. DATE OF SURVEY 08/15/2013 (L34) 8. ACCREDITATION STATUS: (L10) 0 Unaccredited	02 SNF/NF/Dual 06 PRTF 03 SNF/NF/Distinct 07 X-Ray 04 SNF 08 OPT/SI	10 NF 11 ICF/IID P 12 RHC	14 CORF 15 ASC 16 HOSPICE	FISCAL YEAR ENDING DATE: (L35) 09/30
11. LTC PERIOD OF CERTIFICATION From (a): To (b): 12.Total Facility Beds 45 (L18) 13.Total Certified Beds 45 (L17)	A. In Compliance With Program Requirements Compliance Based On1. Acceptable Po X B. Not in Compliance with Requirements and/or A	o C OC n Program	And/Or Approved Waivers Of Th 2. Technical Personnel3. 24 Hour RN4. 7-Day RN (Rural SNF5. Life Safety Code * Code: B*	6. Scope of Services Limit 7. Medical Director
14. LTC CERTIFIED BED BREAKDOWN 18 SNF 18/19 SNF 19 SNF 45 (L37) (L38) (L39)		HID (43)	15. FACILITY MEETS 1861 (e) (1) or 1861 (j) (1):	(L15)
16. STATE SURVEY AGENCY REMARKS (IF APPLICAB See Attached Remarks	LE SHOW LTC CANCELLATION I	DATE):		
17. SURVEYOR SIGNATURE Robin Lewis, HFE NE II	Date : 09/23/20	13 _(L19)	Shellae Dietrich, I	Program Specialist 09/30/2013
PART II - TO B	E COMPLETED BY HCF.	A REGIONAL	OFFICE OR SINGLE ST	
DETERMINATION OF ELIGIBILITY 1. Facility is Eligible to Participate 2. Facility is not Eligible (L21)	20. COMPLIANCE V RIGHTS ACT:	VITH CIVIL	21. 1. Statement of Finan2. Ownership/Contro3. Both of the Above	l Interest Disclosure Stmt (HCFA-1513)
22. ORIGINAL DATE 23. LTC AGREED OF PARTICIPATION BEGINNING 07/01/1991 (L24) (L41)			26. TERMINATION ACTION: VOLUNTARY 00 01-Merger, Closure 02-Dissatisfaction W/ Reimburseme	05-Fail to Meet Health/Safety
25. LTC EXTENSION DATE: 27. ALTERNAT A. Suspension	IVE SANCTIONS on of Admissions: (L44) aspension Date: (L45)		03-Risk of Involuntary Termination 04-Other Reason for Withdrawal	OTHER 07-Provider Status Change 00-Active
28. TERMINATION DATE: 2 (L28)	9. INTERMEDIARY/CARRIER NO 03001	O. (L31)	30. REMARKS Posted 09/30/201	3 CO. VRKS
31. RO RECEIPT OF CMS-1539 (L32)	2. DETERMINATION OF APPROV	AL DATE (L33)	DETERMINATION APPR	OVAL

CENTERS FOR MEDICARE & MEDICAID SERVICES

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00286

C&T REMARKS - CMS 1539 FORM

STATE AGENCY REMARKS

CCN# 24-5566

At the time of the standard survey completed August 15, 2013, the facility was not in substantial compliance and the most serious deficiencies were found 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. The facility has been given an opportunity to correct before remedies are imposed. See attached CMS-2567 for survey results. Post Certification Revisit to follow.



Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7011 2000 0002 5143 5315

August 26, 2013

Ms. Deborah Barnes, Administrator Valley View Healthcare & Rehabilitation 510 East Cedar Street Houston, Minnesota 55943

RE: Project Number S5566024

Dear Ms. Barnes:

On August 15, 2013, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

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

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

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

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

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

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

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

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

DEPARTMENT CONTACT

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

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

Telephone: (507) 206-2731

Fax: (507) 206-2711

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by September 24, 2013, the Department of Health will impose the following remedy:

• State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by September 24, 2013 the following remedy will be imposed:

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

PLAN OF CORRECTION (PoC)

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

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by November 15, 2013 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement

of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by February 15, 2014 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

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

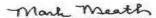
Mr. Patrick Sheehan, Supervisor Health Care Fire Inspections State Fire Marshal Division 444 Cedar Street, Suite 145 St. Paul, Minnesota 55101-5145

Telephone: (651) 201-7205

Fax: (651) 215-0541

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

Sincerely,



Mark Meath, Program Specialist Program Assurance Unit Licensing and Certification Program Division of Compliance Monitoring P.O. Box 64900

St. Paul, Minnesota 55164-0900

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

Email: mark.meath@state.mn.us

Enclosure

cc: Licensing and Certification File

5566s13.rtf

PRINTED: 08/26/2013 FORM APPROVED OMB NO. 0938-0391

		& MEDICAID SERVICES	OOM MILI	TIDI E C	ONSTRUCTION	(X3) DATE	SURVEY
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILD			13.7	PLETED
MIND I DIN O	CONTECTION	245566	B. WING		SEP 6 ~ 20	00/1	15/2013
NAME OF P	ROVIDER OR SUPPLIER				EET ADDRESS, CITY, STATE! ZIP BODE: IIII EAST CEDAR STREET		
VALLEY!	VIEW HEALTHCARE	& REHAB		30.7 00 D. C.	JSTON, MN 55943	1000	
V/LLL.		ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION)N	(X5) COMPLETION
(X4) ID PREFIX TAG	TRACH DESIGNATION	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREF TAG		(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROP DEFICIENCY)	PRIATE	DATE
F 000	INITIAL COMMEN	TS	F	000		20000	
	as your allegation Department's acces bottom of the first be used as verificate Upon receipt of an revisit of your facil	of correction (POC) will serve of compliance upon the eptance. Your signature at the page of the CMS-2567 form will ation of compliance. acceptable POC an on-site ity may be conducted to antial compliance with the					
F 322 SS=D	your verification. 483.25(g)(2) NG TRESTORE EATIN	REATMENT/SERVICES - G SKILLS Apprehensive assessment of a by must ensure that	F	322	F322 483.25(G) (2) NG TREATMENT/SERVICES-RESTOR EATING SKILLS Valley View Healthcare & Reha		
	alone or with assistube unless the redemonstrates that unavoidable; and	o has been able to eat enough stance is not fed by naso gastric esident 's clinical condition t use of a naso gastric tube was	i i		ensures based on the comprehensive assessment of a resident that who is fed by a na gastric or gastrostomy tube receives the appropriate treatment.	a aso- nent	
	gastrostomy tube treatment and ser pneumonia, diarri	o is fed by a naso-gastric or receives the appropriate vices to prevent aspiration nea, vomiting, dehydration, nalities, and nasal-pharyngeal ore, if possible, normal eating	9-9- MP	-(3 ŋ	and services to prevent aspirat pneumonia, diarrhea, vomiting dehydration, metabolic abnormalities, and nasalpharyngeal ulcers and to restor possible, normal eating skills.	7	
LARORATO	This REQUIREM	ENT is not met as evidenced	IGNATUR	E	Debrah Sain	<u>)</u>	8-30- (x6) DATE

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

	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	(X3) DATE SURVEY COMPLETED	
		245566	B. WING _	SED C =)ngg08/15/2013
	PROVIDER OR SUPPLIER VIEW HEALTHCARE	& REHAB	:	STREET ADDRESS, CITY, STATE, ZIP CODE 510 EAST CEDAR STREET HOUSTON, MN 55943	callh
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLÉTION
F 322	by: Based on observat review, the facility frand protocol that we standard of practice through a feeding to (R2) who received it tube system. Findings include: R: the use of the feeding policy which directe minimize complicati free air instilled into R2 was admitted on that included: Hunt chorea is a central indisorder which is exsufferers), constipated of difficulty in swalld excessive salivary so On 8/12/2013 at 3:1 nurse (LPN)-A was several medications into the enter tube for the mix into the storn free air in the entire bag to the gastric tustomach with each in medications were indicated she added medication more "I indicated she added medication more"	ion, interview and document alled to follow their procedure as developed to establish a for medication administration ube for one of one resident medications through a feeding. 2 received medications with medications through a feeding the use a syringe to ons which included having the stomach of the resident. 2/25/2000 with diagnoses ington's chorea (Huntington's nervous system movement attermely disabling for its tion, dysphagia (the symptom owing), esophageal reflux, and secretion disturbance. 5 p.m. a licensed practical observed to administer by putting the medication eeding bag and let gravity run mach. However; there was length of the tubing from the be that was pushed into the medication given. The	F.32:	R2 is the only present resident is the facility with a naso-gastric or gastrostomy tube. No other current resident has the potent to be affected. New residents the would come to us with a tube feeding would have the potential be affected by this practice. On August 13, 2013, The License nurse that administered the medications via the feeding bag 8/12/13 was provided reeducate on facility policy on administration of medications via a Peg tube. On August 13, 2013, the proceded through an enteral tube proceded was updated. The procedure we presented to all licensed staff for reeducation on the sound stand of practice on administration of medications via the PEG Tube. Pharmacy staff will perform ran medication pass audits at least quarterly, which will include en medication administrator. Director of Nursing/Designee we monitor for compliance.	ial hat al to ed gon ion ion lure tras or dard f

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ' '	TIPLE CONSTRU		SEP 6 - 2	COM	E SURVEY MPLETED
		245566	B. WING			MN Dept of Her	0.01	15/2013
	PROVIDER OR SUPPLIER VIEW HEALTHCARE	& REHAB			RESS, CITY, STATEDAR STREET MN 55943		1.11	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	X (EAC	CH CORRECTIVE	OF CORRECTION ACTION SHOULD TO THE APPROPE ENCY)	BE	(X5) COMPLETION DATE
F 322	example custard); stube. After preparing tubing, LPN-A hook percutaneous endo (this is the rubber lifthe skin into the storesident. LPN-A be medication into the medication had run PEG tubing by grave the bag to allow the flow into the peg tubing tubing to go into administration and recommendation for feeding/liquids/med before it is connected decrease the amount of the final water flusting tubing.	ge 2 semifluid]" to go through the ang a new tube feeding bag and ted up the tubing to the scopic gastrostomy (PEG) ke tube which goes through mach) tubing from the agan to administer each feeding tube bag. When each out of the bag and into the atty, then LPN-A would lift-up a medication solution to fully be. A tube full of air was the peg tube after each med water flush (typically the r use of tube bag for s is to purge the tubing of air ed to the PEG tube to ant of free air in the stomach.) In was 100 cc and the LPN be feeding through the same	F	322				
	and read: Nexium packet with water vior water and give vipm; Tylenol ES liquitube; USE SYRING 3:00 p.m.; Beneprotablespoons of powfeeding. Mix with 6:3:00 pm. After administering medications and be ml water daily 3:00 30 cc water after medicality policy for the facility policy for the facilit	sted 4/9/2013 were reviewed (stomach medication) 40 mg 1 ia NG. Mix 1 packet with 15 cc a NG tube once a day at 3:00 id 500 mg 31.25 ml: gastric E TO MEASURE 1.25 ml daily tein powder, two scoops or 3 der with 3:00 p.m. tube 0 cc of water once a day at 1 nexium and other 3:00 p.m. neproteinflush tube with 100 p.m. Flush feeding tube with eds tid (three times a day).						

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CL IDENTIFICATION NUMBER			1		(X3) DATE SURVEY COMPLETED	
		245566	B. WING	~	5/2013	
	PROVIDER OR SUPPLIER VIEW HEALTHCARE	& REHAB		STREET ADDRESS, CITY, STATE, ZIP CODE: 510 EAST CEDAR STREET HOUSTON, MN 55943		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	(EACH CORRECTIVE ACTION SHOULD BE	(X5) COMPLETION DATE	
	as follows "Medica prescribed in accomprinciples and pract authorized to do so syringe in appropria and pour into medication syringe medications through dose with 5-10 ml waddress the use of medications through the feeding bag on she thought it was of through the feeding policy developed to practice to be follow give medication into followed. 483.60(a),(b) PHAR ACCURATE PROC. The facility must prodrugs and biological them under an agree \$483.75(h) of this parallel was permits, but only supervision of a lice. A facility must provide including procedure acquiring, receiving,	ations are administered as dance with standard nursing ices only by staff qualified and #15. Insert medication ate port. Remix medication ration syringe so entire dose is a medications to flow down the via gravity. Do not push a tube. Flush after each rater." This policy did not the food bag to administer the a the PEG tube. 15 p.m., the director of nursing wed regarding the semiconstand the peg tube had not been macked to the PEG tube had not been macked to semiconstand the s	F 4	F425 483.60(a), (b) PHARMACEUTICAL SVC — ACCURATE PROCEDURES, RPH Valley View provides pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.		

	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			ATE SURVEY OMPLETED
		245566	B. WING		8/15/2013
	PROVIDER OR SUPPLIER VIEW HEALTHCARE	& REHAB		STREET ADDRESS, CITY, STATE ZIP CODE 2013 510 EAST CEDAR STREET HOUSTON, MN 55943 MN Dept of Health Rechester	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF CORRECTION X (EACH CORRECTIVE ACTION SHOULD BE	(X5) COMPLETION DATE
F 425	the needs of each in the facility must erral licensed pharmacon all aspects of the services in the facility. This REQUIREMENT by: Based on observative, the facility frast prescribed by the Percutaneous endouble (a PEG tube is stomach through the commonly to provide oral intake is not active (R2) who received the PEG tube. Findings include: In the percutaneous endouble endouble the percutaneous endouble endoubl	resident. Inploy or obtain the services of cist who provides consultation e provision of pharmacy ity. In it is not met as evidenced tion, interview, and document ailed to administer medication e physician into a escopic gastrostomy (PEG) is passed into a patient's e abdominal wall, most le a means of feeding when dequate.) for 1 of 1 resident exeveral medications through R2 received the incorrect dose dication) and 90 cc of water is physicians order for only 60 eation when administering the the PEG tube. 25/2000 with diagnoses that on's chorea, constipation, geal reflux, and excessive isturbance. R2 has a PEG for nutrition/liquids/medication ach. 5 p.m. a licensed practical observed to administer	F 4	nurse that administered the medications including the Liquid Tylenol via the feeding bag on 8/12/13 was provided reeducation on facility policy on administration of medications via a Peg tube including utilizing an oral dose syringe for measuring small and/or fractioned volumes. On August 13, 2013, the procedure for Medication Administered through an enteral tube procedure was updated. The procedure was presented to all licensed staff for reeducation on the sound standard of practice on administration of medications via the PEG Tube including utilizing an oral dose syringe for measuring small and/or fractioned volumes. R2 is the only present resident in the facility with a naso-gastric or gastrostomy tube. Other residents that receive liquid medications that may have a small or fractioned volume have the potential to be affected by this practice.	
		an enteral tube feeding bag. ere identified as nexium		medication pass audits at least	

	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL [*] A. BUILDI	Laboration of the Control of Michigan Control of Control of Michigan Control of Control	(X3) DATE SURVEY COMPLETED
		245566	B. WING		@4908/15/2013
	PROVIDER OR SUPPLIER VIEW HEALTHCARE	& REHAB		STREET ADDRESS, CITY, STATE, ZIP CODE 510 EAST CEDAR STREET HOUSTON, MN 55943	019
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		BE COMPLÉTION
F 425	(stomach medication Tylenol liquid, and reprepared the nexium centimeters (CC) of graduated medication Tylenol into it until it LPN-A indicated by on the cup she was of 31.25 ml per the physician order read and not a graduated LPN-A added the lidus approximately 90 Cophysician order read 90 cc. LPN-A said it make the medication go through the bag poured the medication go through the medication allowed it to run by good through the medication and read: Nexium (packet with water vithrough the nose and nasopharynx and establed to the packet with 15 cc of it is the PEG tube) to Tylenol ES (extra stimit: gastric tube; USi 1.25 ml daily 3:00 p. scoops or 3 tablespores.	n), beneprotein powder, milk of magnesium. LPN-A m packet by adding 60 cubic water. Then LPN-A used a concup and poured the liquid was past the 30 CC mark. going past the 30 CC mark sure to having had the dose doctor's order however; the d'use syringe to measure d'medication cup. Then fuid Tylenol with C of water however; the ds "60 cc of water" and not that she added the water to ms more "liquidy" so it could and tube easily. LPN-A then on into the feeding bag and gravity into the PEG tube.	F 4:	quarterly. Med pass audit will include enteral medication administration and observation of measuring liquid medications. Director of Nursing/Designee will monitor for compliance.	

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	LTIPLE CONSTRUCTION DING		TE SURVEY MPLETED
		245566	B. WING	SEP CO.	. 08	3/15/2013
	PROVIDER OR SUPPLIER VIEW HEALTHCARE	& REHAB		STREET ADDRESS, CITY, STATE, ZIP CO 510 EAST CEDAR STREET Record to HOUSTON, MN 55943	ne ///	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		HOULD BE	(X5) COMPLETION DATE
F 425	The facility policy for through an Enteral "Medications are accordance with star practices only by star do so. #15. Insert rappropriate port. Repropriate port. Repropriate port. Reproducation syringe administered. Allow medication syringe medications through dose with 5-10 ml which was a medication start of R2 informing the DON administration technical staff the DON said to the staff the	r Medication Administered Tube was reviewed and read Iministered as prescribed in andard nursing principles and aff qualified and authorized to nedication syringe in emix medication and pour into so entire dose is r medications to flow down the via gravity. Do not push n a tube. Flush after each rater."	F 4			

DEPART	MENT OF HEALTH	AND HUMAN SERVICES	× 1	_	5566022 0	MB NO.	0938-0391
STATEMENT	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL	TIPLE	E CONSTRUCTION 11 - VALLEY VIEW NURSING HOME	(X3) DATE COMF	SURVEY DETECTED
AND PLAN OF	CORRECTION	IDENTIFICATION NOMBLIX.			71 - VALLET VIEW NO.	08/1	4/2013
		245566	B. WING		TREET ADDRESS, CITY, STATE, ZIP CODE	00/1	4/2013
	ROVIDER OR SUPPLIER			51	0 EAST CEDAR STREET		
VALLEY	VIEW HEALTHCARE			H	OUSTON, MN 55943 PROVIDER'S PLAN OF CORRECTION	N	(X5) COMPLETION
(X4) ID PREFIX TAG	VENOUI DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		(EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	DRF	COMPLETION DATE
K 000	INITIAL COMMEN	TS	K	000	DECEIVE	M	
013	FIRE SAFETY				SEP 5 2013		12
09.24.2	ALLEGATION OF DEPARTMENT'S SIGNATURE AT T	POC WILL SERVE AS YOUR COMPLIANCE UPON THE ACCEPTANCE. YOUR THE BOTTOM OF THE FIRST MS 2567 FORM WILL BE CATION OF COMPLIANCE.			MOLDERT, OS EMBLICIÓNES STATE FISE (A) DE HAL DEACH	ON	
Dc: 0	AN ONSITE REVI BE CONDUCTED SUBSTANTIAL C	OF AN ACCEPTABLE POC, SIT OF YOUR FACILITY MAY TO VALIDATE THE OMPLIANCE WITH THE AS BEEN ATTAINED IN WITH YOUR VERIFICATION.			Rocok 8 9-23-13		
08.15.2013	Minnesota Depart Fire Marshal Divis Valley View Nursi substantial compl participation in Me Subpart 483.70(a	e Survey was conducted by the ment of Public Safety - State sion. At the time of this survey, ng Home was found not in iance with the requirements for edicare/Medicaid at 42 CFR,), Life Safety from Fire, and the ational Fire Protection A) Standard 101, Life Safety pter 19 Existing Health Care.					
	DEFICIENCIES (K-TAGS) TO:	N THE PLAN OF OR THE FIRE SAFETY				ē.	
1 X 1	Health Care Fire State Fire Marsh	al Division t., Suite 145			Debun Dain		8-30-1
LABORATO	DRY DIRECTOR'S OR PRO	OVIDER/SUPPLIER REPRESENTATIVE'S	SIGNATUR	RE	TITLE		(X6) DATE

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

PRINTED: 08/26/2013

CENTER	RS FOR MEDICARE	& MEDICAID SERVICES			CHETRUSTION	(X3) DATE	SURVEY
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILE	TIPLI ING (E CONSTRUCTION 01 - VALLEY VIEW NURSING HOME	COMPLETED	
		245566	B. WING			08/1	4/2013
	PROVIDER OR SUPPLIER	& REHAB		5′	TREET ADDRESS, CITY, STATE, ZIP CODE 10 EAST CEDAR STREET IOUSTON, MN 55943		
(X4) ID PREFIX TAG	SUMMARY STA	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	ıx	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROFILIENCY)	DBE	(X5) COMPLETION DATE
K 000	Continued From pa By email to: Barbara.Lundberg Marian.Whitney@s	@state.mn.us and	К	000	1A		
×	DEFICIENCY MUS FOLLOWING INFO	ORRECTION FOR EACH ST INCLUDE ALL OF THE ORMATION: what has been, or will be, done					
	to correct the defic	roposed, completion date.					
	3. The name and/oresponsible for co	or title of the person rrection and monitoring to rence of the deficiency.			9		
	buildings. Valley building with no be constructed at 3 duilding was considetermined to be 1973, addition was that was determined to the South be Type II (111). If and the 2 addition construction and allowed for existing surveyed as one						
	has a fire alarm sidetection, spaces	tme fully sprinklered. The facility ystem with full corridor smoke open to the corridors that is omatic fire department					

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(X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION COMPLETED AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** A: BUILDING 01 - VALLEY VIEW NURSING HOME 245566 B. WING 08/14/2013 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 510 EAST CEDAR STREET **VALLEY VIEW HEALTHCARE & REHAB** HOUSTON, MN 55943 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) ID (X4) ID COMPLÉTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRFFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) K 000 | Continued From page 2 K 000 The facility has a capacity of 45 beds and had a census of 43 at the time of the survey. The requirement at 42 CFR Subpart 483.70(a) is NOT MET as evidenced by: K 045 NFPA 101 LIFE SAFETY CODE STANDARD K 045 The illumination of means of egress, SS=F including exit discharge, will be Illumination of means of egress, including exit arranged so that failure of any single discharge, is arranged so that failure of any single lighting fixture will not leave the area lighting fixture (bulb) will not leave the area in darkness. (This does not refer to emergency in darkness. This will be lighting in accordance with section 7.8.) accomplished by limiting the lights controlled by the wall switches, so that when switches are turned off, exit access corridors continue to have the required illumination. This will be This STANDARD is not met as evidenced by: This STANDARD is not met as evidenced by: performed by Hoskins Electric the week of September 3 - 7, 2013. Based on observation and interview with staff, the facility failed to provide continuous illumination of 09/07/2013 exit access corridors in accordance with LSC Sections 19.2.8 and 7.8. This deficient practice could affect 35 of the 42 residents, as well as an undeterminable number of staff and visitors, if an evacuation was hindered due to an unilluminated exit access corridor. Findings include: On facility tour between 1:00 PM and 3:00 PM on 08/14/2013, revealed the light switches on the corridor wall in all the exit access corridors controlled all the lights in the exit access corridor. Revealed the light switches on the corridor wall in

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(X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES COMPLETED AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** A. BUILDING 01 - VALLEY VIEW NURSING HOME 245566 B. WING 08/14/2013 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 510 EAST CEDAR STREET **VALLEY VIEW HEALTHCARE & REHAB** HOUSTON, MN 55943 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) K 045 K 045 | Continued From page 3 all the exit access corridors controlled all the lights in the exit access corridor. An interview with the Administrator revealed all the exit access corridors have overhead lights controlled by switches on the wall. With all light switches turned off, the exit access corridors did not have the required level of continuous llumination as required by LSC Section 19.2.8 and 7.8.1. This deficient practice was confirmed by the Administrator at the time of discovery. The staff person responsible for fire K 050 K 050 NFPA 101 LIFE SAFETY CODE STANDARD SS=F drills was terminated. A new Fire drills are held at unexpected times under maintenance director was hired and varying conditions, at least quarterly on each shift. trained in proper procedures for fire The staff is familiar with procedures and is aware that drills are part of established routine. drills and will conduct them once per Responsibility for planning and conducting drills is shift, per quarter, and will document assigned only to competent persons who are qualified to exercise leadership. Where drills are accordingly. conducted between 9 PM and 6 AM a coded announcement may be used instead of audible Ongoing alarms. 19.7.1.2 This STANDARD is not met as evidenced by: Based on documentation review and staff interview, the facility failed to assure fire drills were conducted once per shift per quarter for all staff under varying times and conditions as required by 2000 NFPA 101, Section 19.7.1.2. This deficient practice could affect all 43 residents.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - VALLEY VIEW NURSING HOME			COMPLETED		
	AME OF PROVIDER OR SUPPLIER VALLEY VIEW HEALTHCARE & REHAB			510	STREET ADDRESS, CITY, STATE, ZIP CODE 510 EAST CEDAR STREET HOUSTON, MN 55943		08/14/2013	
(X4) ID PREFIX TAG	SUMMARY ST	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	- 1	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROP DEFICIENCY)	DRF	(X5) COMPLETION DATE	
K 050	08/14/2013, the re August 2012 to Juwere missed: 1. 2012/2013 - 3r shift 2. 2013 - 1st qua 3. 2013 - 2nd qua These deficient p Administrator at the state of th	tween 1:00 PM and 3:00 PM on eview of the fire drills reports for ally 2013 and the following drills and quarter - Day and Evening arter - Night shift earter - Evening shift ractices were confirmed by the the time of discovery.	K	050				
		Svent ID: VRK	1004		acility ID: 00286	ntinuation s	heet Page	

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(X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A BUILDING 02 - 2011 ADDITION 245566 B. WING 08/14/2013 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **510 EAST CEDAR STREET VALLEY VIEW HEALTHCARE & REHAB** HOUSTON, MN 55943 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION ID (X4) ID (X5) COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE **PRFFIX** DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) K 000 INITIAL COMMENTS K 000 FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS 2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. SEP 2013 UPON RECEIPT OF AN ACCEPTABLE POC. AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THE MN DEFT, OF PUBLIC SAFETY SUBSTANTIAL COMPLIANCE WITH THE STATE FIRE MAJESHAL DEVISION REGULATION HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. POC oh
29-29-13 A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety - State Fire Marshal Division. At the time of this survey, Valley View Nursing Home 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 18 New Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: Health Care Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St Paul, MN 55101-5145, or LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

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

PRINTED: 08/26/2013 FORM APPROVED OMB NO. 0938-0391

(X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING 02 - 2011 ADDITION 245566 B. WING 08/14/2013 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **510 EAST CEDAR STREET VALLEY VIEW HEALTHCARE & REHAB** HOUSTON, MN 55943 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) K 000 | Continued From page 1 K 000 By email to: Barbara.Lundberg@state.mn.us and Marian.Whitney@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. This facility will be surveyed as two separate buildings. Valley View Nursing Home, 2011 addition is a 1-story building with no basement. The 2011 addition was determined to be of Type II (111) construction. The building is fully sprinklered. The facility has a fire alarm system with full corridor smoke detection, spaces open to the corridors and resident rooms that is monitored for automatic fire department notification. The facility has a capacity of 45 beds and had a census of 43 at the time of the survey. The requirement at 42 CFR Subpart 483.70(a) is NOT MET as evidenced by: K 050 NFPA 101 LIFE SAFETY CODE STANDARD K 050

PRINTED: 08/26/2013 FORM APPROVED OMB NO. 0938-0391

(X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION COMPLETED AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** A. BUILDING 02 - 2011 ADDITION B. WING 245566 08/14/2013 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER **510 EAST CEDAR STREET VALLEY VIEW HEALTHCARE & REHAB** HOUSTON, MN 55943 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5) COMPLETION ID (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE **PREFIX** PREFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) K 050 | Continued From page 2 K 050 SS=F The staff person responsible for fire Fire drills are held at unexpected times under drills was terminated. A new varying conditions, at least quarterly on each shift. maintenance director was hired and The staff is familiar with procedures and is aware that drills are part of established routine. trained in proper procedures for fire Responsibility for planning and conducting drills is drills and will conduct them once per assigned only to competent persons who are qualified to exercise leadership. Where drills are shift, per quarter, and will document conducted between 9 PM and 6 AM a coded accordingly. announcement may be used instead of audible alarms. 18.7.1.2 Ongoing This STANDARD is not met as evidenced by: Based on documentation review and staff interview, the facility failed to assure fire drills were conducted once per shift per quarter for all staff under varying times and conditions as required by 2000 NFPA 101, Section 19.7.1.2. This deficient practice could affect all 43 residents. Findings include: On facility tour between 1:00 PM and 3:00 PM on 08/14/2013, the review of the fire drills reports for August 2012 to July 2013 and the following drills were missed: 1. 2012/2013 - 3rd quarter - Day and Evening shift 2. 2013 - 1st quarter - Night shift 3. 2013 - 2nd quarter - Evening shift These deficient practices were confirmed by the Administrator at the time of discovery.

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LTIPLE CONSTRUCTION DING 02 - 2011 ADDITION	(X3) DAT COM	(X3) DATE SURVEY COMPLETED	
		245566	B. WING)	08/	/14/2013	
	PROVIDER OR SUPPLIER VIEW HEALTHCARE	& REHAB		STREET ADDRESS, CITY, STATE, ZIP CODE 510 EAST CEDAR STREET HOUSTON, MN 55943			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		LD BE	(X5) COMPLETION DATE	
K 050	Continued From pa	ge 3	K	050			
	TEAM COMPOSIT Gary Schroeder, Lif	FION fe Safety Code Spc.					



Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7011 2000 0002 5143 5315

August 26, 2013

Ms. Deborah Barnes, Administrator Valley View Healthcare & Rehabilitation 510 East Cedar Street Houston, Minnesota 55943

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5566024

Dear Ms. Barnes:

The above facility was surveyed on August 12, 2013 through August 15, 2013 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health, Compliance Monitoring Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

To assist in complying with the correction order(s), a "suggested method of correction" has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is <u>only a suggestion</u> and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the deficiency within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

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

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

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

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

When all orders are corrected, the order form should be signed and returned to this office at Minnesota Department of Health, 18 Wood Lake Drive Southeast Rochester, Minnesota 55904. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact Gary Nederhoff at (507) 206-2731.

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, Program Specialist Program Assurance Unit Licensing and Certification Program Division of Compliance Monitoring P.O. Box 64900

St. Paul, Minnesota 55164-0900

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

Email: mark.meath@state.mn.us

Enclosure(s)

cc: Original - Facility
Licensing and Certification File

5566s13.rtf

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER.	A. BUILDING: _	A. BUILDING:		EIED
		00286	B. WING		08/15/2013	
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	TE, ZIP CODE		
VALLEY V	IEW HEALTHCARE & RI	EHAB	CEDAR STREE	ET		
		HOUSTON	, MN 55943			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETE DATE
2 000	Initial Comments		2 000			
	****ATTEN	TION*****				
	NH LICENSING CORRECTION ORDER					
	144A.10, this correcting pursuant to a survey. found that the deficient herein are not correct not corrected shall be with a schedule of fine the Minnesota Depart. Determination of whe corrected requires corrected requires correquirements of the runumber and MN Rule. When a rule contains comply with any of the lack of compliance.	ther a violation has been				
	result in the assessm	ent of a fine even if the item ng the initial inspection was				
	that may result from rorders provided that a	earing on any assessments non-compliance with these a written request is made to n 15 days of receipt of a for non-compliance.				
	this Department's sta and the following lices When corrections are date, make a copy of original to the Minnes	: & 15, 2013, surveyors of ff visited the above provider nsing orders were issued. completed, please sign and these orders and return the ota Department of Health, se Monitoring, Licensing and		Minnesota Department of Health i documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state	s	

Minnesota Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE (X6) DATE Minnesota Department of Health

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		00286	B. WING		08/15/2013
	ROVIDER OR SUPPLIER	510 EAST	DRESS, CITY, STA CEDAR STRE I, MN 55943		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE
2 000	Continued From page Certification Programs Rochester, MN 55904	18 Wood Lake Drive SE,	2 000	statutes/rules for Nursing Homes. The assigned tag number appears it the far left column entitled "ID Protag." The state statute/rule out of compliance is listed in the "Summa Statement of Deficiencies" column replaces the "To Comply" portion of the correction order. This column a includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the survey findings are the Suggested Method Correction and Time period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES FEDERAL DEFICIENCIES ONL THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT SUBMIT A PLAN OF CORRECTION FOR VIOLATION OF MINNESOTA STATE STATUTES/RULES.	efix ary and of also ne yors of TO Y.

Minnesota Department of Health

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
ANDILAN	SI CONNECTION	IDENTIFICATION NOWIDEN.	A. BUILDING: _		COWI LETE	Б
		00286	B. WING		08/15/2013	
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	ATE, ZIP CODE		
VALLEY	/IEW HEALTHCARE & RI	510 EAST	CEDAR STREE	ĒΤ		
VALLET	TENTIFICATE CITY	HOUSTO	N, MN 55943			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 930	Continued From page	e 2	2 930			
2 930	MN Rule 4658.0525 S Nasogastric, Gastros		2 930			
	and feeding syringes. Based on	the comprehensive resident g home must ensure that:				
	B. a resident who is fed by a nasogastric or gastrostomy tube or feeding syringe receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal feeding function.					
	by: Based on observatior review, the facility fail and protocol that was standard of practice for through a feeding tub	t is not met as evidenced n, interview and document led to follow their procedure developed to establish a for medication administration le for one of one resident edications through a feeding				
	the use of the feeding policy which directed minimize complication	received medications with g bag system vs. the facility the use a syringe to ns which included having ne stomach of the resident.				
	that included: Huntin chorea is a central ne disorder which is extr	2/25/2000 with diagnoses gton's chorea (Huntington's ervous system movement emely disabling for its				

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STATE FORM 6899 VRKS11 If continuation sheet 3 of 9

Minnesota Department of Health							
STATEMEN	Γ OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SI		
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLE	TED	
		00286	B. WING		08/1/	5/2013	
		00200			1 00/1	3/2013	
NAME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE, ZIP CODE			
VALLEY	IEW HEALTHCARE & RI	EHAR 510 EAS	T CEDAR STREE	ET			
VALLET	TEW HEALTHOAKE & KI	HOUSTO	N, MN 55943				
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTIO	N	(X5)	
PREFIX	, -	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD		COMPLETE	
TAG	REGULATORY OR I	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	RIATE	DATE	
2 930	Continued From page	3	2 930				
	of difficulty in ewallow	ing) osophagoal roflux, and					
	of difficulty in swallowing), esophageal reflux, and						
	excessive salivary secretion disturbance.						
	On 8/12/2013 at 3:15 p.m. a licensed practical						
	nurse (LPN)-A was observed to administer						
	several medications by putting the medication						
	into the enter tube feeding bag and let gravity run						
		ach. However; there was					
		ength of the tubing from the					
		e that was pushed into the					
	stomach with each me						
	medications were ide	•					
		Tylenol liquid, and milk of					
	magnesium. LPN-A	prepared the nexium packet					
	by adding approximat	ely 60 cc of water to mix					
	and then add to the T	ylenol liquid. LPN-A					
	indicated she added t	he water to make the					
	medication more " liq	uidy [Having a consistency					
	similar to a liquid, but	also similar to a solid (for					
	example custard); ser	mifluid]" to go through the					
		a new tube feeding bag and					
	tubing, LPN-A hooked	· ·					
		opic gastrostomy (PEG)					
	T	tube which goes through					
	the skin into the stom	· ·					
	resident. LPN-A bega						
		eding tube bag. When each					
		ut of the bag and into the					
		, then LPN-A would lift-up					
	•	nedication solution to fully					
	flow into the peg tube						
	_	e peg tube after each med					
		ater flush (typically the					
	recommendation for u						
	reeding/liquids/meds	is to purge the tubing of air	1				

Minnesota Department of Health

bag.

before it is connected to the PEG tube to decrease the amount of free air in the stomach.) The final water flush was 100 cc and the LPN then initiated the tube feeding through the same

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Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING:			
		00286	B. WING		08	3/15/2013
NAME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STAT	E, ZIP CODE		
VALLEY V	IEW HEALTHCARE & R	EHAB	CEDAR STREET	•		
			N, MN 55943			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
2 930	Continued From page	e 4	2 930			
	and read: Nexium (s packet with water via of water and give via pm; Tylenol ES liquid tube; USE SYRINGE 3:00 p.m.; Beneprote tablespoons of powdefeeding. Mix with 60 3:00 pm. After administering medications and benefit water daily 3:00 p. 30 cc water after medications for the facility policy for	ed 4/9/2013 were reviewed tomach medication) 40 mg 1 NG. Mix 1 packet with 15 cc NG tube once a day at 3:00 500 mg 31.25 ml: gastric TO MEASURE 1.25 ml daily in powder, two scoops or 3 er with 3:00 p.m. tube cc of water once a day at nexium and other 3:00 p.m. eproteinflush tube with 100 m. Flush feeding tube with dis tid (three times a day). Medication Administered ube " was reviewed. It read				
	as follows "Medicating prescribed in accordation principles and practice authorized to do so, syringe in appropriate and pour into medical administered. Allow medication syringe vimedications through dose with 5-10 ml wa	ons are administered as ance with standard nursing es only by staff qualified and #15. Insert medication e port. Remix medication tion syringe so entire dose is medications to flow down the a gravity. Do not push a tube. Flush after each ter." This policy did not e food bag to administer the				
	(DON) was interviewed administering of R2 ' tube feeding bag on 8 she thought it was ok through the feeding be policy developed to e practice to be follower	p.m., the director of nursing ed regarding the s medications through the 8/12/2013. DON indicated ay to give the medications ag. However, the facility stablish a sound standard of d by all staff educated to he PEG tube had not been				

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Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED			
		00286	B. WING		08/15/2013			
NAME OF PROVIDER OR SUPPLIER STREET ADDR				DRESS, CITY, STATE, ZIP CODE CEDAR STREET				
(X4) ID PREFIX TAG	(EACH DEFICIENC)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE		
2 930	TAG REGULATORY OR LSC IDENTIFYING INFORMATION)		2 930					
	recorded in the resided Documentation of the place following the admedication. If administration must administration was not completed as documentation must administration was not follow-up that was pro-	administration must take Iministration of the stration of the medication s prescribed, the nclude the reason the						
	This MN Requiremen	t is not met as evidenced						

Minnesota Department of Health

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Minnesota Department of Health

STATEMENT OF DEFICIENCIES		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN OF CORRECTION IDENTIFICATION N		IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED			
		00286	B. WING		08/1	08/15/2013		
NAME OF B			DDESS CITY STA	ATE ZID CODE	1 00.	.0,2010		
NAME OF P	NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 510 EAST CEDAR STREET							
VALLEY \	/IEW HEALTHCARE & R	EHAB	CEDAR STREE I, MN 55943	=1				
(VA) ID	SLIMMARY ST	ATEMENT OF DEFICIENCIES	1	PROVIDER'S PLAN OF CORREC	TION	(VE)		
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETE DATE		
21585	Continued From page	e 6	21585					
	Based on observation review, the facility fail as prescribed by the Percutaneous endosc tube (a PEG tube is pstomach through the commonly to provide oral intake is not adec (R2) who received set the PEG tube. Findings include: R2 of Tylenol (pain medic with medications vs. pcc water with medicat medication through the R2 was admitted 2/25 included: Huntington dysphagia, esophage salivary secretion disc	n, interview, and document ed to administer medication physician into a copic gastrostomy (PEG) passed into a patient's abdominal wall, most a means of feeding when quate.) for 1 of 1 resident veral medications through 2 received the incorrect dose cation) and 90 cc of water ohysicians order for only 60 tion when administering the ne PEG tube. 5/2000 with diagnoses that 's chorea, constipation, all reflux, and excessive turbance. R2 has a PEG r nutrition/liquids/medication						
	nurse (LPN)-A was of medication through a The medications were (stomach medication). Tylenol liquid, and mi prepared the nexium centimeters (CC) of w graduated medication. Tylenol into it until it w LPN-A indicated by g on the cup she was s of 31.25 ml per the dophysician order read and not a graduated in LPN-A added the liquid.	n enteral tube feeding bag. e identified as nexium h, beneprotein powder, lk of magnesium. LPN-A packet by adding 60 cubic vater. Then LPN-A used a n cup and poured the liquid vas past the 30 CC mark. oing past the 30 CC mark ure to having had the dose octor 's order however; the " use syringe to measure " medication cup. Then						

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Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED	
JEHN BUIGHT STATES		A. BUILDING: _	A. BUILDING:				
		00286	B. WING		08/	15/2013	
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	ATE, ZIP CODE			
VALLEY V	/IEW HEALTHCARE & RI	EHAB	CEDAR STREE	₹T			
		HOUSTON	I, MN 55943				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE	
21585	Continued From page	e 7	21585				
	90 cc. LPN-A said the make the medications go through the bag and poured the medication allowed it to run by grand read: Nexium (standard read: Nexium (standare	phagus into the stomach. c) (However; R2 did not have and received food/liquids/ugh a PEG tube, the not been changed to reflect be being used by R2.) Mix 1 water and give via NG (again be once a day at 3:00 p.m.; ength) liquid 500 mg 31.25 SYRINGE TO MEASURE h.; Beneprotein powder, two ons of powder with 3:00 p.m. th 60 cc of water once a day					
	through an Enteral Tu "Medications are adm accordance with stan	Medication Administered ube was reviewed and read uinistered as prescribed in dard nursing principles and					
	do so. #15. Insert me appropriate port. Rer medication syringe so administered. Allow i medication syringe vi	nix medication and pour into pentire dose is medications to flow down the a gravity. Do not push a tube. Flush after each					
	On 8/14/2013 at 2:45	p.m., the director of nursing					

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Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		00286	B. WING		08	3/15/2013
NAME OF P	ROVIDER OR SUPPLIER		ADDRESS, CITY, STAT			
VALLEY \	/IEW HEALTHCARE & R	EHAB	ON, MN 55943	1		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE LE APPROPRIATE	(X5) COMPLETE DATE
21585	(DON) was interviewed administering of R2's informing the DON or administration technic staff the DON said the followed the physician SUGGESTED METH Director of Nursing or and/or revise the police regarding deliverance could be performed to Training for all staff we could be done.	ed regarding the semantications and after in the observed medication que used by the licensed at the LPN should have insorder as written for R2. OD OF CORRECTION: The redesignee could review cies and procedures et of the medications. Audits	21585			

6899

Minnesota Department of Health STATE FORM

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