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	12/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Spring Valley Care Center	800 Memorial Drive Spring Valley, MN 55975

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation and interview, the facility failed to properly label, store and dispose of refrigerated items. This had the potential to affect all residents served out of the kitchen.During the initial kitchen tour on 12/15/25 at 11:45 a.m., with dietary manager (DM)-A the following undated or expired items were observed in the refrigerator: Undated bin of sandwiches,Undated hot dogs,Undated onion, Undated oranges in syrupPumpkin puree dated 12/10Honeydew dated 11/8Chicken gravy dated 11/20During interview 12/15/25 at 12:01 p.m., DM-A confirmed the previous listed items. She stated the sandwiches and pumpkin puree were expired and should have been discarded. The policy directs them to discard all items after 3 days. DM-A confirmed the importance of dating food was to ensure residents don't become ill from the foods they were served. During interview on 12/18/25 at 12:11 p.m., the administrator stated the dietary staff were expected to follow the facility food safety policy to accurately date and dispose of food items.A facility policy titled Food Receiving and Storage dated August 2025, all foods stored in the refrigerator or freezer will be covered, labeled, and dated. After three days, leftover food should be disposed of.

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

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to ensure advanced directives for emergency treatment were accurately reflected in all areas of the medical record to ensure the residents wishes would be implemented correctly in an emergent situation for 1 of 1 residents R39) reviewed for advanced directives. Findings include:R39's quarterly Minimum Data Set (MDS) dated [DATE], indicated R39 had severe cognitive impairment. R39 had diagnoses of non-traumatic brain dysfunction and dementia. The MDS also indicated R39 was receiving hospice care. R39's medication administration record (MAR) indicated unscheduled other orders DNR Do Not Resuscitate. The Advanced directives section indicated DNR Do Not Resuscitate/Comfort. The MAR also contained hospice weekly charting.R39's care plan indicated R39 was receiving hospice care.During record review on [DATE] the banner on R39's electronic medical record (EMR) indicated Code Status: DNR-Do not resuscitate/comfort. Also contained in the banner was a hyperlink connecting to a signed Provider Orders for Life-Sustaining Treatment (POLST). The hyperlink lead to a POLST dated [DATE] that indicated R39 wished for cardiopulmonary resuscitation (CPR) and full resuscitative treatment (implementation of all life sustaining measures). In a separate section of the medical record a POSLT dated [DATE] indicated R39 wished for comfort-focused treatment and no attempts at resuscitation (allow natural death). During interview on [DATE] at 6:23 p.m., RN-A stated if a resident was found unresponsive, she would verify code status before initiating interventions. RN-A stated the banner on the EMR contained the code status. She stated the information was also on the assignment sheet staff obtained at the beginning of the shift. RN-A stated she would not pay attention to the hyperlink as that was not part of the facility's process to verify code status. If the EMR banner had no code status listed, RN-A stated she would then use the hyperlink. RN-A stated the care coordinator was responsible for entering code status on the EMR upon admission and if code status changes. A blank 24-hour report sheet listed all residents assigned to the nurse. The form indicated R39 was DNR/comfort and also listed the hospice agency. A blank resident notes form used by the nursing assistants indicated H for hospice. During interview on [DATE] at 6:25 p.m., trained medication aide (TMA)-A stated she had been a TMA for 2 weeks. TMA-A stated if a resident was found without signs of life, she would look at the banner on the EMR to establish code status and immediately notify the nurse on duty. TMA-A did not know how to verify if the code status on the banner. During record review on [DATE] at 9:09 a.m., the banner on R39's electronic medical record continues to indicate Code Status: DNR-Do not resuscitate/comfort with the hyperlink connecting to the POLST dated [DATE]. During an interview on [DATE] at 7:53 a.m., licensed practical nurse (LPN)-A stated care coordinators and/or facility social workers were responsible for establishing and entering code status on the EMR. LPN-A stated they would use the EMR banner or 24-hour report sheet to verify code status. LPN-A also stated they might use the hyperlink that connected directly to the POLST. If there was a discrepancy between the EMR banner and the POLST attached to the hyperlink, LPN-A stated they would immediately call the resident's emergency contact, on-call provider, on-call social worker, or on-call registered nurse to verify code status. During interview on [DATE] 10:05 a.m., care coordinator (CC)-A stated the care coordinator was responsible for establishing code status. If the admission was after business hours, the admitting floor nurse was responsible. Code status was verified on the EMR banner or under the miscellaneous tab to find the most recent POLST. CC-A confirmed the banner on R39's EMR indicated DNR-do not resuscitate. CC-A clicked on the hyperlink and confirmed the attached POLST was dated [DATE] and indicated CPR-full resuscitative treatment. CC-A stated she was unsure how the POLST was attached to the hyperlink in the EMR.During interview on [DATE] at 1:29 p.m., the administrator stated the admitting nurse went over code status and upon admission. Code status was also reviewed annually. The admitting nurse (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	entered the code status into the EMR. If a code status changed, the nurse or social worker was responsible for making changes in EMR. The administrator stated having the incorrect POLST linked to the code status was definitely a problem. An undated policy titled Advanced directives indicated Prior to or upon admission of a resident to our facility, the Social Services Director or designee will provide written information to the resident concerning his/her/their right to make decisions concerning medical care, including the right to accept or refuse medical or surgical treatment and the right to formulate advance directives. It continues Changes or revocations of a directive must be submitted in writing to the Administrator. The Administrator may require new documents if changes are extensive. The Care Plan Team will be informed of such changes and/or revocations so that appropriate changes can be made in the resident assessment (MDS) and care plan.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure proper side effect monitoring for potential orthostatic hypotension (sudden drop in blood pressure that occurs when a person changes position from lying to sitting and/or standing) was completed for 1 of 1 resident (R45) reviewed for unnecessary medications who received antipsychotics. R45's quarterly Minimum Data Set (MDS) dated [DATE] indicated R45 had severe cognitive impairment with wandering but no other behaviors. R45 required partial to substantial assist for activities of daily living and was independent with side-to-side bed mobility and sitting on edge of the bed. He required substantial assists for all other transfers and position changes. R34 has a history of traumatic brain dysfunction, and palliative care. The MDS also indicated R45 had a history of 2 or more falls with no injuries and 1 fall with minor injury. R45 received antipsychotic medications on a routine and as needed basis and receives hospice care R45's diagnoses list indicated brain bleed with loss of consciousness, encephalopathy (disease of the brain), disorientation, and palliative care. R45's care plan included hospice care, history of attempts to leave the facility, impaired cognitive function, transfers with stand lift, risk for falls related to deconditioning, incontinence, poor communication/comprehension, psychoactive drug use, unaware of safety needs, and previous falls. R45's care plan also included use of antipsychotic medications with interventions that included monitoring for target behaviors and side effects R45's medication administration record (MAR) indicated R45 received antipsychotic medications on a routine and as needed basis since admission to the facility on 7/1/25. The MAR did not contain orders to obtain monthly orthostatic blood pressures. R45's medical record indicated R45 had 5 falls in July; 2 in August; 6 in September; and 2 in October. The last documented fall was on 10/19/25. Orthostatic blood pressures were obtained once in July, September, and October with an associated fall. No orthostatic blood pressures were obtained in August or November. During an interview on 12/17/25 at 10:32 a.m., medical director (MD)-A stated residents receiving antipsychotic medications should have monthly orthostatic blood pressures obtained. MD-A stated she expected staff to perform as many steps of orthostatic monitoring as resident was physically able to perform, even if it was just lying and sitting. If a resident refused, she expected staff to attempt again. If a resident was actively dying, she would not expect orthostatic blood pressures. She would also expect the consultant pharmacist to request orthostatic blood pressure monitoring during monthly reviews. During an interview on 12/18/25 at 10:36 a.m., the consultant pharmacist stated she reviewed the record for an abnormal movement assessment, target behaviors, and if a resident can stand, orthostatic blood pressures. Her reviews do not change for a resident who was under hospice care. The pharmacist stated she does not always look for orthostatic blood pressure monitoring for hospice residents because hospice will discontinue them anyway. If a resident was on hospice but still able to ambulate or get up, the pharmacist stated she would request to have orthostatic blood pressure monitoring in place. The pharmacist confirmed she did not request orthostatic blood pressure monitoring for R45. During interview on 12/18/25 at 11:25 a.m., care coordinator (CC)-A stated residents who received antipsychotic medications were monitored for side effects, continued behaviors, and monthly orthostatic blood pressures. CC-A stated staff to not attempt orthostatic blood pressures for R45 because he was stand-lift transfer and can't stand long enough. CC-A stated she believed not doing orthostatic blood pressures was discussed with the providers however it was likely a conversation done in person. CC-A was unable to provide documentation the discussion occurred. CC-A stated R45's transfer status and overall health had declined. She confirmed R45 had a history of frequent falls with his last fall on 10/19/25. R45's transfer status changed 10/10/25 from a 1 assist with a walker to a stand lift transfer. During an interview on 12/18/25 at 1:33 p.m., the administrator stated residents started on antipsychotic medications were monitored for side effects and continued behaviors. A policy for antipsychotic medication monitoring was requested but not received.

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F 0710 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Obtain a doctor's order to admit a resident and ensure the resident is under a doctor's care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to ensure a resident had accurate physician orders for medications for 1 of 5 residents (R11) reviewed order accuracy.Findings include:R11's comprehensive Minimum Data Set (MDS) dated [DATE], indicated R11 had no cognitive deficit.R11's diagnosis included: dementia with psychotic and mood disturbance, psychotic disorder with delusions, cognitive function decline, anxiety, and depression.R11's Medication administration Record (MAR) indicated Tylenol-give 1 tablet every 6 hours as needed for pain; the Tylenol order lacked a dosage.R11's Order summary reports, signed by the provider, dated 1/28/25 through 12/17/25 lacked a dosage for Tylenol.During interview on 12/17/25 at 10:32 a.m., medical director (MD) confirmed the current Tylenol order lacked a dosage. MD confirmed an accurate Tylenol order would contain a dosage. MD confirmed her provider team should have picked up the dosage discrepancy with his initial order summary sign off and with each sign off since.During interview on 12/18/25 at 10:36 a.m., pharmacist stated pharmacy reviews were conducted monthly per regulation. Pharmacist stated she reviewed medication orders for accuracy, side effect monitoring, target behaviors and vital signs. Pharmacist confirmed the current Tylenol order lacked a dosage. Pharmacist confirmed the provider team reviewed and signed off the order summary; medications that lacked a dosage should have been identified when the provider signed off on the order summary.A policy titled Consultant Pharmacist Reports-Medication Management dated April 2019, the attending physician/provider perform ongoing monitoring for appropriate, effective, and safe medication use.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to ensure facility staff appropriately transcribed physician orders for 1 of 5 residents (R11) reviewed for order entry.Findings include: R11 was admitted to the facility on [DATE], with orders from the sending facility for Tylenol 500mg, take 1 tablet by mouth every 6 hours as needed for pain. R11's comprehensive Minimum Data Set (MDS) dated [DATE], indicated R11 had no cognitive deficit. R11's diagnosis included: dementia with psychotic and mood disturbance, psychotic disorder with delusions, cognitive function decline, anxiety, and depression. R11's Medication administration Record (MAR) indicated Tylenol-give 1 tablet every 6 hours as needed for pain; the Tylenol order lacked dosage. R11's initial orders were transcribed into the medical record by the health unit coordinator (HUC). During interview on 12/18/25 at 12:11 p.m., the administrator stated the current process for ordering processing was the HUC entered the orders sent from the provider, a registered nurse (RN) double-checked the order was entered correctly, and the provider team reviewed and signed off on the order summary. The administrator confirmed the Tylenol order was inaccurately transcribed at time of admission. During interview on 12/17/25 at 10:32 a.m., medical director (MD) confirmed the current Tylenol order lacked a dosage. MD confirmed an accurate Tylenol order would contain a dosage. MD confirmed the process for entering orders was the responsibility of the HUC. The RN signed off on the order completion. MD stated it was important orders were transcribed accurately so the resident received the medication or treatment as the MD intended. During interview on 12/18/25 at 10:36 a.m., pharmacist stated pharmacy reviews were conducted monthly per regulation. Pharmacist stated she reviewed medication orders for accuracy, side effect monitoring, target behaviors, and vital signs. Pharmacist confirmed the current Tylenol order lacked a dosage. Pharmacist confirmed the facility staff were responsible for entering new orders from the provider. Pharmacist stated transcribing orders accurately was important, so residents received the care the provider ordered An undated facility policy titled Order Processing in the Skilled Nursing Facility, the purpose is to ensure that all physician orders are processed accurately, timely, and in compliance with federal and state regulations to promote resident safety and continuity of care.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the pharmacy consultant identified irregularities in monthly drug regimen reviews for 2 of 5 residents (R11 and R45) reviewed for unnecessary medications.Findings include: R11's comprehensive Minimum Data Set (MDS) dated [DATE], indicated R11 had no cognitive deficit. R11's diagnosis included: dementia with psychotic and mood disturbance, psychotic disorder with delusions, cognitive function decline, anxiety, and depression. R11's Medication administration Record (MAR) indicated Tylenol-give 1 tablet every 6 hours as needed for pain; the Tylenol order lacked a dosage. R11's pharmacy reviews dated July 2025 through December 2025, lacked a dosage for Tylenol. During interview on 12/17/25 at 10:32 a.m., medical director (MD) confirmed the current Tylenol order lacked a dosage. MD confirmed an accurate Tylenol order contained a dosage. MD stated she expected the pharmacist to question the Tylenol order during monthly pharmacy reviews. During interview on 12/18/25 at 10:36 a.m., pharmacist stated pharmacy reviews were conducted monthly per regulation. Pharmacist stated she reviewed medication orders for accuracy, side effect monitoring, target behaviors, and vital signs. Pharmacist confirmed the current Tylenol order lacked a dosage. Pharmacist confirmed she failed to notice the strength of Tylenol was missing. R45's quarterly Minimum Data Set (MDS) dated [DATE] indicated R45 had severe cognitive impairment with wandering but no other behaviors. R45 required partial to substantial assist for activities of daily living and was independent with side-to-side bed mobility and sitting on edge of the bed. He required substantial assists for all other transfers and position changes. R34 has a history of traumatic brain dysfunction, and palliative care. The MDS also indicated R45 had a history of 2 or more falls with no injuries and 1 fall with minor injury. R45 receives antipsychotic medications on a routine and as needed basis and received hospice care. R45's diagnoses list indicated brain bleed with loss of consciousness, encephalopathy (disease of the brain), disorientation, and palliative care. R45's care plan included hospice care, history of attempts to leave the facility, impaired cognitive function, transferred with stand lift, risk for falls related to deconditioning, incontinence, poor communication/comprehension, psychoactive drug use, unaware of safety needs, and previous falls. R45's care plan included use of antipsychotic medications with interventions of monitoring for target behaviors and side effects R45's medication administration record (MAR) indicated R45 received antipsychotic medications on a routine and as needed basis since admission to the facility on 7/1/25. The MAR did not contain orders to obtain monthly orthostatic blood pressures. R45's medical record indicated R45 had 5 falls in July, 2 in August, 6 in September, and 2 in October (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	with the last documented fall on 10/19/25. Orthostatic blood pressures were obtained once in July, September, and October with an associated fall. No orthostatic blood pressures were obtained in August or November. Monthly drug regimen reviews from July 2025-December 2025 lacked monthly orthostatic blood pressure monitoring. During an interview on 12/17/25 at 10:32 a.m., MD stated residents receiving antipsychotic medications should have monthly orthostatic blood pressures obtained. MD expected staff to perform as many steps of orthostatic monitoring as resident was physically able to perform, unless the resident was actively passing away. If a resident refused, she expected staff to attempt again. MD also expected the consultant pharmacist to request orthostatic blood pressure monitoring during monthly reviews. During an interview on 12/18/25 at 10:36 a.m., the consultant pharmacist stated she reviewed the record for an abnormal movement assessment, target behaviors, and if a resident can stand, orthostatic blood pressures. The pharmacist stated she does not always look for orthostatic blood pressure monitoring for hospice residents because hospice will discontinue them anyway. If a resident was on hospice but still able to ambulate or get up, the pharmacist stated she would request to have orthostatic blood pressure monitoring in place. The pharmacist confirmed she did not request orthostatic blood pressure monitoring for R45. During interview on 12/18/25 at 11:25 a.m., care coordinator (CC)-A stated residents who received antipsychotic medications were monitored for side effects, continued behaviors, and monthly orthostatic blood pressures. CC-A stated R45's transfer status and overall health had declined. She confirmed R45 had a history of frequent falls with his last fall on 10/19/25. R45's transfer status changed 10/10/25 from a 1 assist with a walker to a stand lift transfer. CC-A stated staff do not attempt orthostatic blood pressures for R45 because he was stand-lift transfer and can't stand long enough. CC-A stated she believed she discussed with the providers not doing orthostatic blood pressure monitoring for R45 however was unable to provide documentation the discussion occurred. During an interview on 12/18/25 at 1:33 p.m., the administrator expected residents started on antipsychotic medications were monitored for side effects and continued behaviors. A policy titled Consultant Pharmacist Reports-Medication Regimen Review dated April 2019, the consultant pharmacist performs a comprehensive review of each residents' medication regimen and clinical records at least monthly; reporting findings and recommendations for improvement or correction.

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F 0577 Level of Harm - Potential for minimal harm Residents Affected - Many	Allow residents to easily view the nursing home's survey results and communicate with advocate agencies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and document review, the facility failed to ensure the facility's state survey results were kept in a location that was readily accessible to all residents. This had the potential to affect all 42 residents and/or visitors who wished to review the information. R25's quarterly Minimum Data Set (MDS) dated [DATE], indicated R25 had intact cognition. During an interview with the facility resident council president on 12/17/25 at 2:43 pm., R25 (resident council president) stated the survey binder was usually at the front desk; it had been gone for some time though. R25 stated she would like to see it returned. During observation and interview on 12/18/25 at 10:31 a.m., social worker (SW) and administrator confirmed the facility had a survey binder; they were unsure why it wasn't in the designated spot at the front desk. A policy regarding posting survey results was requested and not received.