STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265356	A. BUILDING 01 B. WING	07/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY MANOR AND REHABILITATION CENTER	1410 HOSPITAL DRIVE EXCELSIOR SPRINGS, MO 64024

(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 The emergency preparedness portion of the survey did not result in deficiencies.	E 000		
K 000	INITIAL COMMENTS 42 CFR 483.90 (a) The facility does not meet the applicable provisions of the 2012 edition of the Life Safety Code of the National Fire Protection Association (NFPA) and related reference documents.	K 000		
K 161 SS=E	Building Construction Type and Height CFR(s): NFPA 101 Building Construction Type and Height 2012 EXISTING Building construction type and stories meets Table 19.1.6.1, unless otherwise permitted by 19.1.6.2 through 19.1.6.7 19.1.6.4, 19.1.6.5 Construction Type 1 I (442), I (332), II (222) Any number of stories non-sprinklered and sprinklered 2 II (111) One story non-sprinklered Maximum 3 stories sprinklered 3 II (000) Not allowed non-sprinklered 4 III (211) Maximum 2 stories sprinklered 5 IV (2HH) 6 V (111)	K 161		

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

Doreen Nasenbeck, Administrator 8/2/24

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 161	Continued From page 1 7 III (200) Not allowed non-sprinklered 8 V (000) Maximum 1 story sprinklered Sprinklered stories must be sprinklered throughout by an approved, supervised automatic system in accordance with section 9.7. (See 19.3.5) Give a brief description, in REMARKS, of the construction, the number of stories, including basements, floors on which patients are located, location of smoke or fire barriers and dates of approval. Complete sketch or attach small floor plan of the building as appropriate. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview, the facility failed to maintain the one-hour fire rating of the ceiling and walls when staff failed to ensure the walls were complete and finished. The facility capacity was 120 with a facility census of 68. 1. Observation on 7/15/2024 beginning at 8:00 A.M. to 2:00 P.M. showed the door in the ice machine hallway had a door knob sized hole behind the door leaving the wood studs exposed.. During an interview on 7/15/2024 at 11:00 A.M. the maintenance supervisor said he had not been made aware of the hole in the wall by staff. National Fire Protection Association (NFPA) 101, 2012 (existing), 19.1.6.1 which requires that health care occupancies shall be limited to the building construction type specified in Table 19.1.6.1 unless otherwise permitted by 19.1.6.2 - 19.1.6.7.	K 161		

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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 interview and record review, the facility failed to test one of one fire alarm system in accordance with National Fire Protection Association (NFPA) 72 requirements. This deficient practice has the potential to effect all facility residents. This deficient practice could delay fire and emergency response in the event of a fire. The facility capacity was 120 with a census of 68 residents at the time of the survey. 1. Record review on 7/15/2024 of the facility records did not show a semi annual fire alarm inspection in the records. During an interview on 07/15/2024 at 11:00 A.M., the maintenance director said he/she did not have a record because the facility had changed venders during that time. National Fire Protection Association 101 Life Safety Code, 2000 edition, section 9.6.2.1 states, " Where required by other sections of this code, actuation of the complete fire alarm system shall occur by any or all of the following means of initiation, but shall not be limited to such means: (1) Manual fire alarm initiation	K 345		

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K 345	Continued From page 3 (2) Automatic detection (3) Extinguishing system operation National Fire Protection Association 96 Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, 1998 edition, section 7-6.2 states: " Where a fire alarm signaling system is serving the occupancy where the extinguishing system is located, the activation of the automatic fire-extinguishing system shall activate the fire alarm signaling system." 14.6.2.4* A record of all inspections, testing, and maintenance shall be provided that includes the following information regarding tests and all the applicable information requested in Figure 14.6.2.4: (1) Date (2) Test frequency (3) Name of property (4) Address (5) Name of person performing inspection, maintenance, tests, or combination thereof, and affiliation, business address, and telephone number (6) Name, address, and representative of approving agency(ies) (7) Designation of the detector(s) tested (8) Functional test of detectors (9)*Functional test of required sequence of operations (10) Check of all smoke detectors (11) Loop resistance for all fixed-temperature, line-type heat detectors (12) Functional test of mass notification system	K 345		

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K 345	Continued From page 4 control units (13) Functional test of signal transmission to mass notification systems (14) Functional test of ability of mass notification system to silence fire alarm notification appliances (15) Tests of intelligibility of mass notification system speakers (16) Other tests as required by the equipment manufacturer's published instructions (17) Other tests as required by the authority having jurisdiction (18) Signatures of tester and approved authority representative (19) Disposition of problems identified during test (e.g., system owner notified, problem corrected/successfully retested, device abandoned in place)	K 345		
K 347 SS=E	Smoke Detection CFR(s): NFPA 101 Smoke Detection 2012 EXISTING Smoke detection systems are provided in spaces open to corridors as required by 19.3.6.1. 19.3.4.5.2 This REQUIREMENT is not met as evidenced by: Based on observation and interview, facility staff failed to maintain smoke detection in the exit corridor. This affected one smoke section (partitions in the facility designed to prevent the spread of smoke and fire during a fire). No residents lived in the smoke section. The facility had a capacity of 120 and a census of 68 at the	K 347		

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K 347	Continued From page 5 time of the survey. Observation on 7/15/2024 at 10:15 A.M., showed the Nurse tv area area open to the corridor and not protected with smoke detection. During interview on 7/15/2024 at 10:20 A.M., the maintenance supervisor said he did not know the room required smoke detection. National Fire Protection Association (NFPA) 101, 2012 edition; 19.3.4.5.1: Corridors. An approved automatic smoke detection system in accordance with Section 9.6 shall be installed in all corridors of limited care facilities, unless otherwise permitted.	K 347		
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 any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25	K 353		

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K 353	Continued From page 6 This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and record review, the facility staff failed to inspect, test and maintain the sprinkler system in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems 2011 Edition for one wet sprinkler system. The facility staff failed to ensure the sprinkler systems were inspected according to applicable provisions of NFPA 25. Failure to inspect the sprinkler systems could affect the sprinkler systems performance. This deficient practice has the potential to affect all facility residents. The facility census was 68 with a capacity of 120. 1. Record review showed facility staff did not conduct the quarterly sprinkler inspection on one of four quarters per NFPA 25 Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems 2011. During an interview on 07/15/2024 at 10:40 A.M., the Maintenance Director said the quarterly inspection had been missed when the facility had changed venders. NFPA 101 (2012 ed.) 9.7.5, 9.7.7, 9.7.8, and NFPA 25 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.	K 353		

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K 363 SS=F	Corridor - Doors CFR(s): NFPA 101 Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc.	K 363		

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K 363	Continued From page 8 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility staff failed to maintain corridor doors to resist the passage of smoke, and failed to ensure the kitchen corridor door latched in the door frame. These deficient practices had the potential to affect all residents in the main dining room. The facility capacity was 120 and the census was 68. 1. Observation at 10:30 A.M., showed the door to the kitchen from the main dining room did not seal properly. A 1 inch gap could be seen at the top of the door. This gap would allow smoke to freely move between the kitchen and the dining room. During an interview on 7/15/24 at 10:32 A.M., Maintenance director said he was aware of the door he just had not had time to get it fixed. Review of NFPA 101, 2012 Edition, Section 19.3.6.3, showed the following: -19.3.6.3.1 Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas shall be doors constructed to resist the passage of smoke and shall be constructed of materials such as the following: (1) 1-3/4 inch thick, solid-bonded core wood (2) Material that resists fire for a minimum of 20 minutes - 19.3.6.3.5* Doors shall be provided with a means for keeping the door closed that is acceptable to the authority having jurisdiction, and the following requirements also shall apply: (1) The device used shall be capable of keeping the door fully closed if a force of 5 lb. (22 N) is applied at the latch edge of the door.	K 363		

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K 521 SS=E	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: Based on observation, interview, and record review, the facility failed to ensure the Heating, Ventilation and Air Conditioning (HVAC) system operated properly in order to cool the air temperatures, within the required State and NFPA guidelines with in the laundry area of the facility. The facility had a census of 68 residents and a licensed capacity for 120 residents. 1. Observations on 7/15/2024 between 8:00 A.M. and 1:00 P.M., showed during a tour of the facility: A portable air conditioning unit located in the laundry area. During an interview on 7/15/2024 at 11:00 A.M., the Administrator said: The laundry staff are very hot in that area and the portable unit was used to assist in keeping the area cool for staff. Review of the Centers for Medicare and Medicaid (CMS) regulatory temperature range is 71.0° to 81.0°.	K 521		

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K 521	Continued From page 10 Review of the 2012 edition of the National Fire Protection Association (NFPA) 101 Chapter 9.2.1, showed, "Air-conditioning, heating, ventilating ductwork, and related equipment shall be in accordance with NFPA 90A, Standard for the Installation of Air-Conditioning and Ventilating Systems, or NFPA 90B, Standard for the Installation of Warm Air Heating and Air-Conditioning Systems, as applicable, unless such installations are approved existing installations, which shall be permitted to be continued in service." Review of the 2012 edition of the NFPA 101 Chapter 19.5.2.1, showed, "Heating, ventilating, and air conditioning shall comply with the provisions of Section 9.2 and shall be installed in accordance with the manufacturer's specifications unless otherwise modified by 19.5.2.2."	K 521		
K 741 SS=F	Smoking Regulations CFR(s): NFPA 101 Smoking Regulations Smoking regulations shall be adopted and shall include not less than the following provisions: (1) Smoking shall be prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area shall be posted with signs that read NO SMOKING or shall be posted with the international symbol for no smoking. (2) In health care occupancies where smoking is prohibited and signs are prominently placed at all major entrances, secondary signs with language that prohibits smoking shall not be required. (3) Smoking by patients classified as not	K 741		

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K 741	Continued From page 11 responsible shall be prohibited. (4) The requirement of 18.7.4(3) shall not apply where the patient is under direct supervision. (5) Ashtrays of noncombustible material and safe design shall be provided in all areas where smoking is permitted. (6) Metal containers with self-closing cover devices into which ashtrays can be emptied shall be readily available to all areas where smoking is permitted. 18.7.4, 19.7.4 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure cigarettes were not intermixed with combustible trash. This deficient practice had the potential to affect any residents, visitors or staff who frequented the facility. The facility had a census of 68 with a capacity of 120. 1. Observation on 07/15/24 at 9:45 A.M., during the Life Safety Code tour of the facility, showed the following: -The shared resident and staff smoking area was located inside the facility. Observation on 07/15/24 at 9:48 A.M., during the Life Safety Code tour of the facility, showed the following: -A plastic trash can, located at the facility smoking area contained cigarette butts and ashes intermixed with combustible paper trash. During an interview on 07/15/24 at 9:50 A.M., the Maintenance Director said staff were responsible for keeping the cigarette butts out of the trash. Review of 2012 edition of NFPA 101 section	K 741		

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K 741	Continued From page 12 19.7.4 showed smoking regulations shall be adopted and shall include not less than the following provisions: -Ashtrays of noncombustible material and safe design shall be provided in all areas where smoking is permitted. -Metal containers with self-closing cover devices into which ashtrays can be emptied shall be readily available to all areas where smoking is permitted.	K 741		
K 920 SS=F	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	K 920		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265356	A. BUILDING **01** B. WING _____	**07/08/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY MANOR AND REHABILITATION CENTER	**1410 HOSPITAL DRIVE** **EXCELSIOR SPRINGS, MO 64024**

(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 920	Continued From page 13 by: Based on observation, interview, and record review, the facility failed to maintain the electrical system by allowing improper use of power taps (also known as surge protectors or power strips) and outlet extenders in resident rooms. The facility had a census of 68 with a capacity of 120. Observation on 07/15/24, starting at 8:00 A.M., of the room to room inspection showed the following: -Room 110 contained a 2 non healthcare rated ownerships one connected to a fan; -Room 111 contained a 2 non healthcare rated ownerships one connected to a nebulizer machine; -Room 108 contained a 2 non healthcare rated ownerships one connected to a fan; -Room 109 contained a 2 non healthcare rated ownerships; -Room 107 contained a 2 non healthcare rated ownerships; -Room 106 contained a 2 non healthcare rated ownerships; -Room 104 contained a 2 non healthcare rated ownerships; -Room 105 contained a 2 non healthcare rated ownerships; -Room 102 contained a 2 non healthcare rated ownerships; -Room 100 contained a 2 non healthcare rated ownerships; -Room 101 contained a 2 non healthcare rated ownerships; -Room 302 contained a 2 non healthcare rated ownerships; -Room 303 contained a 2 non healthcare rated ownerships;	K 920		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265356	A. BUILDING **01** B. WING _____	**07/08/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY MANOR AND REHABILITATION CENTER	**1410 HOSPITAL DRIVE** **EXCELSIOR SPRINGS, MO 64024**

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K 920	Continued From page 14 -Room 304 contained a 2 non healthcare rated ownerships; -Room 305 contained a 2 non healthcare rated ownerships; -Room 305 contained a 2 non healthcare rated ownerships; -Room 307 contained a 2 non healthcare rated ownerships; -Room 308 contained a 2 non healthcare rated ownerships; -Room 310 contained a 2 non healthcare rated ownerships; -Room 312 contained a 2 non healthcare rated ownerships; -Room 313 contained a 2 non healthcare rated ownerships; -Room 314 contained a 2 non healthcare rated ownerships; -Room 316 contained a 2 non healthcare rated ownerships; -Room 409 contained a 2 non healthcare rated ownerships; -Room 408 contained a 2 non healthcare rated ownerships; -Room 406 contained a 2 non healthcare rated ownerships; -Room 405 contained a 2 non healthcare rated ownerships; -Room 403 contained a 2 non healthcare rated ownerships; -Room 402 contained a 2 non healthcare rated ownerships; -Room 203 contained a 2 non healthcare rated ownerships; -Room 204 contained a 2 non healthcare rated ownerships; -Room 205 contained a 2 non healthcare rated ownerships; -Room 207 contained a 2 non healthcare rated	K 920		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265356	A. BUILDING **01** B. WING _____	**07/08/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY MANOR AND REHABILITATION CENTER	**1410 HOSPITAL DRIVE** **EXCELSIOR SPRINGS, MO 64024**

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K 920	Continued From page 15 ownerships; -Room 206 contained a 2 non healthcare rated ownerships; -Room 208 contained a 2 non healthcare rated ownerships; -Room 211 contained a 2 non healthcare rated ownerships; -Room 212 contained a 2 non healthcare rated ownerships and; -Room 216 contained a 2 non healthcare rated ownerships. During an interview on 07/15/24 at 11:10 A.M., the Maintenance Supervisor said he did not know the ownerships in the patient care areas had have the rating. Electrical Equipment - Power Cords and Extension Cords NFPA 99 (2012 edition):10.2.3.6, 10.2.4/NFPA 70 (2011 edition):400.8, 590.3(D)/TIA 12-5/ S&C: 14-46-LSC: 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.	K 920		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265356	A. BUILDING **01** B. WING _____	**07/08/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY MANOR AND REHABILITATION CENTER	**1410 HOSPITAL DRIVE** **EXCELSIOR SPRINGS, MO 64024**

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K 920	Continued From page 16 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. NFPA 99 (2012 edition):3.3.139: Patient Care Vicinity: A space, within a location intended for the examination and treatment of patients, extending 1.8 m (6 ft) beyond the normal location of the bed, chair, table, treadmill, or other device that supports the patient during examination and treatment and extending vertically to 2.3 m (7 ft 6 in.) above the floor. (MED)	K 920		

Missouri Department of Health and Senior Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	02425	A. BUILDING: 01 B. WING _____	07/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY MANOR AND REHABILITATION CENTER	1410 HOSPITAL DRIVE EXCELSIOR SPRINGS, MO 64024

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A2019	19 CSR 30-85.022(10)(B) Fire Alarm System-Test/Maintain Complete Fire Alarm Systems. (B) All facilities shall test and maintain the complete fire alarm system in accordance with NFPA 72, 1999 edition. I/II This regulation is not met as evidenced by: Class II Refer to K345 Refer to K347	A2019		
A2035	19 CSR 30-85.022(11)(D) Complete Sprinkler System Sprinkler System. (D) Facilities licensed on or after August 28, 2007, or any section of a facility in which a major renovation has been completed on or after August 28, 2007, shall install and maintain a complete sprinkler system in accordance with NFPA 13, 1999 edition. I/II This regulation is not met as evidenced by: Class II Refer to K353	A2035		
A2057	19 CSR 30-85.022(32) Ashtrays Noncombustibles/Safe/Disposal Designated smoking areas shall have ashtrays of noncombustible material and of safe design. The contents of ashtrays shall be disposed of properly in receptacles made of noncombustible material. II/III This regulation is not met as evidenced by:	A2057		

Missouri Department of Health and Senior Services
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Doreen Haserueck

TITLE: Administrator

(X6) DATE: 8-2-24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	02425	A. BUILDING: 01 B. WING _____	07/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY MANOR AND REHABILITATION CENTER	1410 HOSPITAL DRIVE EXCELSIOR SPRINGS, MO 64024

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A2057	Continued From page 1 Class III Refer to K741	A2057		
A3001	19 CSR 30-85.032(2) Substantially Constructed/Maintained The building shall be substantially constructed and shall be maintained in good repair. New facilities shall comply with the requirements in accordance with the provisions found in 19 CSR 30-85.012. Existing licensed facilities shall meet and maintain the facility's physical plant in accordance with the construction standards in effect at the time of initial licensing, unless there is a specific rule governing the subject cited in this section or in 19 CSR 30-85.022, except that those facilities licensed between 1957 and 1965 shall not increase the capacity of any room or the total capacity of the facility without meeting new construction requirements. Existing licensed facilities with plans approved after April 8, 1972 and prior to January 1, 1999, shall comply as Existing Health Care Occupancies with NFPA 101, 2000 edition. Facilities whose physical plant requirement plans are approved on or after January 1, 1999, shall comply as New Health Care Occupancies with NFPA 101, 2000 edition. II/III This regulation is not met as evidenced by: Class III Refer to K161 Refer to K363	A3001		
A3037	19 CSR 30-85.032(37) Extension Cords/Duplex Receptacles	A3037		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	02425	A. BUILDING: 01 B. WING _____	07/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY MANOR AND REHABILITATION CENTER	1410 HOSPITAL DRIVE EXCELSIOR SPRINGS, MO 64024

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A3037	Continued From page 2 If extension cords are used, they must be Underwriters Laboratories (UL)-approved or shall comply with other recognized electrical appliance approval standards and sized to carry the current required for the appliance used. Only one (1) appliance shall be connected to one (1) extension cord. Only two (2) appliances may be served by one (1) duplex receptacle. Extension cords shall not be placed under rugs, through doorways, or located where they are subject to physical damage. II/III This regulation is not met as evidenced by: Class III Refer to K920	A3037		

PLAN OF CORRECTION

Provider/Supplier Name:	Excelsior Springs#1 DBA Valley Manor and Rehabilitation
Street Address, City, Zip:	1410 Hospital Drive, Excelsior Springs, MO 64024
Date of Survey:	7/08/2024

PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	

ID PREFIX TAG	**PROVIDER'S PLAN OF CORRECTION: (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)**	**COMPLETION DATE**
	This plan of correction is prepared and executed because it is required by the provisions of the state and federal regulations and not because Valley Manor and Rehabilitation Center agrees with the allegations and citations listed on the statement of deficiencies. Valley Manor and Rehabilitation Center maintains that the alleged deficiencies do not, individually, and collectively, jeopardize the health and safety of the residents, or are they of such character as to limit our capacity to render adequate care as prescribed by the regulation. This plan of correction shall operate as Valley Manor and Rehabilitation Center's written credible allegation of compliance. By submitting this plan of correction, Valley Manor and Rehabilitation does not admit to the accuracy of the deficiencies. This plan of correction is not meant to establish any standard of care, contract, obligation, or position, and Valley Manor and Rehabilitation Center reserves all rights to raise all possible contentions and defenses in any civil or criminal, action or proceeding.	8/17/2024

K161	1. **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?** No facility resident was found to have been identified by the alleged deficient practice. 2. **How will you identify other residents having the potential to be affected by the same deficient practice and what correction action(s) will be taken?** Facility residents have the potential to be affected by the deficient practice. 3. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** Administrator and/or designee have educated the maintenance man on the policy for penetration in the walls and smoke bearers. Whole in the wall of the ice machine corridor has been repaired. 4. **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?** Maintenance man will monitor all walls for penetration and or wholes on his monthly rounds.	8/17/2004

	Trends will be identified and addressed through the Quality Assurance Performance Improvement process monthly and quarterly thereafter. Areas of concern will be addressed at the time of discovery for further interventions	
K-345	**1. 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?** No facility resident was found to have been identified by the alleged deficient practice. **2. How will you identify other residents having the potential to be affected by the same deficient practice and what correction action(s) will be taken?** Facility residents have the potential to be affected by the deficient practice. **3. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** Facility semi-annual fire alarm inspection has been completed. Administrator and/or designee have educated the maintenance man on the policy and procedure of fire alarm inspections. **4. 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?** Maintenance supervisor has a schedule for the entire year that will be monitored monthly by the administrator and/or designee. Trends will be identified and addressed through the Quality Assurance Performance Improvement process monthly and quarterly thereafter. Areas of concern will be addressed at the time of discovery for further interventions	8/17/2024
K-347	**1. 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?** No facility resident was found to have been identified by the alleged deficient practice **2. How will you identify other residents having the potential to be affected by the same deficient practice and what correction action(s) will be taken?** Facility residents have the potential to be affected by the deficient practice **3. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** Administrator and/or designee have educated the maintenance man on the policy and procedure of smoke detectors and proper placement per the regulation.	8/17/2024

	Smoke Detectors have been placed in the Nurse tv area open to the corridor and is now protected with smoke detection. **4. 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?** The Maintenance Supervisor and/or designee will monitor all areas monthly to ensure proper placement of smoke detectors on monthly rounds. Maintenance supervisor and/or designee will contact Prodigy Fire for direction of proper placement of smoke detectors if indicated. Trends will be identified and addressed through the Quality Assurance Performance Improvement process monthly and quarterly thereafter. Areas of concern will be addressed at the time of discovery for further interventions	
K-353	**1. 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?** No facility resident was found to have been identified by the alleged deficient practice **2. How will you identify other residents having the potential to be affected by the same deficient practice and what correction action(s) will be taken?** Facility residents have the potential to be affected by the deficient practice **3. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** Administrator and or designee have educated the Maintenance supervisor on the policy and procedure on sprinkler inspections. The quarterly sprinkler inspection has been completed. **4. 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?** The maintenance supervisor has a schedule for the entire year that will be monitored monthly by the administrator and/or designee. Trends will be identified and addressed through the Quality Assurance Performance Improvement process monthly and quarterly thereafter. Areas of concern will be addressed at the time of discovery for further interventions	8/17/2024
K-363	**1. 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?** No facility resident was found to have been identified by the alleged deficient practice.	

	2. How will you identify other residents having the potential to be affected by the same deficient practice and what correction action(s) will be taken? Facility residents have the potential to be affected by the deficient practice. **3. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** The maintenance supervisor has changed out the door leading to the corridor and has repaired all holes in the walls in the corridor and walls. **4. 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?** The maintenance supervisor and or designee will do weekly rounds to ensure no additional penetrations in the walls or corridors occur. If identified on the weekly rounds the maintenance supervisor and or designee will log repair needed and will be placed in que for repair and the administrator will monitor repair is done timely and accurately with her weekly review of all reports.	
K-521	**5. 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?** No facility resident was found to have been identified by the alleged deficient practice **6. How will you identify other residents having the potential to be affected by the same deficient practice and what correction action(s) will be taken?** Facility residents have the potential to be affected by the deficient practice **7. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** **8. 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?** Trends will be identified and addressed through the Quality Assurance Performance Improvement process monthly and quarterly thereafter. Areas of concern will be addressed at the time of discovery for further interventions	8/17/2024
K-741	**1. 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?** No facility resident was found to have been identified by the alleged deficient practice	8/17/2024

	2. How will you identify other residents having the potential to be affected by the same deficient practice and what correction action(s) will be taken? Facility residents have the potential to be affected by the deficient practice **3. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** Administrator and/or designee will educate staff on the proper disposal of smoking material. **4. 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?** Maintenance supervisor and/or designee will dispose of smoking materials once daily and document on daily rounds sheets. Administrator and/or designee will monitor the smoking area once daily five days a week for 4 weeks to ensure smoking materials are properly disposed of. Trends will be identified and addressed through the Quality Assurance Performance Improvement process monthly and quarterly thereafter. Areas of concern will be addressed at the time of discovery for further interventions	
K -920	**1. 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?** No facility resident was found to have been identified by the alleged deficient practice Room 110 has been cleared of non-healthcare related power strips. Room 111 has been cleared of non-healthcare related power strips. Room 108 has been cleared of non-healthcare related power strips. Room 109 has been cleared of non-healthcare related power strips. Room 107 has been cleared of non-healthcare related power strips. Room 106 has been cleared of non-healthcare related power strips. Room 104 has been cleared of non-healthcare related power strips. Room 105 has been cleared of non-healthcare related power strips. Room 102 has been cleared of non-healthcare related power strips. Room 100 has been cleared of non-healthcare related power strips. Room 302 has been cleared of non-healthcare related power strips. Room303 has been cleared of non-healthcare related power strips.	8/17/2024

	Room 304 has been cleared of non-healthcare related power strips. Room 305 has been cleared of non-healthcare related power strips. Room 307 has been cleared of non-healthcare related power strips. Room 308 has been cleared of non-healthcare related power strips. Room 310 has been cleared of non-healthcare related power strips. Room 312 has been cleared of non-healthcare related power strips. Room 313 has been cleared of non-healthcare related power strips. Room 314 has been cleared of non-healthcare related power strips. Room 316 has been cleared of non-healthcare related power strips. Room 409 has been cleared of non-healthcare related power strips. Room 408 has been cleared of non-healthcare related power strips. Room 406 has been cleared of non-healthcare related power strips. Room 405 has been cleared of non-healthcare related power strips. Room 403 has been cleared of non-healthcare related power strips. **2. How will you identify other residents having the potential to be affected by the same deficient practice and what correction action(s) will be taken?** Facility residents have the potential to be affected by the deficient practice **3. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** All residents and responsible parties, DPOA or authorized representatives will be sent a letter informing them of the requirement for all power strips to be hospital grade and that the maintenance supervisor and or administrator needed to approve them before placement in the resident rooms. Admitting residents, responsible parties, DPOA or authorized representatives will be notified at time of admission of the policy for power cords in the facility. The Maintenance Supervisor and/or designee will educate staff on the policy of power cords in the patient care areas. Hospital Grade power cords have been provided to the current residents to not affect the activities of daily living that they are accustomed to.	

	4. 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? Maintenance supervisor and/or designee will check for unauthorized power cords in the patient care areas monthly during his monthly rounds. Trends will be identified and addressed through the Quality Assurance Performance Improvement process monthly and quarterly thereafter. Areas of concern will be addressed at the time of discovery for further interventions	
A-2019	Please refer to K-345 and K-347	
A-2035	Please refer to K-353	
A-2057	Please refer to K-741	
A-3001	Please refer to K-161 and K-363	
A-3037	Please refer to K-920	