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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 3UDZ

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00353

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245238**
2.STATE VENDOR OR MEDICAID NO.
(L2) **739745302**

3. NAME AND ADDRESS OF FACILITY
(L3) **MAHNOMEN HEALTH CENTER**
(L4) **414 WEST JEFFERSON AVENUE, PO BOX 396**
(L5) **MAHNOMEN, MN** (L6) **56557**

4. TYPE OF ACTION: **7** (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 **07/20/2021** (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 **32** (L18)
13.Total Certified Beds **32** (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
	32			
(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 :
Jennifer Bahr, Unit Supervisor 07/27/2021 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Joanne Simon, Enforcement Specialist 07/27/2021 (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
08/04/1981
(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
07/13/2021
(L33)

DETERMINATION APPROVAL

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
July 27, 2021

CMS Certification Number (CCN): 245238

Administrator
Mahnomen Health Center
414 West Jefferson Avenue, Po Box 396
Mahnomen, MN 56557

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 July 2, 2021 the above facility is certified for:

32 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 32 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
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

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
July 27, 2021

Administrator
Mahnomen Health Center
414 West Jefferson Avenue, Po Box 396
Mahnomen, MN 56557

RE: CCN: 245238
Cycle Start Date: May 26, 2021

Dear Administrator:

On June 16, 2021, we notified you a remedy was imposed. On July 20, 2021 the Minnesota Departments of Health and Public Safety completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of July 2, 2021.

As authorized by CMS the remedy of:

- Discretionary denial of payment for new Medicare and Medicaid admissions effective July 1, 2021 be discontinued as of July 2, 2021. (42 CFR 488.417 (b))

However, as we notified you in our letter of June 16, 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 is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from May 26, 2021. 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
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

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 3UDZ

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(L4) **414 WEST JEFFERSON AVENUE, PO BOX 396**
(L5) **MAHNOMEN, MN** (L6) **56557**

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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 **05/26/2021** (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

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Compliance Based On:
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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)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	32			
(L37)	(L38)	(L39)	(L42)	(L43)

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1861 (e) (1) or 1861 (j) (1): (L15)

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17. SURVEYOR SIGNATURE Date :
Amy Charais, HFE - NE II 07/02/2021 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Joanne Simon, Enforcement Specialist 07/12/2021 (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
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3. Both of the Above :

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08/04/1981
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

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(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 Submitted
June 16, 2021

Administrator
Mahnomen Health Center
414 West Jefferson Avenue, Po Box 396
Mahnomen, MN 56557

RE: CCN: 245238
Cycle Start Date: May 26, 2021

Dear Administrator:

On May 26, 2021, survey was completed at your facility by the Minnesota Department 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.

Your facility was not in substantial compliance with the participation requirements and the conditions in your facility constituted immediate jeopardy to resident health or safety. This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted immediate jeopardy (Level J) whereby corrections were required. The Statement of Deficiencies (CMS-2567) is being electronically delivered.

REMOVAL OF IMMEDIATE JEOPARDY

On May 26, 2021, the situation of immediate jeopardy to potential health and safety cited at F886 was removed. However, continued non-compliance remains at the lower scope and severity of D.

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 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 July 1, 2021.

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

This Department is also recommending that CMS impose a 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.

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective July 1, 2021, (42 CFR 488.417 (b)), (42 CFR 488.417 (b)). They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective July 1, 2021, (42 CFR 488.417 (b)).

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.

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than $11,160; 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.

Therefore, your agency is prohibited from offering or conducting a Nurse Assistant Training/Competency Evaluation Programs or Competency Evaluation Programs for two years effective May 26, 2021. This prohibition is not subject to appeal. Under Public Law 105-15 (H.R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

ELECTRONIC PLAN OF CORRECTION (ePOC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable plan of correction (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, Licensing and Certification Program 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 November 26, 2021 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 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 DENIAL OF PAYMENT

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.

APPEAL RIGHTS NURSE AIDE TRAINING PROHIBITION

Pursuant to the Federal regulations at 42 CFR Sections 498.3(b)(13)(2) and 498.3(b)(15), a finding of substandard quality of care that leads to the loss of approval by a Skilled Nursing Facility (SNF) of its NATCEP is an initial determination. In accordance with 42 CFR part 489 a provider dissatisfied with an initial determination is entitled to an appeal. If you disagree with the findings of substandard quality of care which resulted in the conduct of an extended survey and the subsequent loss of approval to conduct or be a site for a NATCEP, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Department Appeals Board. Procedures governing this process are set out in Federal regulations at 42 CFR Section 498.40, et. Seq.

A written request for a hearing must be filed no later than 60 days from the date of receipt of this letter. Such a request may be made to the Centers for Medicare and Medicaid Services (formerly Health Care Financing Administration) at 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

A request for a hearing should identify the specific issues and the findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. You do not need to submit records or other documents with your hearing request. The Departmental Appeals Board (DAB) will issue instructions regarding the proper submittal of documents for the hearing. The DAB will also set the location for the hearing, which is likely to be in Minnesota or in Chicago, Illinois. You may be represented by counsel at a hearing at your own expense.

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 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
	245238	A. BUILDING _____ B. WING _____	C 05/26/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAHNOMEN HEALTH CENTER	**414 WEST JEFFERSON AVENUE, PO BOX 396 MAHNOMEN, MN 56557**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS	F 000		

On 5/23/21, through 5/26/21, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted during the survey. Your facility was found to be NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities.

The survey resulted in an Immediate Jeopardy (IJ) to resident safety. The IJ began on 3/24/21, when a staff member tested positive for COVID-19 and the facility failed to ensure all active staff were immediately tested for COVID-19 prior to working; along with following ongoing outbreak testing to ensure no more active cases were circulating within the facility. The director of nursing (DON), administrator and registered nurse (RN)-A were notified of the IJ on 5/24/21, at 6:34 p.m. The IJ was removed on 5/26/21, at 5:25 p.m. when the facility implemented actions to reduce/prevent the spread of COVID-19 within the facility.

The complaint H5238016C (MN54457) was found to be substantiated; however, no deficiencies were cited due to actions implemented by the facility prior to the survey.

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		06/25/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245238	A. BUILDING _____ B. WING _____	C 05/26/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAHNOMEN HEALTH CENTER	**414 WEST JEFFERSON AVENUE, PO BOX 396 MAHNOMEN, MN 56557**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	Continued From page 1 onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.	F 000		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to report allegations of abuse to the	F 609	F609 06/23/2021 all nurses were entered into	7/2/21

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MAHNOMEN HEALTH CENTER	414 WEST JEFFERSON AVENUE, PO BOX 396 MAHNOMEN, MN 56557

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F 609	Continued From page 2 State Agency (SA) for 2 of 3 residents (R24, R5) reviewed for abuse. Findings include: R24's admission Minimum Data Set (MDS) dated 4/14/21, identified R24 had moderate cognitive impairment. R24 had no behaviors and required supervision for assistance for activities of daily living (ADL)'s. R24's care plan dated 4/19/21, indicated R24 had delusional thoughts that almost all men she came across had affectionate and sexual feelings toward her. The care plan directed staff to re-orient resident about delusions and educate staff about R24's behaviors and be mindful how they acted toward her. The care plan further identified impaired decision making related to a cerebral aneurysm. R24's Resident Progress Note dated 4/26/21, indicated staff reported R24 being sexually inappropriate with a male resident. R24 reported to be "stroking the male resident's inner thigh with her cane." The male resident was "obviously upset and uncomfortable" with the encounter. R24 was educated about her behavior. During interview on 5/25/21, at 11:06 a.m. RN-A stated R24 thought all the men were in love with her. RN-A was aware of the incident in which R24 had been inappropriate with another resident. The incident was discussed with the interdisciplinary team. RN-A did not believe the incident had been reported to the SA and was not sure why. RN-C, also present during the interview stated the incident should have been reported to the SA.	F 609	the OHFC database to ensure access to reporting. OHFC access was added to the orientation checklist to ensure this is completed upon hire. All nurses will be educated on how to make an OHFC report by 07/02/2021 by RN nurse managers. 06/23/2021 Informal education was provided to all staff in regards to OHFC reporting through When I Work as well as in the communication book. Formal education will be provided to all staff by 07/02/2021 on OHFC reporting per facility policy which includes the definition; Immediately: No later than 2 hours after forming the suspicion, if events that cause the suspicion involve abuse or result in serious bodily injury, or no later than 24 hours if events that cause the suspicion do not involve abuse and do not result in serious bodily injury. Random monthly audits will be conducted with OHFC type scenarios by RN staff to ensure staff are competent with what to report, how to report and when to report. QAPI manager or designee will audit monthly past OHFC reports to ensure proper reporting and timely reporting. This will be reported monthly through QAPI. 06/24/2021 Vulnerable Adult policy, protocol and procedure reviewed and updated. A reporting template for staff was created to assist with reporting in a timely manner. Formal education on these changes and reporting tools will be	

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F 609	Continued From page 3 On 5/25/21, at 11:25 a.m. the director of nursing (DON) stated she was not aware of the incident when R24 had been inappropriate with another resident. The DON stated she should have been notified. Further, the DON stated reporting to the SA depended on if staff had handled the situation or not. During a subsequent interview on 5/26/21, at 2:07 p.m. the DON stated she had talked to the staff about the incident with R24. The other resident involved was not harmed so she did not feel the incident needed to be reported. The DON stated she felt the staff acted appropriately by re-educating R24. R5's quarterly MDS dated 3/2/21, identified R5 had intact cognition and required extensive assistance with all ADL's . R5 displayed no behaviors. R5's care plan dated 5/23/21, identified R5 as a vulnerable adult and indicated R5 was to be free from sexual, physical and emotional abuse. The care plan directed staff to report any signs or symptoms of abuse. During interview on 5/23/21, at 4:19 p.m. R5 stated a nursing assistant (NA) had been fired a few months ago and stated, "he was mean." R5 stated he "got in her face" and said she was supposed to say please and thank you. Further, the NA had the idea she was supposed to do things the NA's way. During interview on 5/26/21, at 10:22 a.m. registered nurse (RN)-B stated there was an issue with a "traveler" staff member. The incident	F 609	provided to all staff by 07/02/2021. This will be monitored monthly by Director of Nursing or Designee and reported monthly through QAPI.	

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F 609	Continued From page 4 happened a few months prior and stated the NA was "very scary." The NA grabbed R5's call light and told her she had to go to bed and read, which was not her usual routine. RN-B stated she found out about it after the fact and stated staff reported to her that R5 was afraid of him. An untitled document dated 1/17/21, indicated licensed practical nurse (LPN)-B had spoken to R5 about an incident that happened on the night shift on 1/15/21. R5 reported to LPN-B the NA was getting her ready for bed and he refused to let her sit on the edge of the bed to read her book. R5 stated the NA "got in my face, about a half inch away pointing his finger at me and told me, you don't talk to me like that, you never say please and thank you, you can sit up in bed and read so I don't have to come back in here, I aint coming back in here, I'm not doing this all night." R5 informed LPN-B that the NA frequently neglected cares for her and with tears in her eyes told LPN-B she had been too scared to use her call light and ask for assistance the past few nights. During interview on 5/26/21, at 2:07 p.m. the DON stated the incident that involved R5 was not reported to the state agency as no harm had come to R5. The facility policy Reporting Procedure for Vulnerable Adult dated 11/20, directed staff to report allegations to the SA immediately, no later than two hours, if the events that cause the suspicion involve abuse.	F 609		
F 610 SS=D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4)	F 610		7/2/21

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F 610	Continued From page 5 §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to thoroughly investigate allegations of abuse for 2 of 3 residents (R24, R5) reviewed for abuse. Findings include: R24's admission Minimum Data Set (MDS) dated 4/14/21, identified R24 had moderate cognitive impairment. R24 had no behaviors and required supervision for assistance for activities of daily living (ADL)'s. R24's care plan dated 4/19/21, indicated R24 had delusional thoughts that almost all men she came across had affectionate and sexual feelings toward her. The care plan directed staff to re-orient resident about delusions and educate staff about R24's behaviors and be mindful how	F 610	F610 06/24/2021 Vulnerable Adult policy, protocol and procedure reviewed and updated. 07/01/2021 the investigative process was added to the OHFC reporting tool for nurses. DON or designee will be responsible for all investigations. Investigation process will include conducting observations of the alleged victim, including identification of any injuries, location situation occurred, interactions between staff and residents and interactions between residents. Interviews will be conducted with the victim, perpetrator, witnesses and other personnel as appropriate. Record reviews will be conducted related to the allegations. Formal education on these changes and reporting/investigative tools	

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F 610	Continued From page 6 they acted toward her. The care plan further identified impaired decision making related to a cerebral aneurysm. R24's Resident Progress Note dated 4/26/21, indicated staff reported R24 being sexually inappropriate with a male resident. R24 reported to be "stroking the male resident's inner thigh with her cane." The male resident was "obviously upset and uncomfortable" with the encounter. R24 was educated about her behavior. During interview on 5/25/21, at 11:06 a.m. RN-A stated R24 thought all the men were in love with her. RN-A stated she was aware of the incident where R24 was inappropriate with another resident and stated it was discussed with the interdisciplinary team (IDT). The Interdisciplinary Meeting Minutes dated 4/22/21, identified R24 was "continuing sexual behaviors toward males." There was no further documentation provided to indicate a thorough investigation had been completed at that time, or after the incident involving the male resident occurred four days later, including observation/ interviews with staff and other residents. On 5/25/21, at 11:25 a.m. the director of nursing (DON) stated she was not aware of the incident where R24 was inappropriate with another resident. The DON stated she should have been notified. Further, she was surprised R24 would have behaved that way, even though the behavior had been discussed with the IDT. On 5/26/21, at 9:39 a.m. RN-A stated the DON had gone back and looked into incident with R24 the previous day. RN-A stated the male resident	F 610	will be provided to all scheduled staff by 07/02/2021. QAPI manager or designee will audit monthly past OHFC reports to ensure proper investigation and timely reporting was completed. This will be monitored monthly by Director of Nursing or Designee and reported monthly through QAPI.	

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F 610	Continued From page 7	F 610		

involved was fine and did not display any behaviors.

R5's quarterly MDS dated 3/2/21, identified R5 had intact cognition and required extensive assistance with all ADL's . R5 displayed no behaviors.

R5's care plan dated 5/23/21, identified R5 as a vulnerable adult and indicated R5 was to be free from sexual, physical and emotional abuse. The care plan directed staff to report any signs or symptoms of abuse.

During interview on 5/23/21, at 4:19 p.m. R5 stated a nursing assistant (NA) had been fired a few months ago and stated, "he was mean." R5 stated he "got in her face" and said she was supposed to say please and thank you. Further, the NA had the idea she was supposed to do things the NA's way.

During interview on 5/26/21, at 10:22 a.m. registered nurse (RN)-B stated there was an issue with a "traveler" staff member. The incident happened a few months prior and stated the NA was "very scary." The NA grabbed R5's call light and told her she had to go to bed and read, which was not her usual routine. RN-B stated she found out about it after the fact and stated staff reported to her that R5 was afraid of him.

An untitled document dated 1/17/21, indicated licensed practical nurse (LPN)-B had spoken to R5 about an incident that happened on the night shift on 1/15/21. R5 reported to LPN-B the NA was getting her ready for bed and he refused to let her sit on the edge of the bed to read her

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F 610	Continued From page 8 book. R5 stated the NA "got in my face, about a half inch away pointing his finger at me and told me, you don't talk to me like that, you never say please and thank you, you can sit up in bed and read so I don't have to come back in here, I aint coming back in here, I'm not doing this all night." R5 informed LPN-B that the NA frequently neglected cares for her and with tears in her eyes told LPN-B she had been too scared to use her call light and ask for assistance the past few nights. The facility was unable to provide evidence an investigation was conducted to include observation/ interviews with staff and other residents along with document review. During a subsequent interview on 5/26/21, at 2:07 p.m. the DON stated she had talked to the staff about the incident with R24. The DON stated she felt the staff acted appropriately by re-educating R24. The DON confirmed a thorough investigation into the incidents was not completed. The facility policy Reporting Procedure for Vulnerable Adult dated 11/20, indicated a complete record of the event, investigation and any follow up actions taken would be kept on file by the administration.	F 610		
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	F 880		7/2/21

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F 880	Continued From page 9 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; (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.	F 880		

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F 880	Continued From page 10 (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 interview and document review the facility failed to stop routine indoor visitation according to Centers for Disease Control (CDC) guidance when a facility was in COVID-19 outbreak status. This practice had the potential to affect all 26 residents residing in the facility along with staff and visitors. Findings include: The CDC guidance Updated Healthcare Infection Prevention and Control Recommendations in Response to COVID-19 Vaccination dated 4/27/21, identified facilities in outbreak status should follow guidance from state and local health authorities and Centers for Medicare and Medicaid on when	F 880	06/24/2021: An informal education was sent to all staff via When I Work and communication book regarding outbreak status and restricted visitation. 06/24/2021 visitation status was added to the IDT agenda. 06/28/2021: " Formal education was started for all staff regarding visitation during outbreak and routine status and infection prevention core principles and will be completed on all staff by 07/02/2021. " Resident assessments completed to determine need for compassionate care visits and care plans updated. " Education provided to residents during a resident council meeting and	

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F 880	Continued From page 11 visitation should be paused The CMS Quality, Safety and Oversight (QSO) memo 20-39 revised 4/27/21, identified when a new facility COVID- 19 outbreak (ie. a new COVID-19 case among residents or staff) was identified the facility should immediately suspend all visitation, with the exception of compassionate care visits. Visitation could resume if the first round of outbreak testing revealed no additional COVID-19 cases in other areas (e.g., units) of the facility, then visitation could resume for residents in areas/units with no COVID-19 cases. However, the facility should suspend visitation on the affected unit until the facility meets the criteria to discontinue outbreak testing. If the first round of outbreak testing reveals no additional COVID-19 cases in other areas (e.g., units) of the facility, then visitation could resume for residents in areas/units with no COVID-19 cases. On 5/24/21, at 10:26 a.m. the director of nursing (DON) stated on 5/18/21, two staff members had tested positive for COVID-19. The facility's COVID-19 testing results and staff schedules from 5/16/21 through 5/25/21, identified the following: - On 5/17/21, testing was completed for 5 staff members which resulted in 2 newly identified positive COVID-19 cases and the facility was identified to be in outbreak status. The corresponding schedule identified 20 staff members worked in the facility without timely testing prior to the newly identified COVID-19 cases. The facility then tested 13 staff members, however failed to require all active staff to immediately report for a new round of COVID-19	F 880	face to face regarding visitation and possible restrictions " Resident representatives were educated regarding visitation and possible restrictions via email and letters for those without email. " Visitation policy revised and updated to meet CMS requirements. This will be updated PRN by DON or designee. " Audit sheets were developed to ensure staff are educated and corrective action plan is being followed. These will be reviewed by the DON at least weekly and PRN (based on facility status) and will be brought through QAPI monthly. " Competency tests were developed and completed for scheduled staff and emailed or mailed to those who are PRN. 06/29/2021 " Visitation education was added to the orientation checklist to ensure new staff are aware of visitation requirements. " Completed competency tests on scheduled staff and will continue until all staff are competencied.	

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F 880	Continued From page 12	F 880		

outbreak testing. The corresponding schedule identified 35 of the remaining 37 scheduled staff members did not receive outbreak testing timely and worked in the facility without the required testing.

- From 5/23/21 to 5/25/21, the facility had 40 staff members scheduled to work who required outbreak COVID-19 testing. Testing was completed for 39 staff members. No new positive cases were identified; however, the facility remained in outbreak status as all staff had not received testing and the last case was identified less than 14 days prior. The corresponding schedule identified 18 of 40 staff members did not receive outbreak testing timely and worked in the facility without the required testing.

The facility's Visitor Screening Logs dated May 2021, indicated visitors continued to enter the facility while the facility was in continued outbreak status, as all staff were not tested to discontinue outbreak testing.

5/18/21, Six visitors entered the facility.
5/20/20, Four visitors entered the facility.
5/21/20, Seven visitors entered the facility.
5/22/21, Eleven visitors entered the facility.
5/23/21, Sixteen visitors entered the facility.
5/24/21, Eleven visitors entered the facility.
5/25/21, Twelve visitors entered the facility.
5/26/21, Seven visitors entered the facility.

During interview on 5/26/21, at 2:23 p.m. registered nurse (RN)-D stated she was in charge of the infection control for the whole building. RN-D stated during an outbreak visitors were supposed to be limited to just the essential caregivers. RN-D stated she did not work in the

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F 880	Continued From page 13 long term care portion of the facility every day and stated the essential caregiver was determined by the unit managers (RN-A and RN-C). Further, the facility was using the terms essential caregiver and compassionate care interchangeably. At 2:30 p.m. RN-C stated during an outbreak status the facility tried to restrict the visitors to what she thought was essential or compassionate caregivers. They did restrict visitors initially and was unsure when it was opened back up. Further, the facility did not have a resident assessment to determine criteria for a resident need for compassionate caregiver. The facility just asked each resident who was most capable and who was essential to them. The facility did not have a list of residents who required a compassionate care visitor.	F 880		
F 886 SS=J	COVID-19 Testing-Residents & Staff CFR(s): 483.80 (h)(1)-(6) §483.80 (h) COVID-19 Testing. The LTC facility must test residents and facility staff, including individuals providing services under arrangement and volunteers, for COVID-19. At a minimum, for all residents and facility staff, including individuals providing services under arrangement and volunteers, the LTC facility must: §483.80 (h)((1) Conduct testing based on parameters set forth by the Secretary, including but not limited to: (i) Testing frequency; (ii) The identification of any individual specified in this paragraph diagnosed with COVID-19 in the facility; (iii) The identification of any individual specified in	F 886		7/2/21

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	245238	A. BUILDING _____ B. WING _____	C 05/26/2021

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MAHNOMEN HEALTH CENTER	**414 WEST JEFFERSON AVENUE, PO BOX 396 MAHNOMEN, MN 56557**

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this paragraph with symptoms consistent with COVID-19 or with known or suspected exposure to COVID-19;
(iv) The criteria for conducting testing of asymptomatic individuals specified in this paragraph, such as the positivity rate of COVID-19 in a county;
(v) The response time for test results; and
(vi) Other factors specified by the Secretary that help identify and prevent the transmission of COVID-19.

§483.80 (h)((2) Conduct testing in a manner that is consistent with current standards of practice for conducting COVID-19 tests;

§483.80 (h)((3) For each instance of testing:
(i) Document that testing was completed and the results of each staff test; and
(ii) Document in the resident records that testing was offered, completed (as appropriate to the resident's testing status), and the results of each test.

§483.80 (h)((4) Upon the identification of an individual specified in this paragraph with symptoms consistent with COVID-19, or who tests positive for COVID-19, take actions to prevent the transmission of COVID-19.

§483.80 (h)((5) Have procedures for addressing residents and staff, including individuals providing services under arrangement and volunteers, who refuse testing or are unable to be tested.

§483.80 (h)((6) When necessary, such as in emergencies due to testing supply shortages,

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F 886	Continued From page 15 contact state and local health departments to assist in testing efforts, such as obtaining testing supplies or processing test results. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to test all active staff for COVID-19 prior to working, after an identified COVID-19 outbreak, as directed by the Centers for Disease Control (CDC). This practice resulted in an immediate jeopardy (IJ) situation which had the high likelihood to cause serious illness and/or death for 3 of 26 residents (R13, R15, R20) who resided at the facility and were not fully vaccinated against COVID-19. The IJ began on 3/24/21, when a staff member tested positive for COVID-19 and the facility failed to ensure all active staff were immediately tested for COVID-19 prior to working; along with following ongoing outbreak testing to ensure no more active cases were circulating within the facility. The director of nursing (DON), administrator and registered nurse (RN)-A were notified of the IJ on 5/24/21, at 6:34 p.m. The IJ was removed on 5/26/21, at 5:25 p.m. but noncompliance remained at the lower scope and severity level of D, isolated, which indicated no actual harm with potential for more than minimal harm that was not immediate jeopardy. Findings include: The CDC guidance People with Certain Medical Conditions dated 5/13/21, identified older adults were more likely to get seriously ill from COVID-19. More than 80 percent of COVID-19 deaths have occurred in people over the age of	F 886	F886 Bulletin board with testing status was put at the nurse□s station. Don immediately educated staff through WIW and communication book. DON or designee will update the bulletin board once a week with the weeks testing requirements based on CMS and MDH requirements. 05-25-2021 Staff were immediately educated on routine testing and outbreak testing expectations. Staff were educated again about testing requirements 06-24-2021 and will be completed by 07/02/2021. DON will continue to send weekly messages on When I Work and update the bulletin board weekly so staff are informed of testing requirements for the week. This was added to the orientation checklist to ensure new employees are aware of the testing requirements. DON updated Outbreak testing policy per QSO-20-38-NH. DON will update policy as needed as testing requirements change following CMS and MDH requirements. Staff will be educated as changes are made to the policy via face to face meetings, emails, bulletin board or When I Work messages. Once a week and as needed, Lab will	

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F 886	Continued From page 16 65, and more than 95 percent of COVID-19 deaths have occurred in people older than 45. Further, among adults, the risk for severe illness from COVID-19 increases with age, with older adults at highest risk. Severe illness means that the person with COVID-19 may require hospitalization, intensive care, or a ventilator to help them breathe, or they may even die. The CDC Updated Healthcare Infection Prevention and Control Recommendations in Response to COVID-19 Vaccination dated 4/27/21, identified COVID-19 testing was required regardless of vaccination status during an outbreak. In nursing homes with an outbreak of COVID-19, healthcare workers and residents regardless of vaccination status should have a viral test immediately and every 3-7 days until no new cases were identified for 14 days. During the entrance conference on 5/23/21, at approximately 5:45 p.m. the DON indicated there were no staff or residents with current active or suspected COVID-19 in the facility. Documentation regarding the facility's COVID-19 testing tracking was requested including the testing, testing schedules, list of staff and residents with confirmed or suspected COVID-19 and documentation of contact with state or local health department officials related to any testing issues. The facility returned testing rosters which consisted of multiple testing labels affixed to sheets of paper, grouped by weeks into folders which identified staff and residents tested by date. A roster of untested staff, with an identified accompanying testing strategy to meet testing requirements was not provided. The facility's COVID-19 testing results and	F 886	send DON or designee a list of staff who has tested. DON or DON designee will keep track of staff and their vaccination status to determine who needs to test based on CMS/MDH/CDC testing requirements. Staff will be notified that they need to test based on the testing requirements for that week by the DON or designee or they will not be allowed to return to work. Testing is monitored twice a week through Inter-Disciplinary meetings and brought monthly through QAPI.	

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F 886	Continued From page 17	F 886		

corresponding staff schedules from 3/21/21 through 5/25/21, identified the following:

- During the week of 3/21/21 to 3/27/21, the facility had 50 staff members scheduled to work in the facility. Routine COVID-19 testing was completed for 17 staff members which resulted in one positive test and placed the facility in outbreak status. The facility then tested 20 staff members which resulted in an additional positive COVID-19 test. However, the facility failed to require all active staff to immediately report for COVID-19 outbreak testing. The corresponding schedule identified 17 of 32 remaining scheduled staff members continued to work in the facility without subsequent outbreak COVID-19 testing.

- During the week of 3/28/21 to 4/3/21, the facility had 48 staff members scheduled to work who required outbreak COVID-19 testing. Testing was completed for 28 staff members which resulted in two newly identified positive COVID-19 cases, and maintained the facility's outbreak status. However, the corresponding schedule identified 25 staff members worked in the facility without timely testing (every 3-7 days) prior to the new COVID-19 cases. Additionally, the facility failed to initiate outbreak COVID-19 testing for all staff after the newly identified COVID-19 positive cases and 17 staff members worked in the facility without the additional required testing.

- During the week of 4/4/21 to 4/10/21, the facility had 45 staff members scheduled to work who required outbreak COVID-19 testing. Testing was completed for 28 staff members which resulted in one newly identified positive COVID-19 case, and maintained the facility's outbreak status. However, the corresponding schedule identified

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41 staff members worked in the facility without timely testing prior to the newly identified COVID-19 case. Additionally, the facility failed to initiate outbreak COVID-19 testing for all staff after the newly identified COVID-19 positive case and 17 staff members worked in the facility without the required additional testing.

- During the week of 4/11/21 to 4/17/21, the facility had 44 staff members scheduled to work who required outbreak COVID-19 testing. Testing was only completed for 30 staff members. No new positive cases were identified; however, the facility remained in outbreak status as all staff had not received testing and the last case was identified less that 14 days prior. The corresponding schedule identified 40 of 43 staff members did not receive outbreak testing timely and worked in the facility prior to receiving the required testing.

- During the week of 4/18/21 to 4/24/21, the facility had 46 staff members scheduled to work who required outbreak COVID-19 testing. Testing was completed for only 19 staff members. No new positive COVID-19 cases were identified; however, the last positive case was identified on 4/9/21, and the facility remained in outbreak status as all staff members had not received testing. The corresponding schedule identified 32 of 46 staff members did not receive outbreak testing timely and worked in the facility without the required testing.

- During the week of 4/25/21 to 5/1/21, the facility had 42 staff members scheduled to work who required outbreak COVID-19 testing. Testing was completed for only 30 staff members which resulted in one newly identified positive

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F 886	Continued From page 19	F 886		

COVID-19 case and continued the facility's outbreak status. The corresponding schedule identified 28 staff members worked in the facility without timely testing prior to the newly identified COVID-19 case. The facility then tested 11 staff members; however, failed to require all active staff to immediately report for COVID-19 testing. The corresponding schedule identified 29 of the remaining 34 scheduled staff members worked in the facility without the additional required testing.

- During the week of 5/2/21 to 5/8/21, the facility had 44 staff members scheduled to work who required outbreak COVID-19 testing. Testing was completed for only 21 staff members. No new positive cases were identified; however, the facility remained in outbreak status as all staff had not received testing and the last case was identified less than14 days prior. The corresponding schedule identified 36 of 44 staff members did not receive outbreak testing timely and worked in the facility without the required testing.

- During the week of 5/9/21 to 5/15/21, the facility had 43 staff members scheduled to work who required outbreak COVID-19 testing. Testing was completed for only 10 staff. No new positive COVID-19 cases were identified, and although the last positive case was identified on 4/28/21, the facility remained in outbreak status as all staff had not received testing. The corresponding schedule identified 38 of 42 staff members did not receive outbreak testing timely and worked in the facility without the required testing.

- During the week of 5/16/21 to 5/22/21, the facility had 44 staff members scheduled to work who required outbreak COVID-19 testing. On

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5/17/21, testing was completed for 5 staff members which resulted in 2 newly identified positive COVID-19 cases and continued the facility's outbreak status. The corresponding schedule identified 20 staff members worked in the facility without timely testing prior to the newly identified COVID-19 cases. The facility then tested 13 staff members; however, failed to require all active staff to immediately report for COVID-19 outbreak testing. The corresponding schedule identified 35 of the remaining 37 scheduled staff members did not receive outbreak testing timely and worked in the facility without the required testing.

- From 5/23/21 to 5/25/21, the facility had 40 staff members scheduled to work who required outbreak COVID-19 testing. Testing was completed for 39 staff members. No new positive cases were identified; however, the facility remained in outbreak status as all staff had not received testing and the last case was identified less than 14 days prior. The corresponding schedule identified 18 of 40 staff members did not receive outbreak testing timely and worked in the facility without the required testing.

During interview on 5/24/21 at 10:16 a.m. the DON indicated the most recent COVID-19 positive result for a staff member occurred the previous week. Nursing assistant (NA)-A worked on 5/16/21, and became symptomatic after her shift that evening. On 5/17/21, NA-A's symptoms worsened, and she was tested. The facility notified staff via text message and immediately did outbreak testing on Monday, 5/17/21. On 5/18/21, NA-A's COVID-19 test returned positive along with one additional staff member.

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F 886	Continued From page 21	F 886		

- At 10:45 a.m. the DON stated the facility encouraged but did not force active staff to be tested for COVID-19 and staff who declined testing were allowed to continue working due to the facility's internal staffing concerns. They were in "contingency staffing"; however, were able to utilize agency staff to fill open positions. Further, there were three residents in the facility that were unvaccinated for COVID-19.

R13's quarterly Minimum Data Set (MDS) dated 4/6/21, identified R13 was greater than 65 years of age and had diagnoses which included hypertension, atrial fibrillation (irregular and often rapid heart rate) with rapid ventricular rate and hypothyroidism (underactive thyroid). R13's signed COVID-19 Vaccine Consent Form dated 12/9/20, indicated R13 declined consent for the COVID-19 vaccination.

R15's quarterly MDS dated 4/13/21, indicated R15 was greater than 65 years of age and had diagnoses which included hypertension, heart failure, type 2 diabetes mellitus and hyperkalemia (potassium level in the blood higher than normal. Potassium is a chemical that is critical to the function of nerve and muscle cells, including those in the heart). The undated COVID-19 Vaccine Consent Form indicated R15's family provided verbal declination for the COVID-19 vaccination.

R20's quarterly MDS dated 4/20/21, indicated R20 was greater than 65 years of age and had diagnoses which included hypertension, and hypothyroidism. R20's undated Resident Face Sheet indicated R20 also had a history of colon cancer. The COVID-19 Vaccine Consent Form indicated R20 declined the COVID-19 vaccination

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F 886	Continued From page 22 on 1/25/21.	F 886		

On 5/24/21, at 11:44 a.m. licensed practical nurse (LPN)-A was observed working at the facility. LPN-A stated she tested negative for COVID-19 on 5/10/21, and was unaware of the testing frequency or when she should've been tested again. LPN-A stated she worked during the week of 5/10/21, 5/17/21 and 5/24/21 even though she had not tested for COVID-19 since 5/10/21.

During interview on 5/24/21, at 11:52 a.m. NA-C, who was working in the facility, stated some staff and residents were tested for COVID-19 approximately two weeks ago. NA-C was not tested at that time and did not remember the last time she was tested. NA-C was uncertain when staff were to be tested again.

When interviewed on 5/24/21, at 3:11 p.m. DON stated she was aware of QSO (Quality Safety and Oversight) memo 20-38, updated 4/27/21, which identified the outbreak testing requirements; however, she allowed staff to decline testing and continue to work if they were asymptomatic. Further, not every staff member was tested as required by the QSO memo. She indicated this practice was in the facility staffing plan for contingency staffing; however, had not reached out to the State Agency (SA) regarding her staffing concerns. Additionally, she was not tracking the vaccination status of the staff but estimated approximately 45% of the staff had received the COVID-19 vaccine while 55% remained unvaccinated, which was needed to determine routine testing requirements.

During interview on 5/24/21, at 4:56 p.m. NA-D, who was working in the facility, stated he was last

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tested for COVID-19 "maybe two weeks ago" but had worked in the facility since that time.

On 5/24/21, at 5:02 p.m. NA-B, who was working in the facility, stated she tested negative for COVID-19 the week prior and was not tested since. She was notified via text message of a positive staff member and instructed to be tested again on 5/24/21. NA-B was not tested upon entering the facility on 5/24/21, and continued to perform her NA duties without being tested since the week prior.

The Centers for Medicare and Medicaid (CMS) QSO-20-38-NH memo dated 8/26/20, directed, "Facilities must have procedures in place to address staff who refuse testing. Procedures should ensure that staff who have signs or symptoms of COVID-19 and refuse testing are prohibited from entering the building until the return to work criteria are met. If outbreak testing has been triggered and a staff member refuses testing, the staff member should be restricted from the building until the procedures for outbreak testing have been completed. The facility should follow its occupational health and local jurisdiction policies with respect to any asymptomatic staff who refuse routine testing."

The facility Response Plan to Support COVID-19 Testing updated 2/11/21, identified testing would be conducted in addition to existing infection prevention and control measure recommended by the CDC and/ or SA as appropriate. The testing plan included the following trigger: point prevalent testing when a positive result has occurred among staff who had worked within 48 hours of onset, or any positive result with a resident. While the plan identified the testing

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approach should follow any guidelines put out by SA or CDC it also directed testing was strongly encouraged for all residents, and staff and other essential visiting caregivers indicated in the plan; however, was not mandatory. The plan further directed, if a staff member refused to be tested the testing team would continue to monitor for symptoms. Staff would be allowed to work if they were asymptomatic. If staff were symptomatic and there was no other diagnostic reason, staff would be required to quarantine based on CDC/SA/CMS guidelines before returning to work. If a staff member missed the testing dates, the staff would be tested on their next scheduled shift.

The IJ which began on 3/24/21, was removed on 5/26/21, at 5:25 p.m. when it was verified through interview and document review:
1)The facility updated their testing policy to follow QSO memo 20-38 revised 4/27/21, requiring all staff to be tested regardless of vaccination status during an outbreak and any staff who refused testing would be restricted from work until testing was completed. Further, all unvaccinated staff would be required to routinely test based on county positivity rates.
2) All staff were tested prior to working. They implemented a plan to ensure all staff were tested prior to their next scheduled shift by RN staff. Further, any staff who tested positive would be restricted from working until the recommended return to work guidance per the CDC.
3) The facility educated the RN charge nurses on testing staff prior to their next shift. All facility staff were educated on the requirements for outbreak and routine testing prior to their next scheduled shift, including casual staff.

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K 000	INITIAL COMMENTS FIRE SAFETY A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety. At the time of this survey, Mahnomen Health Center (Nursing Home) 01 Building was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of the Health Care Facilities Code (NFPA 99). 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 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. IF OPTING TO USE AN EPOC, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K TAGS) TO:	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		06/25/2021

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245238	A. BUILDING **01 - 1969 BUILDING WITH 1975 ADDITION** B. WING _____	**05/25/2021**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAHNOMEN HEALTH CENTER	**414 WEST JEFFERSON AVENUE, PO BOX 396** **MAHNOMEN, MN 56557**

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K 000	Continued From page 1 HEALTH CARE FIRE INSPECTIONS STATE FIRE MARSHAL DIVISION 445 MINNESOTA STREET, SUITE 145 ST. PAUL, MN 55101-5145, or By e-mail 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. Mahnomen Health Center (Nursing Home) was built at three different times. In 1969 the main building was added to the east of the Mahnomen Hospital. It is 1-story, without a basement and is Type II(111) construction. In 1996 an addition to the north of the kitchen was added, is 1-story, no basement and Type II (111) construction, In 2000, additions of 1-story, without basements and of Type II(000) construction were built to the west of the 1969 building and to the north of the 1996	K 000		

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K 000	Continued From page 2 building, The 1969 building is separated by a 2-hour fire barrier from the Hospital building and from the 2000 east addition. The facility has 3 smoke compartments separated by at least 30 minute fire barriers. The facility is protected with an automatic fire sprinkler system installed in accordance with NFPA 13 Standard for the Installation of Sprinkler Systems with quick response heads. The facility has a fire alarm system with corridor smoke detection, sleeping room smoke detection, and smoke detection in common areas in accordance with NFPA 72 "The National Fire Alarm Code". The facility has a capacity of 32 beds and had a census of 25 at the time of the survey. The requirements at 42 CFR, Subpart 483.70(a) are NOT MET.	K 000		
K 321 SS=E	Hazardous Areas - Enclosure CFR(s): NFPA 101 Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS.	K 321		6/25/21

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K 321	Continued From page 3 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) This REQUIREMENT is not met as evidenced by: Based on observations and staff interview, it was revealed that the facility has failed to provide proper protection for 1 of several hazardous areas located throughout the facility in accordance with NFPA 101 "The Life Safety Code" 2012 edition (LSC) section 19.3.2.1. This deficient condition could in the event of a fire, allow smoke and flames to spread throughout the affected corridors and areas making them untenable, which could negatively affect 10 of 32 residents. Findings include: On 05/25/2021, at 11:17 a.m., during the facility tour observations revealed that the facility had a 1/8 to 1/4 inch crescent shaped opening around the collar of the door knob on the door to the communications room. This deficient condition was confirmed by a	K 321	05/26/2021 Brass extension was installed under the door knob fixing the gap. Staff educated by 06/10/2021. Facility Director or designee will monitor monthly during environmental rounds and this will be monitored through QAPI	

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K 321	Continued From page 4 Maintenance Supervisor.	K 321		
K 345 SS=F	Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This REQUIREMENT is not met as evidenced by: Based on staff interview and a review of all available documentation, the facility has not maintained the fire alarm system testing and maintenance documentation in accordance with NFPA 101 2012 edition, Life Safety Code, section 9.6.1.3, and NFPA 72 National Fire Alarm Code 2010 edition, section 14.3.1. This deficient practice could affect 32 of 32 residents. Findings include: On 05/25/2021, at 10:09 a.m., during the review of all available fire alarm maintenance and testing documentation for the last 12 months, and an interview with the Maintenance Supervisor it was revealed that the facility did not conduct a semi-annual visual inspection of the fire alarm initiating devices. This deficient condition was confirmed by a Maintenance Supervisor.	K 345	06/03/2021 Forms were developed for documentation purposes for the semi-annual and annual inspection. The annual inspection was performed 05/05/2021. Semi-annual inspection will be conducted in November of 2021. Staff education by 06/10/2021. Facility Director or designee will monitor monthly during environmental rounds to ensure it is conducted when it is due and it will be monitored through QAPI	6/25/21

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K 351 SS=D	Sprinkler System - Installation CFR(s): NFPA 101 Spinkler System - Installation 2012 EXISTING Nursing homes, and hospitals where required by construction type, are protected throughout by an approved automatic sprinkler system in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. In Type I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where state or local regulations prohibit sprinklers. In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area of the closet does not exceed 6 square feet and sprinkler coverage covers the closet footprint as required by NFPA 13, Standard for Installation of Sprinkler Systems. 19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1) This REQUIREMENT is not met as evidenced by: Based on observations and staff interview, the automatic sprinkler system was not installed and maintained in accordance with NFPA 13 the Standard for the Installation of Sprinkler Systems 2010 edition section 6.2.7. The failure to maintain the sprinkler system in compliance with NFPA 13 (2010) could allow the system to be placed out of service causing a decrease in the fire protection system capability in the event of an emergency that could affect the residents within that room. Findings include: On 05/25/2021, at 11:39 a.m. during the facility	K 351	05/26/2021 Escutcheon rings were installed on the sprinkler heads missing them. Staff education by 06/10/2021. Facility director or designee will monitor monthly during environmental rounds and it will be monitored through QAPI.	6/25/21

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K 351	Continued From page 6 tour, it was observed that the escutcheon ring was missing from the fire sprinkler head that is located in the kitchen storage room and in the kitchen locker room. This deficient condition was confirmed by a Maintenance Supervisor.	K 351		
K 751 SS=F	Draperies, Curtains, and Loosely Hanging Fabr CFR(s): NFPA 101 Draperies, Curtains, and Loosely Hanging Fabrics Draperies, curtains including cubicle curtains and loosely hanging fabric or films shall be in accordance with 10.3.1. Excluding curtains and draperies: at showers and baths; on windows in patient sleeping room located in sprinklered compartments; and in non-patient sleeping rooms in sprinklered compartments where individual drapery or curtain panels do not exceed 48 square feet or total area does not exceed 20 percent of the wall. 18.7.5.1, 18.3.5.11, 19.7.5.1, 19.3.5.11, 10.3.1 This REQUIREMENT is not met as evidenced by: Based on observations and staff interview, the privacy curtains in the facility do not meet the requirements for Furnishing, Bedding, and Decorations for use in health care occupancies in accordance with provisions of the NFPA 101 "The Life Safety Code" 2012 edition (LSC) section 19.7.5.1 and the NFPA 13 "The Standard for the Installation of Sprinkler Systems" 2010 edition. This deficient condition is causing a decrease in the fire protection system capability in the event of an emergency that could affect 32 of 32 residents.	K 751	All curtains that are not needed in resident rooms will be removed by 06/30/2021. All other curtains have been re-treated with flame retardant. Staff educated by 06/10/2021 to ensure that curtains are re-treated with fire retardant after they are washed and it is documented on the curtain treatment form. Facility Director or designee will monitor monthly during environmental rounds and it will be monitored through QAPI	6/25/21

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K 751	Continued From page 7 Findings Include: On 05/25/2021, at 12:10 p.m. during the facility tour, observations revealed that the privacy divider curtain located in all of the resident rooms did not have any labeling attached to them stating that it is "inherently fire retardant." This deficient condition was confirmed by a Maintenance Supervisor.	K 751		
K 901 SS=F	Fundamentals - Building System Categories CFR(s): NFPA 101 Fundamentals - Building System Categories Building systems are designed to meet Category 1 through 4 requirements as detailed in NFPA 99. Categories are determined by a formal and documented risk assessment procedure performed by qualified personnel. Chapter 4 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on staff interview and a review of all available documentation, the facility has failed to provide a complete and current facility Risk Assessment in accordance with the NFPA 99 "Health Care Facilities Code" 2012 edition section 4.1. This deficient condition could affect 32 of 32 residents. Findings include:	K 901	A risk assessment was completed on all patient care equipment on 06/08/2021 with the Directors of Nursing in the facility. Facility Director or designee will continue to monitor for changes in new equipment monthly during environmental rounds and add them to the risk assessment. Staff education by 06/10/2021. Risk assessments will be reviewed annually and as needed by Director's of Nursing and will be monitored through QAPI.	6/25/21

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K 901	Continued From page 8 On 05/25/2021, at 10:40 p.m. during the documentation review and an interview with the Maintenance Supervisor it was revealed that the facility could not provide a completed utility risk assessment document at the time of the inspection. The utility risk assessment that was provided at the time of the inspection did not cover patient care equipment as detailed in NFPA 99 "Health Care Facilities Code" 2012 edition Chapter 10 - Electrical Equipment, and Chapter 11 - Gas Equipment. This deficient condition was confirmed by a Maintenance Supervisor.	K 901		
K 911 SS=D	Electrical Systems - Other CFR(s): NFPA 101 Electrical Systems - Other List in the REMARKS section any NFPA 99 Chapter 6 Electrical Systems requirements that are not addressed by the provided K-Tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. Chapter 6 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility had multiple deficient conditions affecting the facility's electrical system that were not in accordance with the NFPA 101 "The Life Safety Code" 2012 edition, section 9.12., and NFPA 70 "National Electrical Code" 2011 edition, section 110.26. This deficient practice could affect 12 of 32 residents.	K 911	05/26/2021 all combustible materials were removed from the front of the electrical panels in the communication room. Staff education by 06/10/2021. Facility Director or designee will monitor this monthly during environmental rounds and monitored through QAPI.	6/25/21

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K 911	Continued From page 9 Findings include: 1. On 05/25/2021 at 11:08 a.m., during the facility tour observations revealed that there is an electrical junction box above the ceiling tile over the resident bed in room H2 that is missing a cover leaving the wiring exposed. 2. On 05/25/2021 at 11:16 a.m., during the facility tour observations revealed that the electrical panels that are located in the communication room had combustible being stored against and in front of the panels. These deficient conditions were confirmed by a Maintenance Supervisor.	K 911		