DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE OF DIRECTOR

ACTION REFERRAL

TO	DATE
Myers	3-17-08

DIRECTOR'S USE ONLY	ACTION REQUESTED
1. LOG NUMBER 000472	[ ] Prepare reply for the Director's signature DATE DUE _____
2. DATE SIGNED BY DIRECTOR cc: Wells ✓	[ ] Prepare reply for appropriate signature DATE DUE _____ [ ] FOIA DATE DUE _____ [X] Necessary Action

APPROVALS (Only when prepared for director's signature)	APPROVE	* DISAPPROVE (Note reason for disapproval and return to preparer.)	COMMENT
1.			
2.			
3.			
4.			

Department of Health & Human Services
Centers for Medicare & Medicaid Services
61 Forsyth Street, SW, Suite 4T20
Atlanta, Georgia 30303-8909

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

Refer to: 5096.LSCFed.Comp.03.13.08

IMPORTANT NOTICE – PLEASE READ CAREFULLY

March 13, 2008

Ms. Linda Horne, RN, Administrator
Valley Falls Terrace Nursing Home
400 Locust Grove Road
Spartanburg, SC 29303

Re: LSC Imposition Notice
CMS Certification Number: 42-5096

Dear Ms. Horne:

A facility must meet the pertinent provisions of Sections 1819 and 1919 of the Social Security Act, and be in substantial compliance with each of the requirements for long term care facilities as established by the Secretary of Health and Human Services in 42 CFR section 483.1 et seq., in order to qualify to participate as a skilled nursing facility in the Medicare program and as a nursing facility in the Medicaid program.

On March 6, 2008, a Federal Life Safety Code Standard Comparative Survey was completed at Valley Falls Terrace Nursing Home, by this office. This survey found that your facility was not in substantial compliance with the participation requirements and that conditions in your facility constituted no actual harm with a potential for minimal harm, however, you will be given an opportunity to correct. A statement of the deficiencies (CMS-2567) is enclosed.

All references to regulatory requirements contained in this letter are found in Title 42, Code of Federal Regulations.

Plan of Correction (PoC)

A PoC for the deficiencies must be submitted 10 days after receipt of the Form CMS-2567. Failure to submit an acceptable PoC by March 23, 2008 may result in the imposition of additional remedies after March 23, 2008.

Please submit your PoC to the following address:

Ms. Alfreda Walker, Branch Manager
S&C Review Branch
Department of Health & Human Services
Centers for Medicare & Medicaid Services
61 Forsyth Street, Suite 4T20
Atlanta, Georgia 30303-8909

Fax: (404) 562-7477

Your PoC must contain the following:

- What corrective action(s) will be accomplished by the facility to correct the deficient practice?
- How you will identify other life safety issues having the potential to affect residents by the same deficient practice and what corrective action will be taken.
- What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur; and,
- How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place.

Proposed Remedies

Based on the findings of this survey, if your facility fails to achieve substantial compliance by the revisit, the following remedies will be imposed:

- A civil monetary penalty in the amount of $50-$3,000 per day, the date when noncompliance was identified to first exist.

Remedies Imposed

- Denial of Payment for New Admissions (DPNA), effective June 6, 2008.
- Mandatory Termination effective September 6, 2008.

Informal Dispute Resolution

In accordance with 488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. To be given this opportunity, 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 our office. This request must be submitted during the same 10 days you have for submitting a PoC for the cited deficiencies. Send your request to Alfreda Walker, Branch manager, at the above address.

An incomplete informal dispute resolution process will not delay the effective date of enforcement action. Informal dispute resolution is not to be construed as a formal evidentiary hearing. It is an informal administrative process to discuss deficiencies. If counsel will accompany you, you must indicate this in your request for informal dispute resolution so that we may also have counsel present. You will be advised orally of our decision concerning the dispute deficiencies. Written confirmation will follow.

Appeal Rights

If you disagree with this determination, you or your legal representative may request a hearing before an administrative law judge of the Departmental Appeals Board of the Department of Health and Human Services, Departmental Appeals Board. Procedures governing this process are set out in section 498.49, et seq. A written request for a hearing must be filed no later than sixty days from the date of this letter. Such a request should be directed to:

Oliver Potts, Chief
Departmental Appeals Board, MS 6132
Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building, Room G-644
Washington, D.C. 20201

Send a copy of your request to this office.

A request for a hearing should identify the specific issues, and the findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. You may be represented by counsel and a hearing at your own expense.

If you have any questions regarding this matter, please contact Ms. Sam Fitzhenry at (404) 562-7469. Information can also be faxed to (404) 562-7540.

Sincerely,

Sandra M. Pace
Associate Regional Administrator
Division of Survey and Certification

cc: State Survey Agency
State Medicaid Agency
Fiscal Intermediary

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	425096	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	03/06/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY FALLS TERRACE NURSING HOME	400 LOCUST GROVE ROAD SPARTANBURG, SC 29303

(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 000	INITIAL COMMENTS This Comparative Federal Life Safety Code (LSC) Survey was conducted on March 6, 2008. It was conducted as per the requirements of the Federal Register at 42CFR 483.70 (a) using the existing Health Care Section of the 2000 edition of the LSC and its referenced publications. This building was constructed completely sprinklered and housed 88 beds. The deficiencies determined during the survey are as follows:	K 000		
K 018 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¾ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3 Roller latches are prohibited by CMS regulations in all health care facilities. Based upon observation and staff interview	K 018		

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

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 018	Continued From page 1 during the survey, it was determined that the facility failed to provide corridor doors that would resist the passage of smoke and were free of impediments to closing. The findings included: Approximately at 1130, it was observed that resident room(101, 304, 310, 314) did not latch. This was verified with maintenance personnel at the times of discovery.	K 018		
K 025 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4 This STANDARD is not met as evidenced by: Based upon observation and staff interview during the survey, it was determined that the facility failed to provide smoke barrier walls. The findings included: Approximately at 1245, it was observed that smoke walls located next to break room and resident room 109 were not smoke tight due to unprotected penetrations This was verified with maintenance staff at that	K 025		

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K 025	Continued From page 2 time.	K 025		
K 027 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Door openings in smoke barriers have at least a 20-minute fire protection rating or are at least 1¾-inch thick solid bonded wood core. Non-rated protective plates that do not exceed 48 inches from the bottom of the door are permitted. Horizontal sliding doors comply with 7.2.1.14. Doors are self-closing or automatic closing in accordance with 19.2.2.2.6. Swinging doors are not required to swing with egress and positive latching is not required. 19.3.7.5, 19.3.7.6, 19.3.7.7 This STANDARD is not met as evidenced by: Based upon observation and staff interview during the survey, it was determined that the facility failed to maintain fire/smoke barrier doors as required. The findings included: Approximately at 1330, it was observed that short hall fire door and B hall smoke door panic hardware did not latch. This was verified with maintenance personnel at that time.	K 027		
K 038 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1	K 038		

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K 038	Continued From page 3 This STANDARD is not met as evidenced by: Based upon observation and staff interview during the survey, it was determined that the facility failed to provide exits readily accessible at all times. The findings included: Approximately at 1300, it was observed that magnetic locking sytem on A hall exit door and and short hall exit door did not release the doors during fire alarm test. This was verified with maintenance staff at the time of discovery.	K 038		
K 050 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2 This STANDARD is not met as evidenced by: Based upon observation and staff interview during the survey, it was determined that the facility failed to conduct fire drills as required. The findings included: At approximately 1330, during record review, it was observed that facility did not conduct fire drill for second shift in the quarter of 10-11-12/2007 Facility also did not conduct any fire drills for 3rd shift in the quarter of 7-8-9/2007.	K 050		

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K 050	Continued From page 4 This was verified with the maintenance personnel at that time. During the interview, maintenance staff indicated that facility was not aware of this requirement until recent state survey.	K 050		
K 062 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by: Based upon observation and staff interview during the survey, it was determined that the facility failed to provide the sprinkler system continuously maintained in reliable operating condition. The findings included: 1. From 1100 to 1200, it was observed that sprinkler heads located in B hall shower room, resident room 206, resident room 206 bathroom and loading dock were dirty due to excessive amount of diet/lint. These were verified with maintenance staff at the time of discovery. 2. Approximately at 1300, during record review, it was observed that facility did not conduct quarterly maintenance/test on the sprinkler system. This was verified with maintenance staff at the	K 062		

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K 062	Continued From page 5 time of discovery. During an interview with maintenance staff, staff indicated that facility was not aware of this requirement until recent state survey.	K 062		
K 147 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2 Based upon observation and staff interview during the survey, it was determined that the facility failed to provide electrical wiring and equipment is in accordance with NFPA 70 . The findings included: Approximately at 1120, it was observed that an extension cord was in use in the beauty shop. This was verified with maintenance staff at the time of discovery.	K 147		