DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

Administrator
Spring Valley Care Center
800 Memorial Drive
Spring Valley, MN 55975

RE: CCN: 245442
Cycle Start Date: November 2, 2021

Dear Administrator:

On November 17, 2021, we notified you a remedy was imposed. On December 10, 2021 the Minnesota Department of Health completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of December 9, 2021.

As authorized by CMS the remedy of:

- Discretionary denial of payment for new Medicare and Medicaid admissions effective January 1, 2022 did not go into effect. (42 CFR 488.417 (b))

In our letter of November 17, 2021, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from January 1, 2022 due to denial of payment for new admissions. Since your facility attained substantial compliance on December 9, 2021, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded. However, this does not apply to or affect any previously imposed NATCEP loss.

The CMS Region V Office may notify you of their determination regarding any imposed remedies.

Feel free to contact me if you have questions.

Sincerely,

Melissa Poepping, Health Program Representative Senior
Program Assurance | Licensing and Certification
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: melissa.poepping@state.mn.us

Electronically delivered
November 17, 2021

Administrator
Spring Valley Care Center
800 Memorial Drive
Spring Valley, MN 55975

RE: CCN: 245442
Cycle Start Date: November 2, 2021

Dear Administrator:

On November 2, 2021, a survey was completed at your facility by the Minnesota Department of Health 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 isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D), as evidenced by the electronically delivered CMS-2567, whereby significant corrections are required.

REMEDIES

As a result of the survey findings and in accordance with survey and certification memo 16-31-NH, this Department recommended the enforcement remedy(ies) listed below to the CMS Region V Office for imposition. The CMS Region V Office concurs and is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective January 1, 2022.

- Directed plan of correction (DPOC), Federal regulations at 42 CFR § 488.424. Please see electronically attached documents for the DPOC.

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective January 1, 2022. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective January 1, 2022.

You should notify all Medicare/Medicaid residents admitted on, or after, this date of the restriction. The remedy must remain in effect until your facility has been determined to be in substantial compliance or your provider agreement is terminated. Please note that the denial of payment for new admissions includes Medicare/Medicaid beneficiaries enrolled in managed care plans. It is

your obligation to inform managed care plans contracting with your facility of this denial of payment for new admissions.

This Department is also recommending that CMS impose:

• Civil money penalty (42 CFR 488.430 through 488.444). You will receive a formal notice from the CMS RO only if CMS agrees with our recommendation.

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than $11,160; has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

If you have not achieved substantial compliance by January 1, 2022, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, Spring Valley Care Center will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from January 1, 2022. You will receive further information regarding this from the State agency. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions.

However, under Public Law 105-15, you may contact the State agency and request a waiver of this prohibition if certain criteria are met.

ELECTRONIC PLAN OF CORRECTION (ePOC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved. The failure to submit an acceptable ePOC can lead to termination of your Medicare and Medicaid participation (42 CFR 488.456(b)).

To be acceptable, a provider's ePOC must include the following:

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.

- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

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:

Karen Aldinger, Unit Supervisor
St. Cloud A District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
3333 Division Street, Suite 212
Saint Cloud, Minnesota 56301-4557
Email: karen.aldinger@state.mn.us
Office: (651) 201-3794 Mobile: (320) 249-2805

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. 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 - Health Regulation Division staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for their respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a Post Certification Revisit (PCR), of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

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.

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

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 May 2, 2022 if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at § 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR § 488.412 and § 488.456.

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.

APPEAL RIGHTS

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40, et seq. You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at https://dab.efile.hhs.gov no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

Tamika.Brown@cms.hhs.gov

Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted as of October 1, 2014, unless you do not have access to a computer or internet service. In those circumstances you may call the Civil Remedies Division to request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a written request for a waiver along with your written request for a hearing. A written request for a hearing must be filed no later than sixty (60) days after receiving this letter, by mailing to the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
(202) 565-9462

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Tamika Brown, Principal Program Representative by phone at (312) 353-1502 or by e-mail at Tamika.Brown@cms.hhs.gov.

INFORMAL DISPUTE RESOLUTION (IDR) / INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

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: https://mdhprovidercontent.web.health.state.mn.us/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 electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

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.

Feel free to contact me if you have questions.

Sincerely,

Melissa Poepping, Health Program Representative Senior
Program Assurance | Licensing and Certification
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: melissa.poepping@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245442	A. BUILDING _____ B. WING _____	C 11/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING VALLEY CARE CENTER	**800 MEMORIAL DRIVE SPRING VALLEY, MN 55975**

(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	F 000		

On 11/1/21 and 11/2/21, a standard abbreviated survey was conducted at your facility. Your facility was found to be NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities.

The following complaints were found to be SUBSTANTIATED:
H5442033C (MN60350), with a deficiency cited at (F689).
H5442029C (MN71711), with a deficiency cited at (F760 and F609).
H5442028C (MN74213), with a deficiency cited at (F609).

The following complaints were found to be SUBSTANTIATED H5442027C (MN77366), H5442030C (MN70299), H5442031C (MN71141), H5442034C (MN63818) AND H5442035C (MN64638) however NO deficiencies were cited due to actions implemented by the facility prior to survey.

The following complaints were found to be UNSUBSTANTIATED: H5442026C (MN77366).

The following complaints were found to be UNSUBSTANTIATED, however related deficiencies were cited.

H5442032C (MN70146), with a deficiency cited at (F880 and F761).

The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required

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

Electronically Signed | 11/24/2021

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F 000	Continued From page 1 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 onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.	F 000		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified	F 609		12/9/21

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F 609	Continued From page 2 appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to report to the state agency (SA) timely, a significant medication for 1 of 1 residents (R8) who had missed doses of an anticoagulant medication, and missing medication for 1 of 1 resident (R6) who had missing Trazodone (an antidepressant medication often used for sleep with the potential for street abuse). Findings include: R8's hospital after visit summary (HAVS), identified R8 had discharged from a hospital stay and was admitted to the facility on 3/25/21. R8 had been hospitalized for atrial fibrillation requiring anticoagulant treatment, and the HAVS indicated R8 was to continue receiving Coumadin (warfarin) 2.5 mg by mouth daily until 3/29/21, and to have a follow-up INR lab on 3/29/21 to check the efficacy of that dose. The identified INR goal level was listed as 2-3. The HAVS form included, "It is extremely important to have your INR blood work checked. Your doctor will follow the results closely. The tablet strength and number of tablets you take each day may change based on the INR result ...if your heart rhythm is abnormal [atrial fibrillation], a clot can form in the heart and go to the brain, where it can cause a stroke." R8's physician orders included, starting 3/25/21, "Resident takes Coumadin, ensure it is given @HS [bedtime] every day. Please assess once daily to ensure no side effects from Coumadin are present. Bruising, prolonged bleeding,	F 609	Update procedure to include: Dispense medications according to the card date/day of week. This will allow staff to easily identify a missing med. Update policy to include reporting missing medication to DON/Designee immediately when discovered. Missing medication will be reported to OHFC per SVL□s abuse prevention plan. In-service to staff to update on policy and procedure updates. We offer zoom for staff unable to make it in person in-services.	

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F 609	Continued From page 3	F 609		

abnormal bleeding. Warfarin Sodium tablet 2.5 mg. Give 2.5 mg by mouth one time a day related to chronic atrial fibrillation unspecified until 3/28/2021." The admission orders listed in R8's EHR did not include a transcription of the lab order for an INR level to be drawn 3/29/21.

R8's information from the Anti-coagulation Clinic dated 4/2/21, included R8 had an INR completed with a result of 1.10 (lower than the 2-3 goal). The Anti-coagulation clinic document identified the clinic had called the facility and spoke to registered nurse (RN)-A about R8's INR being low. RN-A had reported R8 had missed Coumadin/warfarin doses from 3/29/21 through 4/1/21, and had failed to check R8's INR on 3/29/21 as had been ordered.

A nursing home incident report was submitted to the state agency related to R8 missing 4 days of Coumadin on 4/8/21, 6 days after being made aware of the error.

R6's physician orders included, Trazodone 50 mg to be given once a day for insomnia.

A nursing home incident report submitted to the state agency on 6/25/21, identified, the facility had found a prescription medication discrepancy on 6/17/21 where seven doses of R6's Trazodone were missing, and on 6/19/21 seven additional doses of Trazodone were missing. The facility had reported this on 6/25/21, 8 days after discovery of the missing medications.

A hard copy of an e-mail, provided by the facility indicated the director of nursing (DON) reported R8's missing medication to the facility's consulting pharmacist on 6/21/21. The pharmacist replied

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F 609	Continued From page 4	F 609		

that she had no other suggestions about what to do except to get the police involved.

According to a document provided by the facility outlining their steps of investigation, RN-C had noticed and reported the missing medications on 6/17/21. The document indicated additional missing doses were reported to the DON on 6/19/21 and the DON started an investigation on 6/21/21. The document did not identify reporting to the police or to the state agency.

When interviewed on 11/2/21, at 12:49 p.m. registered nurse (RN)-C stated she was the nurse to have first identified the missing Trazodone. RN-C could not recall too much about the incident, but said she had reported it immediately when she first noticed there seemed to be doses missing.

When interviewed on 11/2/21, at 10:37 a.m. the social worker (SW) stated incidences of resident abuse should be reported immediately but no later than 2 hours from discover, and other incidences such as significant medication errors and missing medications should be reported immediately, but no later than 24 hours after discovery.

When interviewed via telephone on 11/02/21, at 12:00 p.m. the DON stated she remembered the Coumadin medication error and the missing Trazodone doses were incidents reported to her. She was unable to recall anything about reporting except that the pharmacist had recommended reporting the missing Trazodone to the police which she had done when they found the second seven doses of Trazodone were missing. DON

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F 609	Continued From page 5 stated the facility policy for reporting vulnerable adult incidents was to report immediately and within 2 hours, but did not recall why either of the NHIR reports were filed later than two hours. When interviewed on 11/02/21, at 1:56 p.m. the facility administrator stated an expectation for reporting missing medications as stolen if they could not easily determine a cause. Administrator stated a theft should be reported within two hours of finding out about it. Administrator also stated a significant medication error should be reported to the state agency, and said the expectations was the same, a report should be made within two hours of discovery. Following a report an investigation could begin. The facility's Abuse Prevention plan, original dated 2/27/20, included, Incidents causing suspicion of a crime are reported to local law enforcement according to timeline described in the Affordable Care Act. The policy also indicated there is a 24/7 designated person to report vulnerable adult issues and this person and their number are listed at the facility "font desk" and at the top of the nurse 24 hour report sheet. The on-call designee was responsible for ensuring the initial report was filed according to the abuse prevention plan. The policy also indicated the designee is responsible to follow through with the five-day report and take appropriate actions with staff as necessary.	F 609		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains	F 689		12/9/21

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F 689	Continued From page 6 as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to follow fall a care plan intervention for 1 of 3 resident (R3). In addition, the facility failed to implement the facility falls procedure for 1 of 3 residents (R3) reviewed for falls. Findings include: R3's admission record indicated an admission date of 11/20/18 with diagnoses that included dementia without behavioral disturbance and history of falling. R3's quarterly Minimum Data Set (MDS) dated 9/1/21 indicated R3 required extensive assist of one staff for toileting, dressing and personal hygiene and limited assist of one staff for transfers. The MDS indicated had R3 severely impaired cognition was understood and understands. The MDS further indicated R3 had zero falls since the last MDS assessment. R3's fall risk assessment dated 9/19/21 indicated a fall risk score of 13 which indicated R3 was at moderate risk for falls. R3's care plan included, "ADL [activities of daily living] Self Care Performance Deficit r/t [related to] macular degeneration and decreased physical mobility secondary to progressing dementia." Interventions included, "TOILET USE: [R3]	F 689	Eliminate duplicate Kardex systems. The paper Kardex forms will no longer be used. In-service on fall policy and procedure, with emphasis on the definition of a fall. Update care plan policy to include: care plan review process, C.N.A. participation and review of the care plan. SVL will provide an in-service for all staff on how to read and follow a care plan. We offer zoom for staff unable to make it in person in-services.	

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F 689	Continued From page 7	F 689		

requires supervision for toileting but may seek assistance due to fear of falling. TRANSFER: [R3] requires supervision for transfers but may seek assistance due to fear of falling."

R3's falls care plan included, "[R3] is at a moderate risk for falls r/t [related to] macular degeneration, the use of an assistive device for ambulation, and the administration of diuretic, antihypertensive, and psychotropic medications." Interventions included, "Encourage and assist with toileting between 1200-1400, Resident is not to be left alone on toilet (date initiated 9/28/21), and Toilet every 3 hours and PRN [as needed]."

R3's Kardex included, "Encourage and assist with toileting between 1200-1400, Resident is not to be left alone on toilet, and Toilet every 3 hours and PRN [as needed]."

R3's written care plan placed in binders on each hallway included, "Assist of one for toileting."

R3's progress note dated 10/17/21 included, "Nurse heard banging in hallway and went to residents [sic] room and found her in the bathroom kneeling against the toilet seat, with her knees on the toilet seat. Bottom was against the wall. Resident was assisted to wheelchair per request by two staff. Resident was very agitated, reported her left knee hurt, no visible sign of injury at this time." The incident report was requested for this incident, and the facility had no further documentation.

R3's incident report dated 9/19/21 included Nursing Description, "CNA [certified nursing assistant] called to writer to residents [sic]room. Resident found laying on right side half way [sic]

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245442	A. BUILDING _____ B. WING _____	C 11/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING VALLEY CARE CENTER	**800 MEMORIAL DRIVE SPRING VALLEY, MN 55975**

(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 689	Continued From page 8	F 689		

in the bathroom and half way [sic]out of the bathroom. Per, CNA [certified nursing assistant] resident has used the bathroom with assistance and transferred back to the wheelchair to wash hands in the sink in bathroom. CNA then left resident and room. When resident done washing her hands and leaving bathroom it is believed that she stood up from wheelchair to turn off bathroom light on her ride side, (light switch is out of reach while sitting in wheelchair), when resident attempted to sit back down in wheelchair, she could not reach it due to breaks not locked and wheelchair up against sink. Resident then went to the floor with door jam on right side and wheelchair behind. Writer has seen resident stand up to shut off bathroom light when leaving bathroom after assisting her in the past. Resident description: Resident stated, "All I know is I bumped my head, my wrist, my arm, my shoulder. While pointing to the side of her head, right wrist arm and shoulder. Immediate action taken, Resident assessed for LOC [level of consciousness], pain, ROM [range of motion], injuries, vital signs and neuro checks at baseline. Resident anxious about transfer to wheelchair with assist of two and falling again. Resident is able to move all extremities with pain to right wrist when flexing or extending. Resident had grippy socks on and was not incontinent. Upon observing resident anti-roll back breaks appear to need adjustment and manual breaks were not locked when resident found. Intervention: Do not leave resident unattended in bathroom. Resident educated on use of wheelchair brakes, using call light, and asking for assistance. Resident does often transfer self without asking for assistance. Resident does have cognitive impairment. Root cause of fall: brakes not engaged on wheelchair. No injuries noted at the time of the incident."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245442	A. BUILDING _____ B. WING _____	C 11/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING VALLEY CARE CENTER	**800 MEMORIAL DRIVE SPRING VALLEY, MN 55975**

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F 689	Continued From page 9	F 689		

During an interview on 11/1/21, at 10:59 a.m. nursing assistant (NA)-A stated R3 takes herself to the bathroom and will put her call light on for assist to wipe if needed. NA-A stated for the most part she takes care of it herself. NA-A stated R3 was getting a little more unstable, but she was still, for the most part independent. During the interview R3 placed her call light on while she was in the bathroom and NA-A was observed to answer R3's call light to provide assistance. NA-A stated R3 was able to be left alone in the bathroom, that staff did not need to stay in the bathroom with her. NA-A stated changes to resident care plans are communicated to staff during report at start of each shift, passed on through report changes, and they put it on the home page in point click care, the electronic medical record.

During an interview on 11/1/21, at 11:41 a.m. with the administrator and director of nursing (DON) the administrator stated R3 was wedged between the toilet and the wall, and the nurse working did not consider the incident to be a fall. The administrator stated the nurse charted a progress note and did not notify anyone of the incident. The administrator verified falls process was not followed. The administrator stated the nurse should have completed an incident report and treated the incident as a fall on 10/17/21.

During an interview on 11/1/21, at 1:38 p.m. NA-B stated R3 will put herself on the toilet, "but she does let us know when she needs to get off." NA-B stated staff are to take R3 into the bathroom place her on the toilet, give her the call light and she will use it to alert staff when she was done. NA-B stated R3 was good about waiting for

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245442	A. BUILDING _____ B. WING _____	C 11/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING VALLEY CARE CENTER	**800 MEMORIAL DRIVE SPRING VALLEY, MN 55975**

(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 689	Continued From page 10	F 689		

staff and not getting up on her own. NA-B stated R3 could be left alone in the bathroom. NA-B stated she was made aware of how to take care of R3 by the written Kardex care plan in the binder on the resident hallway. NA-B produced R3's written care plan in the binder. The written care plan included R3 needed assist of one of for toileting. NA-B stated for R3 that meant, "we assist her with wiping." NA-B stated changes made to resident care plans were passed on in report. R3's written Kardex care plan in the binder did not indicate she was not to be left alone in the bathroom.

During an interview on 11/2/21, at 8:55 a.m. NA-C stated R3 required limited to stand by assist with toileting. NA-C stated staff need to be with R3 when she was in the bathroom. NA-C stated it should say it on her Kardex, not to be left alone in the bathroom but she not sure if the Kardex was up to date. NA-C stated changes to resident care plans were passed through report. NA-C stated it was following a fall the change was made for staff to be with her in the bathroom.

During an interview on 11/2/21, at 11:20 a.m. registered nurse (RN)-B stated R3 was officially an assist of one staff on her care plan for toileting. RN-B stated staff cue R3, and she was able to complete tasks toileting tasks independently. RN-B stated, "we do not need to assist her with transfers and clothing." RN-B stated staff provide assistance with peri care. RN-B stated R3 was not to be alone in the bathroom. RN-B stated R3 at times will try to self transfer and take herself to the bathroom.

During an interview on 11/2/21, at 11:48 a.m. RN-A stated R3 asked for help with toileting when

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245442	A. BUILDING _____ B. WING _____	C 11/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING VALLEY CARE CENTER	**800 MEMORIAL DRIVE SPRING VALLEY, MN 55975**

(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 689	Continued From page 11 she wanted help and stated R3's care plan indicated she needed supervision with toileting. RN-A stated R3 can be in the bathroom unattended. RN-A stated she thought because of the incident on 10/17/21, where R3 was found with her knees on the toilet it would be appropriate to get occupational and physical therapy involved to find out what level of toileting assistance she needed. RN-A stated when she had helped toilet R3 just a week and a half ago, R3 had been able to do everything herself and she was just in the room as stand by assist. RN-A verified by reviewing R3 care plan conflicting level of assistance for toileting. RN-A stated when a change was made to the care plan, nursing was to be notified of the changes, the care plan was updated, and it should be passed through report. RN-A stated the written care plan in the binder on the resident hallways was a temporary care plan completed upon admission to be used until the comprehensive care plan was completed. The Incident and Fall Reporting Procedure undated included, "An Incident Report is to be completed whenever a resident falls, is injured, or involved in an unusual situation in which injury might occur." A policy for staff following the care plan was requested and not provided.	F 689		
F 760 SS=D	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by:	F 760		12/9/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245442	A. BUILDING _____ B. WING _____	C 11/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING VALLEY CARE CENTER	**800 MEMORIAL DRIVE SPRING VALLEY, MN 55975**

(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 760	Continued From page 12 Based on document review and interviews, facility failed to follow its procedure for ensuring transcription of physician orders and follow-up laboratory testing for 1 of 1 residents (R8) reviewed for Coumadin (an anticoagulant) use, resulting in four missed doses and sub-optimal lab results. Findings include: According to a hospital after visit summary (HAVS), R8 was discharged from a hospital stay and admitted to the facility on 3/25/21. R8 had been hospitalized for atrial fibrillation requiring anticoagulant treatment, and the HAVS indicated R8 was to continue receiving Coumadin (warfarin) 2.5 mg by mouth daily until 3/29/21, and to have a follow-up INR lab on 3/29/21 to check the efficacy of that dose. The identified INR goal level was listed as 2-3. The HAVS document did not have a signature by a facility nurse to indicate who had noted and/or transcribed the orders into the facility electronic health record (EHR) for R8, or signatures of any other nurse reviewing the orders at any other time [please refer to facility procedure below]. According to information on the HAVS form, "It is extremely important to have your INR blood work checked. Your doctor will follow the results closely. The tablet strength and number of tablets you take each day may change based on the INR result ...if your heart rhythm is abnormal [atrial fibrillation], a clot can form in the heart and go to the brain, where it can cause a stroke." The following orders related to Coumadin were found to have been transcribed to R8's EHR upon admission, 3/25/21:	F 760	The DON or designee will review and educate nursing staff on the facility plan for transcription of medication orders, specifically of warfarin dose changes with orders for blood work. The DON or designee will audit all facility high risk medication orders and nursing actions to ensure accurate and timely transcription of orders, and evidence of nurses following the facility procedures for tracking and documenting warfarin and INR orders. Will audit weekly x4 then monthly x6. We offer zoom for staff unable to make it in person in-services.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245442	A. BUILDING _____ B. WING _____	C 11/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(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 760	Continued From page 13	F 760		

"Resident takes Coumadin, ensure it is given @HS [bedtime] every day.
Please assess once daily to ensure no side effects from Coumadin are present. Bruising, prolonged bleeding, abnormal bleeding.
Warfarin Sodium tablet 2.5 mg. Give 2.5 mg by mouth one time a day related to chronic atrial fibrillation unspecified until 3/28/2021."
The admission orders listed in R8's EHR did not include a transcription of the lab order for an INR level to be drawn 3/29/21.

According to R8's Medication Administration Record and corresponding progress notes, a registered nurse (RN)-C acknowledged by initialing the order that stated: "resident takes Coumadin, ensure it is given @HS every day" (order for evening shift) on the following dates, 3/29/21, 3/31/21, 4/1/21. No intervention was documented indicating any actions taken to follow-up up on the lack of a current Coumadin order. Another nurse, RN-D also signed the order on 3/30/21 without documented response.

A review of R8's progress notes did not provide any additional information until 4/2/21 which reported lab had been drawn and a new order received.

A document dated 4/2/21 from the Anti-coagulation Clinic (ACC) was signed by RN-A upon receipt by fax. The document indicated R8 had had an INR completed with a result of 1.10 which was a drop from the previous level 3/25/21. The document included the following note: ACC called Spring Valley Living and spoke to the nurse [RN-A] regarding patient INR being low. [RN-A] stated the patient did not get the dose on 3/29/21 to 4/1/21. According to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245442	A. BUILDING _____ B. WING _____	C 11/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING VALLEY CARE CENTER	**800 MEMORIAL DRIVE SPRING VALLEY, MN 55975**

(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 760	Continued From page 14	F 760		

[RN-A] they missed the dose and recheck dates that was instructed to the facility a week ago to recheck on 3/29/21."

A document dated 4/8/21 titled: Questionnaire for staff who had contact with this resident in last 48 hours (Q-48 hr), listed RN-A as a staff who had worked 3/25/21, 7:30 a.m. to 5:00 p.m. RN-A wrote a description of what she did: "I admitted this resident, entered orders, communicated with Anti-coag clinic, received orders from them as well. Coumadin + INR check ordered." This description failed to indicate the date of communication with the ACC or the date the listed orders were received. RN-A wrote: "what I failed to do was place an INR tracking sheet in the INR book. I have updated the Admission check list to include this task." Description failed to indicate why a physician's order was not transcribed into R8's EHR upon admission.

An additional Q-48 hr sheet dated 4/8/21 was signed by RN-C who wrote the following description of her action: "resident was supposed to be on Coumadin but there was no order and no card. I checked off in the MAR that I gave it when I did not." RN-C noted a safety issue that needed to be fixed as, "make sure orders are sent to pharmacy to get correct medication by RN" and wrote a theory as to the cause as being, "order not put in to pharmacy, repetition of charting." Description failed to indicate which RN was to place the order, who did not send the order to pharmacy and what was meant by "repetition of charting."

A third Q-48 hr sheet dated 4/8/21 was signed by RN-D who wrote the following description of action: "administration of HS medications

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245442	A. BUILDING _____ B. WING _____	C 11/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING VALLEY CARE CENTER	**800 MEMORIAL DRIVE SPRING VALLEY, MN 55975**

(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 760	Continued From page 15	F 760		

indicated a Coumadin check, however, I missed that the card [cardboard holder for pills] was missing when multitasking. RN-D wrote a safety issue related to not seeing the Coumadin card and recommended putting Coumadin orders on a separate MAR tab in the EHR to avoid problems with multi-tasking. RN-D wrote a theory that repetition of the daily Coumadin check [to check for an order Vs Coumadin administration order] was a possible contributor to the missing doses, as well as problems with multi-tasking.

A fourth Q-48 hr sheet, not dated, was signed by RN-E who indicated she had found the error when looking at the "physician note" on line for purposes of completing the Minimum Data Set assessment. RN-E wrote that she recalled she had not seen a Coumadin tracking sheet in the facility binder, and wrote that she informed the RN who had completed the admission. RN-E wrote her theory of what had caused the error was that the order was not entered into the MAR or into the INR tracking binder.

Facility provided a document titled Investigative Data Sheet (internal form) dated 4/2/21. This form summarized the evidence as "missed administration of Coumadin for 4 days. No harm or injury resulted in the missed dosages. Her INR on 4/2/21 was 1.1, her goal is 2.0-3.0. Nursing staff checked of on the MAR that they administered the Coumadin, but they did not administer it [note: the statement is in error as staff were actually documenting an order that the resident was supposed to be receiving Coumadin, and they should be checking for that Coumadin order. Nurses did not document they had given Coumadin when they did not.] An INR tracking sheet was not placed in the INR book by

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245442	A. BUILDING _____ B. WING _____	C 11/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING VALLEY CARE CENTER	**800 MEMORIAL DRIVE SPRING VALLEY, MN 55975**

(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 760	Continued From page 16	F 760		

the admitting nurse. Another nurse stated it was not given and no order, but did not follow-up. The document fails to show investigation related to the root cause for why the original INR order was not entered into the MAR and why the original orders were not noted or reviewed by nurses. The document fails to show an investigation as to why nurses did not respond to the order to look for Coumadin dosing or to respond to nurses statement that said this repetitive order may have been part of the problem.

According to a phone interview 11/2/21, 12:49 p.m. RN-C stated she recalled R8 did not have a Coumadin order and said it had seemed "something was off about it." RN-C said she had reported it to RN-E. RN-C said she was aware the facility had a machine to test INR levels and had received training on how to use it. She was also aware there was a book where nurses could document INR levels, but she stated she was unsure of where it was. RN-C stated she thought it was the responsibility of nurses who worked on the day shift to make sure a resident's INR got tested and sent to ACC, but said she had not received any training on the entire process for receiving, documenting Coumadin order, using the INR book or ensuring new INR orders were in place.

According to an interview 11/1/21, 3:50 p.m. RN-A stated the facility had been doing bedside testing of INR level for approximately a year. RN-A stated it was the responsibility of all nurses to follow-up on residents who were receiving Coumadin dosing and whom required INR monitoring. RN-A stated the orders were to be transcribed into the medical record by whichever nurse received them, and if a person who was to be receiving

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245442	A. BUILDING _____ B. WING _____	C 11/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING VALLEY CARE CENTER	**800 MEMORIAL DRIVE SPRING VALLEY, MN 55975**

(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 760	Continued From page 17	F 760		

Coumadin did not have a current order, or an order for a F/U lab, the nurse should call ACC or the on-call provider. RN-A stated the facility had a binder with a record for each person receiving Coumadin where nurses could track the dose and the most recent INR levels, as well as when the next INR was due. This form was to be initiated whenever a Coumadin order was first received. RN-A stated another nurses, RN-E had "taken it upon herself to that the tracking sheets were placed in the binder" but said it was not an assigned task. RN-A stated she could not remember if she or another nurse had completed R8's admission orders.

According to a phone interview 11/02/21, 12:00 am the facility director of nursing (DON) stated the medication error occurred because an INR test was not done and so no new Coumadin orders were received. DON said she had not been working at that time and the facility assistant director of nursing [no longer employed] had failed to follow-up on the missing INR. DON said the root cause of the incident was the nurses responsible for administering the Coumadin doses needed education to call if there was not a Coumadin order. DON said she did not know why they did not know the facility procedure.

According to an interview 11/02/21, 1:56 p.m. the facility administrator stated, R8's missing Coumadin doses constituted a significant medication error, and said, "It was a failure at many levels: reporting the order, reporting the error, pharmacy missed it, there was something about the INR book." Administrator stated she could not remember all the details, but stated an expectation of making sure nurses were aware they needed to follow-up on the orders, notify the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245442	A. BUILDING _____ B. WING _____	C 11/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING VALLEY CARE CENTER	**800 MEMORIAL DRIVE SPRING VALLEY, MN 55975**

(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 760	Continued From page 18	F 760		

pharmacy and the provider, and take action to correct whatever the problem was. Administrator stated the facility had other RN's on call if a nurse has a question about what to do.

A request was made for a written procedure for Coumadin orders. Facility provided a undated document titled, Nursing Admission Checklist. Under a section titled Medications and monitoring the following is written:
"___(***) check (note) medications for accuracy and against known allergies (1st check by nurse). Write "noted" and your signature on the orders AFTER you have checked them.
___2nd check (review) medications for accuracy (2nd nurse). This is to be completed by the cart nurse upon receiving medication from pharmacy. Write "reviewed" and your signature on the orders AFTER you have checked them."

A request was made for evidence of education to nurses on the Coumadin procedures. Facility provided a document titled Nursing Education March 2021 that provided a "INR fact sheet" listing where the INR binder and machine are kept as well as some additional hints related to actual INR testing and cost. Document failed to include evidence of who attended the meeting and did not address the medication error (error was not found until 4/2/21) or the procedure for new residents and transcription of new orders, or checking new orders.

Facility also provided a document titled Quality Assurance Forms Nursing Department 04/8/21 that described a facility area of concern with missing Coumadin doses and missing INR. Document failed to identify a root cause, a review of the current procedure in relation to root cause,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245442	A. BUILDING _____ B. WING _____	C 11/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING VALLEY CARE CENTER	800 MEMORIAL DRIVE SPRING VALLEY, MN 55975

(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 760	Continued From page 19 any work done to see if the current procedure was followed, or how well it was working for staff who are responsible to administer the Coumadin, and failed to indicate any actions had been taken as written: evidence of review of checklists, checking the INR book, or performing monthly audits. Document fails to indicate how persons responsible for the procedure, or those to be reviewed by the plan for their compliance are knowledgeable about the performance improvement plan.	F 760		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can	F 761		12/9/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245442	A. BUILDING _____ B. WING _____	C 11/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING VALLEY CARE CENTER	800 MEMORIAL DRIVE SPRING VALLEY, MN 55975

(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 761	Continued From page 20 be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, facility failed to properly secure a prescribed ointment for 1 of 1 residents (R10), additionally, facility failed to assure that eye drops were properly disposed of when expired on 2 of 2 residents (R20 and R21) reviewed for medication storage. Findings include: According to R10's minimum data set assessment (MDS) dated 9/2/21, R10 was not assessed to have memory loss, but had a diagnosis of frontotemporal dementia and obsessive compulsive disorder (OCD) affecting his ability to make choices or function independently. A review of R10's medical record did not indicate R10 could self-medicate or store his medications in his room. R10's provider orders indicated he did require the use of an enzymatic debridement ointment called Santyl to a wound on his lower right leg. A Material Safety Data sheet (MSDS) for Santyl indicated the medication could be irritating if gotten in the eyes, and could be hazardous if ingested. During an observation 11/01/21, 12:45 p.m. a licensed practical nurse (LPN)-A was observed providing wound care to R10. Wound care supplies were sitting on top of a bedside stand next to R10's bed, and a tube of prescription wound ointment, Santyl, was observed laying on	F 761	The DON or designee will provide training to all staff responsible to medication administration regarding labeling and expired medication. Weekly audits will be done to ensure expired meds are removed and properly labeled. The □Storage of Medications□ policy will be updated to include storage of meds in residents□ rooms. Training will be provided to staff regarding the updated policy. We offer zoom for staff unable to make it in person in-services.	

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	245442	A. BUILDING _____ B. WING _____	C 11/02/2021

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F 761	Continued From page 21	F 761		

the counter. LPN-A did not utilize this ointment and it remained on the counter in plain view when LPN-A left the room.

According to an observation and interview, 11/01/21, 2:33 p.m. a registered nurse (RN)-B, stated medications, including those used for wound care needed to be stored in a locked cart and that only non-medicated lotions could be kept in resident rooms. RN-B confirmed the Santyl was still in R10's room at that time, stated, "that can't be there," removed the ointment and locked it in the medication cart.

During an observation/interview 11/01/2021, 9:03 a.m. two bottles of liquid eye drops were found on the Woodland Path medication cart that were expired. LPN-A confirmed that a stored bottle of Refresh Tears 0.5% moisturizing eye drops belonging to R20 was marked to be disposed of on 6/25/21, but remained in the cart. LPN-A was unable to find when R20 had last received the medication. A bottle of Artificial Tears moisturizing eye drops belonging to R21 was marked as having been opened on 9/18/21, with the label directions stating, "discard after 28 days" (10/16/21), unknown when R21 last received a dose of the medication. LPN-A said both R20's and R21's eye drops were to be used on an "as needed" basis. LPN-A stated labels on eye drops will provide direction as to how long the medication is good for after opening, and it is facility policy to write the date opened on the label, and dispose of the medication as directed by the label. LPN-A removed the two bottles from the cart and said she would dispose of them.

During an interview 11/01/21, 2:39 p.m. the director of nursing (DON) stated an expectation

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	245442	A. BUILDING _____ B. WING _____	C 11/02/2021

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F 761	Continued From page 22 for nurses to write on eye drop labels when the vial was opened, and dispose of the medication when expired or when the label indicated to discard after opening. DON stated expired medications should not be stored in a medication cart as they may be accidentally be used. DON stated all medications must be stored in a locked area, and residents may not have medications in their rooms unless they have been assessed to be capable of self-administering, and have a physician's order. DON confirmed R10 did not have such an order and did not self-provide wound care. DON stated a concern that a confused resident might get into a medication not properly stored. A request was made for a policy on medication storage. A document titled Storage of Medications and dated May 2016 was provided. The document indicated nursing staff are responsible for maintaining medication storage, and "facility shall not use discontinued, outdated, or deteriorated drugs or biologicals. All such drugs shall be returned to the dispensing pharmacy or destroyed." The policy indicates that any compartment for drug storage must be locked when not in use, and any tray or cart for drugs or biologicals is not to be left unattended or open. The policy does not address storage of medications in a resident's room.	F 761		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the	F 880		12/9/21

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F 880	Continued From page 23	F 880		

development and transmission of communicable diseases and infections.

§483.80(a) Infection prevention and control program.
The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:

§483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;

§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:
(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;
(ii) When and to whom possible incidents of communicable disease or infections should be reported;
(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;
(iv)When and how isolation should be used for a resident; including but not limited to:
(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and
(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.

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F 880	Continued From page 24 (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to perform hand washing and utilize a clean field and clean equipment while performing a dressing change for 1 of 1 resident (R10) observed for dressing changes. Findings include: R10's Minimum Data Set (MDS) dated 9/2/21, included cognitively intact with a diagnoses of dementia. R3 had a stage 3 pressure ulcer (a full thickness skin wound through subcutaneous tissue, not involving muscle, tendon, bone, that may have tunneling and undermining). R10's physician orders included a dressing change to left buttock consisting of removing the	F 880	The DON or designee will provide education with nursing staff on infection control practices during wound care, which will include, but not limited to: how to provide a clean environment and maintain cleanliness. Audits will be done weekly x4, then monthly x6. The DON or designee will conduct hand washing audits weekly x4 and monthly x6. We offer zoom for staff unable to make it in person in-services.	

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F 880	Continued From page 25	F 880		

old dressing, rinsing the wound bed with saline, application of a barrier ointment to skin surrounding the wound, and then packing the wound tunnel with 1/2 inch wide packing gauze moistened in Dakin's solution (an antiseptic solution to reduce the risk of infection); then covering the wound with an adherent bordered dressing.

During an observation on 11/1/21, at 12:43 p.m. nursing assistant (NA)-B asssited R10 to stand over the toilet, per R10's preference while licensed practical nurse (LPN)-A performed the dressing change. LPN-A came in the door and gathered a wound dressing and sterile cotton swab, and packing gauze from R10's room and brought them into the bathroom and laid them on the counter of the sink. The counter was not observed to have been cleansed prior to the supplies being set down, and no covering was placed on the counter. A folded towel with personal grooming supplies was noted next to the wound care items, and also a standard scissor that a person might use for crafts or paper was laying on the towel. LPN-A then left the room, returning several minutes later carrying a bottle of solution, several plastic medication cups and an open paper sleeve of bulk 2 x 2 gauze dressings. LPN-A was not observed to have washed hands or used alcohol hand sanitizer upon entering the room. LPN-A opened the solution and poured some in one of the cups and placed several of the 2 x 2 dressings into the solution. LPN-A then applied a pair of vinyl gloves and cleansed around R10's open wound and removed his soiled dressing/packing. LPN-A then pulled off her left glove and threw away the glove and soiled dressings. LPN-A removed a pair of bandage scissors from her pocket with her left hand and

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F 880	Continued From page 26	F 880		

laid them on the counter of the sink, reapplied a fresh left glove then cut a length of packing gauze with the same scissors without first sanitizing them. LPN-A then opened the cotton swabs, and proceeded to pack the open wound with the gauze strip, the wound was observed to be very small in circumference, but several inches deep per LPN-A's statement. While LPN-A was cleansing the wound, R10 began to yell, "I'm going to pee! I can't hold it." NA-B retrieved a urinal that was sitting on the floor under the sink and assisted R10 as he voided. NA-B then emptied the contents of the urinal into the open toilet about 18 inches away from R10's buttocks and while LPN-A was packing the open wound. LPN-A continued to pack the wound, covered it with a clean dressing and gathered up the supplies. LPN-A was observed to return to the medication cart where she took a sanitizing wipe and cleaned the scissors, wrapped the scissors in the wipe and then used hand sanitizer to clean her hands and put away the rest of the supplies.

When interviewed on 11/1/21, at 12:52 p.m. LPN-A stated she should have performed hand hygiene before providing wound care and after removing the soiled dressing and before putting on a new glove. LPN-A stated a clean field for supplies should have been created to place items. LPN-A stated she should not have stored the bandage scissors in her pocket, and should have sanitized them prior to using on the clean dressings.

When interviewed on 11/1/21, at 2:39 p.m. the director of nursing (DON stated, they would expect hand hygiene to be performed upon entering the room, between clean and dirty portions of dressing changes and to have

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F 880	Continued From page 27	F 880		

sanitized the scissors prior to use and to have created a clean field to place dressing supplies. In addition, dumping urine into the toilet during a dressing change had the risk of contaminating the wound.

The facility policy titled Handwashing/Hand Hygiene dated March of 2020, included, hand washing should occur before and after direct contact with residents, when hands are visibly dirty or soiled, after contact with blood, body fluids, secretions, mucous membranes or non-intact skin, after removing gloves, after handling items potentially contaminated with blood, body fluids or secretions. Additionally, the policy indicated alcohol based hand rub was preferred if hands were not visibly soiled. The policy also indicated that hand hygiene is the final step after removing and disposing of personal protective equipment and the use of gloves does not replace handwashing/hand hygiene.

The facility policy entitled, Cleaning and Disinfection of Resident-Care Items and Equipment dated March 2020, identified equipment would be cleaned and disinfected between residents.

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
November 17, 2021

Administrator
Spring Valley Care Center
800 Memorial Drive
Spring Valley, MN 55975

Re: State Nursing Home Licensing Orders
Event ID: CH0011

Dear Administrator:

The above facility was surveyed on November 1, 2021 through November 2, 2021 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 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 and/or statute 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 order within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html. The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered to you electronically. 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 or rule after the statement, "This MN Requirement 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.

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. 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:

Karen Aldinger, Unit Supervisor
St. Cloud A District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
3333 Division Street, Suite 212
Saint Cloud, Minnesota 56301-4557
Email: karen.aldinger@state.mn.us
Office: (651) 201-3794 Mobile: (320) 249-2805

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.

Please feel free to call me with any questions.

Melissa Poepping, Health Program Representative Senior
Program Assurance | Licensing and Certification
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: melissa.poepping@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00121	A. BUILDING: _____ B. WING _____	C 11/02/2021

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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 11/1/21 to 11/2/21, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was found out of compliance with the MN State Licensure. Please indicate in your electronic plan of correction you have reviewed these orders and identify the date when they will be completed.	2 000		

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	00121	A. BUILDING: _____ B. WING _____	C 11/02/2021

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2 000	Continued From page 1 The following complaints were found to be SUBSTANTIATED: H5442028C (MN74213), H5442033C (MN60350), H5442027C (MN77366), H5442030C (MN70299), H5442031C (MN71141), H5442034C (MN63818) AND H5442035C (MN64638) no licensing orders were issued. The following complaints were found to be SUBSTANTIATED: H5442029C (MN71711) with licensing orders issued. The following complaint was found to be UNSUBSTANTIATED: H5442026C (MN77366). The following complaint was found to be UNSUBSTANTIATED: H5442032C (MN70146). However, as a result of the investigation licensing orders were issued. 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 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 surveyor ' s findings are the Suggested Method of Correction and Time Period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health	2 000		

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2 000	Continued From page 2 Informational Bulletin 14-01, available at <https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html> The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "CORRECTED" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. 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.	2 000		
21390	MN Rule 4658.0800 Subp. 4 A-I Infection Control Subp. 4. Policies and procedures. The infection control program must include policies and procedures which provide for the following: A. surveillance based on systematic data collection to identify nosocomial infections in residents; B. a system for detection, investigation, and control of outbreaks of infectious diseases; C. isolation and precautions systems to reduce risk of transmission of infectious agents; D. in-service education in infection prevention and control; E. a resident health program including an immunization program, a tuberculosis program as	21390		12/9/21

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SPRING VALLEY CARE CENTER	800 MEMORIAL DRIVE SPRING VALLEY, MN 55975

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21390	Continued From page 3 defined in part 4658.0810, and policies and procedures of resident care practices to assist in the prevention and treatment of infections; F. the development and implementation of employee health policies and infection control practices, including a tuberculosis program as defined in part 4658.0815; G. a system for reviewing antibiotic use; H. a system for review and evaluation of products which affect infection control, such as disinfectants, antiseptics, gloves, and incontinence products; and I. methods for maintaining awareness of current standards of practice in infection control. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to perform hand washing and utilize a clean field and clean equipment while performing a dressing change for 1 of 1 resident (R10) observed for dressing changes. Findings include: R10's Minimum Data Set (MDS) dated 9/2/21, included cognitively intact with a diagnoses of dementia. R3 had a stage 3 pressure ulcer (a full thickness skin wound through subcutaneous tissue, not involving muscle, tendon, bone, that may have tunneling and undermining). R10's physician orders included a dressing change to left buttock consisting of removing the old dressing, rinsing the wound bed with saline, application of a barrier ointment to skin surrounding the wound, and then packing the wound tunnel with 1/2 inch wide packing gauze moistened in Dakin's solution (an antiseptic	21390	corrected	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00121	A. BUILDING: _____ B. WING _____	C 11/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING VALLEY CARE CENTER	800 MEMORIAL DRIVE SPRING VALLEY, MN 55975

(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
21390	Continued From page 4 solution to reduce the risk of infection); then covering the wound with an adherent bordered dressing. During an observation on 11/1/21, at 12:43 p.m. nursing assistant (NA)-B asssited R10 to stand over the toilet, per R10's preference while licensed practical nurse (LPN)-A performed the dressing change. LPN-A came in the door and gathered a wound dressing and sterile cotton swab, and packing gauze from R10's room and brought them into the bathroom and laid them on the counter of the sink. The counter was not observed to have been cleansed prior to the supplies being set down, and no covering was placed on the counter. A folded towel with personal grooming supplies was noted next to the wound care items, and also a standard scissor that a person might use for crafts or paper was laying on the towel. LPN-A then left the room, returning several minutes later carrying a bottle of solution, several plastic medication cups and an open paper sleeve of bulk 2 x 2 gauze dressings. LPN-A was not observed to have washed hands or used alcohol hand sanitizer upon entering the room. LPN-A opened the solution and poured some in one of the cups and placed several of the 2 x 2 dressings into the solution. LPN-A then applied a pair of vinyl gloves and cleansed around R10's open wound and removed his soiled dressing/packing. LPN-A then pulled off her left glove and threw away the glove and soiled dressings. LPN-A removed a pair of bandage scissors from her pocket with her left hand and laid them on the counter of the sink, reapplied a fresh left glove then cut a length of packing gauze with the same scissors without first sanitizing them. LPN-A then opened the cotton swabs, and proceeded to pack the open wound with the gauze strip, the wound was observed to be very	21390		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00121	A. BUILDING: _____ B. WING _____	C 11/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(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
21390	Continued From page 5	21390		

small in circumference, but several inches deep per LPN-A's statement. While LPN-A was cleansing the wound, R10 began to yell, "I'm going to pee! I can't hold it." NA-B retrieved a urinal that was sitting on the floor under the sink and assisted R10 as he voided. NA-B then emptied the contents of the urinal into the open toilet about 18 inches away from R10's buttocks and while LPN-A was packing the open wound. LPN-A continued to pack the wound, covered it with a clean dressing and gathered up the supplies. LPN-A was observed to return to the medication cart where she took a sanitizing wipe and cleaned the scissors, wrapped the scissors in the wipe and then used hand sanitizer to clean her hands and put away the rest of the supplies.

When interviewed on 11/1/21, at 12:52 p.m. LPN-A stated she should have performed hand hygiene before providing wound care and after removing the soiled dressing and before putting on a new glove. LPN-A stated a clean field for supplies should have been created to place items. LPN-A stated she should not have stored the bandage scissors in her pocket, and should have sanitized them prior to using on the clean dressings.

When interviewed on 11/1/21, at 2:39 p.m. the director of nursing (DON stated, they would expect hand hygiene to be performed upon entering the room, between clean and dirty portions of dressing changes and to have sanitized the scissors prior to use and to have created a clean field to place dressing supplies. In addition, dumping urine into the toilet during a dressing change had the risk of contaminating the wound.

The facility policy titled Handwashing/Hand

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00121	A. BUILDING: _____ B. WING _____	C 11/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(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
21390	Continued From page 6 Hygiene dated March of 2020, included, hand washing should occur before and after direct contact with residents, when hands are visibly dirty or soiled, after contact with blood, body fluids, secretions, mucous membranes or non-intact skin, after removing gloves, after handling items potentially contaminated with blood, body fluids or secretions. Additionally, the policy indicated alcohol based hand rub was preferred if hands were not visibly soiled. The policy also indicated that hand hygiene is the final step after removing and disposing of personal protective equipment and the use of gloves does not replace handwashing/hand hygiene. The facility policy entitled, Cleaning and Disinfection of Resident-Care Items and Equipment dated March 2020, identified equipment would be cleaned and disinfected between residents. SUGGESTED METHOD OF CORRECTION: The Director of Nursing (DON) or designee could review education with nursing staff on how to provide a clean environment, and maintain cleanliness while providing wound care. DON could also review proper steps of PPE use and hand hygiene during wound care. DON or designee could do care audits to ensure facility policies and best nursing practice are being followed during the care of open wounds. TIME PERIOD FOR CORRECTION: Twenty one (21) days.	21390		
21545	MN Rule 4658.1320 A.B.C Medication Errors A nursing home must ensure that:	21545		12/9/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00121	A. BUILDING: _____ B. WING _____	C 11/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING VALLEY CARE CENTER	800 MEMORIAL DRIVE SPRING VALLEY, MN 55975

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21545	Continued From page 7	21545		

A. Its medication error rate is less than five percent as described in the Interpretive Guidelines for Code of Federal Regulations, title 42, section 483.25 (m), found in Appendix P of the State Operations Manual, Guidance to Surveyors for Long-Term Care Facilities, which is incorporated by reference in part 4658.1315. For purposes of this part, a medication error means:

(1) a discrepancy between what was prescribed and what medications are actually administered to residents in the nursing home; or

(2) the administration of expired medications.

B. It is free of any significant medication error. A significant medication error is:

(1) an error which causes the resident discomfort or jeopardizes the resident's health or safety; or

(2) medication from a category that usually requires the medication in the resident's blood to be titrated to a specific blood level and a single medication error could alter that level and precipitate a reoccurrence of symptoms or toxicity. All medications are administered as prescribed. An incident report or medication error report must be filed for any medication error that occurs. Any significant medication errors or resident reactions must be reported to the physician or the physician's designee and the resident or the resident's legal guardian or designated representative and an explanation must be made in the resident's clinical record.

C. All medications are administered as prescribed. An incident report or medication error report must be filed for any medication error that occurs. Any significant medication errors or resident reactions must be reported to the physician or the physician's designee and the resident or the resident's legal guardian or

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00121	A. BUILDING: _____ B. WING _____	C 11/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING VALLEY CARE CENTER	800 MEMORIAL DRIVE SPRING VALLEY, MN 55975

(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
21545	Continued From page 8 designated representative and an explanation must be made in the resident's clinical record. This MN Requirement is not met as evidenced by: Based on document review and interviews, facility failed to follow its procedure for ensuring transcription of physician orders and follow-up laboratory testing for 1 of 1 residents (R8) reviewed for Coumadin (an anticoagulant) use, resulting in four missed doses and sub-optimal lab results. Findings include: According to a hospital after visit summary (HAVS), R8 was discharged from a hospital stay and admitted to the facility on 3/25/21. R8 had been hospitalized for atrial fibrillation requiring anticoagulant treatment, and the HAVS indicated R8 was to continue receiving Coumadin (warfarin) 2.5 mg by mouth daily until 3/29/21, and to have a follow-up INR lab on 3/29/21 to check the efficacy of that dose. The identified INR goal level was listed as 2-3. The HAVS document did not have a signature by a facility nurse to indicate who had noted and/or transcribed the orders into the facility electronic health record (EHR) for R8, or signatures of any other nurse reviewing the orders at any other time [please refer to facility procedure below]. According to information on the HAVS form, "It is extremely important to have your INR blood work checked. Your doctor will follow the results closely. The tablet strength and number of tablets you take each day may change based on the INR result ...if your heart rhythm is abnormal [atrial	21545	corrected	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00121	A. BUILDING: _____ B. WING _____	C 11/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(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
21545	Continued From page 9	21545		

fibrillation], a clot can form in the heart and go to the brain, where it can cause a stroke."

The following orders related to Coumadin were found to have been transcribed to R8's EHR upon admission, 3/25/21:
"Resident takes Coumadin, ensure it is given @HS [bedtime] every day.
Please assess once daily to ensure no side effects from Coumadin are present. Bruising, prolonged bleeding, abnormal bleeding.
Warfarin Sodium tablet 2.5 mg. Give 2.5 mg by mouth one time a day related to chronic atrial fibrillation unspecified until 3/28/2021."
The admission orders listed in R8's EHR did not include a transcription of the lab order for an INR level to be drawn 3/29/21.

According to R8's Medication Administration Record and corresponding progress notes, a registered nurse (RN)-C acknowledged by initialing the order that stated: "resident takes Coumadin, ensure it is given @HS every day" (order for evening shift) on the following dates, 3/29/21, 3/31/21, 4/1/21. No intervention was documented indicating any actions taken to follow-up up on the lack of a current Coumadin order. Another nurse, RN-D also signed the order on 3/30/21 without documented response.

A review of R8's progress notes did not provide any additional information until 4/2/21 which reported lab had been drawn and a new order received.

A document dated 4/2/21 from the Anti-coagulation Clinic (ACC) was signed by RN-A upon receipt by fax. The document indicated R8 had had an INR completed with a result of 1.10 which was a drop from the previous

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00121	A. BUILDING: _____ B. WING _____	C 11/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING VALLEY CARE CENTER	800 MEMORIAL DRIVE SPRING VALLEY, MN 55975

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21545	Continued From page 10	21545		

level 3/25/21. The document included the following note: ACC called Spring Valley Living and spoke to the nurse [RN-A] regarding patient INR being low. [RN-A] stated the patient did not get the dose on 3/29/21 to 4/1/21. According to [RN-A] they missed the dose and recheck dates that was instructed to the facility a week ago to recheck on 3/29/21."

A document dated 4/8/21 titled: Questionnaire for staff who had contact with this resident in last 48 hours (Q-48 hr), listed RN-A as a staff who had worked 3/25/21, 7:30 a.m. to 5:00 p.m. RN-A wrote a description of what she did: "I admitted this resident, entered orders, communicated with Anti-coag clinic, received orders from them as well. Coumadin + INR check ordered." This description failed to indicate the date of communication with the ACC or the date the listed orders were received. RN-A wrote: "what I failed to do was place an INR tracking sheet in the INR book. I have updated the Admission check list to include this task." Description failed to indicate why a physician's order was not transcribed into R8's EHR upon admission.

An additional Q-48 hr sheet dated 4/8/21 was signed by RN-C who wrote the following description of her action: "resident was supposed to be on Coumadin but there was no order and no card. I checked off in the MAR that I gave it when I did not." RN-C noted a safety issue that needed to be fixed as, "make sure orders are sent to pharmacy to get correct medication by RN" and wrote a theory as to the cause as being, "order not put in to pharmacy, repetition of charting." Description failed to indicate which RN was to place the order, who did not send the order to pharmacy and what was meant by "repetition of charting."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00121	A. BUILDING: _____ B. WING _____	C 11/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING VALLEY CARE CENTER	800 MEMORIAL DRIVE SPRING VALLEY, MN 55975

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21545	Continued From page 11 A third Q-48 hr sheet dated 4/8/21 was signed by RN-D who wrote the following description of action: "administration of HS medications indicated a Coumadin check, however, I missed that the card [cardboard holder for pills] was missing when multitasking. RN-D wrote a safety issue related to not seeing the Coumadin card and recommended putting Coumadin orders on a separate MAR tab in the EHR to avoid problems with multi-tasking. RN-D wrote a theory that repetition of the daily Coumadin check [to check for an order Vs Coumadin administration order] was a possible contributor to the missing doses, as well as problems with multi-tasking. A fourth Q-48 hr sheet, not dated, was signed by RN-E who indicated she had found the error when looking at the "physician note" on line for purposes of completing the Minimum Data Set assessment. RN-E wrote that she recalled she had not seen a Coumadin tracking sheet in the facility binder, and wrote that she informed the RN who had completed the admission. RN-E wrote her theory of what had caused the error was that the order was not entered into the MAR or into the INR tracking binder. Facility provided a document titled Investigative Data Sheet (internal form) dated 4/2/21. This form summarized the evidence as "missed administration of Coumadin for 4 days. No harm or injury resulted in the missed dosages. Her INR on 4/2/21 was 1.1, her goal is 2.0-3.0. Nursing staff checked of on the MAR that they administered the Coumadin, but they did not administer it [note: the statement is in error as staff were actually documenting an order that the resident was supposed to be receiving Coumadin, and they should be checking for that	21545		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00121	A. BUILDING: _____ B. WING _____	C 11/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING VALLEY CARE CENTER	800 MEMORIAL DRIVE SPRING VALLEY, MN 55975

(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
21545	Continued From page 12	21545		

Coumadin order. Nurses did not document they had given Coumadin when they did not.] An INR tracking sheet was not placed in the INR book by the admitting nurse. Another nurse stated it was not given and no order, but did not follow-up. The document fails to show investigation related to the root cause for why the original INR order was not entered into the MAR and why the original orders were not noted or reviewed by nurses. The document fails to show an investigation as to why nurses did not respond to the order to look for Coumadin dosing or to respond to nurses statement that said this repetitive order may have been part of the problem.

According to a phone interview 11/2/21, 12:49 p.m. RN-C stated she recalled R8 did not have a Coumadin order and said it had seemed "something was off about it." RN-C said she had reported it to RN-E. RN-C said she was aware the facility had a machine to test INR levels and had received training on how to use it. She was also aware there was a book where nurses could document INR levels, but she stated she was unsure of where it was. RN-C stated she thought it was the responsibility of nurses who worked on the day shift to make sure a resident's INR got tested and sent to ACC, but said she had not received any training on the entire process for receiving, documenting Coumadin order, using the INR book or ensuring new INR orders were in place.

According to an interview 11/1/21, 3:50 p.m. RN-A stated the facility had been doing bedside testing of INR level for approximately a year. RN-A stated it was the responsibility of all nurses to follow-up on residents who were receiving Coumadin dosing and whom required INR monitoring. RN-A stated the orders were to be transcribed into the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00121	A. BUILDING: _____ B. WING _____	C 11/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING VALLEY CARE CENTER	800 MEMORIAL DRIVE SPRING VALLEY, MN 55975

(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
21545	Continued From page 13	21545		

medical record by whichever nurse received them, and if a person who was to be receiving Coumadin did not have a current order, or an order for a F/U lab, the nurse should call ACC or the on-call provider. RN-A stated the facility had a binder with a record for each person receiving Coumadin where nurses could track the dose and the most recent INR levels, as well as when the next INR was due. This form was to be initiated whenever a Coumadin order was first received. RN-A stated another nurses, RN-E had "taken it upon herself to that the tracking sheets were placed in the binder" but said it was not an assigned task. RN-A stated she could not remember if she or another nurse had completed R8's admission orders.

According to a phone interview 11/02/21, 12:00 am the facility director of nursing (DON) stated the medication error occurred because an INR test was not done and so no new Coumadin orders were received. DON said she had not been working at that time and the facility assistant director of nursing [no longer employed] had failed to follow-up on the missing INR. DON said the root cause of the incident was the nurses responsible for administering the Coumadin doses needed education to call if there was not a Coumadin order. DON said she did not know why they did not know the facility procedure.

According to an interview 11/02/21, 1:56 p.m. the facility administrator stated, R8's missing Coumadin doses constituted a significant medication error, and said, "It was a failure at many levels: reporting the order, reporting the error, pharmacy missed it, there was something about the INR book." Administrator stated she could not remember all the details, but stated an expectation of making sure nurses were aware

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00121	A. BUILDING: _____ B. WING _____	C 11/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING VALLEY CARE CENTER	800 MEMORIAL DRIVE SPRING VALLEY, MN 55975

(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
21545	Continued From page 14 they needed to follow-up on the orders, notify the pharmacy and the provider, and take action to correct whatever the problem was. Administrator stated the facility had other RN's on call if a nurse has a question about what to do. A request was made for a written procedure for Coumadin orders. Facility provided a undated document titled, Nursing Admission Checklist. Under a section titled Medications and monitoring the following is written: "___(***) check (note) medications for accuracy and against known allergies (1st check by nurse). Write "noted" and your signature on the orders AFTER you have checked them. ___2nd check (review) medications for accuracy (2nd nurse). This is to be completed by the cart nurse upon receiving medication from pharmacy. Write "reviewed" and your signature on the orders AFTER you have checked them." A request was made for evidence of education to nurses on the Coumadin procedures. Facility provided a document titled Nursing Education March 2021 that provided a "INR fact sheet" listing where the INR binder and machine are kept as well as some additional hints related to actual INR testing and cost. Document failed to include evidence of who attended the meeting and did not address the medication error (error was not found until 4/2/21) or the procedure for new residents and transcription of new orders, or checking new orders. Facility also provided a document titled Quality Assurance Forms Nursing Department 04/8/21 that described a facility area of concern with missing Coumadin doses and missing INR. Document failed to identify a root cause, a review of the current procedure in relation to root cause,	21545		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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SPRING VALLEY CARE CENTER	800 MEMORIAL DRIVE SPRING VALLEY, MN 55975

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21545	Continued From page 15 any work done to see if the current procedure was followed, or how well it was working for staff who are responsible to administer the Coumadin, and failed to indicate any actions had been taken as written: evidence of review of checklists, checking the INR book, or performing monthly audits. Document fails to indicate how persons responsible for the procedure, or those to be reviewed by the plan for their compliance are knowledgeable about the performance improvement plan. SUGGESTED METHOD OF CORRECTION: The Director of Nursing (DON) or designee could review and educate nursing staff on the facility plan for transcription of medication orders, specifically of warfarin dose changes with orders for blood work. DON or designee could audit all facility high-risk medication orders and nursing actions to ensure accurate and timely transcription of orders, and evidence of nurses following the facility procedures for tracking and documenting warfarin and INR orders. TIME PERIOD FOR CORRECTION: Twenty one (21) days.	21545		
21610	MN Rule 4658.1340 Subp. 1 Medicine Cabinet and Preparation Area;Storage Subpart 1. Storage of drugs. A nursing home must store all drugs in locked compartments under proper temperature controls, and permit only authorized nursing personnel to have access to the keys.	21610		12/9/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00121	A. BUILDING: _____ B. WING _____	C 11/02/2021

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(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
21610	Continued From page 16 This MN Requirement is not met as evidenced by: Based on observation, interview and document review, facility failed to properly secure a prescribed ointment for 1 of 1 residents (R10) reviewed for medication storage. Findings include: According to R10's minimum data set assessment (MDS) dated 9/2/21, R10 was not assessed to have memory loss, but had a diagnosis of frontotemporal dementia and obsessive compulsive disorder (OCD) affecting his ability to make choices or function independently. A review of R10's medical record did not indicate R10 could self-medicate or store his medications in his room. R10's provider orders indicated he did require the use of an enzymatic debridement ointment called Santyl to a wound on his lower right leg. A Material Safety Data sheet (MSDS) for Santyl indicated the medication could be irritating if gotten in the eyes, and could be hazardous if ingested. During an observation 11/01/21, 12:45 p.m. a licensed practical nurse (LPN)-A was observed providing wound care to R10. Wound care supplies were sitting on top of a bedside stand next to R10's bed, and a tube of prescription wound ointment, Santyl, was observed laying on the counter. LPN-A did not utilize this ointment and it remained on the counter in plain view when LPN-A left the room. According to an observation and interview,	21610	corrected	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00121	A. BUILDING: _____ B. WING _____	C 11/02/2021

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21610	Continued From page 17 11/01/21, 2:33 p.m. a registered nurse (RN)-B, stated medications, including those used for wound care needed to be stored in a locked cart and that only non-medicated lotions could be kept in resident rooms. RN-B confirmed the Santyl was still in R10's room at that time, stated, "that can't be there," removed the ointment and locked it in the medication cart. During an interview 11/01/21, 2:39 p.m. the director of nursing (DON) stated all medications must be stored in a locked area, and residents may not have medications in their rooms unless they have been assessed to be capable of self-administering, and have a physician's order. DON confirmed R10 did not have such an order and did not self-provide wound care. DON stated a concern that a confused resident might get into a medication not properly stored. A request was made for a policy on medication storage. A document titled Storage of Medications and dated May 2016 was provided. The document indicated nursing staff are responsible for maintaining medication storage, and "facility shall not use discontinued, outdated, or deteriorated drugs or biologicals. All such drugs shall be returned to the dispensing pharmacy or destroyed." The policy indicates that any compartment for drug storage must be locked when not in use, and any tray or cart for drugs or biologicals is not to be left unattended or open. The policy does not address storage of medications in a resident's room. SUGGESTED METHOD OF CORRECTION: The Director of Nursing (DON) or designee could	21610		

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21610	Continued From page 18 train nursing staff in the facility policies for safe storage of medication, specifically storage at resident bedside. DON or designee could audit residents rooms to ensure that medications are not left in rooms unsupervised when not appropriate. TIME PERIOD FOR CORRECTION: Twenty one (21) days.	21610		
21620	MN Rule 4658.1345 Labeling of Drugs Drugs used in the nursing home must be labeled in accordance with part 6800.6300. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to assure that eye drops were properly disposed of when expired on 2 of 2 residents (R20 and R21) reviewed for medication storage. Findings include: During an observation/interview 11/01/2021, 9:03 a.m. two bottles of liquid eye drops were found on the Woodland Path medication cart that were expired. LPN-A confirmed that a stored bottle of Refresh Tears 0.5% moisturizing eye drops belonging to R20 was marked to be disposed of on 6/25/21, but remained in the cart. LPN-A was unable to find when R20 had last received the medication. A bottle of Artificial Tears moisturizing eye drops belonging to R21 was marked as having been opened on 9/18/21, with the label directions stating, "discard after 28 days" (10/16/21), unknown when R21 last received a	21620	corrected	12/9/21

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21620	Continued From page 19	21620		

dose of the medication. LPN-A said both R20's and R21's eye drops were to be used on an "as needed" basis. LPN-A stated labels on eye drops will provide direction as to how long the medication is good for after opening, and it is facility policy to write the date opened on the label, and dispose of the medication as directed by the label. LPN-A removed the two bottles from the cart and said she would dispose of them.

During an interview 11/01/21, 2:39 p.m. the director of nursing (DON) stated an expectation for nurses to write on eye drop labels when the vial was opened, and dispose of the medication when expired or when the label indicated to discard after opening.

A request was made for a policy on medication storage. A document titled Storage of Medications and dated May 2016 was provided. The document indicated nursing staff are responsible for maintaining medication storage, and "facility shall not use discontinued, outdated, or deteriorated drugs or biologicals. All such drugs shall be returned to the dispensing pharmacy or destroyed." The policy indicates that any compartment for drug storage must be locked when not in use, and any tray or cart for drugs or biologicals is not to be left unattended or open. The policy does not address storage of medications in a resident's room.

SUGGESTED METHOD OF CORRECTION:

The consulting pharmacist, director of nursing or designee could provide training to all staff responsible for medication administration in the state requirements to have an accurate label and in the concerns of using expired medications. Audits could be done to ensure that the labels for

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21620	Continued From page 20 eye drops and similar liquids are being appropriately labeled when opened, and expired medications are removed from storage. TIME PERIOD FOR CORRECTION: Twenty one (21) days.	21620		