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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: VRKS

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00286

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245566**

2.STATE VENDOR OR MEDICAID NO.
(L2) **844240100**

3. NAME AND ADDRESS OF FACILITY
(L3) **VALLEY VIEW HEALTHCARE & REHAB**
(L4) **510 EAST CEDAR STREET**
(L5) **HOUSTON, MN** (L6) **55943**

4. TYPE OF ACTION: **7**

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 **11/04/2013** (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 **45** (L18)

13.Total Certified Beds **45** (L17)

10.THE FACILITY IS CERTIFIED AS:

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

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

B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: **A** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	45			
(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):

Post certification revisit (PCR) of Health and Life Safety Code Surveys completed on 11/04/2014. Refer to CMS form 2567B.

17. SURVEYOR SIGNATURE Date :
Gary Nederhoff, Unit Supervisor 11/07/2013 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 06/16/2014 (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
07/01/1991
(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
09/30/2013
(L33)

DETERMINATION APPROVAL

MINNESOTA
MDH
DEPARTMENT OF HEALTH

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
Minnesota Department of Health
Telephone: (651) 201-4112 Fax: (651) 215-9697
cc: Licensing and Certification File

MINNESOTA
MDH
DEPARTMENT OF HEALTH

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

Anne Kleppe, Program Specialist
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

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245566	A. Building B. Wing	11/4/2013

Name of Facility	Street Address, City, State, Zip Code
VALLEY VIEW HEALTHCARE & 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	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **F0322** Reg. # **483.25(g)(2)** LSC	Correction Completed **09/03/2013**	ID Prefix **F0425** Reg. # **483.60(a),(b)** LSC	Correction Completed **09/03/2013**	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	GN/AK	11/07/2013	10160	11/04/2013
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**
Followup to Survey Completed on: 8/15/2013		**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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction A. Building B. Wing	(Y3) Date of Revisit
245566	01 - VALLEY VIEW NURSING HOME	9/26/2013

Name of Facility	Street Address, City, State, Zip Code
VALLEY VIEW HEALTHCARE & 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	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix Reg. # NFPA 101 LSC K0045	09/07/2013	ID Prefix Reg. # NFPA 101 LSC K0050	08/19/2013	ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By State Agency	Reviewed By PS/AK	Date: 11/07/2013	Signature of Surveyor: 25822	Date: 09/26/2013
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:
Followup to Survey Completed on: 8/14/2013		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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

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

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245566	A. Building B. Wing **02 - 2011 ADDITION**	9/26/2013

Name of Facility	Street Address, City, State, Zip Code
VALLEY VIEW HEALTHCARE & 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	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix Reg. # **NFPA 101** LSC K0050	Correction Completed **08/19/2013**	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By State Agency	**Reviewed By** PS/AK	**Date:** 11/07/2013	**Signature of Surveyor:** 25822	**Date:** 09/26/2013
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**
Followup to Survey Completed on: 8/14/2013		**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: VRKS

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00286

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245566**

2.STATE VENDOR OR MEDICAID NO.
(L2) **844240100**

3. NAME AND ADDRESS OF FACILITY
(L3) **VALLEY VIEW HEALTHCARE & REHAB**
(L4) **510 EAST CEDAR STREET**
(L5) **HOUSTON, MN** (L6) **55943**

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 **08/15/2013** (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 **45** (L18)

13.Total Certified Beds **45** (L17)

10.THE FACILITY IS CERTIFIED AS:

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

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

X B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	45			
(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):

See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Robin Lewis, HFE NE II 09/23/2013 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Shellae Dietrich, Program Specialist 09/30/2013 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
07/01/1991
(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
Posted 09/30/2013 CO. VRKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

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.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

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;

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:

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/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:

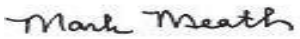
Mr. Patrick Sheehan, Supervisor
Health Care Fire Inspections
State Fire Marshal Division
444 Cedar Street, Suite 145
St. Paul, Minnesota 55101-5145

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

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
	245566	A. BUILDING _____ B. WING _____ SEP 6 - 2013	08/15/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY VIEW HEALTHCARE & REHAB	510 EAST CEDAR STREET HOUSTON, MN 55943

(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 322 SS=D	483.25(g)(2) NG TREATMENT/SERVICES - RESTORE EATING SKILLS Based on the comprehensive assessment of a resident, the facility must ensure that -- (1) A resident who has been able to eat enough alone or with assistance is not fed by naso gastric tube unless the resident ' s clinical condition demonstrates that use of a naso gastric tube was unavoidable; and (2) A resident who is fed by a naso-gastric or gastrostomy tube 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 eating skills. This REQUIREMENT is not met as evidenced	F 322	**F322 483.25(G) (2) NG TREATMENT/SERVICES-RESTORE EATING SKILLS** Valley View Healthcare & Rehab ensures based on the comprehensive assessment of a resident that who is fed by a naso-gastric or gastrostomy tube 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 eating skills. 9-9-13 sPM	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE 8-30-13

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY VIEW HEALTHCARE & REHAB	510 EAST CEDAR STREET HOUSTON, MN 55943 MN Dept of Health Rochester

(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 322	Continued From page 1 by: Based on observation, interview and document review, the facility failed to follow their procedure and protocol that was developed to establish a standard of practice for medication administration through a feeding tube for one of one resident (R2) who received medications through a feeding tube system. Findings include: R2 received medications with the use of the feeding bag system vs. the facility policy which directed the use a syringe to minimize complications which included having free air instilled into the stomach of the resident. R2 was admitted on 2/25/2000 with diagnoses that included: Huntington's chorea (Huntington's chorea is a central nervous system movement disorder which is extremely disabling for its sufferers), constipation, dysphagia (the symptom 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 the mix into the stomach. However; there was free air in the entire length of the tubing from the bag to the gastric tube that was pushed into the stomach with each medication given. The medications were identified as nexium, beneprotein powder, Tylenol liquid, and milk of magnesium. LPN-A prepared the nexium packet by adding approximately 60 cc of water to mix and then add to the Tylenol liquid. LPN-A indicated she added the water to make the medication more " liquidy [Having a consistency similar to a liquid, but also similar to a solid (for	F 322	R2 is the only present resident in the facility with a naso-gastric or gastrostomy tube. No other current resident has the potential to be affected. New residents that would come to us with a tube feeding would have the potential to be affected by this practice. On August 13, 2013, The Licensed nurse that administered the medications via the feeding bag on 8/12/13 was provided reeducation on facility policy on administration of medications via a Peg tube. 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. Pharmacy staff will perform random medication pass audits at least quarterly, which will include enteral medication administrator. Director of Nursing/Designee will monitor for compliance.	09/03/2013

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	245566	A. BUILDING _____ B. WING _____ SEP 0 - 2013 MN Dept of Hea lh	08/15/2013

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F 322	Continued From page 2 example custard); semifluid]" to go through the tube. After preparing a new tube feeding bag and tubing, LPN-A hooked up the tubing to the percutaneous endoscopic gastrostomy (PEG) (this is the rubber like tube which goes through the skin into the stomach) tubing from the resident. LPN-A began to administer each medication into the feeding tube bag. When each medication had run out of the bag and into the PEG tubing by gravity, then LPN-A would lift-up the bag to allow the medication solution to fully flow into the peg tube. A tube full of air was observed to go into the peg tube after each med administration and water flush (typically the recommendation for use of tube bag for feeding/liquids/meds is to purge the tubing of air 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 bag. Physician orders dated 4/9/2013 were reviewed and read: Nexium (stomach medication) 40 mg 1 packet with water via NG. Mix 1 packet with 15 cc of water and give via NG tube once a day at 3:00 pm; Tylenol ES liquid 500 mg 31.25 ml: gastric tube; USE SYRINGE TO MEASURE 1.25 ml daily 3:00 p.m.; Beneprotein powder, two scoops or 3 tablespoons of powder with 3:00 p.m. tube feeding. Mix with 60 cc of water once a day at 3:00 pm. After administering nexium and other 3:00 p.m. medications and beneprotein--flush tube with 100 ml water daily 3:00 p.m. Flush feeding tube with 30 cc water after meds tid (three times a day). The facility policy for Medication Administered through an Enteral Tube " was reviewed. It read	F 322		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 322	Continued From page 3 as follows " Medications are administered as prescribed in accordance with standard nursing principles and practices only by staff qualified and authorized to do so. #15. Insert medication syringe in appropriate port. Remix medication and pour into medication syringe so entire dose is administered. Allow medications to flow down the medication syringe via gravity. Do not push medications through a tube. Flush after each dose with 5-10 ml water." This policy did not address the use of the food bag to administer the medications through the PEG tube. On 8/14/2013 at 2:45 p.m., the director of nursing (DON) was interviewed regarding the administering of R2 ' s medications through the tube feeding bag on 8/12/2013. DON indicated she thought it was okay to give the medications through the feeding bag. However, the facility policy developed to establish a sound standard of practice to be followed by all staff educated to give medication into the PEG tube had not been followed.	F 322		
F 425 SS=D	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet	F 425	**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.	

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	245566	A. BUILDING _____ B. WING _____	08/15/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY VIEW HEALTHCARE & REHAB	510 EAST CEDAR STREET HOUSTON, MN 55943

AUG 2013
MN Dept of Health
Rochester

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F 425	Continued From page 4 the needs of each resident. The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to administer medication as prescribed by the physician into a Percutaneous endoscopic gastrostomy (PEG) tube (a PEG tube is passed into a patient's stomach through the abdominal wall, most commonly to provide a means of feeding when oral intake is not adequate.) for 1 of 1 resident (R2) who received several medications through the PEG tube. Findings include: R2 received the incorrect dose of Tylenol (pain medication) and 90 cc of water with medications vs. physicians order for only 60 cc water with medication when administering the medication through the PEG tube. R2 was admitted 2/25/2000 with diagnoses that included: Huntington's chorea, constipation, dysphagia, esophageal reflux, and excessive salivary secretion disturbance. R2 has a PEG tube which is used for nutrition/liquids/medication access to the stomach. On 8/12/2013 at 3:15 p.m. a licensed practical nurse (LPN)-A was observed to administer medication through an enteral tube feeding bag. The medications were identified as nexium	F 425	On August 13, 2013, The Licensed 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. Pharmacy staff will perform random medication pass audits at least	

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	245566	A. BUILDING _____ B. WING _____	08/15/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY VIEW HEALTHCARE & REHAB	510 EAST CEDAR STREET HOUSTON, MN 55943

SEP 6 - 2013
MN Dept of Health Rochester

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F 425	Continued From page 5 (stomach medication), beneprotein powder, Tylenol liquid, and milk of magnesium. LPN-A prepared the nexium packet by adding 60 cubic centimeters (CC) of water. Then LPN-A used a graduated medication cup and poured the liquid Tylenol into it until it was past the 30 CC mark. LPN-A indicated by going past the 30 CC mark on the cup she was sure to having had the dose of 31.25 ml per the doctor ' s order however; the physician order read " use syringe to measure " and not a graduated medication cup. Then LPN-A added the liquid Tylenol with approximately 90 CC of water however; the physician order reads " 60 cc of water " and not 90 cc. LPN-A said that she added the water to make the medications more " liquidy " so it could go through the bag and tube easily. LPN-A then poured the medication into the feeding bag and allowed it to run by gravity into the PEG tube. Physician orders dated 4/9/2013 were reviewed and read: Nexium (stomach medication) 40 mg 1 packet with water via NG (A tube that is passed through the nose and down through the nasopharynx and esophagus into the stomach. Abbreviated NG tube.) (However; R2 did not have a NG tube at this time and received food/liquids/ and medications through a PEG tube, the physician orders had not been changed to reflect the correct enteral tube being used by R2.) Mix 1 packet with 15 cc of water and give via NG (again it is the PEG tube) tube once a day at 3:00 p.m.; Tylenol ES (extra strength) liquid 500 mg 31.25 ml: gastric tube; USE SYRINGE TO MEASURE 1.25 ml daily 3:00 p.m.; Beneprotein powder, two scoops or 3 tablespoons of powder with 3:00 p.m. tube feeding. Mix with 60 cc of water once a day at 3:00 p.m.	F 425	quarterly. Med pass audit will include enteral medication administration and observation of measuring liquid medications. Director of Nursing/Designee will monitor for compliance.	09/03/2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245566	A. BUILDING _____ B. WING _____	08/15/2013

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F 425	Continued From page 6 The facility policy for Medication Administered through an Enteral Tube was reviewed and read "Medications are administered as prescribed in accordance with standard nursing principles and practices only by staff qualified and authorized to do so. #15. Insert medication syringe in appropriate port. Remix medication and pour into medication syringe so entire dose is administered. Allow medications to flow down the medication syringe via gravity. Do not push medications through a tube. Flush after each dose with 5-10 ml water." On 8/14/2013 at 2:45 p.m., the director of nursing (DON) was interviewed regarding the administering of R2's medications and after informing the DON on the observed medication administration technique used by the licensed staff the DON said that the LPN should have followed the physicians order as written for R2.	F 425		

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

F 5566022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245566	A. BUILDING 01 - VALLEY VIEW NURSING HOME B. WING _____	08/14/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY VIEW HEALTHCARE & REHAB	510 EAST CEDAR STREET HOUSTON, MN 55943

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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 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THE SUBSTANTIAL COMPLIANCE WITH THE REGULATION 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, 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 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 445 Minnesota St., Suite 145 St Paul, MN 55101-5145, or	K 000	RECEIVED SEP 5 2013 MN DEPT. OF PUBLIC SAFETY STATE FIRE MARSHAL DIVISION POC ok KB 9-23-13	

Dc: 09.24.2013
Exit: 08.15.2013

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE 8-30-13

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

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	245566	A. BUILDING **01 - VALLEY VIEW NURSING HOME** B. WING _____	**08/14/2013**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY VIEW HEALTHCARE & REHAB	**510 EAST CEDAR STREET HOUSTON, MN 55943**

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K 000	Continued From page 1 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 is a 1-story building with no basement. The building was constructed at 3 different times. The original building was constructed in 1967 and was determined to be of Type II(111) construction. In 1973, addition was constructed to the West Wing that was determined to be of Type II(111) construction. In 1989, another addition was added to the South Wing and was determined to be Type II (111). Because the original building and the 2 additions are of the same type of construction and meet the construction type allowed for existing buildings, the facility was surveyed as one building. The building became fully sprinklered. The facility has a fire alarm system with full corridor smoke detection, spaces open to the corridors that is monitored for automatic fire department notification.	K 000		

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	245566	A. BUILDING **01 - VALLEY VIEW NURSING HOME** B. WING _____	**08/14/2013**

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K 000	Continued From page 2 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 000		
K 045 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Illumination of means of egress, including exit discharge, is arranged so that failure of any single lighting fixture (bulb) will not leave the area in darkness. (This does not refer to emergency lighting in accordance with section 7.8.) 19.2.8 This STANDARD is not met as evidenced by: This STANDARD is not met as evidenced by: Based on observation and interview with staff, the facility failed to provide continuous illumination of 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	K 045	The illumination of means of egress, including exit discharge, will be arranged so that failure of any single lighting fixture will not leave the area in darkness. This will be 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 performed by Hoskins Electric the week of September 3 – 7, 2013.	09/07/2013

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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.	K 045		
K 050 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible 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.	K 050	The staff person responsible for fire drills was terminated. A new maintenance director was hired and trained in proper procedures for fire drills and will conduct them once per shift, per quarter, and will document accordingly.	8-19-13 & Ongoing

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VALLEY VIEW HEALTHCARE & REHAB	510 EAST CEDAR STREET HOUSTON, MN 55943

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K 050	Continued From page 4 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. *TEAM COMPOSITION* Gary Schroeder, Life Safety Code Spc.	K 050		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245566	A. BUILDING **02 - 2011 ADDITION** B. WING _____	**08/14/2013**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THE SUBSTANTIAL COMPLIANCE WITH THE REGULATION 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, 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	K 000	RECEIVED SEP 5 2013 MN DEPT. OF PUBLIC SAFETY STATE FIRE MARSHAL DIVISION POC ok 9-23-13	

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

9/3/13

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

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K 000	Continued From page 1 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 000		
K 050	NFPA 101 LIFE SAFETY CODE STANDARD	K 050		

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K 050 SS=F	Continued From page 2 Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 18.7.1.2 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. 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.	K 050	The staff person responsible for fire drills was terminated. A new maintenance director was hired and trained in proper procedures for fire drills and will conduct them once per shift, per quarter, and will document accordingly.	8-19-13 Ongoing

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K 050	Continued From page 3 *TEAM COMPOSITION* Gary Schroeder, Life Safety Code Spc.	K 050		

MINNESOTA
MDH
DEPARTMENT OF HEALTH

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 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 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00286	A. BUILDING: _____ B. WING _____	08/15/2013

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On August 12, 13, 14 & 15, 2013, 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, make a copy of these orders and return the original to the Minnesota Department of Health, Division of Compliance Monitoring, Licensing and	2 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state	

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2 000	Continued From page 1 Certification Program; 18 Wood Lake Drive SE, Rochester, MN 55904.	2 000	statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	

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2 930	Continued From page 2	2 930		
2 930	MN Rule 4658.0525 Subp. 7 B. Rehab - Nasogastric, Gastrostomy tubes Subp. 7. Nasogastric tubes, gastrostomy tubes, and feeding syringes. Based on the comprehensive resident assessment, a nursing 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. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to follow their procedure and protocol that was developed to establish a standard of practice for medication administration through a feeding tube for one of one resident (R2) who received medications through a feeding tube system. Findings include: R2 received medications with the use of the feeding bag system vs. the facility policy which directed the use a syringe to minimize complications which included having free air instilled into the stomach of the resident. R2 was admitted on 2/25/2000 with diagnoses that included: Huntington's chorea (Huntington's chorea is a central nervous system movement disorder which is extremely disabling for its sufferers), constipation, dysphagia (the symptom	2 930		

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2 930	Continued From page 3 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 the mix into the stomach. However; there was free air in the entire length of the tubing from the bag to the gastric tube that was pushed into the stomach with each medication given. The medications were identified as nexium, beneprotein powder, Tylenol liquid, and milk of magnesium. LPN-A prepared the nexium packet by adding approximately 60 cc of water to mix and then add to the Tylenol liquid. LPN-A indicated she added the water to make the medication more " liquidy [Having a consistency similar to a liquid, but also similar to a solid (for example custard); semifluid]" to go through the tube. After preparing a new tube feeding bag and tubing, LPN-A hooked up the tubing to the percutaneous endoscopic gastrostomy (PEG) (this is the rubber like tube which goes through the skin into the stomach) tubing from the resident. LPN-A began to administer each medication into the feeding tube bag. When each medication had run out of the bag and into the PEG tubing by gravity, then LPN-A would lift-up the bag to allow the medication solution to fully flow into the peg tube. A tube full of air was observed to go into the peg tube after each med administration and water flush (typically the recommendation for use of tube bag for feeding/liquids/meds is to purge the tubing of air 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 bag.	2 930		

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2 930	Continued From page 4 Physician orders dated 4/9/2013 were reviewed and read: Nexium (stomach medication) 40 mg 1 packet with water via NG. Mix 1 packet with 15 cc of water and give via NG tube once a day at 3:00 pm; Tylenol ES liquid 500 mg 31.25 ml: gastric tube; USE SYRINGE TO MEASURE 1.25 ml daily 3:00 p.m.; Beneprotein powder, two scoops or 3 tablespoons of powder with 3:00 p.m. tube feeding. Mix with 60 cc of water once a day at 3:00 pm. After administering nexium and other 3:00 p.m. medications and beneprotein--flush tube with 100 ml water daily 3:00 p.m. Flush feeding tube with 30 cc water after meds tid (three times a day). The facility policy for Medication Administered through an Enteral Tube " was reviewed. It read as follows " Medications are administered as prescribed in accordance with standard nursing principles and practices only by staff qualified and authorized to do so. #15. Insert medication syringe in appropriate port. Remix medication and pour into medication syringe so entire dose is administered. Allow medications to flow down the medication syringe via gravity. Do not push medications through a tube. Flush after each dose with 5-10 ml water." This policy did not address the use of the food bag to administer the medications through the PEG tube. On 8/14/2013 at 2:45 p.m., the director of nursing (DON) was interviewed regarding the administering of R2 ' s medications through the tube feeding bag on 8/12/2013. DON indicated she thought it was okay to give the medications through the feeding bag. However, the facility policy developed to establish a sound standard of practice to be followed by all staff educated to give medication into the PEG tube had not been	2 930		

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2 930	Continued From page 5 followed. SUGGESTED METHOD FOR CORRECTION: The administrator with the director of nursing (DON) or designee could review and revise policies and procedures regarding the treatment and services provided for tube feeding administration to ensure that the medications are accurately given for a resident who receives tube feedings. The DON or designee could educate staff on the policies and procedures. The DON or designee could monitor the administration of medications through the tube feedings procedures on a periodic basis. TIME PERIOD FOR CORRECTION: Fourteen (14) days.	2 930		
21585	MN Rule 4658.1325 Subp. 8 Administration of Medications; documentation Subp. 8. Documentation of administration. The name, date, time, quantity of dosage, and method of administration of all medications, and the signature of the nurse or authorized person who administered and observed the same must be recorded in the resident's clinical record. Documentation of the administration must take place following the administration of the medication. If administration of the medication was not completed as prescribed, the documentation must include the reason the administration was not completed, and the follow-up that was provided, such as notification of a registered nurse or the resident's attending physician. This MN Requirement is not met as evidenced by:	21585		

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21585	Continued From page 6 Based on observation, interview, and document review, the facility failed to administer medication as prescribed by the physician into a Percutaneous endoscopic gastrostomy (PEG) tube (a PEG tube is passed into a patient's stomach through the abdominal wall, most commonly to provide a means of feeding when oral intake is not adequate.) for 1 of 1 resident (R2) who received several medications through the PEG tube. Findings include: R2 received the incorrect dose of Tylenol (pain medication) and 90 cc of water with medications vs. physicians order for only 60 cc water with medication when administering the medication through the PEG tube. R2 was admitted 2/25/2000 with diagnoses that included: Huntington's chorea, constipation, dysphagia, esophageal reflux, and excessive salivary secretion disturbance. R2 has a PEG tube which is used for nutrition/liquids/medication access to the stomach. On 8/12/2013 at 3:15 p.m. a licensed practical nurse (LPN)-A was observed to administer medication through an enteral tube feeding bag. The medications were identified as nexium (stomach medication), beneprotein powder, Tylenol liquid, and milk of magnesium. LPN-A prepared the nexium packet by adding 60 cubic centimeters (CC) of water. Then LPN-A used a graduated medication cup and poured the liquid Tylenol into it until it was past the 30 CC mark. LPN-A indicated by going past the 30 CC mark on the cup she was sure to having had the dose of 31.25 ml per the doctor ' s order however; the physician order read " use syringe to measure " and not a graduated medication cup. Then LPN-A added the liquid Tylenol with approximately 90 CC of water however; the	21585		

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21585	Continued From page 7	21585		

physician order reads " 60 cc of water " and not 90 cc. LPN-A said that she added the water to make the medications more " liquidy " so it could go through the bag and tube easily. LPN-A then poured the medication into the feeding bag and allowed it to run by gravity into the PEG tube.

Physician orders dated 4/9/2013 were reviewed and read: Nexium (stomach medication) 40 mg 1 packet with water via NG (A tube that is passed through the nose and down through the nasopharynx and esophagus into the stomach. Abbreviated NG tube.) (However; R2 did not have a NG tube at this time and received food/liquids/ and medications through a PEG tube, the physician orders had not been changed to reflect the correct enteral tube being used by R2.) Mix 1 packet with 15 cc of water and give via NG (again it is the PEG tube) tube once a day at 3:00 p.m.; Tylenol ES (extra strength) liquid 500 mg 31.25 ml: gastric tube; USE SYRINGE TO MEASURE 1.25 ml daily 3:00 p.m.; Beneprotein powder, two scoops or 3 tablespoons of powder with 3:00 p.m. tube feeding. Mix with 60 cc of water once a day at 3:00 p.m.

The facility policy for Medication Administered through an Enteral Tube was reviewed and read "Medications are administered as prescribed in accordance with standard nursing principles and practices only by staff qualified and authorized to do so. #15. Insert medication syringe in appropriate port. Remix medication and pour into medication syringe so entire dose is administered. Allow medications to flow down the medication syringe via gravity. Do not push medications through a tube. Flush after each dose with 5-10 ml water."

On 8/14/2013 at 2:45 p.m., the director of nursing

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00286	A. BUILDING: _____ B. WING _____	08/15/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY VIEW HEALTHCARE & REHAB	510 EAST CEDAR STREET HOUSTON, MN 55943

(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
21585	Continued From page 8 (DON) was interviewed regarding the administering of R2's medications and after informing the DON on the observed medication administration technique used by the licensed staff the DON said that the LPN should have followed the physicians order as written for R2. SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designee could review and/or revise the policies and procedures regarding deliverance of the medications. Audits could be performed to ensure compliance. Training for all staff who administer medications could be done. TIME PERIOD FOR CORRECTION: Seven (7) days.	21585		