

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245442	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/21/2024
NAME OF PROVIDER OR SUPPLIER Spring Valley Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 800 Memorial Drive Spring Valley, MN 55975	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48013 Based on observation, interview, and document review, the facility failed to provide a dignified dining experience for 1 of 1 resident (R37) observed for dignity. Findings include: R37's quarterly Minimum Data Set (MDS) dated [DATE], identified R37 had severe cognitive impairment and required assistance with all activities of daily living (ADL)'s. R37's diagnoses included Alzheimer's disease, aphasia, dementia, depression, polyneuropathy (is a condition in which a person ' s peripheral nerves are damaged, and low back pain. R37's care plan, indicated R37 needed assistance with eating, however lacked plastic silverware had been used for R37. During observation on 11/19/24, at 5:10 p.m., R37 was sitting in his wheelchair at a table in the middle of dining room with three other residents. Staff had placed regular silverware in front of the other three residents sitting at the table and placed a plastic spoon and fork on the table in front of R37. Staff assisted R37 with eating while staff utilizing a plastic fork. At 5:42 p.m., staff continued feeding R37 with plastic silverware. During observation on 11/20/24 at 12:07 p.m., R37 was seated at a table in the middle of dining room with three other residents. Staff assisted R37 with eating utilizing plastic silverware. During observation on 11/21/24 at 12:18 p.m., R37 was seated at a table in the middle of dining room with three other residents. Staff assisted R37 with eating utilizing plastic silverware. During interview on 11/19/24 at 2:30 p.m., family member (FM-A) stated R37 had a problem with collecting silverware due to his time in Vietnam where silverware was scarce. FM-A stated facility gave R37 plastic silverware to eat with due to the hoarding of silverware where R37 would take silverware and place in his shirt pocket where he would have six to eight pieces of silverware at a time. During interview on 11/20/24 at 10:02 a.m., nursing assistant (NA)-E stated R37 needed assistance with eating with staff having to feed him. NA-E stated R37 had been utilizing plastic silverware due to him collecting them. NA-E stated staff use plastic silverware when assisting R37 with eating. (continued on next page)		

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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: 245442	Facility ID: 245442 If continuation sheet Page 1 of 27

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interview on 11/21/24 at 10:54 a.m., licensed practical nurse (LPN)-A stated R37 had a history of stealing silverware. LPN-A stated R37 had worked as a jailor so not sure if that behavior correlated with his past occupation. LPN-A stated R37 had one incident in the past year, awhile ago, where he held a knife up to a nurse and due to that incident, R37 had been given plastic silverware ever since. LPN-A stated he is not aware of any other incidents regarding silverware. During interview on 11/21/24 at 11:39 a.m., registered nurse (RN)-A stated R37 was obsessed with collecting of silverware. RN-A stated R37 was a retired police officer, served in the army and also worked at a corrections facility where he would go and remove items from inmates. RN-A stated R37 had one incident a while ago where held a regular butter knife towards a nurse, so plastic silverware was initiated for R37 for the safety of the staff. RN-A stated she is not aware of any other incidents since. During interview on 11/21/24 at 12:59 p.m., assistant director of nursing (ADON) stated R37 liked to hold onto utensils and not give them up. ADON stated R37 previously attempted, within last year or so, to jab out with a knife towards staff so plastic silverware was initiated to make it less likely to cause injury to staff. ADON stated R37 had several episodes since then utilizing the plastic silverware but stated it had been quite a while since she was made aware or heard anything regarding incidents with silverware. ADON confirmed that R37 was assisted by staff with eating at all times due to R37's increased confusion. ADON stated she would expect behaviors to be assessed and characterized quarterly coordinating with MDS assessments. ADON stated an on-going quarterly assessment should have been completed for use of plastic silverware and behaviors and confirmed they were not completed. ADON stated a trial of regular silverware should have been completed to see if R37 was still demonstrating previous behaviors and confirmed trial had not been completed. ADON stated trial and reassessment were important as utilizing plastic silverware could affect R37's dignity and also how he eats and also percentage of how much R37 eats. The facility Dignity and Respect policy, dated 7/24, indicated facility will make sure that everyone is treated with dignity and respect. Every resident has the right to be treated with dignity and respect. Facility provides services and supports in a way that respects and considers personal preferences.		

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48013 Based on observation, interview and document review, the facility failed to ensure residents were comprehensively assessed for self-administration of medications for 1 of 1 resident (R32) reviewed and observed for self-administration of medications. Findings include: R32's quarterly Minimum Data Set (MDS) dated [DATE], identified R32 had severe cognitive impairment and required assistance with all activities of daily living (ADL)'s. R32's physician orders included order for Ipratropium-Albuterol inhalation solution 0.5 - 2.5 (3) mg(milligram)/ml(milliliter) - 3 mL inhale orally two times a day related to mild intermittent asthma. R32's medical record was reviewed and lacked evidence of self-administration of medications order had been obtained for R32. During observation and interview on 11/18/24 at 3:17 p.m., R32 stated she used the nebulizer machine twice daily and has been on it for long-term management of asthma. R32 stated nurse will bring medication into room, pour medicated solution into the canister of the nebulizer mask, apply nebulizer mask to resident's face, will turn on nebulizer machine and will then leave her room. R32 stated the nurse will sometimes come back to her room, at a later time, to make sure nebulizer machine is turned off. Nebulizer mask with canister was standing up in nebulizer machine and contained approximately 1/4 inch of clear solution in canister. During observation on 11/19/24 at 12:49 P.M., nebulizer mask with canister was standing up in nebulizer machine and the canister was full of clear solution. During observation on 11/19/24 at 6:44 p.m., nebulizer mask with canister was standing up in nebulizer machine and contained approximately 1/4 inch of clear solution in canister. During observation on 11/20/24 at 8:47 a.m., nebulizer mask with canister was standing up in nebulizer machine and contained approximately 1/4 inch of clear solution in canister. During observation on 11/20/24 at 3:43 p.m., R32 was sitting in room with the nebulizer mask on her face and the nebulizer machine running. No staff were present in R32's room. During observation on 11/21/24 at 9:45 a.m., nebulizer mask with canister was standing up in nebulizer machine and contained approximately 1/4 inch of clear solution in canister. During record review on 11/20/24, the self-administration of medications (SAM) assessment was completed on 4/16/24, identified R32 was physically unable to self-administer medications and was not a candidate for self-administration of medication. (continued on next page)		

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interview on 11/20/24 at 9:57 a.m., licensed practical nurse (LPN)-B stated there was only one resident that resided in facility who had an order to self-administer medications and confirmed R32 was not the resident. During interview on 11/20/24 at 10:02 a.m., nursing assistant (NA)-E stated the nurse sets the nebulizer up, applies fluid into canister, applies mask to R32's face and then leaves the room. NA-E stated nurse will come back at a later time to shut machine off. During interview on 11/20/24 at 10:16 a.m., LPN C stated there was only one resident who had a SAM order and LPN-C confirmed it was not R32. LPN-C stated if a resident had a SAM order, a little blue person with a circle around would be displayed in R32's electronic medication record (EMR). LPN-C reviewed R32's EMR and confirmed R32 did not have an order for self-administration of medications. During interview on 11/20/24 at 10:36 a.m., LPN-B confirmed R32 did not have an order to self-administer medications. LPN-B stated the nurse would take nebulizer solution into R32's room, set nebulizer up, apply mask and then would go back into R32's room [ROOM NUMBER]-20 minutes later to check on resident and shut machine off. When surveyor asked if R32 should have a self-administer order for nebulizer's, LPN-C stated, I don't know, this is just something we have always done. During interview on 11/21/24 at 10:48 a.m., LPN-A stated when a resident has a nebulizer treatment, the nurses set up the solution, apply the mask and would then leave room and come back later to check on resident. LPN-A stated R32 does her nebulizer treatment independently and confirmed had R32 had no SAM order. During interview on 11/21/24 at 11:39 a.m., registered nurse (RN)-A stated there was only one resident in the facility that had an order to self-administer medications and confirmed R32 did not have a SAM order. RN-A stated the nurse sets up the solution, signs it out in the MAR, fills canister in nebulizer mask with nebulizer solution, applies mask to resident's face and then would come back 15 minutes later to check on resident. When surveyor asked if a nebulizer treatment should be assessed for self-administration and an order obtained, RN-A stated she could understand and how it would be important to assess the resident for a self-administration order. RN-A stated if a resident was confused, the straps could be a safety risk if resident could not get the mask off their face and to also ensure the resident is able to self-administer medications safely. During interview on 11/21/24 at 12:59 p.m., assistant director of nursing (ADON) stated a resident should have a self-administration assessment completed to ensure the resident could reliably and accurately self-administer medications. ADON stated her expectation would be for nebulizer's to be assessed for self-administration of medication after set-up if staff are leaving the room during the treatment. ADON confirmed R32 did not have any SAM orders and stated an assessment should have been completed and an order should have been obtained. ADON stated it was important to ensure that the resident can correctly, accurately, and safely self-administer medications and that the provider agrees with the resident self-administering medications. ADON stated the resident should be reassessed quarterly to ensure there are no changes in resident's cognitive or physical status. (continued on next page)		

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility Self-Administration of Drugs policy, dated 7/24, identified residents in the facility who wish to self-administer their medications may do so, if it is determined that they are capable of doing so. As part of their overall evaluation, the RN and practitioner will assess each resident's mental and physical abilities, to determine whether a resident is capable of self-administering medications. In addition to general evaluation of decision-making capacity, the RN and practitioner will perform a more specific skill assessment, including (but not limited to) the resident's: 1. Ability to read and understand medication labels, 2. Comprehension of the purpose and proper dosage and administration time for his or her medications, 3. Ability to remove medications from a container and to ingest and swallow (or otherwise administer) them, and 4. Ability to recognize risks and major adverse consequences of his or her medications. If the RN determines that a resident cannot safely self-administer medications, the nursing staff will administer the resident's medications. The RN and practitioner review quarterly and as needed a resident's ability to continue to self-administer medications.		

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. 48013 Based on interview and document review, the facility failed to provide the required written Skilled Nursing Facility Advanced Beneficiary Notice (SNFABN) and Notice of Medicare Non-Coverage (NOMNC) forms to 2 of 3 residents (R7 and R16) reviewed whose Medicare A coverage ended and then remained in the facility. Findings include: R7's undated Census Records listing identified on 7/9/24, R7's payer source changed from Medicare Part A to Private Pay, and remained in the facility. R7's medical records lacked evidence that a SNFABN and/or the NOMNC forms were completed and/or reviewed with resident/representative. R16's undated Census Records listing identified on 9/7/24, R16's payer source changed from Medicare Part A to Medicaid, and remained in the facility. R16's medical records lacked evidence that a SNFABN and/or the NOMNC forms were completed and/or reviewed with resident/representative. During interview on 11/20/24 at 2:09 p.m., social worker (SW) stated the facility could not locate any forms for R16. During interview on 11/21/24 at 11:22 a.m., SW stated the facility could not locate any forms for R7. During interview on 11/21/24 at 11:30 a.m., registered nurse (RN)-A stated forms are discussed at the facilities daily stand-up meetings and the MDS coordinator completed them. RN-A stated the MDS coordinator is on medical leave and the director of nursing (DON), assistant director of nursing (ADON) and herself have been splitting the MDS coordinator's tasks between the three of them and completes them. RN-A confirmed she could not locate any forms for R7 or R16. During interview on 11/21/24 at 12:59 p.m., ADON stated the facility could not locate any forms for R16. ADON stated it was important to complete and keep the notices to prove a discussion had been had with the resident and/or representative regarding the services and benefits that are ending. Important for the discussion and review of forms are completed with enough notice so the resident/representative could appeal if they do not agree with the discontinuation of services and they are aware of the daily rate they would be responsible for after coming off Medicare part A. During interview on 11/21/24 at 1:53 p.m., ADON stated the facility could not locate any forms for R7. ADON stated she could not confirm if they had been completed or not. The facility Beneficiary notices policy and procedure was requested but was not received.		

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48013 Based on observation, interview and document review, the facility failed to reassess behaviors and intervention of potential wandering to ensure safety and prevent possible elopement for 2 of 2 residents (R37 and R33) reviewed for accidents. Findings include: R37's quarterly Minimum Data Set (MDS) dated [DATE], identified R37 had severe cognitive impairment and required assistance with all activities of daily living (ADL)'s. R37's diagnoses included Alzheimer's disease, aphasia, dementia, depression, polyneuropathy, and low back pain. MDS indicated wandering was not exhibited. R37's initial Elopement Risk Assessment, dated 7/14/23, indicated R37 was an elopement risk. However, R37's medical record was reviewed and lacked evidence R37 had been comprehensively reassessed quarterly for wandering or a potential elopement risk. R37's order summary, indicated order to check placement of wander guard (alerts when attempting to leave an area or building) on left wrist every shift. R37's care plan, indicated R37 was at risk for eloping and wandering due to history of attempts at home and attempts at eloping rom facility since admission. R37's progress note, dated 10/16/24 at 10:30 a.m., identified wander guard in place due to history of wandering and elopement. R37's progress note, dated 6/11/24 at 5:26 p.m., indicated R37 wandered down hallway during dinner, pushed on the south emergency exit door, and exited the building. Door alarm and wander guard sounded alerting staff that R37 had exited the building. Staff were able to redirect resident back inside. During observation on 11/18/24 at 3:57 p.m., R37 was seated in his wheelchair in the common living room area and was self-propelling self around room reaching out for imaginary items. R37 had a wander guard device on his left wrist. During observation on 11/21/24 at 10:43 a.m., R37 was seated in his wheelchair in the common living room area and was self-propelling self around room. R37 was seated by the front door for several minutes before beginning to wander around area. During observation on 11/21/24 at 1:33 p.m., R37 was seated in his wheelchair in the common living room area and was self-propelling self around room. During interview on 11/20/24 at 9:57 a.m., licensed practical nurse (LPN)-B stated R37 wandered throughout facility. During interview on 11/20/24 at 10:02 a.m., nursing assistant (NA)-E stated R37 was very active and restless, wanders around facility, and requires one on one staff monitoring frequently for safety. (continued on next page)		

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interview on 11/21/24 at 11:14 a.m., social worker (SW)-A stated wandering and elopement assessments are completed by either herself or nursing staff. SW-A stated she is usually the one responsible for completing these assessments. SW-A stated elopement assessments are completed quarterly along with the resident's quarterly assessments. SW-A confirmed R37's last elopement assessment was completed on 7/14/23. SW-A stated quarterly reassessments are important to ensure interventions in place are still appropriate, wander guard was still appropriate, and if there was still an elopement risk/concern. During interview on 11/21/24 at 12:59 p.m., assistant director of nursing (ADON) stated elopement/wandering assessments are to be completed quarterly. ADON confirmed R37 last elopement assessment was completed on 7/14/23. ADON stated it should have been reassessed quarterly. ADON stated it was important to reassess resident quarterly for safety reasons, to determine if resident was still at continued risk for elopement and ensure wander guard is still appropriate as it could be a dignity concern for a resident who no longer needs a wander guard. ADON stated the elopement assessment would help determine if the resident was having increased wandering and may need to be transferred to the memory care unit for their safety. 40938 R33's quarterly MDS dated [DATE], identified R33 had severe cognitive impairment, required extensive assistance with care, R33 wore a wander/elopement alarm. R33's medical diagnoses included parkinsons, dementia, post traumatic stress disorder (PTSD), anxiety, edema, repeated falls, cerebrovascular disease, visual hallucinations, and restless legs. R33's Wandering Risk Assessment done 8/22/23, identified R33 did not understand surroundings or what is being said and had a history of wandering. Wandering Risk Assessment score was 14 indicating R33 was at a high risk of wandering behavior R33's care plan dated 11/02/24, identified R33 was an elopement risk/wanderer due to history of attempts to leave facility unattended. Interventions included redirect from wandering by offering pleasant diversions, structured activities, food, and conversation and wanderguard on wrist. On 11/19/24, at 6:58 p.m. R33 was observed in common area watching television (tv) no attempts to wander. R33 was observed on 11/20/24, at 10:13 a.m. self propelling wheelchair in common area, no attempt to approach front door. on 11/20/24, at 1:43 p.m. R33 was observed self propelling wheelchair down hallway, no attempt to approach front door, no attempts to enter other resident rooms. On 11/21/24, at 9:16 a.m. R33 was observed self-propelling wheelchair from dining room to common area with no attempt to go towards front door. When interviewed on 11/21/24, at 9:20 a.m. nursing assistant (NA)-B stated R33 wandered down hallways, did not enter other residents rooms and had not attempted to leave the building in a long time (continued on next page)		

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	When interviewed on 11/21/24, on 10:03 a.m. licesed practical nurse (LPN)-A stated in R33s head he has somewhere to go. He hasn't done any exit seeking in a very long time, he goes up and down the halls looking for something, never enters other rooms. During interview on 11/21/24, at 10:49 a.m. assistant director of nursing (ADON) stated wandering/elopment assessments were completed at admission and quarterly. ADON confiremd a wandering risk assessment was last completed on 8/22/23, the assessment should be completed quarterly to ensure the wanderguard is still an appropriate intervention. When interviewed on 11/21/24, at 11:14 a.m. social worker - A stated wandering and elopement assessment were completed between social services and nursing. Risk assessments are coordinated with the quarterly assessments. social worker confirmed that lastwandering risk assessment was completed on 8/22/23. Important to assess to determine interventions in place are still appropriate for them. The facility Wandering, Unsafe Resident policy, dated 7/2024, identified the facility will strive to prevent unsafe wandering while maintaining the least restrictive environment for residents who are at risk for elopement. The staff will identify residents who are at risk for harm because of unsafe wandering (including elopement). Nursing staff will assess residents quarterly for risk factors related to unsafe wandering. If determined to be at risk, nursing will consult with social services. The resident's care plan will indicate the resident is at risk for elopement or other safety issues. Interventions to try to maintain safety will be included in the resident's care plan. If wander guard is determined to be needed, consent will be obtained from family for device use. Nursing staff will document circumstances related to unsafe actions, including wandering, by a resident. Staff will institute a detailed monitoring plan, as indicated for residents who are assessed to have a high risk of elopement or other unsafe behavior. Staff will notify the Administrator and Director of Nursing immediately and will institute appropriate measures (including searching) for any resident who is discovered to be missing from the unit or facility.		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48013 Based on observation, interview, and documentation review the facility failed to provide assistance with facial hair removal for 2 of 3 residents (R32 and R37) with grooming needs who was dependent upon staff for assistance. Findings include: R32's quarterly Minimum Data Set (MDS) dated [DATE], identified R32 had severe cognitive impairment and required assistance with all activities of daily living (ADL)'s. R32's diagnoses included heart failure, hypertension, orthostatic hypotension, renal failure, Alzheimer's disease, stroke, dementia, depression, and asthma. R32's care plan lacked evidence of resident's shaving preferences. During observation on 11/19/24 at 6:44 p.m., R32 was sitting in wheelchair in her room. R32 had white facial hair on chin approximately 1 inch long. During observation on 11/20/24 at 8:47 a.m., R32 continued to have facial hair on chin. During observation on 11/20/24 at 3:43 p.m., R32 continued to have facial hair on chin. During observation on 11/21/24 at 9:45 a.m., R32 continued to have facial hair on chin. R37 R37's quarterly Minimum Data Set (MDS) dated [DATE], identified R37 had severe cognitive impairment and required assistance with all activities of daily living (ADL)'s. R37's diagnoses included Alzheimer's disease, aphasia, dementia, depression, polyneuropathy, and low back pain. R37's care plan lacked evidence of resident's shaving preferences. During observation on 11/18/24 at 2:53 p.m., R37 had facial hair located on face located on his check extended down chin and neck approximately one fourth inch to one half inch long. During observation on 11/19/24 at 12:39 p.m., R37 continued to have facial hair on face. During observation on 11/20/24 at 1:04 p.m., R37 continued to have facial hair on face. During observation on 11/21/24 at 10:43 a.m., R37 continued to have facial hair on face. During interview on 11/19/24 at 2:25 p.m., family member (FM)-A stated R37 was very particular with being clean shaven and had detailed hygiene practices he had performed daily. During interview on 11/20/24 at 10:02 a.m., nursing assistant (NA)-E stated if a resident had facial hair and needed to be shaved, she would automatically shave resident with morning cares. (continued on next page)		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interview on 11/20/24 at 10:16 p.m., licensed practical nurse (LPN)-C stated nursing assistants perform shaving when doing morning cares with residents. LPN-C confirmed R32 and R37 had facial hair and should have been shaved. During interview on 11/21/24 at 10:48 a.m., LPN-A stated nursing assistants shave residents on bath days but if facial hair is noted, nursing assistants would shave residents when needed. LPN-A confirmed there was a few scruffy residents at this time who should be shaved. LPN-A confirmed R32 and R37 had facial hair and should have been shaved. During interview on 11/21/24 at 11:39 a.m., registered nurse (RN)-A stated when a resident is admitted , their shaving preference is asked. Shaving is performed by the nursing assistants on the resident's bath day or as needed or based on their preferences. RN-A stated staff should be asking R32 if she would like her chin hairs shaved and that R37 should be shaved daily. RN-A stated we encourage daily grooming for the residents. During interview on 11/21/24 at 12:59 p.m., assistant director of nursing (ADON) stated the nursing assistants should be assisting residents with shaving. ADON stated the resident's shaving preferences should be located on the resident's care plan. ADON stated her expectation is shaving should occur daily with grooming and for staff to ask the resident if they would like to be shaved if facial hair is noted. ADON stated it was a commonsense thing and is important for the resident to be shaved for the dignity of the resident and their sense of self. The facility Shaving the Resident Policy, dated 7/24, indicated shaving residents is to promote cleanliness and to provide skin care.		

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assist a resident in gaining access to vision and hearing services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48013 Based on interview and document review, the facility failed to ensure proper treatment was provided to maintain hearing for 1 of 1 resident (R8) reviewed for hearing. Findings include: R8's annual Minimum Data Set (MDS) dated [DATE], identified R8 had intact cognition and required assistance with all activities of daily living (ADL)'s. MDS indicated R8 had minimal difficulty with the ability to hear and wore hearing aids. R8's Communication Care Area Assessment (CAA) dated 9/19/24, indicated R8 had the potential for communication deficits related to his hearing impairment. Identified R8 had poor hearing in both ears and R8 had a history of cerumen (wax) build up. R8's care plan, indicated R8 has a communication problem related to hearing deficit and he wore bilateral hearing aids. R8's electronic health record (EHR) lacked evidence R8 was offered an audiology appointment. R8's physician's orders identified an order to flush both ears until wax clears every 24 hours as needed for wax buildup. During observation on 11/18/24 at 3:20 p.m., R8 had hearing aid in the left ear but none in the right ear. During observation and interview on 11/18/24 at 3:21 p.m., R8 stated he took his hearing aides out as they are not working well. R8 stated if a new battery is replaced into hearing aids, his hearing improved for a couple of hours and then went back to him not being able to hear. During observation on 11/19/24 at 12:37 p.m., R8 did not have hearing aids present in ears. During observation on 11/19/24 at 7:53 p.m., R8 was sitting out in the common area playing cards with another resident. R8 did not have hearing aids present in ears. R8 was speaking very loudly to another resident. During observation on 11/20/24 at 8:44 a.m., R8 was sitting in common area talking loudly to another resident. R8 did not have hearing aids present in ears. During observation on 11/20/24 at 3:22 p.m., R8 was sitting in common area talking loudly to another resident. R8 did not have hearing aids present in ears. During observation on 11/21/24 at 9:21 a.m., R8 did not have hearing aids present in ears. (continued on next page)		

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interview on 11/20/24 at 10:02 a.m., nursing assistant (NA)-E stated resident had hearing aids, but thought they were broken and she does not know what exactly is going on with them. NA-E stated R8 may have wax buildup in ears and may need his ears flushed as he has a history of wax buildup. NA-E confirmed she has noticed an increase in hearing impairment for R8. During interview on 11/21/24 at 10:48 a.m., licensed practical nurse (LPN)-A stated R8 wore hearing aids but thinks that they do now work very well. LPN-A stated staff assist R8 with changing the batteries. LPN-A stated nursing could check R8's ears for wax if resident has complaints of pressure or staff notices his hearing is worse. LPN-A confirmed R8's hearing has been notably worse in the past month or so. Confirmed R8 had an order to flush ears. During interview on 11/21/24 at 11:39 a.m., registered nurse (RN)-A stated R8 has difficulty hearing and wore hearing aids in both ears. RN-A stated if staff notice a decrease in hearing, nursing should assess R8's ears with an otoscope to check for wax buildup. RN-A confirmed R8 had an order for flushing ears due to wax buildup and stated since R8 had that order in place, it should have been done to see if his hearing would improve at all after flushing. RN-A stated the provider reviewed orders every 30-60 days so due to it being an order, it should be tried to check for hearing improvement. RN-A confirmed flushing of R8's ears had not been completed in the past 6 months as it would be documents on the mediation administration record (EMR). During interview on 11/21/24 at 12:59 p.m., assistant director of nursing (ADON) stated she would expect staff to process the standing order for Debrox (wax softening) ear drops and then to flush ears after drops were initiated. ADON stated she expects the nurse to check for wax buildup when there is an increase in hearing difficulty noted in a resident. ADON stated this was important for the resident to be able to communicate and for staff to be able to communicate with him as this could lead to dignity concerns for the resident. The facility Care of the Hearing-Impaired Resident policy, dated 7/24, indicated the purpose of this procedure is to provide guidelines when providing care to the resident with hearing impairment. The facility to evaluate resident's progress and adjustment at regular intervals.		

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care or services that was trauma informed and/or culturally competent. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48013 Based on observation, interview, and document review the facility failed to comprehensively assess past trauma and implement care plan interventions utilizing a trauma-informed approach for 1 of 1 (R37) resident reviewed who had a history of past traumatic experiences. Findings include: R37's quarterly Minimum Data Set (MDS) dated [DATE], identified R37 had severe cognitive impairment and required assistance with all activities of daily living (ADL)'s. R37's diagnoses included Alzheimer's disease, aphasia, dementia, depression, polyneuropathy, and low back pain. R37's care plan, print date of 11/19/24, lacked individualized trauma-informed approaches or interventions and lacked identification of triggers to avoid potential re-traumatization. R37's trauma questionnaire dated 7/6/23, indicated R37 had trauma in his past. However, no additional information was obtained to determine triggers and/or coping mechanisms. During interview on 11/19/24 at 2:30 p.m., family member (FM)-A stated R37 had post-traumatic stress disorder (PTSD) and behaviors had gotten worse. FM-A stated R37 would see imaginary people coming out of the television and standing outside the windows, would take things apart and remove batteries from items as he disassembled bombs during his time in Vietnam, would sleep during the day and would be awake all night as he would stand in the bedroom or sit in chair in living room where he could see both doors on guard like he was on guard duty, and collected silverware due to limited silverware during his time in Vietnam. FM-A stated facility gave R37 plastic silverware to eat with due to R37 taking the regular silverware, putting them in his shirt pocket and would have six to eight pieces of silverware at a time. During interview on 11/20/24 at 10:02 a.m., nursing assistant (NA)-E stated she was not aware of any past trauma in R37's life. NA-E stated it would be important to know if a resident went to war or had certain triggers so if they exhibit behaviors we know how to respond. NA-E stated if resident had a history of trauma, it would be on resident's care plan. During interview on 11/20/24 at 10:25 a.m., social worker (SW) stated she is responsible for completing assessments for trauma, elopement, and mood/depression. SW stated on the trauma assessments, if a resident answers yes to a question, she would have to talk in detail about triggers and what interventions are effective and put triggers/interventions in the resident's care plan. SW stated she completed the assessments for all residents, no matter what the resident's cognitive level is. SW stated for a resident with severe cognitive impairment, she would interview the resident and may get family input at care conference. SW stated she would be notified by staff with any issues resident may be experiencing and would follow up with resident to determine what could be offered or what interventions could be implemented. (continued on next page)		

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interview on 11/21/24 at 9:15 a.m., SW stated trauma assessments are completed upon resident's admission and uses the information from the assessment to implement in care plan. SW confirmed she completed trauma assessment for R37 when R37 was admitted in 2023. SW stated when a resident has a decline or a change, it is discussed at Tuesday staff meetings and then she would reassess resident and determine what to do next. SW stated if a resident displayed behaviors, they would watch and chart behaviors. Facility has offered small groups for veterans, cognitive bins, real babies, and coordination with therapy for tasks to keep resident busy. During interview on 11/21/24 at 10:45 a.m., licensed practical nurse (LPN)-C stated she was not aware of any past trauma in R37's life. During interview on 11/21/24 at 10:46 a.m., LPN-A stated he was not aware of any past trauma in R37's life. During interview on 11/21/24 at 10:31 a.m., SW confirmed she completed the trauma assessment with R37, who had a severe cognitive impairment, and put information on care plan. SW reviewed R37's record and confirmed trauma was not on care plan. SW stated she should have asked about possible triggers and implement interventions to support the resident the best the facility can. SW stated it was important to include trauma on resident's care plan so staff know how to care for the resident and can provide interventions when needed. During interview on 11/21/24 at 12:59 p.m., assistant director of nursing (ADON) stated that when a resident is admitted, they are asked about past trauma and trauma informed care questionnaire would be completed by the social worker. ADON stated trauma assessments should be assessed quarterly due to new or changing behaviors. ADON stated R37's care plan should have included behavior monitoring, PTSD/trauma triggers, how staff would avoid those triggers and interventions to be used if R37 was triggered. ADON confirmed R37 did not have behavior monitoring or a care plan that addressed R37's past trauma and the last trauma assessment completed was on 7/6/23. A facility Trauma Informed Care policy, dated 7/2024, indicated the facility would demonstrate a culturally competent and trauma informed practice; integrate residents' preferences into care plans and understand the three core principles of Trauma Informed Care. The impact of adversity is not a choice; understanding adversity helps us make sense out of a behavior and prior adversity is not a [NAME]. The facility is to ensure that all those involved in the organization understand the general impact of trauma; paths to recovery and identify signs and symptoms of trauma in resident, families, staff and to incorporate practices that prevents re-traumatization. The facility will incorporate the 4 R's of a Trauma Informed Approach: - Realization: Ensure that all those involved in facility comprehend that trauma can affect individual's families, staff, and the community. - Recognition: Staff will recognize signs and symptoms of trauma and have access to trauma screening tools. - Responding: Staff will respond by using the Trauma informed Approach. - Resisting Re-traumatization: Ensure that practices and behaviors do not create a disruptive environment and re-traumatize.		

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48013 Based on observation, interview, and document review the facility failed to ensure side rails were assessed to determine appropriate and safe to use for 2 of 5 residents (R8 and R19) who were observed to have a side rail affixed to their beds. Findings include: R8's annual Minimum Data Set (MDS) dated [DATE], identified R8 had intact cognition and required assistance with all activities of daily living (ADL)'s. R8's diagnoses included dislocation of internal left hip prosthesis, coronary artery disease, GERD, obstructive uropathy, arthritis, presence of cardiac pacemaker, pain in right shoulder, pain in left shoulder, generalized muscle weakness and other abnormalities of gait and mobility. MDS did not identify use of side rails. R8's care plan, included R8 required limited assist of one staff for bed mobility (to go from lying to sitting/sitting to lying) but was able to turn and reposition in bed himself in bed. Care plan indicated R8 had two half upper side rails to assist with bed mobility and for staff to observe for injury or entrapment related to side rail use. During observation on 11/18/24 at 3:27 p.m., R8's bed had a 1/4 side rail affixed to the head of bed on both sides of bed. R8's medical record lacked evidence that an assessment had been completed timely to determine necessity and whether R8 could safely use side rails. Last side rail assessment was completed on 6/25/24. Additionally, R8s medical record lacked evidence alternatives were tried prior to installing the side rails. R19's annual Minimum Data Set (MDS) dated [DATE], identified R19 had moderate cognitive impairment and required assistance with all activities of daily living (ADL)'s. R19's diagnoses included stroke, hemiplegia following cerebral infarction affecting right dominant side, atrial fibrillation, coronary artery disease, heart failure, hypertension, thyroid disorder, depression, dysphagia following cerebral infarction and Barrett's esophagus without dysplasia. MDS did not identify use of side rails. R19's care plan, print date of 11/20/24, included that R19 required limited assist of one staff for bed mobility. Care plan indicated R19 had two half side rails on both sides of her bed to help her turn and transfer easier. During observation on 11/19/24 at 12:39 p.m., R19's bed had a 1/4 side rail affixed to the head of bed on both sides of bed. (continued on next page)		

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R19's medical record lacked evidence that an assessment had been completed timely to determine necessity and whether R19 could safely use side rails. Last side rail assessment was completed on 8/21/23. Additionally, R19s medical record lacked evidence alternatives were tried prior to installing the side rails. During interview on 11/18/24 at 3:27 p.m., R8 stated he used side rails to reposition himself in bed and to assist him with getting into bed. R8 stated the side rails were in my way when he had to get up to use restroom at night. R8 stated he told staff several times but the staff told resident that it is something I guess I have to have. During interview on 11/20/24 at 10:02 a.m., nursing assistant (NA)-E stated she has seen R8 utilize the side rails on his bed with turning and repositioning NA-E stated she has seen R19 utilize the side rails on her bed with repositioning and to assist her from sitting to standing. During interview on 11/21/24 at 10:48 a.m., licensed practical nurse (LPN)-B stated R8 utilized bed rails to aid in turning and repositioning in bed. LPN-B stated he was not aware R8 was having trouble getting out of bed at night due to the side rails and stated R8 is not supposed to get out of bed on his own anyway's as R8 tends to self-transfer. During interview on 11/21/24 at 11:39 a.m., registered nurse (RN)-A stated side rail assessments are completed quarterly and annually by the MDS nurse. RN-A stated the MDS nurse has been out of medical leave for the past several months and her duties were being completed by director of nursing (DON), assistant director of nursing (ADON) and herself. RN-A confirmed R8's last side rail assessment was completed on 6/25/24 and R8 should have had another assessment completed in September. RN-A confirmed R19's last side rail assessment was started on 8/28/24 but it was not started/completed and the last completed assessment was completed on 8/31/23. RN-A stated facility does not assess the resident for what type of grab bar/side rail would be appropriate for resident but for whatever device is on the bed in the room that the resident was admitted to is what the resident received. RN-A stated some residents get side rails and some get grab bars. RN-A stated she did not assess side rails based on the resident's condition or need, only assessed on if resident wanted them. RN-A was not aware of what alternative methods could be assessed and/or trialed regarding side rails. RN-A stated assessment of side rails is important to ensure resident still wanted to use side rails, determine if resident still needed them and that they are able to still use them safely. During interview on 11/21/24 at 12:59 p.m., assistant director of nursing (ADON) stated side rail assessments are competed quarterly. ADON stated whatever is on the bed in the room the resident was admitted to is what the resident was assessed for. ADON stated the facility treated grab bars and side rails the same. ADON stated assessment of side rails are important to ensure the resident has side rails for the right reasons, that they are still safe for the resident, and that the resident is not having ill effects from having side rails on bed. (continued on next page)		

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility Assessing the Safety of Side Rails policy, dated 8/2024, indicated staff will alert the RN if a client has any type of side rail or similar equipment and the RN will then evaluate whether the side rails appear to be safe for the client. The RN will educate the client, the client's representative and/or family members about the risks related to side rails, and if the client's side rail does not appear to meet FDA standards, the RN will recommend to the client, the client's representative, the client's involved family members that the side rail be removed and will recommend alternative options to reduce the risk of a fall out of bed. The RN will document these conversations and recommendations. 1. The RN will train staff to be alert for any side rail or equipment that resembles a side rail that a client may be using or considering using and to notify the RN immediately about the side rail or equipment. 2. When notified that a client has a side rail, the RN will assess and evaluate what the client's needs are and assess to determine if the client can safely utilize the side rail/equipment and determine whether the side rail/equipment meets the FDA standards for side rails. 3. The RN will provide for any client who has a side rail or is considering obtaining one and, if appropriate, the RN will educate the client's representative and/or the client's family regarding side rail safety and risks including potential death due to falls, entrapment, and asphyxiation. If the RN determines that the client is not able to safely use a side rail, or that the client's side rail does not meet the FDA or most current safety guidelines, the RN will recommend that the side rail should be removed and will document this recommendation, will document to whom the education was directed and will document the person who was given the recommendation to remove the side rail. 4. If the RN determines that the side rails are not a safe device for the client, the RN will provide options and alternatives for reducing fall or positioning self to the client, the client's representative and/or the client's family. The RN will document these recommended options and the response from the client, client's family, and client's representative to the RN's recommendations. 5. The RN may not remove a side rail that is the property of the client, the client's representative or the client's family. If the RN determines that a client's side rail is unsafe, and the client, the client's representative or the client's family does not remove it, the RN will notify the client's physician and consider whether to notify the Common Entry Point. Side rails can be very helpful in assisting individuals in transferring out of bed or repositioning in bed. It is important to recognize that the dangers exist regardless of the purpose for using the side rails. Nursing staff should assess an individual's capabilities for using side rails safely.		

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. 48013 Based on interview and document review, the facility failed to ensure the services of a registered nurse (RN) were available onsite for 8 consecutive hours seven days a week. This had the potential to affect all 41 residents who reside at the facility. Review of the facility staffing schedules dated 4/1/24 through 6/30/24, identified there was not eight consecutive hours of RN coverage for 6/2/24, 6/15/24 and 6/16/24. During interview on 11/21/24 at 12:59 p.m., the assistant director of nursing (ADON) verified there was no RN on for eight consecutive hours on 6/2/24, 6/15/24 and 6/16/24. The ADON stated the facility policy and practice was to have a RN on duty in the building eight consecutive hours but had call-ins for those dates and not sure what happened. The facility Departmental Supervision policy, dated 7/2024, indicated the nursing services department shall be under the direct supervision of a Registered or Licensed Practical/Vocational nurse at all times. 1. A Registered or Licensed Practical/Vocational Nurse (RN/LPN/LVN) is on duty twenty-four hours per day, seven days per week, to supervise the nursing services activities in accordance with physician orders and facility policy. 2. A Registered Nurse (RN) is employed as the Director of Nursing Services (DNS). The DNS is on duty during the day shift Monday through Friday. During the absence of the DNS, the Assistant Director of Nursing (ADON), then a RN Care Coordinator (RNCC) is responsible for the supervision of all nursing department activities including the supervision of direct care staff. During the absence of those Registered Nurses (Weekends and holidays), a registered nurse will be scheduled to be on duty, in the facility, 8 hours out of every 24 hour period.		

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. 48013 Based on observation, interview and document review, the facility failed to ensure the required and complete nurse staffing information was posted and readily available for viewing by the residents and visitors. Additionally, the facility failed to maintain the staffing logs for 18 months, as required, in the event this information was needed for review. This had the potential to affect all 41 residents and visitors who wanted to review the information. Findings include: During observation on 11/19/24, at 5:29 p.m. the nurse staff posting was noted to remain in place for staffing of 11/18/24 and had not been updated to reflect staffing for 11/19/24. During observation on 11/20/24, at 11:12 a.m. the nurse staff posting was noted to remain in place for staffing of 11/19/24 and had not been updated to reflect staffing for 11/20/24. During observation on 11/22/24, at 11:41 a.m. the nurse staff posting was noted to remain in place for staffing of 11/21/24 and had not been updated to reflect staffing for 11/22/24. During interview on 11/19/24 at 5:34 p.m., assistant director of nursing (ADON) stated the health unit coordinator (HUC) is responsible for completing and posting the daily staff postings. ADON confirmed the daily staff posting that was posted was not current and reflected date of 11/18/24. ADON stated it was important to ensure daily staff postings are accurate and posted timely for anyone (visitors, staff, residents, and family) who may have concerns about staffing so they can see what the facilities staffing levels were. A request was made at this time for additional staff posting information to complete the payroll-Based Journal (PBJ) staffing review. During interview on 11/20/24 at 2:04 p.m., HUC stated she was responsible for completing and posting the daily staff postings. HUC stated the daily staff postings should be posted immediately in the morning. HUC stated she was unable to provide the staff postings from prior to 11/18/24 as they were unavailable. HUC stated she had recreated staff postings after request was made for them. HUC stated the staff posting information prior to 11/18/24 had not been retained as the HUC was unaware of the need to retain this information for an extended period. HUC stated it was important to post them right away in the morning so all residents, staff and visitors can view them and that it was important to retain them so that they can be referred to as needed. During interview on 11/21/24 at 12:59 p.m., ADON stated the new HUC was unaware the nurse staff posting information was to be maintained for a period of 18 months. (continued on next page)		

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Centers for Medicare & Medicaid Services

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	The facility Daily Staff Postings policy, dated 7/2024, indicated the facility will post on a daily basis for each shift, the number of nursing personnel responsible for providing direct care to residents. Within two (2) hours of the beginning of each shift, the number of Licensed Nurses (RNs, LPNs) and the number of unlicensed nursing personnel (CNAs) directly responsible for resident care will be posted in a prominent location (accessible to residents and visitors) and in a clear and readable format. The previous shift's forms shall be maintained with the current shift form for a total of 24 hours of staffing information in a single location. Once a form is removed, it shall be forwarded to the Director of Nursing Services' office and filed as a permanent record. Records of staffing information for each shift will be kept for a minimum of eighteen (18) months or as required by state law (whichever is greater).		

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NAME OF PROVIDER OR SUPPLIER Spring Valley Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 800 Memorial Drive Spring Valley, MN 55975	
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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48013 Based on interview and document review, the facility failed to ensure adverse event monitoring was completed for 1 of 4 residents (R37) and failed to monitor adverse behaviors for 1 of 4 residents (R37) reviewed for unnecessary medication use and were taking an antipsychotic medication. Findings include: R37's quarterly Minimum Data Set (MDS) dated [DATE], identified R37 had severe cognitive impairment and required assistance with all activities of daily living (ADL)'s. R37's diagnoses included Alzheimer's disease, aphasia, dementia, depression, polyneuropathy, and low back pain. R37's Order Summary Report, print date 11/19/24, identified R37's current physician ordered medications and treatments at the nursing home. These included orders for haloperidol (an antipsychotic) 1.5 mL (3 mg) three times daily for anxiety/restlessness/agitation. R37's care plan, print date of 11/19/24, lacked evidence for behavior and/or side effect monitoring with use of an antipsychotic medication. R37's medication record, identified the order for haloperidol and recorded R37 received the medication, as ordered, on a daily basis. However, the record lacked evidence staff monitored for adverse effects of the medications. In addition, the record lacked behavioral symptoms to monitor, and track. R37's medical record lacked evidence R37's behaviors were monitored, assessed, and reviewed to justify the daily medication administration and that R37 was being assessed or evaluated for adverse effects as ordered by the physician. During interview on 11/21/24 at 11:39 a.m., registered nurse (RN)-A stated a resident who receives an antipsychotic medication should have the following monitoring: behavioral and adverse effect monitoring, and an abnormal involuntary movements assessment should be completed. RN-A stated antipsychotic monitoring should be included in the resident's care plan. RN-A confirmed R37 did not have an order for side effects monitoring, behavior monitoring and that it was not listed on R37's care plan. RN-A stated it was important for the antipsychotic medication to be listed on the care plan as it is another way for staff to be aware of what types of medication is receiving and it is another way to monitor for side effects. During interview on 11/21/24 at 12:59 p.m., assistant director of nursing (ADON) stated when a resident is receiving an antipsychotic medication, side effect and target behavior monitoring should be completed. ADON stated the antipsychotic medication would be stated in the care plan with what side effects to monitor and interventions for behaviors. ADON stated it was important for the well-being of the resident and if resident was experiencing side effects from medication it could mean than resident may need a dose reduction and/or an alternative medication. (continued on next page)		

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility Antipsychotic Medication Use policy, dated 7/2024, identified antipsychotic medication therapy shall be used only when it is necessary to treat a specific condition. Staff will gather and document information to clarify a resident's behavior, mood, function, medical condition, symptoms, and risks. Nursing staff will document in detail an individual's target symptom(s). The staff will observe, document, and report to the Attending Physician information regarding the effectiveness of any interventions, including antipsychotic medications. Based on assessing the resident's symptoms and overall situation, the Physician will determine whether to continue, adjust, or stop existing antipsychotic medications. Nursing staff shall monitor and report any of the following side effects to the Attending Physician: A) Sedation; B) Orthostatic hypotension; C) Lightheadedness; D) Dry mouth; E) Blurred vision; F) Constipation; G) Urinary retention; H) Increased psychotic symptoms (atropine psychosis); I) Extrapyramidal effects; J) Akathisia; K) Dystonia; L) Tremor; M) Rigidity; N) Akinesia; or tardive dyskinesia.		

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F 0851 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Electronically submit to CMS complete and accurate direct care staffing information, based on payroll and other verifiable and auditable data. 48013 Based on interview and record review, the facility failed to submit complete and/or accurate data for staffing information based on payroll and other verifiable data during 1 of 1 quarter (Quarter 3) reviewed, to the Centers for Medicare and Medicaid Services (CMS), according to specifications established by CMS. Findings include: Review of the Payroll Based Journal (PBJ) [NAME] Report 1705D identified the facility had excessively low weekend staffing during the third quarter of the fiscal year 2024, which included dates between April 1st to June 30th. Review of daily staff schedules and facility staffing report during quarter three indicated adequate levels of staff on weekends. Therefore, the data submitted in the PBJ to CMS was inaccurate. During interview on 11/21/24 at 3:09 p.m. the administrator stated the facility staffing levels did not change from weekdays to weekends. Administrator stated the business office completed and submits the PBJ data based on information off the schedule and daily staff postings. Administrator stated it was important to ensure accurate data is submitted based on requirements. The facility Payroll Based Journal (PBJ) Reporting policy, dated 7/2024, indicated staff and census information will be reported electronically to CMS through the Payroll-Based Journal system in compliance with 6106 of the Affordable Care Act. Direct-care staffing information will include staff hired directly by the facility, those hired through an agency, and contract employees. Providers who are employed by the facility (including physicians) will be included in direct-care staffing information, providers who bill Medicare directly will not be included. For auditing purposes, reported staffing information will be based on payroll records, or other verifiable information.		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48013 Based on observation, interview and document review, the facility failed to ensure appropriate hand hygiene and donning/doffing of personal protective equipment (PPE) was performed in order to prevent the spread of infection for 3 of 3 residents (R8, R32, and R21) observed for enhanced barrier precautions (an infection control intervention designed to reduce transmission of multidrug-resistant organisms that employs targeted gown and glove use during high contact resident care activities). Findings include: ENHANCED BARRIER PRECAUTIONS, PPE USE AND HAND HYGIENE Review of CDC guidance dated 4/1/24, Implementation of Personal Protective Equipment (PPE) Use in Nursing Homes to Prevent Spread of Multidrug-resistant Organisms (MDROs) indicated examples of high-contact resident care activities requiring gown and glove use for Enhanced Barrier Precautions (EBP) include: Dressing, Bathing/showering, Transferring, Providing hygiene, changing linens, changing briefs or assisting with toileting, device care or use: central line, urinary catheter, feeding tube, tracheostomy/ventilator and wound care: any skin opening requiring a dressing. R8's annual Minimum Data Set (MDS) dated [DATE], identified R8 had intact cognition and required assistance with all activities of daily living (ADL)'s and had an indwelling catheter. R8's diagnoses included dislocation of internal left hip prosthesis, coronary artery disease, gastroesophageal reflux disease, obstructive uropathy (excess urine accumulation in kidneys that causes swelling of kidneys), arthritis, presence of cardiac pacemaker, pain in right shoulder, pain in left shoulder, generalized muscle weakness and other abnormalities of gait and mobility. R8's care plan, print date of 11/20/24, indicated R8 required staff assistance with all ADL's and had an indwelling catheter. During observation on 11/18/24 at 3:33 p.m., R8 did not have cart with PPE or hand hygiene in or outside of room, nor did not have signage posted indicating that R8 was on enhanced barrier precautions. R32's quarterly Minimum Data Set (MDS) dated [DATE], identified R32 had severe cognitive impairment and required assistance with all activities of daily living (ADL)'s. R32's diagnoses included heart failure, hypertension, dysphagia (difficulty in swallowing), dyskinesia of esophagus (painful and abnormal contractions of the esophagus (food pipe) that do not lead to wave-like movement (peristalsis) to push the food to the stomach), orthostatic hypotension (form of low blood pressure that occurs when standing after sitting or lying down), renal failure (one or both of the kidneys no long function well on their own), Alzheimer's disease, stroke, dementia, depression, and asthma. MDS indicated R32 received tube feedings. R32's care plan, print date of 11/20/24, indicated R32 required staff assistance with all ADL's and received tube feeding related to dysphagia and dyskinesia of esophagus. (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During observation on 11/18/24 at 3:14 p.m., R32 did not have cart with PPE or hand hygiene in or outside of room, nor did not have signage posted indicating that R32 was on enhanced barrier precautions. During interview on 11/20/24 at 9:57 a.m., licensed practical nurse (LPN)-B stated if a resident was on precautions, there would be a sign posted outside of resident's door, PPE carts would be placed outside resident's room in hallway, and garbage cans/bins would be kept in resident's room to dispose of PPE before exiting room after cares. LPN-B stated for residents with catheters or tube feedings, PPE that is used are gloves. LPN-B was not aware of what EBP precautions were and stated they have not been trained on them. During interview on 11/20/24 at 10:02 a.m., nursing assistant (NA)-E stated they are notified in report if resident goes on precautions. NA-E stated a bin for PPE would be placed outside of resident's room and three bins would be placed inside resident's room for garbage and linens. NA-E stated she was not aware of what enhanced barrier precautions were. During interview on 11/20/24 at 10:16 a.m., LPN-C stated if a resident was on precautions there would be a sign posted on resident's doors, a PPE cart would be in place outside of resident's room, and garbage cans in resident's room. LPN-C stated when caring for the catheter an/or tube feeding, PPE used are gloves and mask. LPN-C was not aware of what EBP precautions were. During interview on 11/21/24 at 10:29 a.m., assistant director of nursing (ADON) stated when a resident is on precautions, PPE cart would be placed outside of resident's room with a sign posted on resident's door directing staff what PPE is needed before caring for resident. ADON stated precautions would also be posted on the resident's home page in the electronic health record. ADON stated standard precautions are used for residents with catheters and/or has tube feedings. ADON stated she had heard about EBP precautions but was not familiar with them and confirmed that EBP precautions are not in place in facility. ADON stated EBP had not been implemented and confirmed R8 and R32 should be on EBP due to R8 having a catheter and R32 receiving tube feedings. ADON stated EBP precautions are important for the resident and staff safety. 49893 R21 R21's quarterly Minimum Data Set (MDS) dated [DATE] indicated R21 had significant cognitive impairment and an indwelling catheter. R21's diagnosis list included: obstructive and reflux uropathy (a disorder limiting the flow of urine), urinary retention (difficulty emptying the bladder) R21's orders included: change urinary catheter every 28 days, change urine collection bag every Thursday, and document catheter output every shift. R21's careplan indicated R21 had urinary catheter. R21's catheter assessment dated [DATE] indicated R21 has an indwelling catheter since 11/4/22. Catheter was last changed 8/24/24. (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interview on 11/19/24 at 1:10 p.m., R21's family member (FM) -D indicated R21 has had a urinary catheter for 2 years. During observation on 11/19/24 at 1:28 p.m., no enhanced barrier precautions signage or protective equipment (PPE) were noted outside R21's room. There were no bins to dispose of PPE noted inside R21's room. During interview on 11/19/24 at 7:26 p.m., nursing assistant (NA)-A stated staff receive infection prevention training once a year. NA-A stated when residents are on precautions, signage is placed on the door and carts containing PPE are placed outside the rooms. Precautions are also indicated on the resident's care sheet. NA-A stated they were not familiar with EBP. R21's care sheet indicated R21 has urinary catheter however lacks indication of EBP. During observation and interview on 11/20/24 at 9:02 a.m., R21 was lying in bed with urinary drainage bag attached to the bedframe. NA-B entered room, sanitized hands, and applied gloves. NA-B was not wearing isolation gown. NA-B obtained R21's daytime urinary bag from bathroom and brought it to the bedside. NA-B removed R21's sweatpants and opened R21's incontinent brief. NA-B provided catheter care, disconnected drainage bag, wiped ends of catheter tubing with alcohol wipes, and attached daytime drainage bag. NA-B placed night drainage bag in the bathroom and removed gloves. NA-B assisted R21 to the edge of the bed and applied gait belt. NA-B assisted R21 to standing position and transferred R21 to the wheelchair. NA-B returned to the bathroom, applied gloves, and placed a paper towel on the bathroom floor. NA-B placed graduate (container used to measure fluids) on paper towel, emptied drainage bag, measured amount and disposed in the toilet. NA-B was not wearing gown. NA-B stated they were not familiar with EBP and had never been instructed to use it. When surveyor explained what EBP was, NA-B stated they never heard of it. The facilities Enhanced Barrier Precautions policy was requested but was not received.		