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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 5TVU

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00414

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245419**

2.STATE VENDOR OR MEDICAID NO.
(L2) **546242800**

3. NAME AND ADDRESS OF FACILITY
(L3) **TWIN VALLEY LIVING CENTER**
(L4) **208 OPPEGARD AVENUE NORTHWEST, PO BOX 480**
(L5) **TWIN VALLEY, MN** (L6) **56584**

4. TYPE OF ACTION: **7**

1. Initial **2. Recertification**
3. Termination **4. CHOW**
5. Validation **6. Complaint**
7. On-Site Visit **9. Other**
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **07/20/2015** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

12.Total Facility Beds **58** (L18)

13.Total Certified Beds **58** (L17)

10.THE FACILITY IS CERTIFIED AS:

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	58			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Gail Anderson, Unit Supervisor 07/20/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath, Enforcement Specialist 08/24/2015 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
02/01/1987
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions:
(L44)
B. Rescind Suspension Date:
(L45)

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal
INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
07/08/2015
(L33)

DETERMINATION APPROVAL

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 245419

August 24, 2015

Ms. Shari Schreiner, Administrator
Twin Valley Living Center
208 Oppegard Avenue Northwest, PO Box 480
Twin Valley, Minnesota 56584

Dear Ms. Schreiner:

The Minnesota Department of Health assists the Centers for Medicare and Medicaid Services (CMS) by surveying skilled nursing facilities and nursing facilities to determine whether they meet the requirements for participation. To participate as a skilled nursing facility in the Medicare program or as a nursing facility in the Medicaid program, a provider must be in substantial compliance with each of the requirements established by the Secretary of Health and Human Services found in 42 CFR part 483, Subpart B.

Based upon your facility being in substantial compliance, we are recommending to CMS that your facility be recertified for participation in the Medicare and Medicaid program.

Effective July 22, 2015 the above facility is certified for:

58 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 58 skilled nursing facility beds.

You should advise our office of any changes in staffing, services, or organization, which might affect your certification status.

If, at the time of your next survey, we find your facility to not be in substantial compliance your Medicare and Medicaid provider agreement may be subject to non-renewal or termination.

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

Sincerely,

Mark Meath

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

cc: Licensing and Certification File

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

July 20, 2015

Ms. Shari Schreiner, Administrator
Twin Valley Living Center
208 Oppegard Avenue Northwest, PO Box 480
Twin Valley, Minnesota 56584

RE: Project Number S5419023

Dear Ms. Schreiner:

On June 19, 2015, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on June 4, 2015. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), hereby corrections were required.

On July 20, 2015, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on July 1, 2015 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on June 4, 2015. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of June 22, 2015. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on June 4, 2015, effective June 22, 2015 and therefore remedies outlined in our letter to you dated June 19, 2015, will not be imposed.

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

Enclosed is a copy of the Post Certification Revisit Form, (CMS-2567B) from this visit.

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

Sincerely,

Mark Meath

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

Enclosure(s)

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245419	A. Building B. Wing	7/20/2015

Name of Facility	Street Address, City, State, Zip Code
TWIN VALLEY LIVING CENTER	208 OPPEGARD AVENUE NORTHWEST, PO BOX 480 TWIN VALLEY, MN 56584

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

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix **F0248** Reg. # **483.15(f)(1)** LSC	**06/22/2015**	ID Prefix **F0282** Reg. # **483.20(k)(3)(ii)** LSC	**06/22/2015**	ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By State Agency	**Reviewed By** GA/mm	**Date:** 07/20/2015	**Signature of Surveyor:** 28034	**Date:** 07/20/2015
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**
Followup to Survey Completed on: 6/4/2015		**Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?**	**YES**	**NO**

Department of Health and Human Services
Centers for Medicare & Medicaid Services

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245419	A. Building B. Wing **01 - MAIN BUILDING 01**	7/1/2015

Name of Facility	Street Address, City, State, Zip Code
TWIN VALLEY LIVING CENTER	208 OPPEGARD AVENUE NORTHWEST, PO BOX 480 TWIN VALLEY, MN 56584

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

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix	Correction Completed **06/04/2015**	ID Prefix	Correction Completed **06/04/2015**	ID Prefix	Correction Completed **06/04/2015**
Reg. # **NFPA 101**		Reg. # **NFPA 101**		Reg. # **NFPA 101**	
LSC K0017		LSC K0050		LSC K0052	
ID Prefix	Correction Completed **06/22/2015**	ID Prefix	Correction Completed **06/22/2015**	ID Prefix	Correction Completed
Reg. # **NFPA 101**		Reg. # **NFPA 101**		Reg. #	
LSC K0054		LSC K0073		LSC	
ID Prefix	Correction Completed	ID Prefix	Correction Completed	ID Prefix	Correction Completed
Reg. #		Reg. #		Reg. #	
LSC		LSC		LSC	
ID Prefix	Correction Completed	ID Prefix	Correction Completed	ID Prefix	Correction Completed
Reg. #		Reg. #		Reg. #	
LSC		LSC		LSC	
ID Prefix	Correction Completed	ID Prefix	Correction Completed	ID Prefix	Correction Completed
Reg. #		Reg. #		Reg. #	
LSC		LSC		LSC	

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	PS/mm	07/20/2015	27200	07/01/2015
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on: 6/3/2015

Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? **YES** **NO**

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 5TVU

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00414

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(L3) **TWIN VALLEY LIVING CENTER**
(L4) **208 OPPEGARD AVENUE NORTHWEST, PO BOX 480**
(L5) **TWIN VALLEY, MN** (L6) **56584**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **06/04/2015** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

12.Total Facility Beds **58** (L18)

13.Total Certified Beds **58** (L17)

10.THE FACILITY IS CERTIFIED AS:
A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	58			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Sherri Sorting HPR - Dietary Specialist 06/29/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath, Enforcement Specialist 07/07/2015 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :
_____

22. ORIGINAL DATE OF PARTICIPATION
02/01/1987
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions:
(L44)
B. Rescind Suspension Date:
(L45)

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal
INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS
Posted 07/08/2015 Co.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7010 1670 0000 8044 5995

June 19, 2015

Ms. Shari Schreiner, Administrator
Twin Valley Living Center
208 Oppegard Avenue Northwest, Po Box 480
Twin Valley, MN 56584

RE: Project Number S5419023

Dear Ms. Schreiner:

On June 4, 2015, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

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

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

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

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

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

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

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

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

DEPARTMENT CONTACT

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

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

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

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by July 14, 2015, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by July 14, 2015 the following remedy will be imposed:

- Per instance civil money penalties. (42 CFR 488.430 through 488.444)

PLAN OF CORRECTION (PoC)

A PoC for the deficiencies must be submitted within **ten calendar days** of your receipt of this letter. Your PoC must:

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

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

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

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

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

- Include signature of provider and date.

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by September 4, 2015 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may

still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by December 4, 2015 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

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

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

Telephone: (651) 201-7205
Fax: (651) 215-0525

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

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
85 East Seventh Place, Suite 220
P.O. Box 64900
St. Paul, Minnesota 55164-0900
Email: mark.meath@state.mn.us

Telephone: (651) 201-4118
Fax: (651) 215-9697

Enclosure

cc: Licensing and Certification File

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245419	A. BUILDING _____ B. WING _____	06/04/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TWIN VALLEY LIVING CENTER	208 OPPEGARD AVENUE NORTHWEST, PO BOX 480 TWIN VALLEY, MN 56584

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. Upon receipt of an acceptable POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. Census 57	F 000		
F 248 SS=D	483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure 1 of 3 residents (R30) was invited/assisted, on a consistent basis, to participate in activities of interest to the resident which were based on a comprehensive activity assessment. Findings include: R30's annual Minimum Data Set (MDS) dated 1/27/15 identified R30 was interviewed for daily preferences. R30 reported activities were very	F 248	6/29/15 OK Da	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Shari Schneider TITLE: Executive Director (X6) DATE: 6/23/15

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245419	A. BUILDING _____ B. WING _____	06/04/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TWIN VALLEY LIVING CENTER	208 OPPEGARD AVENUE NORTHWEST, PO BOX 480 TWIN VALLEY, MN 56584

(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 248	Continued From page 1 important to her including; reading, music, animals, news, attending groups, going outside and religious services/practices. R30's quarterly MDS dated 4/21/15 identified R30 had diagnosis which included dementia and depression, had moderate decision making impairment that required cues and supervision and no acute changes in mental status. MDS identified R30 had clear speech, adequate hearing with hearing aids, was able to make herself understood, usually understood others and had adequate vision with glasses. The MDS also indicated R30 was totally dependent for locomotion on and off the unit. R30's Care Area Assessment (CAA)dated 1/27/15 identified R30 appeared to enjoy most activities and heard the best when the speaker is in front of her and spoke slightly louder than conversation level. CAA also identified R30 was at risk for social isolation due to communication problems. R30's Care Plan (CP) dated 4/25/15 identified R30 needed to be escorted to all meals, activities and events, and needed to be reminded of daily schedule and happenings. R30 was to be monitored for changes in communication, staff should stand to be seen and speak slowly and distinctly. CP also identified R30 was understood by others and usually understands others. CP identified R30 will receive adequate communication from others and all needs were to be met. The care plan listed various interventions which included 1:1 visits as needed, assess interests, inform of activities, assist to activities, monitor for depression, sleeping throughout the day, isolating herself in her room. CP identified R30's activity goal was to minimize depression,	F 248	Twin Valley Living Center must provide for an ongoing program of activities designed to meeting, in accordance with the comprehensive assessment, the interests and physical, mental, and psychosocial well-being of each resident. Based on observation, interview and document review, the facility failed to ensure 1/3 residents was invited or encouraged, on a consistent basis to attend activities of interest for the resident which were based on a comprehensive activity assessment. This resident (R30) care plan was updated on 6/8/2015 to meet resident's current therapeutic recreational needs. Staff in-service was held6/11/2015 to educate staff on care plans, and the importance of inviting, encouraging and assisting resident in scheduled activities of their interest. Random audits will be completed by Activity Director or her designee to assure accuracy of care plans and involvement of activities. Findings of these audits will be brought to Quality Assurance meetings until compliance is met.	4/22/15

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F 248	Continued From page 2 participate in activities, needs reminders and directions and assistance to groups, NA to assist to activities, goal to participate in daily group activities and reminders and assistance to groups, R30 was to visit with staff, visitors and other residents at meals and activities. CP identified R30 has shown interest in group activities, special events, games, worship services, pastoral visits, beauty shop weekly, intergenerational groups, and bible studies. CP also identified R30 had good eyesight and will read lips in groups, seat resident in the front row across from the speaker so staff are facing where she can see them. Social Services were to provide 1:1 visits as needed and encourage R30 to attend activities. On 06/02/15, at 8:37 a.m. R30 was observed in the, "Stand up for the Group" activity in the activity room led by A-A. R30 was seated in her wheelchair, lacked facial expression and stared straight forward or down to the floor prior to quickly falling asleep during the activity. A-A was not observed to encourage or cue R30 to participate in the activity. -8:42 a.m. A-B replaced A-A in leading the group and A-A left the area. A-B told the group of residents they were going to do some stand up exercises for those who are able. The activity, which lasted until 8:51 a.m., included stretching exercises, arm lifts, marching, knee raises, merry go round, twist at the waist, squeeze knees, opening and closing hands and rock the baby. R30 was observed sleeping throughout the entire activity and did not participate. A-B was not observed to encourage or cue R30 to participate during the entire activity. -8:51 a.m. A-B told the group they would next be	F 248		

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F 248	Continued From page 3 conducting the trivia activity. During observations from 8:51 a.m. to 9:07 a.m., A-B was seated at the center of the long table in the activity room and read stories to the residents. A-B face and mouth turned away from R30, who was seated at the end of the long table. R30 remained seated in her wheelchair, eyes closed, asleep during the entire activity. A-B was not observed to encourage or cue R30 to participate during the entire activity. On 06/03/2015, at 8:24 a.m. to 9:19 a.m., R30 was seated in her wheelchair, slightly tilted back with a pillow under her head with her eyes closed, asleep in front of the TV. A-A was observed at the nurses desk and in the hallway, inviting and gathering various residents for Wake up and Walk, paddle ball and word game activities being conducted. A-A did not enter R30 ' s room, and did not encourage/invite or cue R30 to participate in any of the activities being held during that time. On 6/4/15, at 11:31 a.m. Trained Medication Assistant (TMA-A) stated R30 likes church, reading, and attending groups. She stated she felt R30 was quiet and listened during activities. She stated R30 is hard of hearing and the usual practice was to seat R30 next to staff when they are reading so she could hear. On 06/04/2015, at 10:15 a.m. during interview NA-A stated R30 usually attended activities in the morning after breakfast and church on Tuesday. NA-A stated she was not aware of anything special staff needed to do for R30 during activities. On 6/04/2015, at 2:26 p.m. during interview	F 248		

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F 248	Continued From page 4	F 248		

Licensed Practical Nurse (LPN-A) stated R30 rarely attended activities and was not sure her age or hearing problems attributed to her not attending activities. She stated she understood R30 needed 1:1 assistance during activities and staff would assist her during the activities if she wasn ' t really participating.

On 06/04/2015, at 2:58 p.m. during interview A-A confirmed R30 ' s current care plan and stated R30 usually attended morning activities. A-A confirmed R30 required assistance with hearing during activities and the usual practice was to have R30 sit next to the speaker in groups. She stated R30 does the best when she's across from the person speaking. She stated R30 required total assistance from staff with games. She stated she would verbally and physically participate in activities but required staff assistance to engage or participate in activities. A-A stated she expected R30 to be routinely invited to all activities.

On 06/04/2015, at 3:39 p.m. during interview DON confirmed R30's activities care plan. She indicated the usual facility practice was for the nursing assistants or the activities staff to inform the residents what activities were being held, invite them to attend and provide assistance with transportation to the activity as needed. DON stated she would expect staff to routinely implement R30 ' s care plan.

The facility ' s undated and untitled policy related to activities identified they will provide activities to meet the psychosocial, physical, mental and spiritual needs of all the residents who reside with them. The policy also identified they would encourage residents to their fullest ability,

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F 282	Continued From page 6 directions and assistance to groups, NA to assist to activities, goal to participate in daily group activities and reminders and assistance to groups, R30 was to visit with staff, visitors and other residents at meals and activities. CP identified R30 has shown interest in group activities, special events, games, worship services, pastoral visits, beauty shop weekly, intergenerational groups, and bible studies. CP also identified R30 had good eyesight and will read lips in groups, seat resident in the front row across from the speaker so staff are facing where she can see them. On 06/02/15, at 8:37 a.m. R30 was observed in the, "Stand up for the Group" activity in the activity room led by A-A. R30 was seated in her wheelchair, lacked facial expression and stared straight forward or down to the floor prior to quickly falling asleep during the activity. A-A was not observed to encourage or cue R30 to participate in the activity. -8:42 a.m. A-B replaced A-A in leading the group and A-A left the area. A-B told the group of residents they were going to do some stand up exercises for those who are able. The activity, which lasted until 8:51 a.m., included stretching exercises, arm lifts, marching, knee raises, merry go round, twist at the waist, squeeze knees, opening and closing hands and rock the baby. R30 was observed sleeping throughout the entire activity and did not participate. A-B was not observed to encourage or cue R30 to participate during the entire activity. -8:51 a.m. A-B told the group they would next be conducting the trivia activity. During observations from 8:51 a.m. to 9:07 a.m., A-B was seated at the center of the long table in the activity room and read stories to the residents. A-B face and	F 282	Twin Valley Living Center must ensure the services provided or arranged by the facility are provided by qualified persons in accordance with each resident's written plan of care. Base on observation, interview and documentation review the facility did not ensure care plan interventions were implemented for 1/1 resident, R30. Care plan was updated 6/8/2015 to meet resident's current therapeutic and recreational needs. Staff educational in-service was held 6/11/2015 regarding the updates made to the plan of care. Staff were educated on reminded of the importance of inviting, encouraging and assisting resident in scheduled group activities. Care plans will be audited monthly by Activity Director or her designee to ensure compliance. Findings will be brought to Quality Assurance until compliance is met.	4/22/15

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F 282	Continued From page 7	F 282		

mouth turned away from R30, who was seated at the end of the long table. R30 remained seated in her wheelchair, eyes closed, asleep during the entire activity. A-B was not observed to encourage or cue R30 to participate during the entire activity.

On 06/03/2015, at 8:24 a.m. to 9:19 a.m., R30 was seated in her wheelchair, slightly tilted back with a pillow under her head with her eyes closed, asleep in front of the TV. A-A was observed at the nurses desk and in the hallway, inviting and gathering various residents for Wake up and Walk, paddle ball and word game activities being conducted. A-A did not enter R30 ' s room, and did not encourage/invite or cue R30 to participate in any of the activities being held during that time.

On 6/4/15, at 11:31 a.m. Trained Medication Assistant (TMA-A) stated R30 likes church, reading, and attending groups. She stated she felt R30 was quiet and listened during activities. She stated R30 is hard of hearing and the usual practice was to seat R30 next to staff when they are reading so she could hear.

On 06/04/2015, at 10:15 a.m. during interview NA-A stated R30 usually attended activities in the morning after breakfast and church on Tuesday. NA-A stated she was not aware of anything special staff needed to do for R30 during activities.

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F 282	Continued From page 8 staff would assist her during the activities if she wasn ' t really participating. On 06/04/2015, at 2:58 p.m. during interview A-A confirmed R30 ' s current care plan and stated R30 usually attended morning activities. A-A confirmed R30 required assistance with hearing during activities and the usual practice was to have R30 sit next to the speaker in groups. She stated R30 does the best when she's across from the person speaking. She stated R30 required total assistance from staff with games. She stated she would verbally and physically participate in activities but required staff assistance to engage or participate in activities. A-A stated she expected R30 to be routinely invited to all activities. On 06/04/2015, at 3:39 p.m. during interview DON confirmed R30's activities care plan. She indicated the usual facility practice was for the nursing assistants or the activities staff to inform the residents what activities were being held, invite them to attend and provide assistance with transportation to the activity as needed. DON stated she would expect staff to routinely implement R30 ' s care plan. The facility Care Plan Policy dated 6/3/14 identified each department will perform interviews, review charting and perform assessment to complete the RAI process and formulate a plan of care with measurable time limited goals which address the individual resident's needs, desires, and approaches towards reaching those goals.	F 282		

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	245419	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**06/03/2015**

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K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey Twin Valley Living Center was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K TAGS) TO: HEALTH CARE FIRE INSPECTIONS STATE FIRE MARSHAL DIVISION 444 CEDAR STREET, SUITE 145 ST. PAUL, MN 55101-5145, or By e-mail to:	K 000	POC ok JB 6-29-15 RECEIVED JUN 26 2015 MN DEPT. OF PUBLIC SAFETY STATE FIRE MARSHAL DIVISION	

DC: 7-14-15
Exit: 6-4-15

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Shari Schreier | TITLE: Executive Director | (X6) DATE: 6/29/15

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

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K 000	Continued From page 1 Marian.Whitney@state.mn.us or Angela.Kappenman@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency Twin Valley Living Center is a 1-story building without a basement. The building was constructed at six different times. The original building was constructed in 1965 and was determined to be of Type II(111) construction. In 1969, a dining room addition was constructed to the south of the building that was determined to be of Type II(000) construction. In 1975 additions to the dining room and a activates were constructed and was determined to be Type II (000) constitution. In 1981, a sleeping room addition was constructed on the east side of the facility that was determined to be of Type V(111) construction. In 1992, a dayroom was added to the north of the 1965 building that is of Type II(111) construction. In 1995, a small dining room addition was added to the east side of the north wing of the 1965 building that is of Type II(111) construction. The latest addition was an administration wing in 1996 to the south of the 1981 addition, which is of Type V(111)	K 000		

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K 000	Continued From page 2 construction. The building is divided into 9 smoke zones. The building is fully sprinklered throughout in accordance with NFPA 13 Standard for the Installation of Sprinkler Systems 1999 edition . The facility has a fire alarm system with smoke detection at smoke barrier doors and in spaces open to the corridors that is monitored for automatic fire department notification in accordance with NFPA 72 "The National Fire Alarm Code" 1999 edition with single station smoke detection in all resident sleeping rooms Other hazardous areas have automatic fire detection that is on the fire alarm system in accordance with the Minnesota State Fire Code 2007 edition. The facility has a capacity of 58 beds and had a census of 57 at the time of the survey. Because the original building and its additions meet the construction type allowed for existing buildings, this facility was surveyed as a single building. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 017 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD Corridors are separated from use areas by walls constructed with at least ½ hour fire resistance rating. In sprinklered buildings, partitions are only required to resist the passage of smoke. In non-sprinklered buildings, walls properly extend above the ceiling. (Corridor walls may terminate at the underside of ceilings where specifically permitted by Code. Charting and clerical stations,	K 017	Ceiling tile was replace 6/3/2015 by maintenance Department.	6-4-15 ~~6/3/15~~

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K 017	Continued From page 3 waiting areas, dining rooms, and activity spaces may be open to the corridor under certain conditions specified in the Code. Gift shops may be separated from corridors by non-fire rated walls if the gift shop is fully sprinklered.) 19.3.6.1, 19.3.6.2.1, 19.3.6.5 This STANDARD is not met as evidenced by: Based on observations and staff interview, it was revealed that the facility had penetrations located in the ceiling tile located in the facility that are not in compliance with NFPA Life Safety Code 101 (00) Sections 19.3.6.2 and 8.2.4.4.1 in resisting the passage of smoke. This deficient conditions could in the event of a fire, allow smoke and flames to spread throughout the effected corridors and areas making them untenable, which could negatively affect the exiting capabilities for 6 of 58 residents, staff and visitors. Findings include: On facility tour between 10:30 AM to 2:30 PM on 06/03/2015, observations revealed, that there was a 2 inch diameter hole in the ceiling tile located by room 502. This deficient condition was verified by the Maintenance Supervisor.	K 017		
K 050	NFPA 101 LIFE SAFETY CODE STANDARD	K 050		

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K 050 SS=D	Continued From page 4 Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2 This STANDARD is not met as evidenced by: Based on review of reports, records and staff interview, it was determined that the facility failed to conduct fire drills in accordance with NFPA Life Safety Code 101(00), 19.7.1.2, during the last 12-month period. This deficient practice could affect how staff react in the event of a fire. Improper reaction by staff would affect the safety of all residents. Findings include: On facility tour between 10:30 AM to 2:30 PM on 06/03/2015, during the review of all available maintenance documentation and interview with the Maintenance Supervisor it was revealed that the facility failed to provide documentation for 1 day shift fire drill in the furst calendar quarter within the last 12 months. This deficient condition was verified by the Maintenance Supervisor.	K 050	Twin Valley Living Center conducted fire drill 6/4/2015 on the day shift. Fire drills will be monitored by maintenance Director or his designee to ensure all drills are completed in a timely manner on varying shifts.	6/4/15
K 052	NFPA 101 LIFE SAFETY CODE STANDARD	K 052		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245419	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**06/03/2015**

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K 052 SS=F	Continued From page 5 A fire alarm system required for life safety is installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. The system has an approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72. 9.6.1.4 This STANDARD is not met as evidenced by: Based on observation and staff interview, it was revealed that the facility had failed to install and maintain the fire alarm system in accordance with the requirements of 2000 NFPA 101, Sections 19.3.4.1 and 9.6, as well as 1999 NFPA 72, Sections 7.1. This deficient condition could adversely affect the functioning of the fire alarm system, and could delay the timely notification and emergency actions for the facility thus negatively affecting all residents, staff, and visitors of the facility. Findings include: On facility tour between 10:30 AM to 2:30 PM on 06/03/2015, observations and documentation review of all available fire alarm documentation for the last 12 months, and an interview with the Maintenance Supervisor, it was revealed that at the time of the inspection that the facility could not provide any current testing documentation for	K 052	Twin Valley Living Center must ensure a fire alarm system required for life safety is installed, tested, and maintained in accordance of NFPA 70 National Electrical Code and NFPA 72 and that the system has an approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72. Fire alarm testing was completed 6/4/2015, smoke and sensitivity testing completed by protections systems. Testing will be completed on a yearly basis and monitored by Maintenance Director and Administrator.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245419	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**06/03/2015**

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K 052	Continued From page 6 their fire alarm system. This deficient condition was verified by the Maintenance Supervisor.	K 052		
K 054 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD All required smoke detectors, including those activating door hold-open devices, are approved, maintained, inspected and tested in accordance with the manufacturer's specifications. 9.6.1.3 This STANDARD is not met as evidenced by: Based on staff interview and a review of the available documentation, the facility has not conducted that required sensitivity testing of the smoke detectors on the fire alarm system in accordance with NFPA 72 National Fire Alarm Code (99), Sec. 7-3.2.1. This deficient practice could affect all residents, visitors, and staff. Findings include: On facility tour between 10:30 AM to 2:30 PM on 06/03/2015, a review of the facility's available fire alarm maintenance and testing documentation revealed that at the time of the inspection the facility could not provide any current documentation verifying the completion of the required sensitivity testing of each smoke detector located throughout the facility. This deficient condition was verified by the Maintenance Supervisor.	K 054	Twin Valley Living Center must ensure a fire alarm system required for life safety is installed, tested, and maintained in accordance of NFPA 70 National Electrical Code and NFPA 72 and that the system has an approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72. Fire alarm testing was completed 6/4/2015, smoke and sensitivity testing completed by protections systems. Testing will be completed on a yearly basis and monitored by Maintenance Director and Administrator.	4/22/15
K 073	NFPA 101 LIFE SAFETY CODE STANDARD	K 073		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245419	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**06/03/2015**

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K 073 SS=D	Continued From page 7 No furnishings or decorations of highly flammable character are used. 19.7.5.2, 19.7.5.3, 19.7.5.4 This STANDARD is not met as evidenced by: Based on observations and staff interview, the facility failed to maintain combustible decoration in accordance with NFPA Life Safety Code 101 (00) section 19.7.5.4. The failure to treat and maintain the combustible decorations throughout the facility in accordance with NFPA Life Safety Code 101 (00) could allow smoke and fire to rapidly migrate through the corridors and negatively affect the egress capability in the event of an emergency for residents, visitors and staff of the facility. Findings include: On facility tour between 10:30 AM to 2:30 PM on 06/03/2015, observations revealed that the facility could not verify if the decoration that are hanging on resident room doors are flames retardant of if they have been treated with any type of approved flame retardant treatment. This deficient condition was verified by the Maintenance Supervisor.	K 073	Twin Valley Living Center must ensure no furnishing or decorations of highly flammable material are used in corridors (room doors). Twin Valley Living Center has treated any highly flammable material that is hanging on resident doors. Items will be treated, dated and documentation kept on file. Information will be given to residents and families upon admission.	6/22/15