Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Submitted
March 17, 2020

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

RE: CCN: 245442
Cycle Start Date: February 28, 2020

Dear Administrator:

On February 28, 2020, survey was completed at your facility by the Minnesota Department of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

Your facility was not in substantial compliance with the participation requirements and the conditions in your facility constituted **both substandard quality of care and immediate jeopardy** to resident health or safety. This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted immediate jeopardy (Level J) whereby corrections were required. The Statement of Deficiencies (CMS-2567) is being electronically delivered.

REMOVAL OF IMMEDIATE JEOPARDY

On February 28, 2020, the situation of immediate jeopardy to potential health and safety cited at F600 was removed. However, continued non-compliance remains at the lower scope and severity of G.

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 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 May 18, 2020.

This Department is also recommending that CMS impose a civil money penalty. You will receive a formal notice from the CMS RO only if CMS agrees with our recommendation.

- Civil money penalty (42 CFR 488.430 through 488.444).

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective May 18, 2020, (42 CFR 488.417 (b)). They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective May 18, 2020, (42 CFR 488.417 (b)).

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.

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 $10,483; 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.

Therefore, your agency is prohibited from offering or conducting a Nurse Assistant Training/Competency Evaluation Programs or Competency Evaluation Programs for two years effective February 28, 2020. This prohibition is not subject to appeal. Under Public Law 105-15 (H.R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

SUBSTANDARD QUALITY OF CARE

Your facility's deficiencies with with one or more of the following: §483.10, Residents Rights, §483.12, Freedom from Abuse, Neglect, and Exploitation, §483.15, Quality of Life and §483.25, Quality of Care, 483.40 Behavioral Health Services, §483.45 Pharmacy Services, §483.70 Administration, or §483.80 Infection control has been determined to constitute substandard quality of care as defined at §488.301. Sections 1819(g)(5)(C) and 1919(g)(5)(C) of the Social Security Act and 42 CFR 488.325(h) require that the attending physician of each resident who was found to have received substandard quality of care, as well as the State board responsible for licensing the facility's administrator, be notified of the substandard quality of care. If you have not already provided the following information, you are required to provide to this agency within ten working days of your receipt of this letter the name and address of the attending physician of each resident found to have received substandard quality of care.

Please note that, in accordance with 42 CFR 488.325(g), your failure to provide this information timely will result in termination of participation in the Medicare and/or Medicaid program(s) or imposition of alternative remedies.

Federal law, as specified in the Act at Sections 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care. Therefore, Spring Valley Care Center is prohibited from offering or conducting a Nurse Assistant Training / Competency Evaluation Programs (NATCEP) or Competency Evaluation Programs for two years effective February 28, 2020. This prohibition remains in effect for the specified period even though substantial compliance is attained. Under Public Law 105-15 (H. R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

ELECTRONIC PLAN OF CORRECTION (ePOC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable plan of correction (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:

Jennifer Kolsrud Brown, Unit Supervisor
Rochester Survey Team
Licensing and Certification Program
Health Regulation Division

Minnesota Department of Health
18 Wood Lake Drive Southeast
Rochester, Minnesota 55904-5506
Email: jennifer.kolsrud@state.mn.us
Phone: 507-206-2727

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, Licensing and Certification Program 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 August 28, 2020 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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 DENIAL OF PAYMENT

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.

APPEAL RIGHTS NURSE AIDE TRAINING PROHIBITION

Pursuant to the Federal regulations at 42 CFR Sections 498.3(b)(13)(2) and 498.3(b)(15), a finding of substandard quality of care that leads to the loss of approval by a Skilled Nursing Facility (SNF) of its NATCEP is an initial determination. In accordance with 42 CFR part 489 a provider dissatisfied with an initial determination is entitled to an appeal. If you disagree with the findings of substandard quality of care which resulted in the conduct of an extended survey and the subsequent loss of approval to conduct or be a site for a NATCEP, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Department Appeals Board. Procedures governing this process are set out in Federal regulations at 42 CFR Section 498.40, et. Seq.

A written request for a hearing must be filed no later than 60 days from the date of receipt of this letter. Such a request may be made to the Centers for Medicare and Medicaid Services (formerly Health Care Financing Administration) at 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

A request for a hearing should identify the specific issues and the 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. You do not need to submit records or other documents with your hearing request. The Departmental Appeals Board (DAB) will issue instructions regarding the proper submittal of documents for the hearing. The DAB will also set the location for the hearing, which is likely to be in Minnesota or in Chicago, Illinois. You may be represented by counsel at a hearing at your own expense.

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

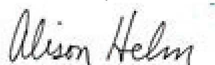
This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: https://mdhprovidercontent.web.health.state.mn.us/ltc_idr.cfm

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 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,



Alison Helm, Enforcement Specialist
Licensing and Certification

Minnesota Department of Health
P.O. Box 64970
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4206
Email: alison.helm@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 02/28/2020

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 On 2/26/20-2/28/20 an abbreviated survey was completed at your facility to conduct a complaint investigation. Your facility was found not to be in compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. During the survey an immediate jeopardy was identified at F600. The IJ began on 8/15/19, the vice president and social services were notified of the immediate jeopardy on 2/26/20. The IJ was removed on 2/28/20, but noncompliance remained at the lower scope and severity level of G - isolated scope and severity level, which indicated actual harm that is not immediate jeopardy. In addition, an extended survey was completed on 2/27/20, related to the substandard quality of care findings. The following complaint was substantiated: H5442023C was found at F600 The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 600	Free from Abuse and Neglect	F 600		3/31/20

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed — TITLE — (X6) DATE: 03/25/2020

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

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F 600 SS=J

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CFR(s): 483.12(a)(1)

§483.12 Freedom from Abuse, Neglect, and Exploitation
The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms.

§483.12(a) The facility must-

§483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion;
This REQUIREMENT is not met as evidenced by:
Based on observation, interview and document review, the facility failed to ensure residents were free from abuse, failed to investigate, and failed to protect residents during an investigation, following an allegation of sexual abuse by staff. This resulted in an immediate jeopardy (IJ) for 1 of 1 (R1) resident reviewed for an allegation of sexual abuse.

The IJ began on 8/15/19, when R1 alleged a tall dark haired man had raped her. The IJ was identified on 2/26/20, and the vice president and social services (SS) were informed of the IJ on 2/26/20, at 5:21 p.m. The IJ was removed on 2/28/20, at 12:29 p.m. but noncompliance remained at the lower scope and severity level of G, isolated with actual psychosocial harm.

Findings include:

F 600

Preparation, submission and implementation of this Plan of Correction does not constitute an admission of or agreement with the facts and conclusions set forth in the statement of deficiencies. This Plan of Correction is prepared and/or executed as a means to continuously improve the quality of care, to comply with all applicable state and federal regulatory requirements and constitutes the facility's allegation of compliance.

At Risk:
Residents residing within the facility of Spring Valley Living are all considered vulnerable adults and are to be protected under the Spring Valley Living Abuse Prevention Plan.
Action to be taken will include any of the

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During an observation and interview on 2/26/20, at 10:22 a.m. R1 was lying in her bed uncovered, wearing pajamas. When interviewed at that time, R1 denied any concerns with her care stating, "Even the little kids get care here."

R1's Investigative Data Sheet dated 8/15/19 included, "Resident started to go towards the Estates (the attached assisted living) when staff stopped her. Resident then stated that a tall dark haired man had raped her. Staff asked if it was environmental services (ES)-A and [R1] stated no. [NA-A] then asked if it was registered nurse (RN)-A and [R1] got quiet." The Investigative Data Sheet indicated there had been no previous circumstances of this type. Three facility staff members were interviewed regarding the allegation. The form included, "What immediate action was taken upon learning of the incident to protect resident from further abuse? The Investigation was started right away. It was then decided that no male staff should be in resident's room without a witness." The Investigation Team comments and recommendations included, "IDT (interdisciplinary team) recommended no male should be alone with resident unless there is a witness. It was also discussed that the last stay the resident was here for she was in the same exact room and maybe switching rooms may help due to another resident coming into her room during the last stay." The rest of the form was incomplete and was left blank including the place to indicate 'Results reported to State Agency(ies)'."

R1's admission record indicated R1 was admitted to the facility on 8/9/19, and had diagnoses of

F 600

allegation forms listed in the Abuse & Prevention Plan to be taken seriously, submitted to the State Agency, and for any form of abuse the alleged penetrator to be suspended during the investigation.

Policy and Procedure:
The interdisciplinary team reviewed the vulnerable adult policy and procedure and the Abuse Prevention Plan on February 27th, 2020, with changes to made effective by the end of February 27, 2020. Changes to be made include any allegations to staff members to result in immediate suspension pending investigation.

Systems:
Effective as of February 27, 2020, the Spring Living Care Center has implemented a 24/7 on-call VA report designee. The on-call VA designee is listed in the Important Phone Numbers binder (at front desk) and on top of the 24 hour Nurse Report Sheet. The on-call VA designee is responsible for ensuring the initial report was filed and completed according to Spring Valley Living's Abuse Prevention Plan. The participating designee is responsible for following through with the five-day report and taking appropriate actions with staff as necessary.

VA's:
Will be reviewed on a weekly basis at the weekly IDT meeting. Discussion will include those that were submitted and the

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Alzheimer's disease, major depressive disorder, and recurrent and unspecified dementia without behavioral disturbance.

R1's admission Minimum Data Set (MDS) assessment dated 8/15/19, indicated R1 was severely cognitively impaired, had no delusional behaviors or hallucinations and displayed physical and verbal behaviors towards others. The MDS identified R1 had clear speech, was understood and understands with clear comprehension. Further R1, required extensive assist of one staff for bed mobility, transfers, dressing, toilet use and personal hygiene.

R1 had a PHQ-9 (questionnaire for depression scoring and interpretation guide) score of 1 on 8/15/19, which indicated minimal depression.

R1 had a PHQ-9 score of 10 on 8/22/19, which indicated moderate depression.

R1's care plan dated 8/26/19 included, "R1 has a history of making false accusations against staff members. Goal for R1 will be to accurately report any maltreatment through the next review period. R1 will communicate accurately any concerns to social services and other staff in the facility. Interventions/task put in place were: If a male staff member is providing cares, another staff must be present. Social Services will meet with R1 on a regular basis in order for R1 to process any negative feelings or thoughts she may have. Staff will monitor behavior and will document all negative behaviors as soon as possible after each occurrence."

R1's progress notes included:

F 600

internal investigation taken place.
VA reports will be reviewed on a quarterly basis at the QA meeting with the QAPI team present. Discussion will include ways to monitor and improve process if needed.

Psychological Changes:
Social services director will notify facility provider of any changes in PHQ-9 and BIMS that are of noticeable changes. The PHQ-9 and BIMS scores that were of change will be reviewed monthly at the IDT meeting with provider present.

The deficiencies will be corrected immediately and carried out in process at each weekly IDT meeting and quarterly QA meeting from here on out.

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-8/13/19, "During PT (physical therapy) treatment session, patient reported that someone had been in her room at night... She then stated someone came into her room at night and abused her, touching her. She stated 'they said they would kill my family if I said anything.' She then wanted to walk around and look to identify him. I then witnessed her telling her [family member (FM)-A], [licensed practical nurse (LPN)-A] and [ES-A]. She reported him as tall white male with black hair."

-8/15/19, "Late Entry: SS (social services) was informed by a staff member that resident started to go towards the Estates when staff walked over to resident and said that she needed to stay at the nursing home side. Resident then backed up in her wheelchair and pinned staff up to the wall. Another staff member was then able to calm resident down and then resident gave a brief description of someone that she said raped her. Staff listed off a name and resident said no. Staff listed off another name and resident went very quiet. Staff informed SS about this incident and SS interviewed staff and filled out an investigative data sheet. DOQ (director of quality) notified daughter of the allegations and made sure daughter was aware that an investigation was done and answered the questions that the daughter had. SS will remain available."

-8/19/19, "RN spoke with resident's FM-A and POA (power of attorney) this morning at the request of the FM-A. Resident's FM-A reported to RN that resident made nonspecific suggestions that resident was touched inappropriately on the lower genital area by a specific male nurse on staff. FM-A reported the same type of behavior

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from resident at last stay in 11/2018. RN asked FM-A how FM-A felt about the accusations. FM-A was unable to discern if resident report is accurate as FM-A gave examples of resident's memory recollection is unreliable most times with moments of clarity. FM-A gave example of clarity with discussion of this weekend activities resident was able to recall parts but unable to recall names of immediate family members. RN referred FM-A to speak to social services. RN reassured FM-A that resident's safety was utmost importance to the staff. FM-A verbalized understanding. RN suggested to FM-A to meet again tomorrow to discuss results of the social service investigation. FM-A verbalized agreement. RN will continue to monitor as necessary."

-8/29/19, " ...During the conversation FM-A referenced statements made by resident regarding pain in her genital area. VP (vice president) told FM-A that it was reported that an allegation was made and SS and nursing completed an internal investigation which allegation was not substantiated. VP asked FM-A if she felt allegation was substantiated and she responded, 'I don't know because she has made accusations as such in the past'. VP also asked FM-A if she felt her parents were safe and being cared for appropriately in the care center and FM-A responded 'yes' ..."

-8/29/19, "SS Note: SS followed up with resident's FM-A, and FM-B regarding a number of concerns ... Resident's family concluded that no staff in Spring Valley Living has attempted to abuse their parents. FM-A also stated that any previous request to prohibit any staff from

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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
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providing cares should be discontinued and anyone in the building should provide needed services for their parents ...FM-A and FM-B stated resident in the past has accused family members of abuse and poisoning and acknowledged that allegations are not substantiated ..."

-8/30/19, "Resident was very tearful at lunch. Per resident, she couldn't feed herself because her hand was shaking. Writer said let's give it a try and I will be right here. Resident was able to feed self with one noodle and then threw the fork onto the plate and stated, "I'm done with this. I don't want to be here!" Resident continued to say, "I'm scared." Writer asked why are you scared? Resident stated, "I can't tell you. If I tell you they will kill me. If I eat they will kill me". Writer asked who said they will you kill you? Resident stated "I can't tell you. They will kill me if I tell." Writer took resident back to room and offered snacks but resident refused."

On 2/26/20, at 9:29 a.m. social services (SS)-A stated back in August 2019, R1 made an allegation against one of our male staff members and stated R1 did not verbally state specifically a concern but pointed down to her groin area. SS-A stated every time this staff member would go into the room she would become agitated and yell at him to get out. SS-A stated she went in there (R1's room) and asked R1 her reasons why she did not want the male staff member to provide cares for her and R1 yelled at me to get out. SS-A stated R1 was agitated and she went back later when she was less agitated. SS-A stated, "[R1] told me she did not want [RN-A] caring for her, she did not want to see [RN-A] and she did

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	245442	A. BUILDING ______ B. WING ______	C 02/28/2020

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F 600	Continued From page 7 not want to tell me why." SS-A stated the director of nursing (DON) had asked R1 if any staff had touched her inappropriately and R1 did not answer the DON. SS-A verified there was no documentation of the social service or DON interviews with R1 regarding the allegation of rape/sexual abuse. SS-A stated they did not interview any other residents to see if they had a similar concern and stated she interviewed three staff members as a part of the investigation. SS-A stated no other residents had made an allegation of inappropriate touch to the facility. SS-A stated RN-A still worked at the facility. SS-A stated at the time of the allegation, RN-A was the MDS coordinator and "did not work on the floor a ton". SS-A stated at this time he worked as the overnight nurse. SS-A stated, "In a meeting we had with [FM-A] and [FM-B] they requested [RN-A] not do cares, we explained to them if [RN-A] was the only nurse on, he may need to provide cares for [R1] and [FM-A] and [FM-B] were ok and understood. We stated we couldn't eliminate the staff members that care for her and stated he mostly did not work on the floor at that time (of the allegation)." When asked why the allegation of rape/sexual abuse was not reported to the state agency (SA), SS-A stated, "we asked FM-B and FM-A if they wanted us to make a report to the SA regarding the allegation of abuse and they stated no." SS-A stated the policy was since the resident had a POA we would ask the POA if they wanted the allegation of sexual abuse reported to the SA." SS-A stated that was the impression she'd had, that she was a social worker intern at the time, and was following the direction of the vice president. SS-A verified the facility did not make a report to the SA as she was under the impression R1's POA could make	F 600		

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the decision if an allegation of sexual abuse was reported to the SA. SS-A also verified the allegation of rape/sexual abuse was not reported to police. SS-A stated an allegation of abuse needed to be reported to the SA within 2 hours.

On 2/26/20, at 10:47 a.m. the vice president (VP) stated a report was not made to the SA because they did not find anything. The VP stated abuse should be reported immediately to the SA within two hours. A few minutes later, at 10:54 a.m., the VP stated she was not aware the facility had not reported the allegation of sexual abuse. The VP stated it was a standard of practice that a report should have been done. The VP stated her expectation was this allegation of sexual abuse should have been reported within two hours to the state agency and to the police. The VP stated the five-day investigation should have included a resident interview, staff interviews, other resident interviews and a body assessment of the resident and of their psychosocial wellbeing. At 11:33 a.m., the VP stated based on what we have right now the facility did not follow the policy and procedure for abuse reporting.

On 2/26/20, at 11:56 a.m. family member (FM)-A stated R1 had told her she needed to talk to her and "daddy can't hear this". FM-A stated R1 had then told her "this guy, and she tapped on her leg, and pointed to her private area, but never stated any words." FM-A stated, "At that time there were only two men that worked here." FM-A stated she had at that time spoken with the interim director of nursing (IDON) and had also mentioned it to the social worker that was here at that time. FM-A stated she'd been informed they couldn't do anything about it. FM-A stated

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"Whenever that gentleman was here, [R1] would get tense and did not want him caring for her at all." FM-A stated the facility was not going to do anything about it because R1 was always telling stories. FM-A stated, "[R1] did not say it, but she pointed to her crotch and stated he, he. [R1] would never make any accusations against anyone, especially something like that. It wasn't right for them to say to me they couldn't pursue this because [R1] had exaggerated lots of things." FM-A also said, "All I know was they did visit with [RN-A], but he did continue to work with [R1]. The facility let me know they were not going to pursue any issues with it. I don't know if she [R1] was sexually abused or not. She does have dementia and her ability to recall fluctuates. Yes, [R1] has embellished somethings, and maybe he did not do anything, but to her it was an uncomfortable situation. It almost felt like they were going to sweep it under the rug."

On 2/26/20, at 1:26 p.m. nursing assistant (NA)-A stated, "The first time [R1] told me (she had been raped) she had me pinned against the wall with her wheelchair." NA-A stated she told the nurse right away and RN-A was told not to provide any cares for R1, and the social worker talked to R1 privately. NA-A also stated a different time she was in R1's room to provide cares, and R1 told her she did not want the male nurse in the room anymore. NA-A said when she'd asked R1 if she was talking about RN-A, R1 said "yes, he raped me." NA-A stated she had reported to the nurse both times R1 had reported to her she had been raped. NA-A could not recall the nurses she had reported to.

On 2/26/20, at 1:37 p.m. RN-A stated R1 had

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made a comment that it (allegation of sexual abuse) was done by me, and SS-A did a work up on this. RN-A said SS-A had him write down a thing (statement) on it. RN-A stated when R1 was first admitted he had conducted a skin check on her. RN-A stated he thought it (allegation of sexual abuse) may have been related to the skin check. RN-A also stated R1 had experienced some skin breakdown from loose stools, so he'd had to look at her peri area and buttock area during the skin check. RN-A stated since R1 made the comments (allegation of rape) he has had female staff members help her and provide her cares. RN-A stated a few days after that (skin check) R1's behaviors changed. RN-A stated R1 didn't want me in her room, she would become angry with me and then she started making accusations to other people. RN-A stated he was working in the office a lot at that time. RN-A stated, "When I started working on the floor she would come up to me and state "just do not do that kind of thing again"." RN-A stated he does not provide any cares for her alone at this time, but always had another staff member present if he needs to work with her, and stated other staff members give R1 her medications.

On 2/26/20, at 3:51 p.m. nursing assistant (NA)-C stated no residents had reported any concerns to her about inappropriate touch or being sexually abused. NA-C stated, "I know a female resident accused [RN-A] of doing something and he was not allowed into that room for a while." NA-C also stated R1 did not like RN-A even to this day. NA-C stated, "If [R1] sees [RN-A], she will just go off. [R1] will scream at him to get away, to go to hell, and scream 'you bastard'." NA-C stated R1 will go right towards

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RN-A and start yelling at him, NA-C stated, "it was mean."

On 2/26/20, at 4:31 p.m. SS-A stated, "Looking back at it (allegation of rape/sexual abuse), I think there was a lot of miscommunication with the whole situation from all of the stand points that I can see." SS-A stated she thought it was a reportable incident at the time in August, and stated she had shared she thought it was a reportable incident with the leadership team. SS-A stated, "Nnobody stated it should not be reported. At the time of the incident it was the interim DON, social work intern or the vice president making reports to the SA." SS-A stated she was aware this allegation was not reported to the SA and stated at the time, she was still in the learning process as an intern and this was the first instance that had occurred for her. SS-A stated, "Looking back, yes this should have been reported to the SA within two hours, and it should have been followed through to the end. The VP, social work intern and the interim DON, were all aware of this allegation. For me at that time, it was overwhelming, and I may not have thought about all the pieces that needed to be put together, for example a rape exam."

On 2/26/20 at 4:46 p.m. the VP stated an initial report to the SA could be filed by any of the nursing staff on their shifts. The VP stated the five-day investigations were to be completed by social services and the DON. The VP stated the DON was to ensure initial reports and five-day reports were submitted to the SA. The VP said it had been discussed in IDT (interdisciplinary team) meetings about whether initial and five day reports were being completed. The VP added,

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IDT meetings are held on Tuesdays. The VP stated it was a part of her normal practice to ensure vulnerable adult reports were being made.

On 2/26/20, 6:14 p.m. SS stated there was no documentation in the medical record the physician had been made aware of the allegations of sexual abuse. SS-A stated when R1 sees RN-A she does have increased behaviors. SS-A stated RN-A mostly worked overnights so he did not work with R1 that much. SS-A stated from what she was aware of, R1 would tell RN-A to get away from her and would become agitated when she sees RN-A.

On 2/27/20, at 9:37 a.m. physical therapist (PT)-A stated when she'd started working with R1 on the morning of the allegation, R1 had been quite agitated and upset. PT-A said, "[R1] told me somebody had been in her room, specifically under her bed. She alleged she knew that because there was a Kleenex on her floor that had not been there before. [R1] then started talking about someone being in her room stating they abused her." PT-A further stated R1 made the comment she was told not to tell anybody because they would hurt her family. PT-A stated at that point, R1 would not focus on therapy all she wanted to do was walk around the facility and look for him to identify him. PT-A stated she had tried to reassure R1 that she was safe, staff would take care of her and nobody would hurt her. PT-A stated she wheeled R1 around the facility, "The more we wheeled around, the less agitated [R1] got." PT-A said when they had finished their session, she was not sure what to do and went into the IDT morning meeting and

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informed the staff. PT-A stated she specifically told the executive director, the vice president, a registered nurse and the social work intern. PT-A stated she told them she was not sure of the validity of the accusations because of R1 extremes signs of dementia, which included confusion, need for continuous redirection on tasks, trying to walk into other people's room and offices, and not being sure where she was. PT-A stated she was told by the executive director to put it (allegation of abuse) in point click care in a progress note, as they would have to open an investigation. PT-A stated after she was done telling staff in the IDT meeting, she'd left the meeting and R1 was still perseverating on it and was talking to FM-A, ES-A and LPN-A about it.

On 2/27/20, at 11:33 a.m. nursing assistant (NA)-B stated R1 did not like RN-A and had not liked RN-A since arriving in the TCU (transitional care unit). NA-B stated R1 would get very upset and tell staff to tell RN-A to, "get the [profanity] away and that he rapes kids." NA-B stated R1 had never told her that RN-A had raped her. NA-B stated R1 would state RN-A had raped kids. NA-B stated R1 displayed an increase in agitation and behaviors when she sees RN-A.

On 2/27/20, at 2:30 p.m. SS-A stated she did not have a memory of being informed of an allegation of abuse for R1 on 8/13/19 by PT-A. SS-A stated she looked back in her planner and there was nothing written down. SS-A stated it could have gotten through the cracks but she normally wrote everything down. SS-A verified the allegation of abuse that was documented in R1's progress notes by PT-A on 8/13/19, was not reported to the SA that she was aware of. SS-A

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F 600	Continued From page 14 stated the first time she was aware of an allegation of abuse for R1 was on 8/15/19, when R1 made the allegation of rape and SS-A completed an internal investigation. SA-A stated R1's PHQ-9 score was a 1 on 8/15/19 indicating minimal depression. SS-A stated she completed a PHQ-9 on 8/22/20 with R1, her score was a 10, which indicated moderate depression, indicating an increase in her score. SS-A stated when a resident had a PHQ-9 score of 7 or higher, or when there was a significant change in PHQ-9 score, social services worked with nursing to come up with an intervention and the physician was informed. SS-A stated whenever the score was higher than a seven, she usually followed up with the resident, did a check in and depending on the feedback SS-A determined how often she would continue to follow up on the concern with the increased PHQ-9 score. SS-A stated sometimes depending on the time of day and her mood R1 may respond differently to questions. At 4:16 p.m. SS-A stated, she was unable to find any documentation related to any follow-up on R1's increase in PHQ-9 score in R1's medical record. SS-A also verified after R1 made the allegation of rape on 8/15/19, there was no documented physician notification of the allegation, or physician notification of the significant increase in PHQ-9 score. Nor was their an increase in social service visits following the change in PHQ-9 score from a 1 on 8/15/19 to a score of 10 on 8/22/19. On 2/27/20, at 3:08 p.m. the VP stated she did not remember the physical therapist reporting the allegation of abuse in the IDT meeting on 8/13/19. The VP stated the allegation of abuse was not reported to the SA and an investigation	F 600		

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was not completed related to R1's allegation of abuse on 8/13/19. The VP stated an initial report should have been filed, R1 should have been sent out for an evaluation, staff working in the previous 72 hours should have been interviewed and other residents should have been interviewed. The VP stated her family and the physician should have been notified. The VP stated if there was an AP (alleged perpetrator), they should have been suspended from the staffing schedule pending completion of the investigation. The VP verified neither of R1's allegations of sexual abuse 8/13/19, and 8/15/19, had been reported to the SA, nor had there been a thorough investigation completed. The VP stated the facility did not put interventions in place to protect all of the residents in the building at the time of the allegations.

The facility's Abuse Prevention Plan dated 3/2017 included, "Protection: Residents, the alleged perpetrator, and other staff are protected from harm during the investigation. Reporting/Response: All incidents of alleged mistreatment/maltreatment, as identified in the regulations and statues are reported to the Minnesota Department of Health and the Fillmore County Common Entry point immediately after they are identified. Incidents causing suspicion of a crime are reported to the local law enforcement according to the timeline described in the affordable care act."

The immediate jeopardy that began on 8/15/19 was removed on 2/28/20, when the facility had developed and implemented an appropriate removal plan including: suspension of the alleged

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F 600	Continued From page 16 perpetrator, comprehensive education for staff related to the facility's Abuse Prevention Plan, and implementation of a system for a 24 hour on-call vulnerable adult designee, to improve on their vulnerable adult reporting and investigating.	F 600		

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
March 17, 2020

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

Re: Event ID: CGXC11

Dear Administrator:

The above facility survey was completed on February 28, 2020 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted no violations of these rules promulgated under Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10.

Electronically posted is the Minnesota Department of Health order form stating that no violations were noted at the time of this survey. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Please disregard the heading of the fourth column which states, "Provider's Plan of Correction." This applies to Federal deficiencies only. There is no requirement to submit a Plan of Correction.

Please feel free to call me with any questions.

Sincerely,

Alison Helm

Alison Helm, Enforcement Specialist
Licensing and Certification
Minnesota Department of Health
P.O. Box 64970
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4206
Email: alison.helm@state.mn.us

Minnesota Department of Health

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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: 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 http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm The State licensing orders are delineated on the attached Minnesota	2 000		

Minnesota Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		03/25/20

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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
2 000	Continued From page 1 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. On 2/26/20 through 2/28/20, surveyors of this Department's staff conducted an complaint investigation. There are no corrections orders issued. Complaints investigated were: H5442023C was substantiated Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed. 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 surveyors findings are the Suggested Method of Correction and Time period for Correction.	2 000		

Minnesota Department of Health

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 02/28/2020

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2 000	Continued From page 2 PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000		