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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 0185

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00712

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245412**
2.STATE VENDOR OR MEDICAID NO.
(L2) **961043000**

3. NAME AND ADDRESS OF FACILITY
(L3) **COKATO MANOR**
(L4) **182 SUNSET AVENUE**
(L5) **COKATO, MN** (L6) **55321**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **08/26/2021** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

12.Total Facility Beds **56** (L18)
13.Total Certified Beds **56** (L17)

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

B. Not in Compliance with Program Requirements and/or Applied Waivers:

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

* Code: **A*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	56			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date : 10/24/2021 (L19)

18. STATE SURVEY AGENCY APPROVAL Date: 10/29/2021 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
11/01/2021
(L33)

DETERMINATION APPROVAL

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
November 23, 2021

CMS Certification Number (CCN): 245412

Administrator
Cokato Manor
182 Sunset Avenue
Cokato, MN 55321

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 November 1, 2021 the above facility is certified for:

56 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 56 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,

Joanne Simon, Enforcement Specialist
Minnesota Department of Health
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
November 23, 2021

Administrator
Cokato Manor
182 Sunset Avenue
Cokato, MN 55321

RE: CCN: 245412
Cycle Start Date: August 26, 2021

Dear Administrator:

On September 20, 2021, we notified you a remedy was imposed. On October 6, 2021 the Minnesota Department(s) 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 November 1, 2021.

As authorized by CMS the remedy of:

- Discretionary denial of payment for new Medicare and Medicaid admissions effective November 4, 2021 did not go into effect. (42 CFR 488.417 (b))

In our letter of September 20, 2021, 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 November 4, 2021 due to denial of payment for new admissions. Since your facility attained substantial compliance on November 1, 2021, 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,

Joanne Simon, Enforcement Specialist
Minnesota Department of Health
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us
cc: Licensing and Certification File

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 0185

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5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **08/26/2021** (L34)

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04 SNF	**08 OPT/SP**	**12 RHC**	**16 HOSPICE**	

FISCAL YEAR ENDING DATE: (L35)
09/30

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To (b) :

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X B. Not in Compliance with Program Requirements and/or Applied Waivers:

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

* Code: **B*** (L12)

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18 SNF	18/19 SNF	19 SNF	ICF	IID
	56			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Nicole Sassen, HFE - NE II 10/24/2021 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Joanne Simon, Enforcement Specialist 10/29/2021 (L20)

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

19. DETERMINATION OF ELIGIBILITY
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___ 2. Facility is not Eligible (L21)

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

Electronically delivered
September 20, 2021

Administrator
Cokato Manor
182 Sunset Avenue
Cokato, MN 55321

RE: CCN: 245412
Cycle Start Date: August 26, 2021

Dear Administrator:

On August 26, 2021, 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 November 4, 2021.

- 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 November 4, 2021. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective November 4, 2021.

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 (Delete this section if SQC tags are cited and this note)

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 $11,160; 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 November 4, 2021, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, Cokato Manor will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from November 4, 2021. 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" tag), and emergency preparedness deficiencies (those preceded by an “E” tag), i.e., the plan of correction should be directed to:

Jen Bahr, RN, Unit Supervisor
Bemidji District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
705 5th Street NW, Suite A
Bemidji, MN 56601-2933
Email: Jennifer.bahr@state.mn.us
Office: (218) 308-2104 Mobile: (218) 368-3683

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 February 26, 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,

Joanne Simon, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245412	A. BUILDING _____ B. WING _____	C 08/26/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COKATO MANOR	**182 SUNSET AVENUE COKATO, MN 55321**

(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 8/23/21 through 8/26/21, a survey for compliance with Appendix Z, Emergency Preparedness Requirements, §483.73(b)(6) was conducted during a standard recertification survey. The facility was NOT in compliance. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulation has been attained.	E 000		
E 041 SS=C	Hospital CAH and LTC Emergency Power CFR(s): 483.73(e) §482.15(e) Condition for Participation: (e) Emergency and standby power systems. The hospital must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section and in the policies and procedures plan set forth in paragraphs (b)(1)(i) and (ii) of this section. §483.73(e), §485.625(e) (e) Emergency and standby power systems. The [LTC facility and the CAH] must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section. §482.15(e)(1), §483.73(e)(1), §485.625(e)(1) Emergency generator location. The generator must be located in accordance with the location requirements found in the Health Care Facilities	E 041		9/29/21

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

Electronically Signed | 09/29/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245412	A. BUILDING _____ B. WING _____	C 08/26/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COKATO MANOR	**182 SUNSET AVENUE COKATO, MN 55321**

(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 041	Continued From page 1 Code (NFPA 99 and Tentative Interim Amendments TIA 12-2, TIA 12-3, TIA 12-4, TIA 12-5, and TIA 12-6), Life Safety Code (NFPA 101 and Tentative Interim Amendments TIA 12-1, TIA 12-2, TIA 12-3, and TIA 12-4), and NFPA 110, when a new structure is built or when an existing structure or building is renovated. 482.15(e)(2), §483.73(e)(2), §485.625(e)(2) Emergency generator inspection and testing. The [hospital, CAH and LTC facility] must implement the emergency power system inspection, testing, and [maintenance] requirements found in the Health Care Facilities Code, NFPA 110, and Life Safety Code. 482.15(e)(3), §483.73(e)(3), §485.625(e)(3) Emergency generator fuel. [Hospitals, CAHs and LTC facilities] that maintain an onsite fuel source to power emergency generators must have a plan for how it will keep emergency power systems operational during the emergency, unless it evacuates. *[For hospitals at §482.15(h), LTC at §483.73(g), and CAHs §485.625(g):] The standards incorporated by reference in this section are approved for incorporation by reference by the Director of the Office of the Federal Register in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. You may obtain the material from the sources listed below. You may inspect a copy at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202-741-6030, or go to:	E 041		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245412	A. BUILDING _____ B. WING _____	C 08/26/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COKATO MANOR	**182 SUNSET AVENUE COKATO, MN 55321**

(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 041	Continued From page 2 http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html. If any changes in this edition of the Code are incorporated by reference, CMS will publish a document in the Federal Register to announce the changes. (1) National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02169, www.nfpa.org, 1.617.770.3000. (i) NFPA 99, Health Care Facilities Code, 2012 edition, issued August 11, 2011. (ii) Technical interim amendment (TIA) 12-2 to NFPA 99, issued August 11, 2011. (iii) TIA 12-3 to NFPA 99, issued August 9, 2012. (iv) TIA 12-4 to NFPA 99, issued March 7, 2013. (v) TIA 12-5 to NFPA 99, issued August 1, 2013. (vi) TIA 12-6 to NFPA 99, issued March 3, 2014. (vii) NFPA 101, Life Safety Code, 2012 edition, issued August 11, 2011. (viii) TIA 12-1 to NFPA 101, issued August 11, 2011. (ix) TIA 12-2 to NFPA 101, issued October 30, 2012. (x) TIA 12-3 to NFPA 101, issued October 22, 2013. (xi) TIA 12-4 to NFPA 101, issued October 22, 2013. (xiii) NFPA 110, Standard for Emergency and Standby Power Systems, 2010 edition, including TIAs to chapter 7, issued August 6, 2009.. This REQUIREMENT is not met as evidenced by: Based on observation, interview and documents review,, the facility failed to maintain facility emergency power supply systems and components per NFPA 99 (2012 edition), Health Care Facilities Code, section 6.6.4.1, 6.4.4.2, 6.4.1.1.13, and NFPA 110 (2010), Standard for	E 041	The battery on generator #1 was replaced on 8/27/21. The battery on generator #2 was replaced on 9/29/21. At this time the Environmental Services Director has spoken with Mike Brandel	

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	245412	A. BUILDING _____ B. WING _____	C 08/26/2021

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E 041	Continued From page 3 Emergency and Standby Power Systems, sections 5.6.4.5.1, A.5.6.4.5.1, 8.3.4, 8.3.4.1. This deficient condition had the potential to affect all 53 residents residing in the facility. Findings include: On 8/25/21, between 11:00 a.m. to 4:00 p.m. a facility tour was conducted with maintenance director (M)-A. A visual inspection was completed of the emergency power supply systems and were dated as follows: Generator 1 = 2018 / Generator 2 = 2016. No emergency stops could be located in the building for the two roof-top generators. The facility monthly generator testing and results identifed testing was not completed since July of 2020. This deficient practice was confirmed by the M-A during the tour and at the time of discovery.	E 041	Electric of Cokato about installation of Emergency Stop switches for the generators. We are waiting on detailed information to provide a quote, and a timeline for installation of new equipment. Documentation of Generator maintenance has begun through the TELS Maintenance app. Cokato Manor installed and began using the software program in July of 2021 to track and record maintenance activities. The TELS app requires that monthly testing of the generators is completed. The EVS Director or designee will complete the task each month in the TELS program. This program now provides a check and balance that the monthly check is being done. The EVS Director or designee will complete the task each month to ensure completion.	
F 000	INITIAL COMMENTS On 8/23/21 through 8/26/21, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was found to be NOT compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were found to be UNSUBSTANTIATED: H5412017C (MN54284) H5412018C (MN55634) H5412019C (MN57173) H5412020C (MN70553)	F 000		

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F 000	Continued From page 4 H5412021C (MN71363) 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 that substantial compliance with the regulations has been attained.	F 000		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview, the facility failed to provide assistance with activities of daily living (ADLs) to 1 of 1 residents (R42) reviewed who was dependent on facility staff for nail care. Findings include: R42's quarterly Minimum Data Set (MDS) dated 7/26/21, R42's cognition was moderately impaired and required physical assist with personal hygiene and bathing. R42 occasionally refused cares. R42's signed physician orders dated 7/13/21,	F 677	How corrective action will be accomplished for the resident found to have been affected by the deficient practice: R42's fingernails were immediately trimmed and cleaned on 8/26/21. How will the facility identify other residents having the potential to be affected by the same deficient practice: On 8/26/21 The Director of Nursing and Charge Nurse audited all resident's residing in Cokato Manor to ensure adequate nail care.	9/28/21

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F 677	Continued From page 5 indicated R42's diagnoses included dementia and diabetes mellitus. R42's care plan revised 7/30/21, indicated R42 required a nurse to trim her nails as needed. The care plan did not indicate R42 refused care. R42's progress note on 8/11/21, at 2:03 p.m. indicated R42 refused cares but after staff re-approached, cares were completed. Other progress notes reviewed 4/1/21 through 8/25/21, did not indicate R42 refused cares, including nail care. On 8/23/21, at 3:10 p.m. R42's nails on both hands were observed to be long with a dark brown unidentified substance under all nails on her right hand. On 8/24/21, at 9:20 a.m. R42 was in the day room reading a newspaper. Nails on both hands were long and the dark brown substance remained under all nails on her right hand. On 8/25/21, at 1:23 p.m. R42's family member (FM)-A stated R42 would prefer to have clean, short nails and she was never one to have long nails. On 8/25/21, at 2:21 p.m. registered nurse (RN)-A stated R42 required physical assistance with nail care which included trimming and cleaning underneath them. Due to R42's diabetes diagnosis, she required a licensed nurse to trim her nails. RN-A preferred to clean under R42's nails also due to risk of infection. RN-A inspected R42's nails and confirmed they were long and had a brown substance under all nails on her right hand. RN-A stated R42 sometimes refused	F 677	What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur: On 8/30/21 A treatment was added to all resident's Treatment Medication Administration Record (TMAR) for the nurse to check off that nail care is completed on bath day. On 9/1/21 The Director of Nursing educated and retrained the nursing assistants and nurses on Cokato Manor's bathing policy which includes nail care to be provided. How will the facility monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur: The Director of Nursing and designee audited nail care on bath days and will continue to audit on both shifts four times a week for two weeks, then monthly until compliance is achieved. The Director of Nursing will review results of the audits and monitoring with the Quality Assurance Committee.	

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F 677	Continued From page 6 cares, including nail care, that refusal of cares was not typically documented in R42's chart. RN-A stated R42's long nails and substance under her nails place her at risk for infection if she were to scratch herself. R42 was at risk for infection if she ate with her right hand and ingested some of the substance under her nails. On 8/26/21, at 10:37 a.m. director of nursing (DON) stated she expected nail care was done weekly on the resident's bath day and as needed. Nail care included trimming and cleaning underneath them. Unlicensed staff were able to clean under R42's nails. The risks of dirt under fingernails included infection and possible ingestion of the substance if she ate with her hands. Regarding long finger nails with dirt underneath them, DON stated, "It is not a good practice." The facility Bathing Policy revised 3/21, indicated nail care was part of the procedure on bath day: Provide nail care, if diabetic a licensed nurse needed to complete.	F 677		
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility	F 812		9/28/21

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F 812	Continued From page 7 gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure the ice scoop was stored in a manner to avoid cross contamination. This had the potential to affect all 53 residents that consumed ice from the kitchen. Findings include: On 8/23/21, at 12:25 p.m. a tour of the facilities kitchen was conducted with director of food services (DM)-B. DM-B opened the ice machine to examine the contents. Upon lifting the lid, there was a large metal ice scoop pressed into the ice in the ice machine. DM-B stated the scoop had a holder on the wall for proper storage when not being used and was not to be left in the ice machine. Further, DM-B stated all resident recieved fresh ice water made from this machine, at least daily. The facility's undated policy for Production, Storage, and Dispensing of Ice identified ice scoops would be stored outside of the ice dispenser in a closed, clean container or in the ice machine in the scoop storage container provided by the manufacturer.	F 812	How corrective action will be accomplished for the resident found to have been affected by the deficient practice: Ice scoop was immediately removed from ice machine and placed in the dishwasher to be sanitized and disinfected. How will the facility identify other residents having the potential to be affected by the same deficient practice: On 8/23/21 kitchen staff were immediately re-trained on where to store the ice scoop. What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur: Director of Food Services created Cokato Manor's Ice Chests and Machine Policy, which includes proper storage of ice scoop. Director of Food Services will have all kitchen staff review and sign off on the new policy. How will the facility monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur:	

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F 812	Continued From page 8	F 812	Director of Food Services or designee will audit scoop placement on different shifts for two weeks, then monthly until 100% compliance is achieved and will report back to the Quality Assurance Committee.	
F 880 SS=F	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; §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;	F 880		9/29/21

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F 880	Continued From page 9 (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. §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 perform proper hand hygiene and glove use for 1 of 2 residents (R17) observed for personal cares. In addition, the	F 880	How corrective action will be accomplished for the resident found to have been affected by the deficient practice:	

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F 880	Continued From page 10 facility failed to ensure eye protection was used by all facility staff while in resident care areas per the Centers for Disease Control (CDC) guidance. This had the potential to affect all 53 residents in the facility. Findings include: R17's admission Minimum Data Set (MDS) dated 6/11/21, indicated R17 had cognitive impairment and required extensive assistance with toileting, dressing, and personal hygiene. During observation on 8/25/21, at 7:28 a.m. nursing assistant (NA)-A was in R17's room. NA-A had removed covers and donned pants and placed shoes. R17 sat up with assistance. When R17 stood there was evidence R17 was incontinent of bowel while in bed. R17 transferred to the wheelchair, was moved to bathroom door, and stood to walk to the toilet. NA-A removed R17's soiled brief with ungloved hands. NA-A then washed their hands and put on clean gloves. NA-A washed and dried R17's peri area then pulled up R17's clean brief and pants. NA-A removed gloves and washed hands appropriately. NA-A assisted R17 to the wheelchair. With ungloved hands, NA-A removed the soiled linens from the bed and placed them into a bag. NA-A opened the resident door, pressed a button on the wall to indicate she was leaving the resident room and proceeded to the soiled utility room. NA-A placed the bag in the appropriate bin and then performed hand hygiene. During interview on 8/25/21, at 8:00 a.m. NA-A stated she had not realized R17 was incontinent of bowel until after she arose from the bed. Further, NA-A stated she should have worn	F 880	NA-A was immediately re-trained on Cokato Manor's policy on contact, standard, and transmission based precautions. How will the facility identify other residents having the potential to be affected by the same deficient practice: Charge nurses audited proper glove use and hand hygiene to ensure no other residents were affected by this deficient practice. What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur: Root cause analysis completed. Infection Preventionist will provide competency training on hand hygiene, glove use, standard, and contact precautions. Standard and Contact precautions will be added to Cokato Manor's Nursing Assistant orientation sheet for all new hires. How will the facility monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur: Director of Nursing or Designee will audit appropriate glove use and hand hygiene on different shifts everyday for one week, then will decrease the frequency based upon compliance. Audits will continue until 100% compliance is achieved. Director of Nursing will review audits and report back to the Quality Assurance Committee.	

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F 880	Continued From page 11 gloves while handling soiled linens. During interview on 8/26/21, at 10:30 a.m. director of nursing (DON) stated staff were expected to wear gloves when doing morning cares and removing soiled linens. The undated facility policy Standard Precautions, identified all body fluids were to be treated as suspect and standard precautions were to be used. Further, the policy directed staff to wear clean gloves when touching body fluids, feces or contaminated items and to remove gloves promptly and perform hand hygiene. On 8/23/21, at 12:45 p.m. during entrance conference with the director of nursing (DON) and administrator, it was reported there were no active cases of COVID-19 in the facility and there were no current staff or residents with signs or symptoms of COVID-19. On 8/25/21, at 10:31 a.m. activity staff (AS)-A was observed assisting residents in a group activity. AS-A had several resident interactions when she was within one foot of the residents. AS-A was noted to have glasses on with side shields that slide on to the bow of her glasses. On 8/25/21, at 1:04 p.m. housekeeper (HSK)-A was observed in a resident care area wearing glasses with side shields that slide on to the bow of her glasses. On 8/25/21, at 10: 43 a.m. AS-A confirmed her glasses were prescription and the side shields were removable and were safety shields. She stated she purchased them herself because using goggles over her prescription glasses	F 880	How corrective action will be accomplished for the resident found to have been affected by the deficient practice: On 8/25/21 Immediate auditing occurred of all staff's eye protection by the Director of Nursing, Infection Preventionist, and Charge Nurse. The staff in the building wearing the side shields were instructed to remove them and apply proper eye protection (Face shields, or goggles). All Cokato Manor employees were re-educated with instructions given to be sure they are wearing proper eye protection (Face shields, or goggles.) How will the facility identify other residents having the potential to be affected by the same deficient practice: All eyewear was replaced with correct eye protection immediately. What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur: Root cause analysis was completed. A Covid-19 Eye Protection Policy was created by the Infection Preventionist on 9/7/21, staff were then educated by the Infection Preventionist on the Eye Protection Policy. Infection Preventionist will provide competency training of staff that covers standard infection control practices, including transmission-based precautions, appropriate PPE use, and donning and doffing of PPE.	

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F 880	Continued From page 12 caused too much fogging. AS-A was not aware if the side shields were intended to be used for infection control. AS-A stated the DON gave her permission to use them. AS-A confirmed she had frequent, close contact with several residents each day. On 8/25/21, at 1:10 p.m. HSK-A confirmed she was wearing prescription glasses with safety shields that can slide on and off the bow of the glasses. She stated she got permission from the DON to use them when in resident care areas. HSK-A was aware there were goggles available for use, that would go over her glasses but did not indicate why she did not use them. HSK-A confirmed she has frequent, close contact interaction with several residents each day. On 8/25/21, at 2:13 p.m. the infection preventionist registered nurse (RN)-B expected eye protection was worn in all resident care areas and anytime interaction with residents was likely. Eye protection was most effective when it sat flush against the brow, extended below the eyes and to behind the eyes on the side of the face. She stated she ordered safety shields for staff to use with their prescription glasses and that the description on the shields did not specify if they were approved for infection control, only for safety. She has given direction to some staff to use them in place of the goggles that would fit over their glasses. IP stated the DON gave approval to use the safety shields and directed her to order them for staff. On 8/26/21, at 10:32 a.m. DON stated she expected staff to have goggles on or the other glasses that cover the sides of the eyes and to the brow. DON confirmed she had given the	F 880	How will the facility monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur: Director of Nursing or designee will conduct routine audits on different shifts four times a week for one week, then twice weekly for one week until compliance is achieved. Audits will continue until 100% compliance is met for staff, visitors, and residents. The Director of Nursing will review the audits and report back to the Quality Assurance Committee.	

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F 880	Continued From page 13 approval for staff with prescription glasses to use the safety shields, she was not aware they were not appropriate for use as infection control. The facility provided education, The Basics of Eye Protection for COVID-19 indicated regular eye glasses did not offer adequate eye protection because they leave gaps around the face and would not protect eyes from all splashes and sprays The CDC guidance Eye Safety nfection Control dated 7/29/21, "Safety glasses provide impact protection but do not provide the same level of splash or droplet protection as goggles and generally should not be used for infection control purposes.	F 880		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COKATO MANOR	**182 SUNSET AVENUE** **COKATO, MN 55321**

(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 FIRE SAFETY An annual Life Safety Code survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 08/25/2021. At the time of this survey, COKATO MANOR 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		09/30/2021

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. COKATO MANOR was constructed at five different times. A one-story building with a partial basement was constructed in 1964 and determined to be Type II (000). Additions were added in 1984, 1994, 1999, and 2006. The 1999 addition included a Physical Therapy Area, and a 2-story Assisted Living facility determined to be Type V (111) construction. The Assisted Living facility is separated from the Physical Therapy Area portion of the addition by a 2-hour fire-rated building separation wall.	K 000		

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K 000	Continued From page 2 Because the original building and additions are compatible construction types allowed for existing buildings of this height, the facility was surveyed as one building as allowed in the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care Occupancies. The facility is fully protected throughout by an automatic sprinkler system and has a fire alarm system with smoke detection in the corridors, spaces open to the corridors that is monitored for automatic fire department notification. Smoke detectors located in the resident room report to a Nurse Call system that is monitored at the Nurses Station. The facility has a capacity of 56 beds and had a census of 50 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidence by:	K 000		
K 111 SS=D	Building Rehabilitation CFR(s): NFPA 101 Building Rehabilitation Repair, Renovation, Modification, or Reconstruction Any building undergoing repair, renovation, modification, or reconstruction complies with both of the following: * Requirements of Chapter 18 and 19 * Requirements of the applicable Sections 43.3, 43.4, 43.5, and 43.6 18.1.1.4.3, 19.1.1.4.3, 43.1.2.1 Change of Use or Change of Occupancy Any building undergoing change of use or change	K 111		9/23/21

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K 111	Continued From page 3 of occupancy classification complies with the requirements of Section 43.7, unless permitted by 18.1.1.4.2 or 19.1.1.4.2 18.1.1.4.2 (4.6.7 and 4.6.11), 19.1.1.4.2 (4.6.7 and 4.6.11), 43.1.2.2 (43.7) Additions Any building undergoing an addition shall comply with the requirements of Section 43.8. If the building has a common wall with a nonconforming building, the common wall is a fire barrier having at least a 2-hour fire resistance rating constructed of materials as required for the addition. Communicating openings occur only in corridors and are protected by approved self-closing fire doors with at least a 1-1/2-hour fire resistance rating. Additions comply with the requirements of Section 43.8. 18.1.1.4.1 (4.6.7 and 4.6.11), 18.1.1.4.1.1 (8.3), 18.1.1.4.1.2, 18.1.1.4.1.3, 19.1.1.4.1 (4.6.7 and 4.6.11), 19.1.1.4.1.1 (8.3), 19.1.1.4.1.2, 19.1.1.4.1.3, 43.1.2.3(43.8) This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility had uncompleted repairs per NFPA 101 (2012 edition), Life Safety Code, sections 19.1.1.3.1, 4.6.7.1(3), 43.3.1.3 This deficient condition could have an isolated impact on the residents within the facility. Findings include: On 08/24/2021 between 11:00 AM to 4:00 PM, it was revealed during a walk-through of the facility that the Electrical Room had an opening of approximately 1 foot by 2 foot in the sidewall of the room. No information was provided as to plans or timing to repair the opening in the sidewall.	K 111	The hole in the wall of the Electrical room was repaired on 9/23/21 by the Environmental Services Director at Cokato Manor. The Environmental Services Director will see all maintenance and repair projects to completion.	

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K 111	Continued From page 4 This deficient condition was verified by the Maintenance Director.	K 111		
K 271 SS=D	Discharge from Exits CFR(s): NFPA 101 Discharge from Exits Exit discharge is arranged in accordance with 7.7, provides a level walking surface meeting the provisions of 7.1.7 with respect to changes in elevation and shall be maintained free of obstructions. Additionally, the exit discharge shall be a hard packed all-weather travel surface. 18.2.7, 19.2.7 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain exit discharge in accordance with the NFPA 101 (2012 edition), Life Safety Code, section 7.1.6.2. This deficient condition could have an isolated impact on the residents within the facility. Findings include: On 08/24/2021 between 11:00 AM to 4:00 PM, it was revealed during the walk-through of the facility that the Dining Room exit door had a vertical displacement greater than one-half inch to the exit discharge. This deficient condition was verified by the Maintenance Director.	K 271	Cokato Manor is currently working with two contractors to receive bids to replace the concrete outside the dining room door. It is the intent of the Administration to make the necessary repairs before November 1st, 2021. Correction/Replacement to the exit discharge will be completed fall of 2021. The Environmental Services Director will assure the work is completed.	11/1/21
K 293 SS=E	Exit Signage CFR(s): NFPA 101 Exit Signage 2012 EXISTING	K 293		9/1/21

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K 293	Continued From page 5 Exit and directional signs are displayed in accordance with 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1 (Indicate N/A in one-story existing occupancies with less than 30 occupants where the line of exit travel is obvious.) This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain exit signs in accordance with NFPA 101 (2012 edition), Life Safety Code, sections 19.2.10.1, 7.10.5.1, and 7.10.7.1. This deficient condition could have a patterned impact on the residents within the facility. Findings include: On 08/24/2021 between 11:00 AM to 4:00 PM, it was revealed during the walk-through of the facility that the exit signs located adjacent to Room 192 and Room 163 had non-functioning illumination elements. This deficient condition was verified by the Maintenance Director.	K 293	Lightbulbs in Exit signs located adjacent to Room 192 and Room 163 were replaced. Exit signs are scheduled to be checked for illumination on a routine schedule. This will be done on the 15th of each calendar month. The EVS Director will verify compliance through a form used by maintenance. The TELS maintenance program has a reminder set each month and must be checked off by the EVS Director.	
K 324 SS=D	Cooking Facilities CFR(s): NFPA 101 Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2	K 324		9/1/21

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K 324	Continued From page 6 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2 This REQUIREMENT is not met as evidenced by: Based on document review and staff interview, the facility failed to provide clear access to the commercial kitchen fire extinguishing equipment manual activation in accordance with the NFPA 101 (2012 edition), Life Safety Code, sections 19.3.2.5.1, and 9.2.3, and NFPA 96 (2011 edition), the Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, section 10.5.1. This deficient condition could have an isolated impact on the residents within the facility. Findings Include: On 08/25/2021 between 11:00 AM and 1:00 PM, it was revealed during a walk-through of the facility Kitchen that the manual pull-station for the Ansul fire suppression system was access obstructed.	K 324	Carts obstructing the manual pull-station for the Ansul Fire Suppression system were moved on 8/25/21. Red Caution tape has been affixed to the floor to create a "Keep Clear" area and maintain a clear access to the pull station. "Do Not Block" signage has also been placed on the wall to warn staff and assist in keeping the area clear. Repairs were completed by the Environmental Services Director and Maintenance staff on 9/1/21. Kitchen staff have also been made aware of the keep clear area. Routine inspections of this area will be completed monthly to ensure compliance.	

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K 324	Continued From page 7 This deficient condition was verified by the Maintenance Director.	K 324		
K 345 SS=E	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 observation and staff interview, the facility failed to maintain manual activation of the fire alarm system in accordance with NFPA 101 (2012 edition), Life Safety Code, sections 9.6.1.3 and 9.6.1.4, and NFPA 72 (2010 edition), National Fire Alarm, and Signal Code, section 17.14.5. This deficient condition could have a patterned impact on the residents within the facility. Findings include: On 08/24/2021 between 11:00 AM to 4:00 PM, it was revealed during the walk-through of the facility that the manual pull stations located in the Physical Therapy Area and the rear exit area of the Kitchen had obstructed access. This deficient condition was verified by the Maintenance Director.	K 345	On 8/25/21 Items obstructing the manual pull stations located in the Physical Therapy area and the rear exit are of the kitchen have been removed. Red caution tape has been affixed to the floor in both areas to create a "Keep Clear" area and maintain a clear access to the manual pull station. Do NOT Block signage has also been placed on the walls to warn staff and assist in keeping the area clear. Repairs were completed by the Environmental Services Director and Maintenance staff on 9/1/21. Kitchen and therapy staff have also been made aware of the keep clear area. Routine inspections of this area will be completed monthly to ensure compliance.	9/1/21
K 353 SS=F	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101	K 353		10/15/21

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K 353	Continued From page 8 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 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to inspect and maintain the sprinkler system in accordance with NFPA 101 (2012 edition), Life Safety Code, section 9.7.5 and NFPA 25 (2011 edition), Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, sections 4.1.2, 5.2.1.1.1, 5.2.1.1.2, 5.2.1.1.4, 5.2.1.2, and NFPA13 (2010 edition), Standard for the Installation of Sprinkler Systems, section 8.5.6.1. This deficient condition could have a widespread impact on the residents within the facility. Findings include: 1. On 08/24/2021 between 11:00 AM to 4:00 PM, it was revealed during the walk-through of the facility that items were stacked too high, less than	K 353	Finding #1: All items in rooms 116 and 145 were organized and moved to provide the proper clearance for the sprinkler heads on 9/2/21. A new blue line was added to the wall 18 inches below the sprinkler head. Signage was posted in these areas to warn staff not to stack items above the blue line. Environmental Services staff will assist in maintaining sufficient clearance on a daily basis. Finding #2: All sprinkler heads in the kitchen and dishwashing room were replaced by Brother's Fire & Security on 9/14/21. Material has been ordered by Brother's Fire & Security to replace the sprinkler	

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K 353	Continued From page 9 18 inches, from sprinkler heads in the closets of Room 116 and Room 145. 2. On 08/24/2021 between 11:00 AM to 4:00 PM, it was revealed during the walk-through of the facility that oxidized sprinkler heads were observed in the Kitchen Freezer, Kitchen ceiling - right of the griddle, and Kitchen Housekeeping closet. 3. On 08/24/2021, between 11:00 AM to 4:00 PM, it was revealed during the walk-through of the facility that a paint-covered sprinkler head was observed in Room 179. 4. On 08/24/2021, between 11:00 AM to 4:00 PM, it was revealed during the walk-through of the facility that a sprinkler head located in the Dining Room, just to the right of the serving window, was covered in some form of oily substance. 5. On 08/24/2021 between 11:00 AM to 4:00 PM, it was revealed during the walk-through of the facility that the fire sprinkler riser located in the Housekeeping and Boiler Room was access obstructed This deficient condition was verified by the Maintenance Director.	K 353	heads in the 2 walk-on freezers and the walk-in refrigerator. Finding #3: Sprinkler head in room 179 has been replaced by Brother's Fire & Security on 9/14. Finding #4: The Sprinkler head located in the dining room to the right of the serving counter was replaced b Brother's Fire & Security on 9/14/21. Finding #5: All items removed from area in front of sprinkler riser and electrical panel to provide clear access. Red tape has been placed in this area to mark a "Keep Area Clear" space. Signage has been placed in this area to warn staff of the need to keep the area clear with open access at all times. The EVS Director and maintenance team will audit this area on a monthly basis.	
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		9/1/21

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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 maintain the installation of portable fire extinguishers in accordance with NFPA 101 (2012 edition), Life Safety Code, sections 19.3.5.12 and 9.7.4.1, and NFPA 10 (2010 edition), Standard for Portable Fire Extinguishers, section 6.1.3.3, 6.1.3.4, 6.1.3.8, 7.2.2. This deficient condition could have a widespread impact on the residents within the facility. Findings include: 1. On 08/24/2021, between 11:00 AM to 4:00 PM, it was revealed during the walk-through of the facility that in the Data Room, there was obstructed access to the fire extinguisher by a clip lamp attached to the fire extinguisher and power cord wrapped around the handle. 2. On 08/24/2021, between 11:00 AM to 4:00 PM, it was revealed during the walk-through of the facility that there was obstructed access to the fire extinguisher located adjacent to Room 135. 3. On 08/24/2021, between 11:00 AM to 4:00 PM, it was revealed during the walk-through of the facility that there was obstructed access to the fire extinguisher located in the rear Exit Area of the Kitchen. This deficient condition was verified by the Maintenance Director.	K 355	Finding #1: The clip lamp and cord were removed immediately on 8/25/21. Staff who work in this area were informed of the issue and will assist in maintaining free access to the fire extinguisher at all times. Finding #2: The small table which was partially blocking access to the fire extinguisher was removed on 8/25/21. Signage has been placed in this area to warn all staff of the need to keep the area clear with open access at all times. The EVS Director and maintenance team will monitor the area monthly. Finding #3: Carts blocking the fire extinguisher were removed on 8/25/21. Red caution tape has been affixed to the floor to create a keep clear area and maintain a clear access to the extinguisher. Do Not Block signage has been placed on the wall to warn staff and keep area clear. Repairs were completed by the EVS Director and Maintenance staff on 9/1/21. Kitchen staff made aware of the clear area. Routine inspections of this area to ensure compliance will be monthly.	
K 374 SS=F	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101	K 374		8/30/21

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K 374	Continued From page 11 Subdivision of Building Spaces - Smoke Barrier Doors 2012 EXISTING Doors in smoke barriers are 1-3/4-inch thick solid bonded wood-core doors or of construction that resists fire for 20 minutes. Nonrated protective plates of unlimited height are permitted. Doors are permitted to have fixed fire window assemblies per 8.5. Doors are self-closing or automatic-closing, do not require latching, and are not required to swing in the direction of egress travel. Door opening provides a minimum clear width of 32 inches for swinging or horizontal doors. 19.3.7.6, 19.3.7.8, 19.3.7.9 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain smoke barrier doors per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.7.6 and 8.5.4.1. This deficient condition could have a widespread impact on the residents within the facility. Findings include: On 08/24/2021 between 11:00 AM to 4:00 PM, it was revealed during the walk-through of the facility that upon testing, the following smoke barrier doors did not close to resist the passage of smoke. 1. Smoke Barrier doors - adjacent to Room 139 2. Smoke Barrier Doors - Dining room 3. Smoke Barrier doors - adjacent to Room 118 This deficient condition was verified by the Maintenance Director.	K 374	Finding #1: Smoke Barrier door adjacent to room 139,smoke barrier door in Dining room, and smoke barrier door adjacent to room 118 were adjusted on 8/30/21 by Russel's Lock & Key of Buffalo, MN. Russel's adjusted closing hardware and hinges to allow or correct and complete functions of the doors. Fire/Smoke doors will be checked on a monthly schedule by the maintenance team. The TELS maintenance app used at Cokato Manor will notify EVS Director and send a reminder to complete a monthly inspection.	
K 511 SS=D	Utilities - Gas and Electric	K 511		9/29/21

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	245412	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**08/25/2021**

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K 511	Continued From page 12 CFR(s): NFPA 101 Utilities - Gas and Electric Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NFPA 70, National Electric Code. Existing installations can continue in service provided no hazard to life. 18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain accessibility to electrical panels in accordance with NFPA 101 (2012 edition), Life Safety Code, sections 19.5.1.1 and 9.1.2, and NFPA 70 (2011 edition), National Electrical Code, section 110.26. This deficient condition could have an isolated impact on the residents within the facility. Findings include: On 08/24/2021 between 11:00 AM to 4:00 PM, it was revealed during the walk-through of the facility that the electrical panels in the Housekeeping and Boiler Room were obstructed. This deficient condition was verified by the Maintenance Director.	K 511	All items blocking access to the electrical panels identified in the report were removed from the area on 8/26/21. Red tape has been placed on the floor in front of the electrical panels to maintain a "Keep Clear" area. Signage has been posted in this area to warn staff and help maintain assess to the electrical panels. Improvements and corrections were completed by the EVS Director on 8/26/21	
K 712 SS=F	Fire Drills CFR(s): NFPA 101 Fire Drills	K 712		9/28/21

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K 712	Continued From page 13 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: Based on document review and staff interview, the facility failed to randomly conduct fire drills in accordance with the NFPA 101 (2012 edition), Life Safety Code, sections 19.7.1.6, 4.7.2, and 4.7.6. This deficient condition could have a widespread impact on the residents within the facility. Findings include: On 08/24/2021 between 11:00 AM to 4:00 PM, it was revealed that no documentation was presented for review to confirm that fire drills were conducted for the 1st shift during the 3rd quarter, the 2nd shift during the 2nd and 4th quarters, and the 3rd shift during the 2nd and 3rd quarters of the calendar year. This deficient condition was verified by the Maintenance Director.	K 712	A fire drill is scheduled has been posted in the office of the EVS Director. The fire drill was successful and completed on 9/28/21. The TELS maintenance app is set up with a task each month to complete a fire drill. Paperwork (sign in sheet) will be uploaded to the TELS system to complete this task each month. The EVS will be responsible to complete each month for each shift.	
K 761 SS=F	Maintenance, Inspection & Testing - Doors CFR(s): NFPA 101 Maintenance, Inspection & Testing - Doors Fire doors assemblies are inspected and tested	K 761		10/1/21

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K 761	Continued From page 14 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) 5.2, 5.2.3 (2010 NFPA 80) This REQUIREMENT is not met as evidenced by: Based on document review and staff interview, the facility failed to provide documentation for the inspection and testing of fire-rated door assemblies in accordance with NFPA 101 (2012 edition), Life Safety Code, sections 19.7.3.1, 19.7.6, 4.6.12, and 8.3.3.1, and NFPA 80 (2010 edition), Standard for Fire Doors and Other Opening Protectives, section 5.2.1. This deficient condition could have a widespread impact on the residents within the facility. Findings Include: On 08/24/2021 between 11:00 AM to 4:00 PM, it was revealed that no documentation was presented for review to confirm that the annual fire-rated door assembly inspections had been completed since 01/20/2020. This deficient condition was verified by the Maintenance Director.	K 761	Fire door inspections are scheduled for the first week in October, 2021. The TELS maintenance app is set up with a fire door inspection task which must be completed each calendar year in October. The EVS Director must complete the task in the TELS app each calendar year and will ensure the doors are being checked annually.	
K 918 SS=F	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101	K 918		9/30/21

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K 918	Continued From page 15 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This REQUIREMENT is not met as evidenced by: Based on observation, documents review, and staff interview, the facility failed to maintain the	K 918	Finding #1: The battery on generator #1 was	

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K 918	Continued From page 16 emergency essential electrical system per NFPA 99 (2012 edition), Health Care Facilities Code, section 6.6.4.1, 6.4.4.2, and 6.4.1.1.13, and NFPA 110 (2010), Standard for Emergency and Standby Power Systems, sections 5.6.4.5.1 and 8.3.4.1. This deficient condition could have a widespread impact on the residents within the facility. Findings include: 1. On 08/24/2021, between 11:00 AM to 4:00 PM, it was revealed during a facility walk-through that the current installation date of the batteries for the emergency power supply system was dated as follows: Generator 1 = 2018 / Generator 2 = 2016. 2. On 08/24/2021, between 11:00 AM to 4:00 PM, it was revealed during a facility walk-through that no emergency shutdown switched could be located in the building for the two roof-top generators. 3. On 08/24/2021 between 11:00 AM to 4:00 PM, it was revealed during documentation review that formal record keeping of monthly generator testing had not been completed since July 2020. This deficient condition was verified by the Maintenance Director.	K 918	replaced on 8/27/21. The battery on generator #2 was replaced on 9/29/21. Finding #2: At this time Environmental Services Director has spoken to Mike Brandel Electric of Cokato about installation of Emergency Stop Switches for the generators. We are waiting for detailed information from Brandel Electric to provide a quote, and a timeline for installation of new equipment. Finding #3: Documentation of the Generator maintenance has begun through the TELS Maintenance App. Cokato Manor installed and began using the software program as of July 2021 to track and record maintenance activities. The TELS app requires that monthly testing of the generators is completed. The EVS Director or designee will complete the task monthly. The program provides a check and balance that the monthly check is being done. The EVS Director will be the responsible person to ensure completion is completed each month.	
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	K 920		9/24/21

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K 920	Continued From page 17 (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 implement power strips and extension cords in accordance with NFPA 99 (2012 edition), Health Care Facilities Code, sections 10.2.3.6 and 10.2.4, and NFPA 70 (2011 edition), National Electrical Code, sections 400-8 and 590.3(D). This deficient condition could have a widespread impact on the residents within the facility. Findings include: 1. On 08/24/2021 between 11:00 AM to 4:00 PM, it was revealed during a facility walk-through that an extension cord was being used in conjunction with a power-strip in the Housekeeping and Boiler Room.	K 920	Finding #1: The extension cord and power strip identified in the inspection were removed from the housekeeping/boiler room on 8/25/21. New outlets were installed by Brandel Electric on 9/1/21 to provide sufficient power supply. Housekeeping and maintenance staff were trained on 8/26/21 of the danger of using extension cords and surge protectors together. Finding #2: 9/14/21 maintenance removed daisy chained power strips. Appliances in the staff break room were connected to a wall outlet. Additional wall	

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K 920	Continued From page 18 2. On 08/24/2021 between 11:00 AM to 4:00 PM, it was revealed during a facility walk-through that daisy-chained power-strips were found in the following locations: Activities Director Office, Physical Therapy Area, Staff Break Room, Room 106, Room 104, and Room 103. 3. On 08/24/2021 between 11:00 AM to 4:00 PM, it was revealed during facility walk-through that heating appliances were plugged into power-strips in the following locations: Room 112, Room 157, Staff Break Room, and the Kitchen food prep area. This deficient condition was verified by the Maintenance Director.	K 920	units were installed on 9/1/21. Daisy-chained connection in the Physical Therapy are was removed on 8/26/21. The daisy-chained connection in the Activity Directors office was removed on 9/24/21 and was replaced with a surge protector that was properly sized and connected. Daisy-chained power strip was removed was removed on 9/24/21 and all items were re-connected properly to a direct power supply. On 9/24/21 the EVS director removed the extra power strip in room 103,104, and 106. All items were re-connected properly to a direct power supply. Finding #3: Power strips were removed in rooms 112,157, staff break room, and the kitchen food prep area. All were connected to a direct power supply. The EVS Director will monitor these appliances connections monthly and as needed. A task was created in the TELS maintenance program set up to remind to complete the task.	