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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: WNIZ

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00968

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245281**
2.STATE VENDOR OR MEDICAID NO.
(L2) **198148100**

3. NAME AND ADDRESS OF FACILITY
(L3) **VALLEY CARE AND REHAB LLC**
(L4) **600 FIFTH STREET SOUTHEAST, BOX 129**
(L5) **BARNESVILLE, MN** (L6) **56514**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9) **11/01/2015**

6. DATE OF SURVEY **02/24/2016** (L34)

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

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

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

12.Total Facility Beds **35** (L18)
13.Total Certified Beds **35** (L17)

10.THE FACILITY IS CERTIFIED AS:
× A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC
B. Not in Compliance with Program Requirements and/or Applied Waivers:

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

* Code: **A** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	35			
(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 :
Denise Erickson, HFE NEII — 03/02/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Mark Meath
Enforcement Specialist — 03/02/2016 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
07/01/1985
(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.
06201
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
01/08/2016
(L33)

DETERMINATION APPROVAL

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
March 2, 2016

Mr. Mark Rustad, Administrator
Valley Care And Rehab LLC
600 Fifth Street Southeast, Box 129
Barnesville, Minnesota 56514

RE: Project Number S5281026

Dear Mr. Rustad:

On January 15, 2016, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on December 31, 2015. This survey found the most serious deficiencies to be a pattern of deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level E), whereby corrections were required.

On February 24, 2016, the Minnesota Department of Health completed a Post Certification Revisit (PCR) and on February 11, 2016 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on December 31, 2015. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of February 8, 2016. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on December 31, 2015, effective February 8, 2016 and therefore remedies outlined in our letter to you dated January 15, 2016, will not be imposed.

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

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

Sincerely,

Mark Meath

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

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
March 2, 2016

Mr. Mark Rustad, Administrator
Valley Care And Rehab LLC
600 Fifth Street Southeast, Box 129
Barnesville, Minnesota 56514

RE: Project Number S5281026

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

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

Sincerely,

Mark Meath

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

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
245281	A. Building B. Wing	2/24/2016

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY CARE AND REHAB LLC	600 FIFTH STREET SOUTHEAST, BOX 129 BARNESVILLE, MN 56514

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0170 Reg. # 483.10(i)(1) LSC	Correction Completed 01/23/2016	ID Prefix F0279 Reg. # 483.20(d), 483.20(k)(1) LSC	Correction Completed 02/08/2016	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction 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 (INITIALS) GA/mm	DATE 03/02/2016	SIGNATURE OF SURVEYOR 31256	DATE 02/04/2016
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	
12/31/2015	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
245281	A. Building 01 - MAIN BUILDING 01 B. Wing	2/11/2016

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY CARE AND REHAB LLC	600 FIFTH STREET SOUTHEAST, BOX 129 BARNESVILLE, MN 56514

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix Reg. # NFPA 101 LSC K0147	Correction Completed 01/22/2016	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction 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 (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
☑	GA/mm	03/02/2016	36536	02/11/2016
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON	
12/29/2015	☐ 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: WNIZ

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00968

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245281**
2.STATE VENDOR OR MEDICAID NO.
(L2) **198148100**

3. NAME AND ADDRESS OF FACILITY
(L3) **VALLEY CARE AND REHAB LLC**
(L4) **600 FIFTH STREET SOUTHEAST, BOX 129**
(L5) **BARNESVILLE, MN** (L6) **56514**

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) **11/01/2015**

6. DATE OF SURVEY **12/31/2015** (L34)

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

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

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

12.Total Facility Beds **35** (L18)
13.Total Certified Beds **35** (L17)

10.THE FACILITY IS CERTIFIED AS:
A. In Compliance With Program Requirements Compliance Based On:
___1. Acceptable POC
X B. Not in Compliance with Program Requirements and/or Applied Waivers:

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	35			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Patrici Bernstetter, HFE NEII 01/26/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath, Enforcement Specialist 02/21/2016 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
07/01/1985
(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.
06201
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
01/08/2016
(L33)

DETERMINATION APPROVAL

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered
January 15, 2016

Mr.. Mark Rustad, Administrator
Valley Care And Rehab Llc
600 Fifth Street Southeast, Box 129
Barnesville, MN 56514

RE: Project Number S5281026

Dear Mr.. Rustad:

On December 31, 2015, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs. This survey found the most serious deficiencies in your facility to be a pattern of deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level E), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed. I

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

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

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

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

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

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

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

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

DEPARTMENT CONTACT

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

Gail Anderson, Unit Supervisor
Fergus Falls Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
1505 Pebble Lake Road, Suite 300
Fergus Falls, Minnesota 56537-3858
Email: gail.anderson@state.mn.us

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

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by February 9, 2016, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;

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

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

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

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by March 31, 2016 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was

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

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by July 1, 2016 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

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

Tom Linhoff, Fire Safety Supervisor
Health Care Fire Inspections
Minnesota Department of Public Safety
State Fire Marshal Division
445 Minnesota Street, Suite 145
St Paul, Minnesota 55101-5145
Email: tom.linhoff@state.mn.us
Phone: (651) 430-3012 Fax: (651) 215-0525

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

Sincerely,

Mark Meath

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

Enclosure

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245281	A. BUILDING _____ B. WING _____	12/31/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY CARE AND REHAB LLC	600 FIFTH STREET SOUTHEAST, BOX 129 BARNESVILLE, MN 56514

(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. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic 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 170 SS=C	483.10(i)(1) RIGHT TO PRIVACY - SEND/RECEIVE UNOPENED MAIL The resident has the right to privacy in written communications, including the right to send and promptly receive mail that is unopened. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to ensure mail was delivered to the residents on Saturdays for 2 of 2 residents (R6, R16) in the sample. This deficient practice had the potential to affect all 34 residents residing in the facility. Findings include: R16's annual Minimum Data Set (MDS) dated 11/8/15, indicated R16 had intact cognition and required supervision with his activities of daily	F 170	1. Delivery of mail received from post office box and delivery of outgoing mail from R #16, #6 will been done within 24 hours of delivery of mail to post office box. 2. Educated staff that all residents will have mail delivery from the post office within 24 hours of receiving it from the postal service and delivery of outgoing mail at that time. 3. Nursing home staff will be responsible for the delivery of incoming and outgoing mail within 24 hours of its delivery from the postal service.	1/23/16

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

Electronically Signed | 01/22/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245281	A. BUILDING _____ B. WING _____	12/31/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY CARE AND REHAB LLC	600 FIFTH STREET SOUTHEAST, BOX 129 BARNESVILLE, MN 56514

(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 170	Continued From page 1 living (ADL). On 12/30/15, at 11:27 a.m. during interview R16 stated he did not receive mail on Saturday in the facility, and stated he felt the Saturday mail was passed out on Monday because facility staff went to pick up the mail on Monday. R16 indicated he thought the administrator or social worker would pick up the mail and R16 didn't think they picked up the mail on Saturdays. R6's quarterly MDS dated 11/5/15, indicated R6 was cognitively intact, required extensive assistance with ADL's and supervision with ambulating in her room. On 12/30/15, at 11:49 a.m. R6 stated the facility had never delivered mail on Saturdays in the past and indicated the office wasn't open on Saturdays. R16 stated on Monday mornings facility staff would deliver the Saturday mail. On 12/30/15, at 11:49 a.m. the administrator had stated the mail is picked up at the post office Monday through Friday and no one picks up the mail on Saturdays. The administrator stated the residents don't get any mail on Saturdays because the facility did not have staff available to go to the post office to get the mail. The administrator stated he was the one who would go to the post office to pick up the mail, and when he was not there the business office manager would pick up the mail. Review of the undated facility policy titled Photograph/Directory/Mail Services, identified mail was received daily at the center and would be distributed to each resident in their room.	F 170	4. Administrator will audit weekly for the first four weeks, then quarterly through resident interview to ensure compliance and resident satisfaction. 5. Corrective action will be completed by January 23, 2016	

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F 279	Continued From page 2	F 279		
F 279 SS=E	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to develop a comprehensive care plan for 1 of 5 resident(R44) newly admitted to the facility. In addition, the facility failed to develop a comprehensive care plan related to activities. medication use, diabetes/nutrition, mood monitoring for 3 of 5 residents(R31, R9, R36) reviewed. Findings include: R44's admission MDS dated 11/3/15, identified	F 279	1. Care plans with appropriate diagnoses, interventions and goals for medical and nursing needs, as well as nutritional, psychosocial, and activity approaches were implemented for R #44, #31, #9, and #36 on January 20, 2016. 2. All resident care plans will be were reviewed and updated by IDT consisting of MDS Coordinator, Social Service Designee, Activity Director, Registered Dietitian, and DON to include diagnoses, interventions and goals for medical and	2/8/16

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	245281	A. BUILDING _____ B. WING _____	12/31/2015

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F 279	Continued From page 3 R44 had diagnoses which included heart failure, diabetes, COPD (chronic obstructive pulmonary disease), and gastro esophageal reflux (GERD). R44's MDS identified R44 had intact cognition, routinely received a diuretic medication and was independent with all areas of daily living. Review of R44's clinical record revealed the following: -A nursing progress noted dated 12/29/2015, identified R44 had displayed behaviors of restlessness and refusing meals. -Nutrition Care Area Assessment (CAA) dated 11/3/15, identified the following: " [R44] does have episodes of paranoia which prevent her from eating all of her meal." R44's clinical record lacked evidence of a comprehensive care plan to meet R44's individual needs and the facility On 12/31/2015, at 9:23 a.m. the DON confirmed the usual facility practice was to develop a comprehensive care plan after completion of the admission MDS and CAA. The DON confirmed R44 had a problem of diabetes and care related to diabetes and confirmed a care plan had not been developed to implement interventions for this problem for R44. The DON verified the nursing assistants utilized care guides to follow for resident care, and indicated the care guides did not include all specific concerns for each resident. The undated nursing assistant care guide identified R44 was a DNR (do not resuscitate), paranoia, assist of one for toileting, peri care, dressing and grooming, diet regular, upper and	F 279	nursing needs, as well as nutritional, psychosocial, and activity approaches. 3. Comprehensive care plan development will begin on day of admission and be completed no later than 7 days after the completion of the admission MDS and CAA. This shall include input from all disciplines including but not limited to nursing, social services, activities, dietary, rehab, pharmacy, physician, resident and family. 4. Review of comprehensive care plan shall be reviewed on day 21 after admission and quarterly by MDS Coordinator, DON, and QA nurse. All disciplines will receive ongoing education on initiating and updating care plans to reflect new orders and change in status. Monthly audits of Care Plans, MARS and care guides, to include all disciplines, with any discrepancies reported to MDS Coordinator. QI/QA update quarterly with compliance findings. 5. Corrective action will be completed by February 8, 2016.	

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F 279	Continued From page 4 lower dentures. On 12/31/2015, at 10:32 a.m. R44 indicated since admitted to the facility he/she had undergone many tests, scans, and had concerns with cancer, diabetes, dehydration and kidney problems. On 12/31/2015, at 12:33 p.m. the DON indicated R44 was admitted to the facility following a hospitalization due to not managing health conditions of COPD, heart failure and diabetes on his/her own. Due to R44 not managing the health conditions at home, it had resulted in an episode of psychosis for R44. The DON verified R44 did not have a comprehensive care plan in place and indicated she was aware the facility had a systemic problem with care plans not being completed. The DON identified the specific areas of concern to be addressed in R44's care plan would include the following: diabetes precautions, signs symptoms and interventions of hypo and hyper glycemia, dietary needs, activities, diuretic medication use precautions and concerns. The DON verified the top priority for R44's care plan to be social service considerations due to the reason R44 was admitted the the facility being an episode of psychosis. R31's Order Summary Report dated 12/31/15, indicated R31 had diagnoses which included major depression disorder, Alzheimer's and hypothyroidism. The report also indicated R31 was prescribed an antidepressant (Zoloft) 50 mg(milligrams) orally daily for major depression.	F 279		

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F 279	Continued From page 5 Review of R31's care plan, dated 12/23/15, did not identify the use of an antidepressant for major depression and lacked mood/behavior monitoring, risk factors, goals and non-pharmalogical interventions related to symptoms of depression. Review of the nursing aid care sheets, dated 12/30/15, lacked direction for staff to monitor R 31 for mood/behaviors symptoms. On 12/31/15, at 3:36 p.m. the director of nursing (DON) confirmed R31 was currently receiving Zoloft for major depression daily and verified R31's diagnosis and routine medication use were not addressed on R31's current care plan. Nutrition: A comprehensive care plan was not developed to identify diabetic needs/ nutrition for R9. R9's Order Summary Report dated 12/31/15, indicated R9 had diagnoses which included heart failure, diabetes, hypertension, and iron deficiency anemia. The report also indicated R9 was prescribed a diabetic diet with regular texture and thin consistency liquids. R9's physician order report dated 12/1/15, included diabetic diet with thin liquids and to check blood sugar Monday, Wednesday, and Friday once a day. Review of R9's care plan, dated 10/27/15, failed to identify any risk factors, goals or interventions in regards to R9's diabetes. further, R9's care plan did not direct any diabetic nutritional needs	F 279		

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F 279	Continued From page 6 or diet. Review of the nursing aid care sheets, dated 12/30/15, indicated R9 was on a regular diet and not a diabetic diet per doctors orders. On 12/31/15 at 11:19 a.m. DON confirmed R9 was a diabetic and required a diabetic diet and verified these issues were not addressed in R9 current care plan. The DON verified she was responsible for developing the care plan once the dietician completed resident assessments and stated resident care plans were not getting done. The DON also verified the nursing assistant sheets were not accurate and confirmed R9's care sheet should include the direction for a diabetic diet instead of regular diet. The DON confirmed other residents in the facility also did not have dietary care plans developed and stated "yes there has been a systemic problem with the development of the care plans." Activities: A comprehensive care plan was not developed to identify the activity needs for R36. R36's Order Summary Report dated 12/31/15, indicated R36 had diagnoses which included dementia without behavioral disturbance, chronic kidney disease and anemia. The report also indicated R36 could do activity as tolerated. R36's admission Minimum Data Set (MDS), dated 5/31/15, indicated it was very important for R36 to do his favorite activities and some what important to listen to music, keep up with the news, do things with groups of people, and go outside to get fresh air when the weather is good.	F 279		

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F 279	Continued From page 7 R36's activity assessment, dated 5/27/15, indicated R36 liked to spend time with his wife, prefers activities in his room, one on one, in the morning, walking/wheeling outdoors, and likes talking/conversing with others. Review of R36's care plan, dated 12/27/15, failed to identify any goals or interventions in regards to R36's leisure time/activity needs. Review of the nursing aid care sheets, dated 12/30/15, did not identify any activity needs for R36. On 12/31/15 at 8:40 a.m. activities director (AD) confirmed she currently working on the activity program and making changes. AD verified R36 did not currently have a activity care plan and stated "we are going through the care plans right now and we need to get the care plan ups to date." On 12/31/15 at 8:51 a.m. DON confirmed R36 did not have a activity care plan and stated "correct nobody has activity care plans." The DON also indicated they had not had an AD until recently. The DON stated the facility was aware care plans had not been developed for residents and indicated activities care plans for residents needed improvement for the past year. Requested facility policy in regards to developing a comprehensive care plans, policy not provided by the facility.	F 279		

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	245281	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**12/29/2015**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY CARE AND REHAB LLC	**600 FIFTH STREET SOUTHEAST, BOX 129 BARNESVILLE, MN 56514**

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K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety. At the time of this survey Clayco Care Center was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: Health Care Fire Inspections State Fire Marshal Division 445 Minnesota Street, Suite 145 St Paul, MN 55101 Or by e-mail to:	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		01/22/2016

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 Marian.Whitney@state.mn.us or Angela.Kappenman@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. Clayco Care Center is a 1-story building with no basement. The building was constructed at 3 different times. The original building was constructed in 1963 and was determined to be of Type II(000) construction. In 1980, a Sun Room addition was added to the south of the Dining Room/Day Room that was determined to be of Type V(000) construction. In 1994 an addition to the main entrance, to the west was constructed and was determined to be of Type II(111) construction. The building is completely protected by an automatic fire sprinkler system installed and also has a fire alarm system with smoke detection in the corridors and areas open to the corridors that is monitored for automatic fire department notification. The facility has a capacity of 35 beds and a census of 34 at the time of the survey..	K 000		

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K 000	Continued From page 2	K 000		
K 147 SS=D	The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by: NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2 This STANDARD is not met as evidenced by: Based on observation and interview with the staff, the facility was using unapproved electrical devices that are not in accordance with NFPA 70 (99), National Electrical Code. This deficient practice could negatively affect the safety of residents, staff and visitors. Findings include: On facility tour between 9:00am to 11:30am on 12/29/2015, observations revealed that there is an unlisted multi-plug adaptor being used in resident room 39. This was confirmed by the Adminstrator (MR)	K 147	1. Multi-plug electrical adapter removed from resident room 39. 2. All resident rooms audited for fire hazards to include but not limited to multi-plug electrical adapters. 3. Room 39 family educated on electrical and fire hazard policy and what is allowed in resident room. Fire safety and allowed electrical devices will be reviewed with all residents and families at admission and quarterly by Administrator. 4. Resident room audits for fire hazards will be done weekly by Environmental Services, Nursing, and Maintenance personnel. 5. Corrective action completed January 22, 2016.	1/22/16