DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
July 6, 2022

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

RE: CCN: 245442
Cycle Start Date: March 17, 2022

Dear Administrator:

On April 5, 2022 we notified you a remedy was imposed. On May 4, 2022 the Minnesota Departments of Health and Public Safety completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of April 15, 2022.

As authorized by CMS the remedy of:

- Discretionary denial of payment for new Medicare and Medicaid admissions effective May 5, 2022 did not go into effect. (42 CFR 488.417 (b))

In our letter of April 5, 2022, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from May 5, 2022 due to denial of payment for new admissions. Since your facility attained substantial compliance on April 15, 2022, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded. However, this does not apply to or affect any previously imposed NATCEP loss.

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

Feel free to contact me if you have questions.

Sincerely,

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: melissa.poepping@state.mn.us

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
July 6, 2022

CMS Certification Number (CCN): 245442

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

Dear Administrator:

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 April 15, 2022 the above facility is certified for:

50 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 50 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/or Medicaid provider agreement may be subject to non-renewal or termination.

Please contact me if you have any questions.

Sincerely,

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: melissa.poepping@state.mn.us

Electronically delivered
April 5, 2022

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

RE: CCN: 245442
Cycle Start Date: March 17, 2022

Dear Administrator:

On March 17, 2022, a 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 electronically delivered CMS-2567, whereby significant corrections are required.

REMEDIES

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

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective May 5, 2022.

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

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective May 5, 2022. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective May 5, 2022.

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

This Department is also recommending that CMS impose:

- Civil money penalty (42 CFR 488.430 through 488.444). You will receive a formal notice from the CMS RO

only if CMS agrees with our recommendation.

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than $11,292; has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

If you have not achieved substantial compliance by May 5, 2022, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, Spring Valley Care Center will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from May 5, 2022. You will receive further information regarding this from the State agency. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions.

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

ELECTRONIC PLAN OF CORRECTION (ePOC)

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

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

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.
- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

DEPARTMENT CONTACT

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health - Health Regulation Division staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for their respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

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

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by September 17, 2022 if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at § 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR § 488.412 and § 488.456.

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

APPEAL RIGHTS

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

file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

Tamika.Brown@cms.hhs.gov

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

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

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

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

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

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

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

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at:
https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

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

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:

William Abderhalden, Fire Safety Supervisor
Deputy State Fire Marshal
Health Care/Corrections Supervisor – Interim
Minnesota Department of Public Safety
445 Minnesota Street, Suite 145
St. Paul, MN 55101-5145
Cell: (507) 361-6204
Email: william.abderhalden@state.mn.us
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

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

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER #	MULTIPLE CONSTRUCTION	DATE SURVEY COMPLETE:
	245442	A. BUILDING: _____ B. WING _____	3/17/2022

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

ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
F 640	Encoding/Transmitting Resident Assessments CFR(s): 483.20(f)(1)-(4) §483.20(f) Automated data processing requirement- §483.20(f)(1) Encoding data. Within 7 days after a facility completes a resident's assessment, a facility must encode the following information for each resident in the facility: (i) Admission assessment. (ii) Annual assessment updates. (iii) Significant change in status assessments. (iv) Quarterly review assessments. (v) A subset of items upon a resident's transfer, reentry, discharge, and death. (vi) Background (face-sheet) information, if there is no admission assessment. §483.20(f)(2) Transmitting data. Within 7 days after a facility completes a resident's assessment, a facility must be capable of transmitting to the CMS System information for each resident contained in the MDS in a format that conforms to standard record layouts and data dictionaries, and that passes standardized edits defined by CMS and the State. §483.20(f)(3) Transmittal requirements. Within 14 days after a facility completes a resident's assessment, a facility must electronically transmit encoded, accurate, and complete MDS data to the CMS System, including the following: (i)Admission assessment. (ii) Annual assessment. (iii) Significant change in status assessment. (iv) Significant correction of prior full assessment. (v) Significant correction of prior quarterly assessment. (vi) Quarterly review. (vii) A subset of items upon a resident's transfer, reentry, discharge, and death. (viii) Background (face-sheet) information, for an initial transmission of MDS data on resident that does not have an admission assessment. §483.20(f)(4) Data format. The facility must transmit data in the format specified by CMS or, for a State which has an alternate RAI approved by CMS, in the format specified by the State and approved by CMS. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to transmit quarterly Minimum Data Set (MDS) assessments for 1 of 1 residents (R2) reviewed for resident assessment. Findings include: R2's Admission Record indicated R2 was admitted to the facility on 10/19/21.

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

The above isolated deficiencies pose no actual harm to the residents

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER #	MULTIPLE CONSTRUCTION	DATE SURVEY COMPLETE:
	245442	A. BUILDING: _____ B. WING _____	3/17/2022

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

ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
F 640	Continued From Page 1 R2's quarterly MDS was completed and signed on 1/25/22, but was never submitted to Centers for Medicare and Medicaid Services (CMS). On 3/17/22, at 3:02 p.m. the administrator verified MDS assessments should be submitted to CMS within 14 days of completion as required. On 3/17/22, at 3:08 p.m. the registered nurse care coordinator (RNCC)-B verified R2's MDS assessment was never submitted. A policy regarding submittals of MDS Assessments was requested but not received from the facility. Center for Medicare and Medicaid Services' Long -Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's Manual, Version 1.16, dated October 2018, indicated an RAI must be completed for any resident residing in the facility and quarterly MDS assessments must be submitted within 14 days of the MDS completion date.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245442	A. BUILDING _____ B. WING _____	C 03/17/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments On 3/14/22 through 3/17/22, a survey for compliance with Appendix Z, Emergency Preparedness Requirements, §483.73(b)(6) was conducted during a standard recertification survey. The facility was in compliance. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	E 000		
F 000	INITIAL COMMENTS On 3/14/22 through 3/17/22, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was found to be not in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaint was found to be UNSUBSTANTIATED: H5442052C (MN88050). The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulations has been attained.	F 000		
F 686	Treatment/Svcs to Prevent/Heal Pressure Ulcer	F 686		4/14/22

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		04/14/2022

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
	245442	A. BUILDING _____ B. WING _____	C 03/17/2022

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

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F 686 SS=D	Continued From page 1 CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to consistently assess and report changes in wound condition for 1 of 1 residents (R4) observed for pressure ulcers which had the potential for a worsening condition to go unnoticed. Findings include: R4's admission Minimum Data Set (MDS) dated 12/9/21, included cognitively intact with diagnosis including diabetes mellitus, stage 3 PU of sacral region, (Stage III pressure ulcers (Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle is not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining or tunneling.) non-pressure chronic ulcer of right and left calf, and peripheral vascular disease. R4 required extensive assistance with most activities of daily living (ADL's).	F 686	" Implementing the use of a paper format for wound assessment. This will allow for quicker/easier documentation and ensure all needed criteria□s have been met. (DON will audit the pressure injury binder every week for 4 weeks and then monthly for 6 months to ensure completion) " Education provided to the floor nurses regarding thorough documentation especially on weekly skin and health notes. " Consulting with AMT to have In-service on pressure injuries/wounds schedule for June 3, 2022 " On days that RNCC is gone, RNCC will ensure wound assessments are completed the day before. If gone for a	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245442	A. BUILDING _____ B. WING _____	C 03/17/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 686	Continued From page 2 R4's care plan included a problem area dated 12/9/21, and indicated one sacrum pressure ulcer (PU). PU will show signs of healing and remain free from infection. R4 was admitted with PU on 12/3/21. R4's care plan included administering treatments as ordered, monitoring for effectiveness, and documenting assessment weekly. R4's physician orders dated 12/9/21, indicated R4 receive weekly skin and health assessment every evening shift on Thursdays and to document in progress note. R4's wound documentation identified wound measurements were taken on: 12/3/21, 12/10/21, 1/19/22, and 2/18/22. In the electronic health record (EHR) wound assessment, the system provided the following prompt, "wounds, bruises, dimensions and characteristics (YOU MUST MEASURE);" however, on dates 12/23/21, 12/30/21, 1/6/22, 1/13/22, 1/27/22, 2/3/22, 2/10/22, 2/17/22, 2/24/22, 3/3/22, and 3/10/22 no measurements were found. During observation on 3/16/22, at 1:17 p.m. registered nurse (RN)-C was observed changing the dressing on R4's sacrum. RN-C did not measure dimensions of PU at the time. RN-C stated RN-A was responsible for measuring PU on Friday's and that she was unaware of where skin and wound notes were documented. When interviewed on 3/17/22, at 10:26 a.m. RN-A stated she was responsible for monitoring PU weekly on Friday's. RN-A stated facility has a	F 686	length of time, MDS RN will be alternative or another designee RN, it will be arranged prior to RNCC being gone.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245442	A. BUILDING _____ B. WING _____	C 03/17/2022

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F 686	Continued From page 3	F 686		

wound application on phone that automatically creates a skin and wound evaluation in EHR. RN-A stated she saw wounds weekly but no documentation was provided. RN-A stated last measurements of PU were taken on 2/18/22.

When interviewed on 3/17/22, at 12:33 p.m. licensed practical nurse (LPN)-A stated RN-A is responsible for measuring all PU and RN-B was responsible for measuring during RN-A's absence.

When interviewed on 3/17/22, at 12:35 p.m. RN-A stated measurements of all pressure ulcers should be completed weekly. RN-A stated that RN-B will complete measurements in her absence. RN-A stated floor nurses should be measuring during weekly skin checks. RN-A stated she should be better at gathering measurements and charting them into EHR.

On 3/17/22, at 12:35 p.m. a message was left for DON who did not return the call.

When interviewed on 3/17/22, at 1:07 p.m. the administrator stated RN-A, RN-B, and DON were responsible for weekly measurements. Administrator stated expectation for PU to be measured weekly as there could be the potential of worsening condition.

When interviewed on 3/17/22, at 3:08 p.m. RN-B stated RN-A was responsible for measuring pressure ulcers. RN-B stated the director of nursing (DON) and herself were responsible for measurements when RN-A was absent. RN-B stated it was not discussed who would complete R4's measurements during RN-A's absence. DON completed wound measurements during

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245442	A. BUILDING _____ B. WING _____	C 03/17/2022

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 686	Continued From page 4 R4's telehealth appointment on 3/3/22, but no documentation was provided. On 3/17/22, at 3:18 p.m. a message was left for DON who did not return the call. The policy titled Pressure Ulcer Risk Assessment not dated specified skin will be assessed for the presence of developing pressure ulcers on a weekly basis or more frequently if indicated. Nurses will conduct skin assessments at least weekly to identify changes. The policy titled Pressure Ulcer Treatment not dated indicated the following information should be recorded in the resident's medical record: All assessment data (i.e., color, size, pain, drainage, etc.) when inspecting the wound.	F 686		
F 756 SS=D	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a	F 756		4/14/22

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

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F 756	Continued From page 5 separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure consulting pharmacist recommendations were acted upon, addressed, and documented in the medical record for 1 of 5 residents (R5) reviewed for unnecessary medication use. Findings include: R5's quarterly Minimum Data Set (MDS), dated 12/16/21, identified R5 had diagnoses of Bipolar II Disorder and Schizoaffective Disorder. R5's Physician Order Sheet printed 3/17/22, identified R5's current medication regimen with their corresponding start dates. This included an order for Zyprexa (an antipsychotic used to treat	F 756	" Pharmacy recommendation will be completed within a week of receiving. " DON/designee will audit every month for 6 months, that the pharmacy recommendations were completed within 1 week. " Revision of quarterly and annually MDS assessments have been completed to add AIMS assessment every quarter assessment, for those on antipsychotics. DON or designee will audit weekly x4 and monthly x3 of all residents receiving antipsychotics and audit that the AIMS are up to date.	

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F 756	Continued From page 6 Bipolar Disorder) 20 milligrams (mg) by mouth one time a day. This medication was last dose adjusted on 12/2/21. R5's monthly Consultant's Pharmacist's Medication Review, dated 1/7/22, identified a review of available data in the medical record - nursing recommendation to update Abnormal Involuntary Movement Scale (AIMS) (used to assess the severity of involuntary movements) exam if not recently done. R5's monthly Consultant's Pharmacist's Medication Review, dated 2/7/22, identified a review of available data in the medical record, nursing recommendation to update AIMS exam and clarify dose of Reserpine. R5's monthly Consultant's Pharmacist's Medication Review, dated 3/7/22, identified a review of available data in the medical record, nursing recommendation to assess AIMS or Dyskinesia Identification System:Condensed User Scale (DISCUS) (used to rate tardive dyskinesia symptoms) exam. R5's medical record was reviewed and lacked evidence the consulting pharmacist's recommendation on R5's AIMS Assessment had been forwarded, reviewed and/or acted upon by the facility despite the recommendation being made for the previous 3 months. When interviewed on 3/16/22, at 12:59 p.m. registered nurse care coordinator (RNCC)-A stated she was responsible to follow-up on the pharmacy recommendations for all residents.	F 756	• An immediate AIMS assessment was completed on 03/16/2022 for resident R5, resident was added to the provider list to be seen by our nurse practitioner. • While DON or designee does an audit on antipsychotics and the correlations with an AIMS assessment, this will identify any residents who will need to have an AIMS assessments completed. Once identified the DON/designee will complete the aims or delegate to appropriate party.	

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F 756	Continued From page 7	F 756		

RNCC-A reviewed R5's medical record and verified the pharmacist recommendations dated 1/7/22, 2/7/22 and 3/7/22 had not been addressed at this time.

On 3/17/22, at 10:47 a.m. facility administrator stated pharmacy recommendations are sent to the director of nursing and the RNCC-A and the RNCC-A is responsible for follow up of said recommendations. Furthermore, the administrator stated the expectation was that pharmacy recommendations should be addressed "right away."

On 3/17/22, at 11:55 a.m. the Consultant Pharmacist (CP) was interviewed and explained AIMS Assessments should be completed every 6 months and pharmacy recommendations should generally be addressed when made. CP verified her records showed R5's recommendations had not yet been addressed and the last AIMS completed was 6/22/21. Further, CP stated while R5's recommendation not being addressed was likely not a significant issue, it was a clinical recommendation and should have been acted upon as symptoms can develop over time the longer a resident is on the medication.

Facility policy titled Pharmacy Recommendation Procedure, dated 10/1/21 indicated the pharmacist emails the pharmacy recommendations to the director of nursing, the RNCC or designee and the medical provider. The RNCC then reviews the pharmacy recommendations and completes/addresses what nursing recommendations are requested, document in a follow-up progress note from the pharmacist's note, file in the pharmacy recommendation binder and fax back to

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F 756	Continued From page 8 pharmacy. Facility policy titled Antipsychotic Medication Use, dated 3/2021 indicated nursing staff shall monitor and report any of the following side effects to the Attending Physician as well as complete an AIMS assessment every 6 months and the physician shall respond appropriately.	F 756		
F 804 SS=D	Nutritive Value/Appear, Palatable/Prefer Temp CFR(s): 483.60(d)(1)(2) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure food was served at a palatable and appetizing temperature for 1 of 3 residents (R23) who had concerns with food temperatures. Finding include: During an observation on 03/14/22, at 12:38 p.m. Cook-A provided a tour of the kitchen. During this tour the cook-A was unable to produce documentation on how they monitor food temperatures. During observation and interview on 03/14/22, at 12:48 p.m. DC reported the facility did not have a	F 804	" Temperature of food will be done upon removal from oven as well as prior to plating. The logs will be located on the tray line. The dietary staff will ensure the temperatures are within the regulatory guidelines. " Spring Valley Living has purchased a new plate warmer to ensure plates keep the food at an optimal temperature. " The CDM will perform audits weekly x4 and monthly x3 that the above is within compliance.	4/14/22

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F 804	Continued From page 9	F 804		

certified dietary manager (CDM). The DC stated they did not have access to the blank log sheets that the temperatures would be recorded on. DC stated they were no longer recording food temperatures because of this.

During an interview on 03/14/22, at 4:59 p.m. the facility administrator stated the certified dietary manager (CDM) had been gone for about a month. They had another dietary manager (DM) who had been covering and came in around once a week. The administrator also reported they had hired a new CDM who was going to be training soon.

When interviewed on 3/14/22, at 6:02 p.m. R23 stated the food is often very cold. R23 received meal tray service in their room.

During observation on 03/17/22, at 11:53 a.m. an extra tray was requested for the lunch meal. Dietary aid (DA)-A loaded the insulated food cart along with the sample tray at 12:14 p.m. DA-A began to pass the room trays at 12:18 p.m. At 12:34 p.m. the last tray was provided to a resident. At 12:37 p.m. temperatures were taken on the sample tray along with DC. The following was found: ham and cabbage were 97.0 degrees Fahrenheit (F), potatoes 95 degrees F and carrots 94 degrees F. The food was also tasted and was found to be cold. DC reported," The food is cold because the plate is cold, our warmer needs help." "Maybe I'll need to get a new plate warmer, or warm plates in oven." DC confirmed they had complaints about cold room trays and stated, they were going to talk to the administrator about ways of keeping the plates warmer before sending them out."

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F 804	Continued From page 10 When interviewed on 03/17/22, at 1:05 p.m. R23 stated, her corned beef, cabbage and potatoes were very cold and had refused to eat it. R23 was eating peanut butter toast instead. On 3/17/22, at 1:46 p.m. a message was left for registered dietician who did not return the call. The facility policy titled Food Temperatures, undated, included, all hot food items would be served at or above 150 degrees. "Record food temperature reading on "Food Temperature Record."	F 804		
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;	F 880		4/14/22

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F 880	Continued From page 11 §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.	F 880		

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F 880	Continued From page 12 §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to follow standard precautions while processing laundry including the use of (PPE) personal protective equipment. The lapses in infection control had the potential to impact all residents who had their laundry washed by the facility. Findings include: During an observation of the soiled laundry area of the facility on 3/15/22, at 7:30 a.m. a laundry aide (LA)-A was observed wearing gloves, mask and eye protection, but was not wearing a protective gown over her personal uniform while sorting soiled personal laundry from three large bins and from an open wired basket used to transport linens to units. LA-A stated she was not trained to wear a gown while sorting soiled laundry. LA-A stated she sorts the dirty laundry by color without using a gown to cover her personal clothing. LA-A stated she was the person responsible for washing the soiled clothing and folding the clean clothing after it was done. LA-A stated two other housekeeping aides will perform laundry if she is absent. During an observation on 3/16/22, at 8:10 a.m. LA-A was observed passing clean laundry on Sunny Lane hallway wearing the same uniform she had worn while sorting soiled laundry. Clean towels were observed touching LA-A's uniform before being placed into clean utility room.	F 880	" All staff will be re-educated on handling soiled linen. The education will be followed with a test for competency. " All new staff will be educated on handling of soiled linens as well as complete the competency after the training. " The housekeeping/laundry supervisor will conduct audits weekly x4 and monthly x3 to ensure the soiled linen policy/procedure is being followed. Directed plan of correction: Please see the attached documents: Infection Control Audit, Infection Control Outline used for Relias, Relias completion list of employees, updated standard precaution policy, updated PPE gown policy, updated transmission precaution policy, PPE Audits. Education has been provided to the direct staff at SVL. Audits are in place per plan of correction. The survey results and plan of correction, including, but not limited to audits will be presented at the next QA/QAPI meeting.	

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F 880	Continued From page 13 During an observation on 3/16/22, at 8:22 a.m. LA-A was observed passing clean laundry on Western Trails hallway wearing the same uniform she had worn while sorting soiled laundry. During an observation on 3/16/22, at 10:49 a.m. LA-A was observed passing clean laundry on River Crossing hallway wearing the same uniform she had worn while sorting soiled laundry. When interviewed on 3/17/22, at 12:19 p.m. the administrator stated the expectation would be to wear all PPE which includes a nonpermeable gown when sorting dirty laundry as all laundry is considered infectious and personal clothing could become contaminated when going from soiled to clean. The facility policy titled Laundry and Bedding, Soiled not dated specified soiled laundry/bedding shall be handled in a manner that prevents gross microbial contamination of the air and persons handling the linen. -Anyone who handles soiled laundry must wear protective gloves and other appropriate protective equipment (e.g., gowns if soiling of clothing is likely). -The Environmental Services Director or supervisor will ensure that forceps/tongs or similar safe sorting devices are available for sorting laundry.	F 880		

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K 000	INITIAL COMMENTS FIRE SAFETY An annual fire safety recertification survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 03/15/2022. At the time of this survey, SPRING VALLEY CARE CENTER Building 01 was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. 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. 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. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: IF PARTICIPATING IN THE E-POC PROCESS, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED.	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		04/15/2022

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 Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR By email to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A detailed description of the corrective action taken or planned to correct the deficiency. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. 4. Identify who is responsible for the corrective actions and monitoring of compliance. 5. The actual or proposed date for completion of the remedy. SPRING VALLEY CARE CENTER is a one-story building with a partial basement The building was constructed at (4) different times. The original building was constructed in 1962 and was determined to be of Type II (222) construction. In 1964, an addition was constructed (Western Trail) that was determined to be of Type II (222) construction. In 2014 an addition was constructed to the Northside of the	K 000		

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K 000	Continued From page 2 building and was determined to be Type V (111) with a 1-hour separation between buildings. Because the original building and the (2) additions meet the construction types allowed for existing buildings, those portions of the facility were surveyed as one building (Building 01). In 2021 a new addition was added to the facility and was determined to be of Type V (111). The addition was constructed to meet the standards and requirements of NFPA 101 (2012 edition), Chapter 18 - New Health Care Occupancies, and was surveyed as a separate building (Building 03). The building is protected by a full fire sprinkler system. In addition, the facility has a fire alarm system with full corridor smoke detection and spaces open to the corridors that is monitored for automatic fire department notification. The facility has a capacity of 50 beds and had a census of 40 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 222 SS=F	Egress Doors CFR(s): NFPA 101 Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the	K 222		4/15/22

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K 222	Continued From page 3 clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING ARRANGEMENTS Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted.	K 222		

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K 222	Continued From page 4 18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain means of egress components per NFPA 101 (2012 edition), Life Safety Code, sections 7.2, 7.2.1.4, 7.2.1.4.5, 7.2.1.4.5.1, 7.2.1.15.7(1), 7.2.1.15.8 These deficient findings could have a widespread impact on the residents within the facility. Findings include: 1. On 03/15/2022, between 9:15 AM to 1:15 PM, it was revealed by observation that the egress doors at the end of 700 Wing and 400 Wing required more than 15 pounds of force to release the latch and more than 30 pounds of force to set the leaf in motion. 2. On 03/15/2022, between 9:15 AM to 1:15 PM, it was revealed by observation that the egress doors at the end of 700 Wing and 500 Wing did not close, indicating potential issues with the door assembly or door closer. An interview with the Maintenance Director verified these deficient findings at the time of discovery.	K 222	Maintenance repaired the framework and threshold to make adjustments so that the door will close freely. SVL will ensure all fire door assemblies close and latch in accordance with NFPA 80. Annual egress fire door inspection has been added to our preventative maintenance software, HIPPO. Spring Valley Living Maintenance staff checks HIPPO daily, which will include completing the egress doors down our 400,500,600 and 700 wings annually. The administrator will ensure that the preventative maintenance (PM) has been entered in HIPPO. The Administrator will audit HIPPO monthly x12 to ensure all PM has been completed.	

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K 345	Continued From page 5	K 345		
K 345 SS=F	Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to test the fire alarm system in accordance with NFPA 101 (2012 edition), Life Safety Code, sections 9.6.1.3, 19.3.4, and NFPA 72 (2010 edition) National Fire Alarm and Signal Code, section 14.4.5.3 This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 03/15/2022, between 09:15 AM to 1:15 PM, it was revealed by a review of available documentation that no fire alarm sensitivity testing documentation was available or presented for review to confirm that sensitivity testing is occurring. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 345	The smoke sensitivity testing was done on 3/3/2022 by Custom Alarms. Please see document named K345 SVL. Education has been provided to the Maintenance department to keep copies of the testing readily available for documentation and survey purposes. The administrator, or designee will audit that the sensitivity tests are done every other year and copies of the testing will be readily available. The audits will be done indefinitely and presented every other year to the safety committee.	4/15/22
K 346 SS=F	Fire Alarm System - Out of Service CFR(s): NFPA 101	K 346		4/15/22

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K 346	Continued From page 6 Fire Alarm - Out of Service Where required fire alarm system is out of services for more than 4 hours in a 24-hour period, the authority having jurisdiction shall be notified, and the building shall be evacuated or an approved fire watch shall be provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service. 9.6.1.6 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to implement an out-of-service timeframe for the fire alarm system per NFPA 101 (2012 edition), Life Safety Code, sections 9.6.1.6. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 03/15/2022, between 09:15 AM to 1:15 PM, it was revealed by a review of available documentation that the documentation incorrectly identified the out-of-service timeframe allowed for a fire alarm system prior to the fire-watch being initiated. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 346	Maintenance has updated the Fire Alarm Systems Out of Service policy to reflect current standards. See attached copy of □Fire Alarm Systems Out of Service,□ policy named K346 SVL. Staff will be trained at a one time all staff in-service in April 2022 as well as new hire training has been updated.	
K 353 SS=F	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection,	K 353		4/15/22

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K 353	Continued From page 7 Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on observation, a review of available documentation, and staff interview, the facility failed to inspect and maintain the sprinkler system in accordance with NFPA 101 (2012 edition), Life Safety Code, sections 9.7.5, 9.7.7, and NFPA 25 (2011 edition), Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, sections 5.1, 5.2. These deficient findings could have a widespread impact on the residents within the facility. Findings include: 1. On 03/15/2022, between 09:15 AM to 1:15 PM, it was revealed by a review of available documentation that no documentation was available or presented for review associated with the 10/18/2021 inspection tag that was observed attached to the sprinkler riser located in 700 Wing.	K 353	Maintenance staff located the documentation dated 10/18/2021 that describes the sprinkler system inspection report. See attached document named □K353 SVL□. Audits will be done quarterly x4 to ensure the sprinkler inspections and record keeping are being completed and available for review upon request. The sprinkler inspection has been added to our HIPPO system for tracking and management. SVL has contacted Viking to coordinate the 5-year sprinkler inspection. It will be completed on 5/11/2022. Education will be provided to staff April 2022 during an all-staff in-service. The 5-year sprinkler inspection has been added to the HIPPO system. The Hippo	

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K 353	Continued From page 8 2. On 03/15/2022, between 09:15 AM to 1:15 PM, it was revealed by a review of available documentation that no documentation was available or presented for review to confirm that fire sprinkler quarterly inspections are being completed for the sprinkler system. 3. On 03/15/2022, between 09:15 AM to 1:15 PM, it was revealed by a review of available documentation that no documentation was available or presented for review to assess when the last 5-year inspection of the sprinkler system was completed. 4. On 03/15/2022, between 09:15 AM to 1:15 PM, it was revealed by observation that the 500 Wing - bath/shower room exhibited signs of oxidation and paint on the sprinkler heads. An interview with the Maintenance Director verified these deficient findings at the time of discovery.	K 353	system is checked daily by maintenance staff. Preventative Maintenance will be audited monthly indefinitely to ensure completed.	
K 354 SS=F	Sprinkler System - Out of Service CFR(s): NFPA 101 Sprinkler System - Out of Service Where the sprinkler system is impaired, the extent and duration of the impairment has been determined, areas or buildings involved are inspected and risks are determined, recommendations are submitted to management or designated representative, and the fire department and other authorities having jurisdiction have been notified. Where the sprinkler system is out of service for more than 10 hours in a 24-hour period, the building or portion of the building affected are evacuated or an approved fire watch is provided until the sprinkler	K 354		4/15/22

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K 354	Continued From page 9 system has been returned to service. 18.3.5.1, 19.3.5.1, 9.7.5, 15.5.2 (NFPA 25) This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to implement an out-of-service timeframe for the fire sprinkler system in accordance with NFPA 101 (2012 edition), Life Safety Code, sections 19.3.5.1, 9.7, and NFPA 25 (2011 edition), Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, section 15.5.2(4). This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 03/15/2022, between 09:15 AM to 1:15 PM, it was revealed by a review of available documentation that the documentation presented for review did not identify an out-of-service timeframe for the fire sprinkler system but rather an out-of-service timeframe for the fire alarm system. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 354	Maintenance has updated the Fire Sprinkler Systems Out of Service policy to reflect current standards. See attached copy of □Fire Sprinkler Systems Out of Service,□ policy named K354 SVL. Staff will be trained at a one time all staff in-service in April 2022 as well as new hire training has been updated.	
K 355 SS=F	Portable Fire Extinguishers CFR(s): NFPA 101 Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10	K 355		4/15/22

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K 355	Continued From page 10 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to inspect portable fire extinguishers in accordance with NFPA 101 (2012 edition), Life Safety Code, sections 19.3.5.12, 9.7.4.1, and NFPA 10 (2010 edition), Standard for Portable Fire Extinguishers, section 6.1.3.3. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 03/15/2022 between 09:15 AM to 1:15 PM, it was revealed based on observation that fire extinguishers throughout the facility were not dated or initialed for the months of JAN., FEB., MAR., providing no indication that inspection had occurred. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 355	Policy name, □Fire Extinguishers□, has been updated to include to date and initial fire extinguisher tags when inspected. See document names, □K355 SVL.□ The fire extinguisher inspections have been added to HIPPO. Staff will be trained at a one time all staff in-service in April 2022 as well as new hire training has been updated. Audits will be done monthly x3 to ensure that the inspections have been done and that the tags have initials and dates.	
K 521 SS=F	HVAC CFR(s): NFPA 101 HVAC Heating, ventilation, and air conditioning shall comply with 9.2 and shall be installed in accordance with the manufacturer's specifications. 18.5.2.1, 19.5.2.1, 9.2 This REQUIREMENT is not met as evidenced by:	K 521		4/15/22

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K 521	Continued From page 11 Based on a review of available documentation and staff interview, the facility failed to test and inspect the facility smoke dampers system per NFPA 101 (2012 edition), Life Safety Code, sections 8.5, 8.5.5.2, 8.5.5.4.2, and NFPA 105 (2010 edition), Standard for Smoke Door Assemblies and Other Opening Protectives, section 6.5.2. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 03/15/2022, between 09:15 AM to 1:15 PM, it was revealed by a review of available documentation presented for review that smoke dampers were last tested in March 2016. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 521	Smoke damper testing was done by Custom Alarms on 3/3/2022. See document named, □K521 SVL.□ Maintenance staff did a damper test on 4/15/2022 and will continue to inspect and document quarterly. The damper testing has been added to the HIPPO software. The maintenance staff will maintain documentation readily available upon request. Audits will be done quarterly x4 to ensure the inspections have been done.	
K 712 SS=F	Fire Drills CFR(s): NFPA 101 Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and 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. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 This REQUIREMENT is not met as evidenced by:	K 712		4/15/22

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K 712	Continued From page 12 Based on document review and staff interview, the facility failed to conduct fire drills per the NFPA 101 (2012 edition), Life Safety Code, sections 19.7.1.6, 4.7.2, and 4.7.6. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 03/15/2022 between 9:15 AM and 1:15 PM, it was revealed during a review of the available documentation that no documentation was presented to confirm that fire drills were conducted for the 1st and 3rd shifts in the 1st quarter; 2nd and 3rd shifts in the 2nd quarter; 1st, 2nd, and 3rd shifts in the 3rd quarter; and 1st and 3rd shifts in the 4th quarter. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 712	Fire drills will be done quarterly for each shift, one drill a month rotating 1st, 2nd and 3rd shifts. See document named, □K712 SVL□ for drill matrix. Fire drill dates and summary will be presented at the safety meeting monthly as an audit. SVL will conduct monthly safety meetings to ensure all fire drill regulations have been completed as well as documented.	
K 761 SS=F	Maintenance, Inspection & Testing - Doors CFR(s): NFPA 101 Maintenance, Inspection & Testing - Doors Fire doors assemblies are inspected and tested annually in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives. Non-rated doors, including corridor doors to patient rooms and smoke barrier doors, are routinely inspected as part of the facility maintenance program. Individuals performing the door inspections and testing possess knowledge, training or experience that demonstrates ability. Written records of inspection and testing are maintained and are available for review. 19.7.6, 8.3.3.1 (LSC)	K 761		4/15/22

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K 761	Continued From page 13 5.2, 5.2.3 (2010 NFPA 80) This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to inspect and test doors per NFPA 101 (2012 edition), Life Safety Code, sections 19.7.6, 4.6.12, 7.2.1.15, and NFPA 80 (2010 edition), Standard for Fire Doors and Other Opening Protectives, sections 5.2.1, 6.1, 6.1.4.2. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 03/15/2022, between 09:15 AM to 1:15 PM, it was revealed by a review of available documentation that no documentation was available or presented for review to confirm that annual inspection and testing of doors is occurring. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 761	SVL will ensure all fire door assemblies close and latch in accordance with NFPA 80. Spring Valley Living Maintenance staff will check the HIPPO PM regularly and ensure that the annual door inspections are in our HIPPO system. The administrator, or designee, will ensure that the preventative maintenance (PM) has been entered in HIPPO. The Administrator will audit HIPPO monthly x12 to ensure all PM has been completed.	
K 781 SS=F	Portable Space Heaters CFR(s): NFPA 101 Portable Space Heaters Portable space heating devices shall be prohibited in all health care occupancies, except, unless used in nonsleeping staff and employee areas where the heating elements do not exceed 212 degrees Fahrenheit (100 degrees Celsius). 18.7.8, 19.7.8 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to implement	K 781	SVL has updated its Space Heater Policy, see attached document named, □K781	4/15/22

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K 781	Continued From page 14 a policy addressing this use of portable space-heating devices per NFPA 101 (2012 edition), Life Safety Code, section 19.7.8. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 03/15/2022, between 09:15 AM to 1:15 PM, it was revealed by a review of available documentation that no documentation was available or presented for review to confirm that the facility has a policy addressing portable space-heating devices in non-staff areas. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 781	SVL.□ Education will be provided at the April 2022 all staff meeting on 4/19/2022. The training will also be provided upon hire to all employees. Audits will be done weekly x4 and monthly x3 to ensure there are no space heaters in the building.	
K 914 SS=F	Electrical Systems - Maintenance and Testing CFR(s): NFPA 101 Electrical Systems - Maintenance and Testing Hospital-grade receptacles at patient bed locations and where deep sedation or general anesthesia is administered, are tested after initial installation, replacement or servicing. Additional testing is performed at intervals defined by documented performance data. Receptacles not listed as hospital-grade at these locations are tested at intervals not exceeding 12 months. Line isolation monitors (LIM), if installed, are tested at intervals of less than or equal to 1 month by actuating the LIM test switch per 6.3.2.6.3.6, which activates both visual and audible alarm. For LIM circuits with automated self-testing, this manual test is performed at intervals less than or equal to 12 months. LIM circuits are tested per 6.3.3.3.2 after any repair or renovation to the	K 914		4/15/22

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 914	Continued From page 15 electric distribution system. Records are maintained of required tests and associated repairs or modifications, containing date, room or area tested, and results. 6.3.4 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to conduct electrical receptacle testing in resident rooms per NFPA 99 (2012 edition), Health Care Facilities Code, section(s) 6.3.3.2. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 03/15/2022, between 09:15 AM to 1:15 PM, it was revealed by a review of available documentation that no documentation was available or presented for review to confirm that annual inspection and testing of electrical outlets is occurring. An interview with the Maintenance Director and Administrator verified this deficient finding at the time of discovery.	K 914	Spring Valley Living last conducted the annual outlet testing on 5/3/2021. See attached document names, □K914 SVL.□ SVL will continue to conduct annual outlet testing. The administrator, or designee will audit that the current outlet testing and upcoming testing is properly done and documented at the annual safety meeting in 2022.	
K 923 SS=E	Gas Equipment - Cylinder and Container Storag CFR(s): NFPA 101 Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or	K 923		4/15/22

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K 923	Continued From page 16 limited- combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain proper medical gas storage per NFPA 99 (2012 edition), Health Care Facilities Code, sections 5.1.3.3.2, 11.3.2.3, 11.3.4, 11.6.2, 11.6.5 This deficient finding could have an isolated impact on the residents within the facility. Findings include:	K 923	All cardboard has been removed from the oxygen room. Tubing has been placed in plastic containers on shelves. Staff education will be done on 4/19/2022 as well as upon new hire. Audits will be done of the oxygen room weekly x4 and monthly x3.	

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K 923	Continued From page 17 On 03/15/2022, between 09:15 AM to 1:15 PM, it was revealed by observation that the Med Gas Room had storage of cardboard boxes in close proximity to liquid oxygen cylinders. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 923		

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	245442	A. BUILDING **03 - SPRING VALLEY CARE CENTER** B. WING _____	**03/15/2022**

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K 000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety Code survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 03/15/2022. At the time of this survey, SPRING VALLEY CARE CENTER BLDG 03 was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. 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. 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. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: IF PARTICIPATING IN THE E-POC PROCESS, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED.	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		04/15/2022

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	K 000		

Healthcare Fire Inspections
State Fire Marshal Division
445 Minnesota St., Suite 145
St. Paul, MN 55101-5145, OR

By email to:
FM.HC.Inspections@state.mn.us

THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION:

1. A detailed description of the corrective action taken or planned to correct the deficiency.

2. Address the measures that will be put in place to ensure the deficiency does not reoccur.

3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained.

4. Identify who is responsible for the corrective actions and monitoring of compliance.

5. The actual or proposed date for completion of the remedy.

SPRING VALLEY CARE CENTER is a one-story building, with a partial basement

The building was constructed at (4) different times. The original building was constructed in 1962 and was determined to be of Type II (222) construction. In 1964, an addition was constructed (Western Trail) that was determined to be of Type II (222) construction. In 2014 an addition was constructed to the Northside of the

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K 000	Continued From page 2 building and was determined to be Type V (111) with a 1-hour separation between buildings. Because the original building and the (2) additions meet the construction types allowed for existing buildings, those portions of the facility were surveyed as one building (Building 01). In 2021 a new addition was added to the facility and was determined to be of Type V (111). The addition was constructed to meet the standards and requirements of NFPA 101 (2012 edition), Chapter 18 - New Health Care Occupancies, and was surveyed as a separate building (Building 03). The building is protected by a full fire sprinkler system. The facility has a fire alarm system with full corridor smoke detection and spaces open to the corridors that is monitored for automatic fire department notification. The facility has a capacity of 50 beds and had a census of 40 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 345 SS=F	Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72	K 345		4/15/22

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K 345	Continued From page 3 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to test the fire alarm system in accordance with NFPA 101 (2012 edition), Life Safety Code, sections 9.6.1.3, 18.3.4, and NFPA 72 (2010 edition) National Fire Alarm and Signal Code, section 14.4.5.3 This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 03/15/2022, between 09:15 AM to 1:15 PM, it was revealed by a review of available documentation that no fire alarm sensitivity testing documentation was available or presented for review to confirm that sensitivity testing is occurring. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 345	The smoke sensitivity testing was done on 3/3/2022 by Custom Alarms. Please see document named K345 SVL. Education has been provided to the Maintenance department to keep copies of the testing readily available for documentation and survey purposes. The administrator, or designee will audit that the sensitivity tests are done every other year and copies of the testing will be readily available. The audits will be done indefinitely and presented every other year to the safety committee.	
K 346 SS=F	Fire Alarm System - Out of Service CFR(s): NFPA 101 Fire Alarm - Out of Service Where required fire alarm system is out of services for more than four hours in a 24 hour period, the authority having jurisdiction shall be notified, and the building shall be evacuated or an approved fire watch shall be provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service. 9.6.1.6 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation	K 346	Maintenance has updated the Fire Alarm	4/15/22

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K 346	Continued From page 4 and staff interview, the facility failed to implement an out-of-service timeframe for the fire alarm system per NFPA 101 (2012 edition), Life Safety Code, sections 9.6.1.6. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 03/15/2022, between 09:15 AM to 1:15 PM, it was revealed by a review of available documentation that the documentation incorrectly identified the out-of-service timeframe allowed for a fire alarm system prior to the fire-watch being initiated. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 346	Systems Out of Service policy to reflect current standards. See attached copy of 'Fire Alarm Systems Out of Service,' policy named K346 SVL. Staff will be trained at a one time all staff in-service in April 2022 as well as new hire training has been updated.	
K 353 SS=F	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for	K 353		4/15/22

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K 353	Continued From page 5 any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on observation, a review of available documentation, and staff interview, the facility failed to inspect and maintain the sprinkler system in accordance with NFPA 101 (2012 edition), Life Safety Code, sections 9.7.5, 9.7.7, and NFPA 25 (2011 edition), Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, sections 5.1, 5.2. These deficient findings could have a widespread impact on the residents within the facility. Findings include: 1. On 03/15/2022, between 09:15 AM to 1:15 PM, it was revealed by a review of available documentation that no documentation was available or presented for review associated with the 10/18/2021 inspection tag that was observed attached to the sprinkler riser located in 700 Wing. 2. On 03/15/2022, between 09:15 AM to 1:15 PM, it was revealed by a review of available documentation that no documentation was available or presented for review to confirm that fire sprinkler quarterly inspections are being completed for the sprinkler system. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 353	Maintenance staff located the documentation dated 10/18/2021 that describes the sprinkler system inspection report. See attached document named 'K353 SVL'. Audits will be done quarterly x4 to ensure the sprinkler inspections and record keeping are being completed and available for review upon request. The sprinkler inspection has been added to our HIPPO system for tracking and management. SVL has contacted Viking to coordinate the 5-year sprinkler inspection. It will be completed on 5/11/2022. Education will be provided to staff April 2022 during an all-staff in-service. The 5-year sprinkler inspection has been added to the HIPPO system. The Hippo system is checked daily by maintenance staff. Preventative Maintenance will be audited monthly indefinitely to ensure completed.	
K 354 SS=F	Sprinkler System - Out of Service	K 354		4/15/22

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K 354	Continued From page 6 CFR(s): NFPA 101 Sprinkler System - Out of Service Where the sprinkler system is impaired, the extent and duration of the impairment has been determined, areas or buildings involved are inspected and risks are determined, recommendations are submitted to management or designated representative, and the fire department and other authorities having jurisdiction have been notified. Where the sprinkler system is out of service for more than 10 hours in a 24 hour period, the building or portion of the building affected are evacuated or an approved fire watch is provided until the sprinkler system has been returned to service. 18.3.5.1, 19.3.5.1, 9.7.5, 15.5.2 (NFPA 25) This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to implement an out-of-service timeframe for the fire sprinkler system in accordance with NFPA 101 (2012 edition), Life Safety Code, sections 18.3.5.1, 9.7, and NFPA 25 (2011 edition), Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, section 15.5.2(4). This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 03/15/2022, between 09:15 AM to 1:15 PM, it was revealed by a review of available documentation that the documentation presented for review did not identify an out-of-service timeframe for the fire sprinkler system but rather an out-of-service timeframe for the fire alarm	K 354	Maintenance has updated the Fire Sprinkler Systems Out of Service policy to reflect current standards. See attached copy of 'Fire Sprinkler Systems Out of Service,' policy named K354 SVL. Staff will be trained at a one time all staff in-service in April 2022 as well as new hire training has been updated.	

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K 354	Continued From page 7 system. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 354		
K 355 SS=F	Portable Fire Extinguishers CFR(s): NFPA 101 Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to inspect portable fire extinguishers in accordance with NFPA 101 (2012 edition), Life Safety Code, sections 18.3.5.12, 9.7.4.1, and NFPA 10 (2010 edition), Standard for Portable Fire Extinguishers, section 6.1.3.3. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 03/15/2022 between 09:15 AM to 1:15 PM, it was revealed based on observation that fire extinguishers throughout the facility were not dated or initialed for the months of JAN., FEB., MAR., providing no indication that inspection had occurred. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 355	Policy name, 'Fire Extinguishers', has been updated to include to date and initial fire extinguisher tags when inspected. See document names, 'K355 SVL.' The fire extinguisher inspections have been added to HIPPO. Staff will be trained at a one time all staff in-service in April 2022 as well as new hire training has been updated. Audits will be done monthly x3 to ensure that the inspections have been done and that the tags have initials and dates.	4/15/22
K 712	Fire Drills	K 712		4/15/22

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K 712 SS=F	Continued From page 8 CFR(s): NFPA 101 Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and 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. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 18.7.1.4 through 18.7.1.7 This REQUIREMENT is not met as evidenced by: Based on document review and staff interview, the facility failed to conduct fire drills per the NFPA 101 (2012 edition), Life Safety Code, sections 18.7.1.6, 4.7.2, and 4.7.6. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 03/15/2022 between 9:15 AM and 1:15 PM, it was revealed during a review of the available documentation that no documentation was presented to confirm that fire drills were conducted for the 1st and 3rd shifts in the 1st quarter; 2nd and 3rd shifts in the 2nd quarter; 1st, 2nd, and 3rd shifts in the 3rd quarter; and 1st and 3rd shifts in the 4th quarter. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 712	Fire drills will be done quarterly for each shift, one drill a month rotating 1st, 2nd and 3rd shifts. See document named, 'K712 SVL' for drill matrix. Fire drill dates and summary will be presented at the safety meeting monthly as an audit. SVL will conduct monthly safety meetings to ensure all fire drill regulations have been completed as well as documented.	
K 761 SS=F	Maintenance, Inspection & Testing - Doors	K 761		4/15/22

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K 761	Continued From page 9 CFR(s): NFPA 101 Maintenance, Inspection & Testing - Doors Fire doors assemblies are inspected and tested annually in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives. Non-rated doors, including corridor doors to patient rooms and smoke barrier doors, are routinely inspected as part of the facility maintenance program. Individuals performing the door inspections and testing possess knowledge, training or experience that demonstrates ability. Written records of inspection and testing are maintained and are available for review. 18.7.6, 8.3.3.1 (LSC) 5.2, 5.2.3 (NFPA 80) This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to inspect and test doors per NFPA 101 (2012 edition), Life Safety Code, sections 18.7.6, 4.6.12, 7.2.1.15, and NFPA 80 (2010 edition), Standard for Fire Doors and Other Opening Protectives, sections 5.2.1, 6.1, 6.1.4.2. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 03/15/2022, between 09:15 AM to 1:15 PM, it was revealed by a review of available documentation that no documentation was available or presented for review to confirm that annual inspection and testing of doors is occurring. An interview with the Maintenance Director verified this deficient finding at the time of	K 761	SVL will ensure all fire door assemblies close and latch in accordance with NFPA 80. Spring Valley Living Maintenance staff will check the HIPPO PM regularly and ensure that the annual door inspections are in our HIPPO system. The administrator, or designee, will ensure that the preventative maintenance (PM) has been entered in HIPPO. The Administrator will audit HIPPO monthly x12 to ensure all PM has been completed.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245442	A. BUILDING **03 - SPRING VALLEY CARE CENTER** B. WING _____	**03/15/2022**

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K 761	Continued From page 10 discovery.	K 761		
K 781 SS=F	Portable Space Heaters CFR(s): NFPA 101 Portable Space Heaters Portable space heating devices shall be prohibited in all health care occupancies, except, unless used in nonsleeping staff and employee areas where the heating elements do not exceed 212 degrees Fahrenheit (100 degrees Celsius). 18.7.8, 19.7.8 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to implement a policy addressing this use of portable space-heating devices per NFPA 101 (2012 edition), Life Safety Code, section 18.7.8. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 03/15/2022, between 09:15 AM to 1:15 PM, it was revealed by a review of available documentation that no documentation was available or presented for review to confirm that the facility has a policy addressing portable space-heating devices in non-staff areas. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 781	SVL has updated its Space Heater Policy, see attached document named, 'K781 SVL.' Education will be provided at the April 2022 all staff meeting on 4/19/2022. The training will also be provided upon hire to all employees. Audits will be done weekly x4 and monthly x3 to ensure there are no space heaters in the building.	4/15/22
K 914 SS=F	Electrical Systems - Maintenance and Testing CFR(s): NFPA 101 Electrical Systems - Maintenance and Testing Hospital-grade receptacles at patient bed	K 914		4/15/22

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K 914	Continued From page 11 locations and where deep sedation or general anesthesia is administered, are tested after initial installation, replacement or servicing. Additional testing is performed at intervals defined by documented performance data. Receptacles not listed as hospital-grade at these locations are tested at intervals not exceeding 12 months. Line isolation monitors (LIM), if installed, are tested at intervals of less than or equal to one month by actuating the LIM test switch per 6.3.2.6.3.6, which activates both visual and audible alarm. For LIM circuits with automated self-testing, this manual test is performed at intervals less than or equal to 12 months. LIM circuits are tested per 6.3.3.3.2 after any repair or renovation to the electric distribution system. Records are maintained of required tests and associated repairs or modifications, containing date, room or area tested, and results. 6.3.4 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to conduct electrical receptacle testing in resident rooms per NFPA 99 (2012 edition), Health Care Facilities Code, section(s) 6.3.3.2. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 03/15/2022, between 09:15 AM to 1:15 PM, it was revealed by a review of available documentation that no documentation was available or presented for review to confirm that annual inspection and testing of electrical outlets is occurring.	K 914	Spring Valley Living last conducted the annual outlet testing on 5/3/2021. See attached document names, 'K914 SVL.' SVL will continue to conduct annual outlet testing. The administrator, or designee will audit that the current outlet testing and upcoming testing is properly done and documented at the following safety meeting in 2022.	

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K 914	Continued From page 12 An interview with the Maintenance Director and Administrator verified this deficient finding at the time of discovery.	K 914		
K 920 SS=D	Electrical Equipment - Power Cords and Extens CFR(s): NFPA 101 Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to properly manage the implementation of electrical adaptive devices in accordance with NFPA 99 (2012 edition), Health Care Facilities Code, section 10.2.3.6, 10.2.4 and NFPA 70, (2011 edition), National Electrical Code, sections 400-8, 590.3(D). This deficient condition	K 920	The 3 in 1 multi-tap outlet extender was immediately removed from room 641. Staff education will be done on 4/19/2022 as well as upon all new hires. Residents will receive our 'Electrical Safety for Residents' policy. See attachment named, F920 SVL.	4/15/22

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K 920	Continued From page 13 could have an isolated impact on the residents within the facility. Findings include: On 03/15/2022, between 09:15 AM to 1:15 PM, observation revealed that in Resident Room 641, a 1-to-3 multi-tap outlet extender was in use. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 920		