DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
December 12, 2024

Administrator
Good Samaritan Society - Bethany
804 Wright Street
Brainerd, MN 56401

RE: CCN: 245500
Cycle Start Date: October 17, 2024

Dear Administrator:

On December 2, 2024, the Minnesota Departments of Health and Public Safety, completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Health Regulation Division
Telephone: (651) 201-4112
Email: Kamala.Fiske-Downing@state.mn.us

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
October 28, 2024

Administrator
Good Samaritan Society - Bethany
804 Wright Street
Brainerd, MN 56401

RE: CCN: 245500
Cycle Start Date: October 17, 2024

Dear Administrator:

On October 17, 2024, 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 constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

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.

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.

The state agency may, in lieu of an onsite revisit, determine correction and compliance by accepting the facility's ePoC if the ePoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

If an acceptable ePoC is not received within 10 calendar days from the receipt of this letter, we will recommend to the CMS Region V Office that one or more of the following remedies be imposed:

- Denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417);
- Civil money penalty (42 CFR 488.430 through 488.444).
- Termination of your facility's Medicare and/or Medicaid agreement (488.456(b)).

DEPARTMENT CONTACT

Questions regarding this letter and all documents submitted as a response to the resident care deficiencies (those preceded by an "F"and/or an "E" tag), i.e., the plan of correction should be directed to:

Jen Bahr, RN, Regional Operations Supervisor
Bemidji District Office
Health Regulation Division
Minnesota Department of Health
705 5th Street NW, Suite A Bemidji, Minnesota 56601-2933
Email: Jennifer.bahr@state.mn.us
Office: (218) 308-2104

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 the 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 THIRD OR SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

If substantial compliance with the regulations is not verified by January 17, 2025 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by April 17, 2025 (six months after the identification of noncompliance) your provider agreement will be terminated. 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.

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:

Travis Z. Ahrens
State Fire Safety Supervisor
Health Care & Correctional Facilities
MN Department of Public Safety-Fire Marshal Division
445 Minnesota St., Suite 145
St. Paul, MN 55101
Email: travis.ahrens@state.mn.us
Web: www.sfm.dps.mn.gov
Cell: 1-507-308-4189

Feel free to contact me if you have questions.

Sincerely,

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245500	A. BUILDING _____ B. WING _____	C 10/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - BETHANY	804 WRIGHT STREET BRAINERD, MN 56401

(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 10/14/24 through 10/17/24, a survey for compliance with Appendix Z, Emergency Preparedness Requirements, §483.73(b)(6) was conducted during a standard recertification survey. The facility was IN compliance. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	E 000		
F 000	INITIAL COMMENTS On 10/14/24 through 10/17/24, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was not compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were reviewed H55009387C (MN104765), and H55009388C (MN100690) with no deficiencies cited. 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 550	Resident Rights/Exercise of Rights	F 550		11/27/24

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		11/07/2024

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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F 550 SS=D	Continued From page 1 CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her	F 550		

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F 550	Continued From page 2 rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure a urinary catheter bag was placed in a privacy bag to maintain dignity for 1 of 3 residents (R25) reviewed for dignity. Findings include: R25's quarterly Minimum Data Set (MDS) dated 8/14/24, identified R25's cognition was severely impaired and diagnoses included Huntington's disease (a rare genetic disorder that affects the brain and causes movement, cognitive and mental health problems). R25 used an indwelling urinary catheter due to having a neurogenic bladder (when the relationship between the nervous system and bladder function was disrupted by injury or disease). R25's care plan revised 2/12/24, identified R25 had an indwelling catheter due to urinary outlet obstruction and neurogenic bladder. The care plan directed catheter care was performed by nursing assistants twice daily with cares and as needed. A non-adhesive secure anchor on leg. However, the care plan failed to direct staff to keep the catheter bag in a privacy bag to maintain dignity. During an observation on 10/14/24 at 5:20 p.m., R25 was lying in bed on his back with a fleece blanket covering R25 to his chest. The room lights were on and R25 was watching a tv program. R25's catheter bed bag was hanging	F 550	Disclaimer Preparation and execution of this response and plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/ or executed solely because it is required by the provisions of federal and state law. For the purposes of any allegation that the center is not in substantial compliance with federal requirements of participation, this response and plan of correction constitutes the center's allegation of compliance in accordance with section 7305 of the State Operations Manual. F550 SS= D On 10/17/24 the DNS and designees swept the whole building for residents with catheter bags that did not have privacy bags over them and made sure the residents without them were given one. The initial affected resident, R25, was provided with a privacy bag. All residents with catheter bags are at risk for having their privacy violated by others seeing that they have a catheter, if they do not have a privacy bag to cover it up. The DNS and designees will provide re-education for all staff on the importance	

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F 550	Continued From page 3 from the bed frame and clearly visible from the hallway. The catheter bag was not in a privacy bag. During an observation on 10/15/24 at 2:18 p.m., R25 was lying in bed in his room. R25's catheter bed bag was hanging from the bed frame and was visible from the hallway. -At 3:16 p.m., activity aide (AA)-A visited with R25 at his bedside but did not cover R25's catheter bed bag before leaving. - At 3:59 p.m., R25's catheter bed bag continued to hang from R25's bed frame without a privacy bag and was clearly visible from the hallway. During an observation on 10/16/24 at 7:14 a.m., R25 was lying in bed with his catheter bed bag hanging from the bed frame without a privacy bag and was clearly visible from the hallway. - At 8:19 a.m., R25 was assisted into his wheelchair and registered nurse (RN)-C was observed placing R25's catheter bed bag in a privacy bag underneath R25's wheelchair. During an observation on 10/16/24 at 1:12 p.m., R25 was lying in bed with his catheter bed bag hanging from the bed frame. The catheter bed bag was clearly visible from the hallway. During an interview on 10/16/24 at 3:06 p.m., nursing assistant (NA)-D stated it was "normal" to hang the catheter bed bag from the bed frame on the hallway side of the bed because the catheter tubing was anchored to R25's right leg. NA-D stated she did put R25's catheter bed bag in a privacy bag when he was in his wheelchair but did not even consider it when he was in bed. NA-D stated a privacy bag was important to maintain R25's dignity and privacy. Noone needs to know	F 550	of protecting resident dignity through the use of a privacy bag. This training will be finished on 11/22/24. The DNS and designees will audit all residents with catheters 2 times a week for 6 weeks to ensure that staff have been properly re-educated on the use of privacy bags. Audits will be reviewed by the QAPI committee, and they will give direction for any further needed action. Completion Date 11/27/22	

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F 550	Continued From page 4 about R25 catheter except R25. During an interview on 10/16/24 at 3:20 p.m., RN-C stated yea, staff hung R25's catheter bed bag from the bed frame without a privacy bag. "That's just what we do." A privacy bag was available on the wheelchair, but it was not easily removed from the wheelchair because it was tied on. The facility used to use a different supply company that provided covers, but they no longer used that brand. The facility did not have privacy bags available for the resident's bed. RN-C stated it was much better because the catheter bed bag was always covered to maintain privacy and dignity and now anyone walking past R25's door could see R25's catheter. During an interview on 10/17/24 at 9:07 a.m., RN-B stated a catheter bed bag was supposed to have a privacy bag. Staff "knew better". Staff had never been directed to place the catheter bed bag on one side of the bed or the other but had been directed to keep the catheter bed bag always covered because it was a privacy and dignity issue but also an infection prevention issue as well. Staff needed to allow as much dignity as possible because it was nobody's business that R25 had a catheter. During an interview on 10/17/24 at 10:53 a.m., the director of nursing stated all residents should have a privacy bag for their catheter bed bag on their bed and wheelchair. It was important to protect every resident's dignity and privacy as a person. The facility policy Resident Dignity revised 11/16/23, identified the facility would promote care for residents in a manner and in an	F 550		

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F 550	Continued From page 5 environment that maintained or enhanced each resident's dignity and respect in full recognition of his or her individuality.	F 550		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed ensure clinical monitoring was completed and documented for 2 of 3 residents (R37, R39) reviewed with recent COVID-19 infections. Findings include: R37's significant change Minimum Data Set (MDS) dated 9/27/24, identified R37 was 86 years old, had a severe cognitive impairment and diagnoses included chronic respiratory failure, atrial fibrillation, and chronic kidney disease. R37's care plan revised 9/26/24, identified R37 had a respiratory infection: COVID-19 and directed staff to observe for symptoms and monitor/document/report new or worsening signs/symptoms of COVID-19. R37's Order Summary Report dated 10/1/24 -	F 684	F684 SS= D On 10/18/24 the DNS and designees swept the whole building for residents with active infections and ensured that staff were completing clinical monitoring assessments as indicated. The identified residents, R37 and R39, had infections that were resolved at this time and no longer required clinical monitoring assessments. All residents with active infections are at risk of having negative health outcome if their infections are not monitored by trained staff. The DNS and designees will provide re-education to all staff regarding completion of clinical monitoring assessments with each suspected or active infection. Continued monitoring of the need and completion of clinical monitoring assessments will be a part of	11/27/24

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F 684	Continued From page 6 10/13/24, directed staff to obtain clinical monitoring - infection/suspected infection two times a day for 12 days. R37's progress from 9/26/24 through 10/4/24, identified R37 was positive for COVID-19 on 9/26/24 and R37's urine was collected for a urinary analysis and culture on 9/30/24. However, the progress notes failed to identify any monitoring of vitals, conditions, or symptoms during R37's COVID-19 infection and/or why the urine sample was collected. R37's Clinical Monitoring - Infection/Suspected Infection V10 dated 10/4/24 at 2:16 p.m., identified R37 was monitored for a respiratory and urinary infection, weight 189.8 pounds, temperature 97.0 degrees Fahrenheit (F), pulse 70, respirations 20, blood pressure 130/70 and oxygen saturations 98% on room air. R37 was alert and oriented t person and place and exhibited agitation and impaired decision making. R37 had a cough, lung sounds were clear and normal quality. Interventions included monitor/observe and fluids/hydration. However, R37's medical record failed to identify any clinical monitoring starting 9/26/24 through 10/3/24. R37's vitals record failed to identify vitals collected 9/26/24 though 10/4/24. R39's significant change MDS dated 10/7/24, identified R39 was 96 years old with diagnoses that included chronic obstructive pulmonary disease (COPD) (a common, preventable, and treatable disease that is characterized by persistent respiratory symptoms like progressive breathlessness and cough), chronic kidney disease atherosclerotic heart disease, and atrial	F 684	the new infection surveillance process developed by the DNS. Education will be completed by 11/22/24. The DNS and designees will audit 3 residents 3 times per week for 6 weeks that have active infections to ensure that clinical monitoring is being done as ordered. Audits will be reviewed by the QAPI committee, and they will give direction for any further needed action. Completion Date 11/27/22	

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F 684	Continued From page 7 fibrillation. R39's care plan revised 7/23/24, identified R39 had an altered respiratory status/difficulty breathing related to COPD. Staff were directed to monitor for signs of respiratory distress and report to health care provider as needed: increased respirations; decreased pulse oximetry; increased heart rate (tachycardia); restlessness, headaches, lethargy, confusion, hemoptysis, cough, pleuritic pain, accessory muscle usage; skin color changes to blue/grey. Monitor/document changes in orientation, increased restlessness, anxiety, and air hunger. However, the care plan did not direct staff to obtain vitals and/or where/how to document nor how frequently to do so, especially in times of illness. R39's progress notes 9/28/24 through 9/30/24, identified R39 tested positive for COVID-19 on 9/28/24, was "hoarse" and felt "pukey". However, the progress notes failed to identify any monitoring of vitals, conditions, or symptoms during R39's COVID-19 infection. R39's vitals record failed to identify vitals collected 9/28/24 through 9/30/24. R39's medical record failed to identify Clinical Monitoring - Infection/Suspected Infection V10 completed for R39 from 9/28/24 through 9/30/24. During an interview on 10/16/24 at 3:14 p.m., registered nurse (RN)-C stated when a resident had COVID-19, RN-C would get vitals and, at least, lung sounds every shift and that's documented in the Clinical Monitoring - Infection/Suspected Infection V10 in the	F 684		

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F 684	Continued From page 8 resident's assessment tab. During an interview on 10/16/24 at 3:59 p.m., RN-F stated, when a resident was ill, but especially COVID-19, RN-F would get vitals every shift and assess the resident for changes. RN-F would document this in the progress notes. RN-F stated she was unaware of the Clinical Monitoring - Infection/Suspected Infection V10 the assessment tab and had never used it. During a telephone interview on 10/16/24 at 7:42 p.m., nursing assistant (NA)-E stated, when a resident showed a possible sign or symptom of COVID-19, she notified the nurse on the unit and then would obtain a set of vitals for the nurse. NA-E would encourage the resident to stay in his/her room until a test was collected. After that, staff needed to be aware of a resident's condition, were they showing signs of COVID-19 and report that to the nurse. During a telephone interview on 10/16/24 at 7:43 p.m., RN-A stated when a resident started to show symptoms of illness, staff collected an COVID-19 antigen test and, if positive, the resident would be placed into transmission-based precautions "that sort of thing". Clinical monitoring of the resident depended on symptoms. If the resident was having respiratory issues, nursing staff would listen to lung sounds and clinical monitoring documentation would be triggered in the resident's medical record. Implementation of clinical monitoring depended on the nurse on duty that shift. If it was a "seasoned" nurse, the unit nurse on duty would implement clinical monitoring. RN-E stated she did work 9/28/24 and 9/29/24. RN-A was aware of positive COVID-19 residents in the facility but did not	F 684		

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F 684	Continued From page 9 recall personally assessing residents for illness and/or implementing clinical monitoring documentation in the residents' medical records. During an interview on 10/17/24 at 8:54 a.m., RN-F stated, when a resident was symptomatic for respiratory illness, an antigen COVID-19 test, and vitals were collected to determine if the resident had a fever and/or something else going on. RN-F then would document those findings in the vitals tab of the resident's medical record. After that, vitals would be collected and documented in the vitals tab every shift or more often depending on the resident's condition. RN-F stated she has never implemented the clinical monitoring form in the assessment tab nor put an order into direct staff to assess the resident every shift. During an interview on 10/17/24 at 9:06 a.m., RN-B stated residents symptomatic for respiratory illness, staff were expected to evaluate the resident at least twice a day: lung sounds, vitals, etc. Night shift could also evaluate the resident depending on condition. Staff were directed to do this by implementing the Clinical Monitoring- Infections/Suspected Infections V10 form in the resident's assessments because that provided for the facility's infection control program. During weekend hours, nursing was expected to implement the Clinical Monitoring-Infections/Suspected Infections V10 form and, on Monday, RN-B would ensure this had been implemented. If not, RN-B would implement at that time. During a telephone interview on 10/17/24 at 10:00 a.m., RN-G stated, when a resident was showing symptoms of respiratory illness, the resident was	F 684		

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F 684	Continued From page 10 first tested for COVID-19 with an antigen test and vitals were collected. After this, vitals and the resident's condition would be documented in a nursing progress note. This is what was routinely done, but how often really depended on how sick the resident was. RN-G stated R37 was "fine" on 9/28/24 and 9/29/24. RN-G did not collect vitals and/or assess R37 on 9/28/24 and/or 9/29/24 because R37 "wouldn't stay in his room and he kept coming out and screaming at me." During an interview on 10/17/24 at 10:34 a.m., the director of nursing (DON) stated it was very disappointing to not find nursing assessments twice daily for R37 or R39 from 9/26/24 to 10/4/24. The DON expected staff to collect vitals and do a nursing assessment of any ill resident every shift while not feeling well. Any nurse can initiate the Clinical Monitoring-Infections/Suspected Infections V10 form in the resident's medical record. Additionally, the DON expected the unit manager to ensure it was implemented as well; this included the weekend nursing managers. This was the facility infection control process, and it allowed communication between staff. During an interview on 10/17/24 at 11:53 a.m., the administrator stated she expected staff to follow the facility's policies, procedures and/or processes and to also communicate with each other to keep the residents, staff, and visitors safe. The facility policy Emerging Threats - Acute Respiratory Syndromes Coronavirus (COVID) revised 4/19/24, identified residents were monitored for signs and symptoms of COVID-19 per routine practice. However, the policy failed to	F 684		

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F 684	Continued From page 11 direct staff on frequency of monitoring and/or how monitoring should be documented. A policy regarding illness monitoring and documentation was requested but not received.	F 684		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must	F 690		11/27/24

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F 690	Continued From page 12 ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure an appropriate provider's order and rational for use were obtained for an indwelling urinary catheter for 1 of 3 residents (R30) who were reviewed for catheter care. Findings include: R30's significant change Minimum Data Set (MDS) dated 9/23/24 identified no cognitive impairment and identified R30 was always continent of bladder. R30's urinary/catheter assessment dated 9/30/24, identified resident was admitted to the unit with indwelling urinary catheter in place. The rational provided was the resident was on hospice. R30's provider's orders dated 9/30/24, identified an order for Foley Cath (catheter) Care dated 9/30/24. The provider's orders lacked any order for insertion or use of a Foley Cath, or the rational for the use of it. During observation on 10/16/24 at 12:25 p.m., R30 sat up in her bed and ate lunch. R30's Foley catheter bag was hanging on the side of her bed. During interview on 10/16/24 at 1:24 p.m., R30 stated she did not know why the catheter was placed. She could not think of a reason why she would need it.	F 690	F690 SS= D On 10/17/24 DNS and designees did a whole house sweep of the facility to ensure that all residents with catheters had physician's orders for said catheter and proper reasoning for its use. For identified resident, R30, the physician was contacted and appropriate orders and indication for use was obtained. All residents with a catheter are at risk of increased levels of infection and loss of continence due to the unneeded use of a catheter. DNS and designees will provide re-education to all applicable staff on the importance of having a physician's order and proper reasoning for the use of a catheter. New catheters will be audited for orders and indication of use through the IDT process. Education will be completed by 11/22/24. The DNS and designees will audit all residents with catheters 1 times a week for 6 weeks to ensure that they all have correct physician's orders for their catheters and proper reasoning for their use. Audits will be reviewed by the QAPI committee, and they will give direction for any further needed action. Completion Date 11/27/22	

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F 690	Continued From page 13 During an interview on 10/17/24 at 10:33 a.m., licensed practical nurse (LPN)-A stated R30 was admitted to the unit with the catheter already in place and could not find an order or reason it was placed. During an interview on 10/17/24 at 10:48 a.m., registered nurse (RN)-D stated if a resident needed a catheter there should be a provider's order and a rational for why a catheter was needed. This information would be important as it would drive the plan of care for the catheter. R30's medical record lacked any documentation of why the catheter was inserted. The R30's medical record did not contain an order for the catheter or the rational for why it was needed. During an interview on 10/17/24 at 11:02 a.m., the director of nursing (DON) stated it is the expectation that every resident who had a catheter in place would have had a provider's order for the catheter and the rational for why the catheter was needed. It would not be appropriate for a catheter to be placed just because a resident was on hospice. The facility's Catheter: Care, Insertion & Removal, Drainage Bags, Irrigation and Specimen-LTC policy dated 7/30/24, identified a resident is not to be catheterized unless the clinical condition demonstrates that catheterization is medically necessary and is not used solely for nurse/physician convenience. Also identified Catheters will be utilized only with a physician's order.	F 690		
F 693 SS=D	Tube Feeding Mgmt/Restore Eating Skills CFR(s): 483.25(g)(4)(5)	F 693		11/27/24

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F 693	Continued From page 14 §483.25(g)(4)-(5) Enteral Nutrition (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(4) A resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical condition demonstrates that enteral feeding was clinically indicated and consented to by the resident; and §483.25(g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure staff provided care according to standards of practice and per physician orders for gastrostomy tube feeding for 1 of 1 resident (R15) reviewed for tube feedings. Finding include: R15's quarterly Minimum Data Set (MDS) dated 8/20/24, identified severe cognitive impairment and diagnoses of traumatic brain dysfunction, hemiplegia (one-sided paralysis or weakness), and seizure disorder. R15 was dependent on staff for bed mobility and had a gastrostomy tube (g-tube) for feeding.	F 693	F693 SS= D R15 is the only resident in house receiving nutrition via enteral tube at this time. Upon observation the head of bed was elevated when tube feeding was in progress. Staff on duty had verbal on the spot education completed. Additional verbage was added to the careplan under the ADL section to re-inforce ensuring head of bed elevated at least 30 degrees during tube feedings as well as for at least 30 minutes after tube feeding has been stopped. All residents with enteral feeding are at risk of aspiration if the head of bed is not raised during feeding and at least 30	

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F 693	Continued From page 15 R15's Order summary report signed by the primary Physician on 8/28/24, identified an order for enteral feeding two times a day with Nutren 1.5 at 75 milliliters per hour (ml/hr., to run for 16 hours per 24-hour period. Elevate head of bed (HOB) greater than 30 degrees with tube feeding running, Start at 1700 (5:00 p.m.), end at 0900, for a total of 1200ml/day. Reset count to zero with new bag. R15's care plan dated 5/15/17, identified R15 required a tube feeding related to the inability to swallow. Staff were directed to elevate the head of the bed at least 30 degrees during and 30-40 minutes after tube feeding was stopped. During an observation on 10/16/24 at 8:56 a.m., nursing assistant (NA)-A and NA-B put on gowns and gloves and went to R15's room. R15 tube feeding was running at 75 (ml/hr.). R15's head of the bed was at a 30-degree angle. Staff lowered the head of the bed to do morning hygiene care. NA-A washed R15's face, hands, underarms, and breast, and performed perineal care. NA-A put on new gloves and applied a cream under R15's bilateral breasts. NA-A put a new gown on R15. The head of the bed was raised after the morning activities of daily living (ADL's) were completed around 9:20 a.m. During an interview on 10/15/24 at 9:36 a.m., NA-A stated R15 had a g-tube and R15 did not have negative effects when the head of the bed was lowered for care. Licensed nurses do not stop feeding when ADLs are being performed. During an interview on 10/16/24 at 9:36 a.m., NA-B stated nursing assistants cannot stop the	F 693	minutes after feeding. DNS and designees will provide re-education for all staff on the importance of following the care plan for feeding, especially related to the standard practice of raising the head of bed while enteral feeding and at least 30 minutes after. Education will be completed by 11/22/24. The DNS and designees will audit all residents with enteral feeding 3 times a week to ensure that their head of bed is raised to the correct height for the correct amount of time while feeding. Audits will be reviewed by the QAPI committee, and they will give direction for any further needed action. Completion Date 11/27/22	

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F 693	Continued From page 16 g-tube feedings, and only a licensed nurse can stop a feeding. Lowering R15's head of the bed when doing care had not bothered R15. During an interview on 10/16/24 at 12:26 p.m., registered nurse (RN)-C stated the nursing assistants put the head of the bed down long enough to do care. The nursing assistant had never asked for the tube feeding to be stopped as it had not been an issue. On nights the tube feeding would be paused as R15 has vomited in the past on the night shift. During an interview on 10/16/24 at 2:00 p.m., RN-B stated staff would try to keep the head of the bed up. The nursing assistants did not ask the licensed nurses to put the feeding on hold. Between 2:00 a.m. and 4:00 a.m., R15 has vomited in the morning, and then the licensed staff will turn off the tube feeding and run it later during the day. During an interview on 10/16/24 at 3:18 p.m., the director of nursing (DON) stated it would be her expectation that the head of the would be elevated if R15 could tolerate it. If staff needed to perform extensive care, then the feeding could be stopped. The facility Tube-Gastrostomy or Jejunostomy-Enteral Feeding, Care, Placement or Removal policy dated 12/4/24, directed staff to raise the head of the bed 30-45 degrees during feeding and keep elevated for 30-60 minutes after feeding to prevent regurgitation or aspiration unless contraindicated per physician's order.	F 693		
F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3)	F 755		11/27/24

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F 755	Continued From page 17 §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(f). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure a discontinued presciption topical antifungal medication was detroyed and not administered; and failed to ensure only authorizied staff administered	F 755	F755 SS= D On 10/18/24 DNS and designees made a whole facility sweep of all resident rooms for medications and prescription creams not designated for self-administration.	

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F 755	Continued From page 18 prescribed adminstered prescribed creams for 1 of 1 resident (R15) observed to have nursing assistants apply prescribtion creams during cares without an order. Finding include: R15's quarterly Minimum Data Set (MDS) dated 8/20/24, identified R15 had severe cognitive impairment and diagnoses of traumatic brain dysfunction, non-Alzheimer's dementia, hemiplegia (one-sided paralysis or weakness), and seizure disorder. R15 was dependent on staff for all activities of daily living (ADLs) such as personal hygiene, oral hygiene, bed mobility, and dressing. R15's Order summary report signed by the primary Physician on 8/28/24, identified Nystatin External Cream 1000 unit/gram (nystatin topical) and appply to under breast topically two times a day for rash related to rash and other nonspecific skin eruption until resolved; however the ordered was discontinued on 1/10/24. R15's electronic medical administration record (EMAR) for October 2024 identified no administration for nystatin cream. During an observation on 10/16/24 at 8:56 a.m., nursing assistant (NA)-A and NA-B donned gowns and gloves and went to R15's room. NA-A and NA-B washed R15's face, underarms, under breasts, and performed perineal care. NA-A changed gloves and picked up a white tube of cream from the bedside table. Tube had a label from the pharmacy, NA-A squeezed out the last of the cream onto a gloved finger. NA-A applied the cream under both breasts. NA-A reported the	F 755	Current medications and creams were then stored properly, and discontinued or expired medications and prescribed creams were destroyed. R15's cream was removed from the room and destroyed. All residents are at risk for a negative outcome that can arise from receiving a medication, and or treatment from staff who are not properly trained and/or licensed. The DNS and designees will provide re-education for all staff on the importance of having a properly trained and licensed staff administer all medications or treatments. And ensuring each medication and treatment has a current physician's order. Education will be completed by 11/22/24. The DNS and designees will inspect 3 resident rooms 3 times per week for 6 weeks for medications that should not be there. Additionally the DNS and designees will audit resident cares of 3 residents 3 times per week to ensure that staff are not practicing out of there scope. Audits will be reviewed by the QAPI committee and they will give direction for any further needed action. Completion Date 11/27/22	

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F 755	Continued From page 19 cream being applied was Nystatin which goes under R15 breasts. The Nystatin tube was placed back on the side table. The pharmacy label was old, and the writing was worn off in some areas and unable to read the date it was filled and the date it expired. R15's name with the name of the medication nystatin was visible. During an interview on 10/16/24 at 12:26 p.m., registered nurse (RN)-C verified that R15 did not have a current order for nystatin cream. During an interview on 10/16/24 at 2:00 p.m., RN -B verified R15 did not have a current order for nystatin and the nursing assistants do not apply prescription creams. Prescription creams should be locked in the medication cart. During an interview on 10/16/24 at 3:18 p.m. director of nursing (DON) stated creams with a prescription like nystatin should be kept in the medication cart unless the resident had an order to keep them at the bedside. The DON's expected there would be an order for the medication being applied. The facility Medication: Administration including Scheduling and Medication Aids policy dated 5/21/24, directed the following: A provider's order for any medication is required and must include: diagnosis, name of medication, dose, route, frequency and STOP order if indicated. If the medication order is not legible or does not include the items listed above, the provider is notified for clarification prior to administration of medications. Medications are administered to the resident according to the "Six Rights." All employees passing medications are familiar with action and adverse reactions of medications.. Perform three	F 755		

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(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 755	Continued From page 20 checks: read the label on the medication container and compare with the MAR when removing the container from the supply drawer, Do not touch the medication with ungloved hands. Do not leave medications at the bedside or at the table unless there is a specific physician order to do so, and the resident has been evaluated for self-administration.	F 755		
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 §483.71 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	F 880		11/27/24

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F 880	Continued From page 21 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. (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	F 880	Here's the updated F880	

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F 880	Continued From page 22 review, the facility failed to initiate appropriate transmission based precautions according to The Centers for Disease Control (CDC) for 2 of 3 residents (R11, R224) reviewed for transmission based precautions, failed to track and trend potential/actual infections for 6 of 6 residents (R11, R35, R36, R24, R1, R224) identified to have potential/actual infections; and failed to conduct COVID-19 testing per CDC guidelines for 5 of 5 residents (R11, R35, R36, R24, R15) who were identified to have COVID-19 signs and symptoms. This had the potential to affect all 68 residents residing in the facility. Findings include: Transmission-Based Precautions: R11's quarterly Minimum Data Set (MDS) dated 7/12/24, identified R11 was 77 years old, cognitively intact and diagnoses included acute prostatitis (a disorder of the prostate gland associated with inflammation), urinary tract infection (UTI), COVID-19, and Type 2 diabetes. R11's care plan revised 7/24/24, identified R11 had an activities of daily living (ADL) self-care performance deficit related to weakness exhibited by inability to complete at baseline level. Staff were directed to provide extensive assistance of 1-2 for all care activities. However, the care plan failed to identify R11's COVID-19 diagnosis and/or need for transmission-based precautions. During an observation on 10/14/24 at 12:41 p.m., R11's room door was shut, and 3 signs were taped to the outside of the door: Enhanced Barrier Precautions, Contact Precautions and Droplet Precautions. In the hallway, to the left of	F 880	F880 SS= F The DNS and designees performed a whole house sweep on 10/18/24 to ensure proper precautions were in place including proper PPE. R11 and R224 had proper precautions initiated and staff educated. The DNS has created a new system to track potential infections as well as actual infections. Identified residents R11, R25, R36, R24, R1, and R224 no longer had suspected or active infections that required tracking. The DNS and designees audited all suspected COVID 19 cases in the facility to ensure that proper follow up precautions and testing was done after the first test. Identified resident R11 had already been diagnosed with COVID and was placed in droplet precautions. Identified residents R35, R36, R24, and R15 no longer had symptoms and had confirmatory negative testing. All residents are at risk of infection and negative health outcomes because of incorrect precautions, as well as from failure to track potential infections that may later manifest as infections. All residents are at risk when follow up precautions and testing is not done for potential cases of COVID 19. The DNS and designees will re-educate all staff on proper precautions and the correct use of PPE. The DNS has created a new system to track potential infections as well as actual infections. The DNS and designees will re-educate staff about COVID-19 cases including initial testing, implementing precautions and follow up confirmatory testing. The facility will follow	

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F 880	Continued From page 23 R11's closed room door was a 3-drawer bedside stand next to the door that contained disinfectant wipes, N95 masks, gloves, surgical masks, and face shields. There was a facility laundry bin next to the bedside stand containing reusable gowns and was covered with a folded flat sheet. On the right of R11's closed room door was a covered, red biohazard linen container and a trash container. - At 1:13 p.m., nursing assistant (NA)-A approached R11's door and donned gloves, gown and continued to wear the same surgical mask. NA-A did not don eye protection and entered R11's door. - At 1:32 p.m., NA-A exited R11's room and doffed her gown, gloves and mask throwing the items in the uncovered trash. NA-A used hand sanitizer and donned a clean surgical mask. During an interview on 10/14/24 at 1:35 p.m., NA-A stated R11 had "COVID". Staff needed to wear a gown, gloves, and a mask when they went into R11's room. The N95 and/or eye protection wasn't needed but was "extra". NA-A stated you could wear it if you wanted to be extra careful. NA-A had never been directed to wear eye protection in a COVID positive room during her employment at the facility. During an interview on 10/14/24 at 1:45 p.m., registered nurse (RN)-C was observed exiting R11's room and doffed a gown, gloves, mask, and face shield. RN-C cleaned the face shield with a disinfectant wipe, put the soiled gown in the biohazard linen bin and threw the soiled gloves in the uncovered trash. RN-C stated the biohazard linen bin and trash container should be on the inside of R11's door, but there was no room for it. If it was on the inside of the door it	F 880	current CDC guidelines on COVID-19 testing and implementation of precautions. Education will be completed by 11/22/27. The DNS and designees will audit 3 resident cares 3 times a week for 6 weeks to ensure that PPE is being used correctly, audits will be reviewed by the QAPI committee and they will give direction for any further needed action. The Senior Quality Analyst will audit the DNS's potential infection tracking system to ensure that it is being used 1 time a week for 6 weeks. Audits will be reviewed by the QAPI committee and they will give direction for any further needed action. The DNS and designees will audit all residents that have a negative test for COVID 19 that are suspected of having COVID 19 based on symptoms weekly to ensure that they are put on precautions as needed and are given a follow up test as needed for 6 weeks. Audits will be reviewed by the QAPI committee and they will give direction for any further needed action. Completion Date 11/27/24	

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F 880	Continued From page 24 would have to be at least 6 feet inside the room and that defeated the purpose of wearing personal protective equipment (PPE) inside R11's room. Staff were expected to wear a gown, gloves, N95 mask and eye protection whenever entering R11's door. During an interview on 10/15/24 at 12:38 p.m., the director of nursing (DON) stated R11 was placed into Droplet Precautions when he tested positive for COVID-19 on 10/7/24. The signage on the door tells staff what PPE was required. The DON stated no audits had been conducted to determine if staff were following guidance during the facility's COVID-19 outbreak. Because R11 had a suprapubic catheter, R11 was in Enhanced Barrier Precautions prior to getting ill. Having multiple signs on the door would be confusing for staff because which one should staff follow. However, the DON stated staff have been educated what PPE was required for COVID-19 and were expected to use it as directed. Additionally, all biohazard linen bins and trash bins should have been in the R11's room for staff to doff while in the room. There was room in the resident rooms for them. This was important to prevent the potential spread of infection between other residents, staff, and visitors. The Centers for Disease Control and Prevention (CDC) Appendix A - Type and Duration of Precautions Recommended for Selected Infections and Conditions of the CDC Guideline for Isolation Precautions updated 9/20/24, identified severe acute respiratory syndrome (SARS) (COVID-19) required droplet precautions for the duration of illness plus 10 days after resolution of fever, provided respiratory symptoms were absent or improving.	F 880		

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F 880	Continued From page 25 R224's 5-day MDS dated 9/29/24, identified R224 was 56 years old and had intact cognition. R224's diagnoses included bacteremia, weakness, acute kidney injury and hypertension. R224 used an indwelling catheter and an antibiotic. The MDS failed to identify R224 had an infection with a multi drug resistant organism (MDRO). R224's Urinary Incontinence and Indwelling Catheter care area assessment (CAA) dated 9/29/24, identified R224 had an indwelling catheter, a urinary tract infection (UTI) and benign prostatic hyperplasia (BPH) (an enlarged prostate). The CAA further identified urinary incontinence and indwelling catheter use would "not" be addressed on R224's care plan. R224's care plan dated 10/14/24, identified R224 required Enhanced Barrier Precautions (EBP) related to R224's indwelling urinary catheter. Staff were directed to don a gown and gloves when performed high contact care activities including dressing, changing linens, repositioning, check and changing, device care and/or use, and wound care. Staff were directed to doff gown and gloves inside R224's room and perform hand hygiene. R224's physician orders identified R224's indwelling urinary catheter was placed on 9/11/24. R224's progress note dated 10/7/24 at 4:05 p.m., identified R224 had been hospitalized due to hypotension related hypovolemia (a condition in which the volume of blood plasma is too low. This causes a rapid heart beat, weak pulse, confusion, and loss of consciousness); acute kidney injury superimposed on chronic kidney disease, history	F 880		

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F 880	Continued From page 26 of Methicillin-resistant staph aureus (MRSA). R224's hospital discharge summary dated 9/26/24, identified R224 discharge diagnoses included MRSA sepsis and early septic shock due to complicated UTI and MRSA complicated UTI. R224 was to continue vancomycin (an antibiotic) for 4 weeks. During an interview on 10/15/24 at 8:29 a.m., R224's indwelling catheter was in a cloth cover lying on the floor of his room. R224 stated nursing was good about cleaning his indwelling catheter, but R224 never saw factility staff wear a gown like the hospital nurses did. During an observation on 10/15/24 at 11:03 a.m., R224's door was open with an Enhanced Barrier Precautions sign taped to the door.Registered nurse (RN)-H exited R224's room and doffed a gown and gloves. RN-H placed the gown in the red, covered biohazard linen container in the hallway and placed the soiled gloves in the uncovered trash. RN-H did not doff her surgical mask. - At 11:05 a.m., RN-H went approximately 50 feet down the hallway, around the corner to the nurses' station and donned gown and gloves on the way back to R224's room and entered. No PPE supplies were near R224's room. - At 11:10 a.m., RN-I approached R224's door, looked around then walked away asking staff why there were no gowns for R224. RN-I went to the nurses' station and donned a gown and gloves while returning to R224's room. RN-I stated over half the resident rooms required Enhanced Barrier Precautions due to surgical wounds. Because of this, there were not enough carts to go around and the nurses' placed gowns at the	F 880		

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F 880	Continued From page 27 nurses' station to be centrally located. - At 11:15 a.m., RN-H exited R224's room with the soiled gown bunched up in her hand and placed the gown in the biohazard linen bin. - At 11:17 a.m., RN-I exited R224's room with a gown bunched up in her hand and placed the soiled gown in the biohazard bin. RN-I did not use hand sanitizer and went to her office with a visitor. During an interview on 10/15/24 at 11:19 a.m., RN-H stated R224 was on precautions due to having an indwelling catheter. RN-H stated she did not know what an MDRO was, but confirmed R224 did have MRSA. Well, R224 should have been on Contact Precautions but what's the difference. Staff were already wearing gowns, gloves, and masks. RN-H then stated she "guessed" it would depend on the infection, where the infection was and what the precautions should be. However, staff probably weren't even aware R224 had an infection. RN-H stated she was unaware R224 had an infection until asked and a Contact Precautions sign on R224's door may have triggered her to review his chart earlier to see what R224 had and what R224 required to keep other residents, staff, and visitors safe. During an interview on 10/15/24 at 11:45 a.m., laundry aide (LA)-A was observed donning a gown and gloves while walking down the hall from the nurses' station. LA-A stated a huge stack of gowns were delivered in a facility laundry bin on 10/14/24. LA-A had put one bin in each hallway and stated there just was not enough carts for each room, so she had tried to keep them centrally located. During an interview on 10/15/24 at 12:04 p.m., RN-J stated nursing staff moved the gowns to the	F 880		

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F 880	Continued From page 28 nurses' station that morning because staff didn't want to run all over to get gowns. During an interview on 10/15/24 at 12:12 p.m., the director of nursing (DON) stated she was not aware R224 had MRSA. R224 did have MRSA in his diagnosis list. However, diagnoses are entered by health information management (HIM) who only input the diagnosis code. Nursing is not alerted to high risk/high alert diagnoses by HIM. The admitting nurse reviewed a potential resident's hospital medical record then would send an email with information. The DON stated the initial review did not identify R224 required Enhanced Barrier Precautions on his initial admission. However, R224 was re-hospitalized and returned on 10/7/24 and Enhanced Barrier Precautions were then implemented. However, the DON stated R224's hospital discharge summary identified R224 had an active MRSA UTI and should have been placed into Contact Precautions when he was admitted to the facility on 9/26/24. It was important for the staff to know the differences in the different type of transmission-based precautions and Enhanced Barrier Precautions to prevent the chance to spread infection not only between the residents but the staff as well. During an interview with the DON and RN-I on 10/15/24 at 12:57 p.m., RN-I stated she didn't review resident's charts for MDRO unless she had time to do so. If a resident was admitted on an antibiotic, it would prompt the implementation of Clinical Monitoring- Infections/Suspected Infections V10 form in the resident assessments. If there was an identified history of MDRO, Enhanced Barrier Precautions were implemented as well. After admission, if an infection was	F 880		

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F 880	Continued From page 29 diagnosed, any nurse could implement the Clinical Monitoring- Infections/Suspected Infections V10 form as well. R224, RN-I stated more than likely RN-I was aware of the MRSA infection but could not verify that. If RN-I wasn't told by admission nurse, RN-I wouldn't go diving for that. RN-I stated she implemented Enhanced Barrier Precautions for R224 on 10/14/24 due to R224's indwelling catheter but R224 should have been in Contact Precautions since his admission on 9/26/24 because he had an active MRSA infection to prevent the spread of infection. Additionally, the soiled bins should be on the inside of the room. The DON stated they clearly had a process problem and needed to educate their staff. The Centers for Disease Control and Prevention (CDC) Appendix A - Type and Duration of Precautions Recommended for Selected Infections and Conditions of the CDC Guideline for Isolation Precautions updated 9/20/24, identified Multidrug-Resistant organisms (e.g. MRSA) required contact precautions recommended in settings with evidence of ongoing transmission, acute care settings with increased risk for transmission or wounds that cannot be contained by dressings. The facility policy Multidrug-Resistant Organisms, MRSA, VRE, CRE and ESBL, All Service Lines revised 4/12/24, identified residents colonized with a CDC-targeted MORO and select epidemiologically important MDROs at the facilities discretion are intended to remain on Enhanced Barrier Precautions for the duration of their stay in a facility. Because MORO colonization is prolonged and follow-up testing to determine clearance may yield false negatives,	F 880		

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F 880	Continued From page 30 CDC does not recommend routine retesting of residents with a history of colonization or infection with a targeted MDRO. Use contact precautions when the resident is infected or colonized with an MDRO and secretions and excretions are unable to be contained. This includes: - Residents with multidrug-resistant organism infected or colonized wounds that cannot be covered fully by dressings or who have drainage that cannot be contained by dressings. Residents with fecal or urinary carriage of multidrug-resistant organisms whose urine or stool cannot be contained in incontinent products, urine bags or ostomy bags. - Residents with a tracheostomy who have colonized or infected respiratory tracts and large amounts of uncontained respiratory secretions. - Residents who have been linked to transmission of multidrug-resistant organisms. The policy further directed for infections (e.g., C. difficile, norovirus, scabies) and other conditions where Contact Precautions is recommended see Appendix A - Type and Duration of Precautions Recommended for Selected Infections and Conditions of the CDC Guideline for Isolation Precautions. Surveillance: The Infection Control Report - September 2024, identified the infection rates for the facility, an analysis of the data collected, resident name, room, source, site, comments and dates of infection and a color-coded map. R11's quarterly Minimum Data Set (MDS) dated 7/12/24, identified R11 was 77 years old, cognitively intact and had diagnoses that included acute prostatitis (a disorder of the prostate gland	F 880		

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F 880	Continued From page 31 associated with inflammation), urinary tract infection (UTI), COVID-19, and Type 2 diabetes. R11's progress note dated 9/26/24 at 8:30 p.m., identified R11 reported that he was feeling feverish. Temperature 98.3 degrees F. However, R11's medical record failed to identify if R11 was placed in transmission-based precautions until a confirmatory test was collected. The facility's Infection Control Report - September 2024 failed to identify R11's symptoms. R35's annual MDS dated 7/2/24, identified R35 was 78 years old and had diagnoses that included chronic kidney disease and Type 2 diabetes. R35's progress note dated 9/26/24 at 1:48 p.m., identified R36 slept in bed throughout shift. R35 reported feeling run down and achy. The facility's Infection Control Report - September 2024 failed to identify R35's potential infection symptoms. R36's quarterly MDS dated 7/8/24, identified R36 was 86 years old and had diagnoses that included hypertension, heart disease, dysphagia, and congestive heart failure. R36's progress note date 10/2/24 at 1:38 p.m., identified R36 was withdrawn and not eating or drinking much. R36's face was flushed, dry and ruddy. R36 was slow to respond when spoken to. R36's temperature was 98 degrees F. The facility's Infection Control Report -	F 880		

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F 880	Continued From page 32 September 2024 failed to identify R35's potential infection symptoms. R24's quarterly MDS dated 8/22/24, identified R24 was 66 years old and had diagnoses that included hypertension and Type 2 diabetes. R24's progress note dated 10/16/24 at 4:33 p.m., identified R24 was warm to touch, diaphoretic (excessive sweating). R24's vitals were as follows: blood pressure 118/73, temperature 98.0 degrees F, blood sugar 129, respirations 18, heartrate 74. R24 complained of increased discomfort to bilateral legs after therapy. Tylenol 650 mg administered x 1. The facility's Infection Control Report - September 2024 failed to identify R24's potential infection symptoms. R15's quarterly MDS dated 8/20/24, identified R15 was 33 years old and had diagnoses that included diabetes insipidus and hypertension. R15's progress note dated 10/15/24 at 4:24 p.m., identified R15's skin felt very warm, but her temp was 97.7 degrees F. R15 was frowning and upset when staff approached her. R15 was less irritable when not touched. R15 she pinched and scratched nurse's forearms when nurse attempted to take temperature. The facility's Infection Control Report - September 2024 failed to identify R15's potential infection symptoms. During an interview on 10/17/24 at 10:30 a.m., the DON stated she was responsible for the facility's infection control program. The DON used	F 880		

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	245500	A. BUILDING _____ B. WING _____	C 10/17/2024

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F 880	Continued From page 33 two processes for the facility's infection surveillance. The first process was the infection "dashboard" in the facility's electronic medical record system. The nurses entered resident infection data into Clinical Monitoring-Infections/Suspected Infections V10 form in the resident assessments. Every morning that information was pulled into the infection log. The DON stated the facility's infection surveillance log was dependent on nursing to enter the data or it would not be reflected on the surveillance reports. When reviewing the infection control dashboard in the electronic medical record system, each individual resident would need to be reviewed. For an example, when a resident tested positive for COVID-19, Clinical Monitoring-Infections/Suspected Infections V10 form was completed every shift until the resident's illness resolved. If the form was not completed, the data would not be pulled into the log. The second process was a paper log. The DON was taking information from the "dashboard" and entered the data in the paper log. The DON stated she did not know how to print any reports from the dashboard, and this eased tracking and trending. The DON stated resident illness needed to be tracked to determine trends in the facility and for the prevention of possible spread of infection. A facility policy regarding infection control surveillance was requested but not received. A copy of the facility's dashboard surveillance was requested but not received. A copy of the facility's Infection Control Report - October 2024 was requested but not received. COVID-19 Testing:	F 880		

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F 880	Continued From page 34 The Centers for Disease Control and Prevention (CDC) Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic updated 3/18/24, identified the decision to discontinue empiric Transmission-Based Precautions by excluding the diagnosis of current SARS-CoV-2 infection for a patient with symptoms of COVID-19 can be made based upon having negative results from at least one viral test. - If using NAAT (molecular) (A Nucleic Acid Amplification Test is a type of viral diagnostic test for SARS-CoV-2, the virus that causes COVID-19. NAATs detect genetic material (nucleic acids). NAATs for SARS-CoV-2 specifically identify the RNA (ribonucleic acid) sequences that comprise the genetic material of the virus), a single negative test is sufficient in most circumstances. If a higher level of clinical suspicion for SARS-CoV-2 infection exists, consider maintaining Transmission-Based Precautions and confirming with a second negative NAAT. - If using an antigen test, a negative result should be confirmed by either a negative NAAT (molecular) or second negative antigen test taken 48 hours after the first negative test. - If a patient suspected of having SARS-CoV-2 infection is never tested, the decision to discontinue Transmission-Based Precautions can be made based on time from symptom onset as described in the Isolation section below. Ultimately, clinical judgment and suspicion of SARS-CoV-2 infection determine whether to continue or discontinue empiric Transmission-Based Precautions.	F 880		

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F 880	Continued From page 35 R11's quarterly Minimum Data Set (MDS) dated 7/12/24, identified R11 was 77 years old, cognitively intact and had diagnoses that included acute prostatitis (a disorder of the prostate gland associated with inflammation), urinary tract infection (UTI), COVID-19, and Type 2 diabetes. R11's progress note dated 9/26/24 at 8:30 p.m., identified R11 reported that he was feeling feverish. Temperature 98.3 degrees F. COVID test repeated with negative results. R11's medical record failed to identify if R11 had a confirmatory COVID-19 test and/or if/when R11 had been placed in isolation. R35's annual MDS dated 7/2/24, identified R35 was 78 years old and had diagnoses that included chronic kidney disease and Type 2 diabetes. R35's progress note dated 9/26/24 at 1:48 p.m., identified R36 slept in bed throughout shift. R35 reported feeling run down and achy. Covid swab was negative. R35's medical record failed to identify if R35 had a confirmatory COVID-19 test and/or if/when R35 had been placed in isolation. R36's quarterly MDS dated 7/8/24, identified R36 was 86 years old and had diagnoses that included hypertension, heart disease, dysphagia, and congestive heart failure. R36's progress note date 10/2/24 at 1:38 p.m., identified R36 was withdrawn and not eating or drinking much. R36's face was flushed, dry and ruddy. R36 was slow to respond when spoken to.	F 880		

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F 880	Continued From page 36 R36's temperature was 98 degrees F. R36's Covid Swab test was negative. R36's medical record failed to identify if R36 had a confirmatory COVID-19 test and/or if/when R36 had been placed in isolation. R24's quarterly MDS dated 8/22/24, identified R24 was 66 years old and had diagnoses that included hypertension and Type 2 diabetes. R24's progress note dated 10/16/24 at 4:33 p.m., identified R24 was warm to touch, diaphoretic (excessive sweating). R24's vitals were as follows: blood pressure 118/73, temperature 98.0 degrees F, blood sugar 129, respirations 18, heartrate 74. Rapid Covid screen negative. R24 complained of increased discomfort to bilateral legs after therapy. Tylenol 650 mg administered x 1. R24's medical record failed to identify if R24 had a confirmatory COVID-19 test and/or if/when R24 had been placed in isolation. R15's quarterly MDS dated 8/20/24, identified R15 was 33 years old and had diagnoses that included diabetes insipidus and hypertension. R15's progress note dated 10/15/24 at 4:24 p.m., identified R15's skin felt very warm, but her temp was 97.7 degrees F. R15 was frowning and upset when staff approached her. R15 was less irritable when not touched. R15 she pinched and scratched nurse's forearms when nurse attempted to take temperature. R15 was tested for COVID-19 and R15's antigen test was negative.	F 880		

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F 880	Continued From page 37 R15's medical record failed to identify if R15 had a confirmatory COVID-19 test and/or if/when R15 had been placed in isolation. During an interview on 10/17/24 at 10:30 a.m., the DON stated she tracked positive COVID-19 residents and staff. Also, a list of residents and staff tested due to outbreak testing was available. However, residents who were tested due to symptoms were only tracked by the progress note in each resident's medical record and were not tracked. Additionally, symptomatic residents who had an antigen test negative result were not placed into transmission-based precautions and/or a confirmatory test collected. The facility policy Emerging Threats - Acute Respiratory Syndromes Coronavirus (COVID) revised 4/19/24, identified residents were monitored for signs and symptoms of COVID-19 per routine. practice. Residents with symptoms of COVID-19 will be isolated and tested immediately. Removal from isolation will follow current CDC guidelines.	F 880		

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K 000	INITIAL COMMENTS An annual Life Safety recertification survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 10/15/2024. At the time of this survey, Good Samaritan Society-Bethany 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 NFPA 101 (2012 edition), Life Safety Code, Chapter 19 Existing Health Care, and the NFPA 99 (2012 edition), 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 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: HEALTH CARE FIRE INSPECTIONS	K 000		

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

Electronically Signed | 11/07/2024

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 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. The facility was inspected as one building. Good Samaritan Society-Bethany is a 1-story building without a basement. The building was constructed at six different times. The original building was constructed in 1969, is 1-story, and was determined to be of Type II(000) construction. In 1974, two 1-story additions were constructed, one to the southwest and one to the east side of the original building, that were determined to be of Type II(111) construction and are separated with	K 000		

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K 000	Continued From page 2 2-hour fire barriers from the existing building. In 1980 a 1-story addition was constructed to the south and east of the 1974 south addition, which was determined to be of Type II(111) construction, and is separated with a 2-hour fire barrier. In 1983 a small 1-story connecting link was added to the south of the 1980 addition to connect the facility to an apartment building and was determined to be Type V(000) construction. This link is not separated from the facility, but a 2-hour fire barrier is between the link and the apartment building. In 1994 the Physical Therapy 1- story addition was added to the north of the original building and was determined to be Type II (111) construction. In 1998 a 1-story addition was constructed to the north of the 1960 building and in 1974, an addition that was determined to be of Type V(111) construction and is separated by a 2-hour fire barrier. The main level is divided into 11 smoke zones by 30 minute and 90-minute fire barriers. The entire building is protected by a complete automatic fire sprinkler system and also has a fire alarm system with smoke detection in the corridors, spaces open to the corridor system, in common areas, and in all sleeping rooms that is monitored for automatic fire department notification. The facility has a capacity of 76 beds and had a census of 68 at the time of the survey. The requirements at 42 CFR, Subpart 483.70(a) are NOT MET as evidenced by:	K 000		
K 351 SS=D	Sprinkler System - Installation CFR(s): NFPA 101	K 351		11/27/24

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K 351	Continued From page 3 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 observation and staff interview, the facility failed to install the sprinkler system in accordance with the NFPA 101 (2012 edition), Life Safety Code, section 9.7.1.1, and NFPA 13 (2010 edition), Standard for the Installation of Sprinkler Systems section 8.15.4.3.1. This deficient finding could have an isolated impact on the residents within the facility. Findings include: On 10/15/2024 between 09:30 AM to 1:00 PM, it was revealed in the medical storage room there are 3 sprinkler heads that are within 6 feet of each other due to construction in the past. An interview with the Administrator and the	K 351	Disclaimer Preparation and execution of this response and plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/ or executed solely because it is required by the provisions of federal and state law. For the purposes of any allegation that the center is not in substantial compliance with federal requirements of participation, this response and plan of correction constitutes the center's allegation of compliance in accordance with section 7305 of the State	

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K 351	Continued From page 4 Maintenance Director verified this deficient finding at the time of discovery.	K 351	Operations Manual. K351 SS= D By 11/27/24 the two sprinkler heads that interfered with proper spray patterns of other sprinkler heads will be removed and capped by our sprinkler service company. By 11/27/24 the Director of Environmental Services and the sprinkler service provider will have made a whole facility sweep to identify any other sprinkler heads that may need to be removed. The Director of Environmental Services or designee will report quarterly to the QAPI committee on any updates that may be needed to the sprinkler system, until such time as the QAPI committee feels that the new system will be sustained going forward. Completion Date 11/27/24	
K 353 SS=C	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source	K 353		11/27/24

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K 353	Continued From page 5 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, documentation review, and staff interview the facility failed to inspect and maintain the sprinkler system in accordance with NFPA 101 (2012 edition), Life Safety Code, sections 4.6.12, 9.7.5, 9.7.6, NFPA 25 (2011 edition) Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, section(s), 4.4, 5.2.1.1.1. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 10/15/2024, between 9:30 AM and 1:00 PM, it was revealed during documentation review of the quarterly sprinkler documentation provided during the time of the survey, the quarterly sprinkler testing was completed 3 days before the first quarter of 2024 resulting in the first quarter of the 2024 not being completed during the quarterly timeframe. An interview with the Maintenance Director and Administrator verified this deficient finding at the time of discovery.	K 353	K353 SS= C On 11/06/24 a calendar was made of all the sprinkler inspection dates and times for the next year by the Director of Environmental Services and shared with the Administrator and the Senior Quality Analyst. On 11/06/24 these dates were entered into a Microsoft Outlook calendar that the Director of Environmental Services, Administrator, and the Senior Quality Analyst have access to. This will ensure accountability and redundancy to ensure that sprinkler inspections are done as planned. This will be the ongoing procedure for the facility. Going forward it will be the responsibility of the Director of Environmental Services or designee to maintain the Outlook calendar and report quarterly to the QAPI committee on the timeliness of the sprinkler inspections until such time as the QAPI committee feels that the new system will be sustained going forward. Completion Date 11/06/24	
K 712 SS=C	Fire Drills CFR(s): NFPA 101 Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions.	K 712		11/27/24

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K 712	Continued From page 6 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 a review of available documentation and staff interview, the facility failed to conduct fire drills per NFPA 101 (2012 edition), Life Safety Code section 19.7.1.6. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 10/15/2024 between 09:30 AM and 1:00 PM, it was revealed by a review of available documentation at the time of the survey the facility provided documentation that in the first quarter of 2024, 1 fire drill in the first shift and 2 fire drills were conducted in the second shift and could not provide documentation showing that a third shift fire drill was conducted. An interview with the Administrator and the Maintenance Director verified this deficient finding at the time of discovery.	K 712	K712 SS= C On 11/06/24 a calendar was made of all the fire drill dates and times for the next year by the Director of Environmental Services and privately shared with the Administrator and the Senior Quality Analyst. On 11/06/24 these dates were entered into a private Microsoft Outlook calendar that only the Director of Environmental Services, Administrator, and the Senior Quality Analyst have access to. This will ensure accountability and redundancy to ensure that fire drills are done as planned. This will be the ongoing procedure for the facility. Going forward it will be the responsibility of the Director of Environmental Services or designee to maintain the Outlook calendar and report quarterly to the QAPI committee on the timeliness of the drills until such time as the QAPI committee feels that the new system will be sustained going forward. Completion Date 11/06/24	