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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 4Z53

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00087

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245500**

2.STATE VENDOR OR MEDICAID NO.
(L2) **078040500**

3. NAME AND ADDRESS OF FACILITY
(L3) **GOOD SAMARITAN SOCIETY - BETHANY**
(L4) **804 WRIGHT STREET**
(L5) **BRAINERD, MN** (L6) **56401**

4. TYPE OF ACTION: **2** (L8)

1. Initial	**2. Recertification**
3. Termination	**4. CHOW**
5. Validation	**6. Complaint**
7. On-Site Visit	**9. Other**
8. Full Survey After Complaint	

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **10/21/2021** (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)
12/31

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

12.Total Facility Beds **106** (L18)

13.Total Certified Beds **106** (L17)

10.THE FACILITY IS CERTIFIED AS:

A. In Compliance With Program Requirements Compliance Based On:
___1. Acceptable POC

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
	106			
(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 :
Dani Yuretic HFE - NE II 12/13/2021 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Joanne Simon, Enforcement Specialist 12/31/2021 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
01/01/1988
(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.
00140
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

Electronically delivered
November 16, 2021

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

RE: CCN: 245500
Cycle Start Date: October 21, 2021

Dear Administrator:

On October 21, 2021, a survey was completed at your facility by the Minnesota Department(s) of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), as evidenced by the electronically delivered CMS-2567, whereby significant corrections are required.

REMEDIES

As a result of the survey findings and in accordance with survey and certification memo 16-31-NH, this Department recommended the enforcement remedy(ies) listed below to the CMS Region V Office for imposition. The CMS Region V Office concurs and is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective December 31, 2021.

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

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective December 31, 2021. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective December 31, 2021.

You should notify all Medicare/Medicaid residents admitted on, or after, this date of the restriction. The remedy must remain in effect until your facility has been determined to be in substantial compliance or your provider agreement is terminated. Please note that the denial of payment for new admissions includes Medicare/Medicaid beneficiaries enrolled in managed care plans. It is your obligation to inform managed care plans contracting with your facility of this denial of payment for new admissions.

This Department is also recommending that CMS impose:

• Civil money penalty (42 CFR 488.430 through 488.444). You will receive a formal notice from the CMS RO only if CMS agrees with our recommendation.

NURSE AIDE TRAINING PROHIBITION

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

If you have not achieved substantial compliance by December 31, 2021, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, Good Samaritan Society - Bethany will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from December 31, 2021. You will receive further information regarding this from the State agency. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions.

However, under Public Law 105-15, you may contact the State agency and request a waiver of this prohibition if certain criteria are met.

ELECTRONIC PLAN OF CORRECTION (ePOC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved. The failure to submit an acceptable ePOC can lead to termination of your Medicare and Medicaid participation (42 CFR 488.456(b)).

To be acceptable, a provider's ePOC must include the following:

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.
- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

DEPARTMENT CONTACT

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health - Health Regulation Division staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for their respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a Post Certification Revisit (PCR), of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

FAILURE TO ACHIEVE SUBSTANTIAL COMPLIANCE BY THE SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by April 21, 2022 if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at § 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR § 488.412 and § 488.456.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

APPEAL RIGHTS

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40, et seq. You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at https://dab.efile.hhs.gov no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

Tamika.Brown@cms.hhs.gov

Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted as of October 1, 2014, unless you do not have access to a computer or internet service. In those circumstances you may call the Civil Remedies Division to request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a written request for a waiver along with your written request for a hearing. A written request for a hearing must be filed no later than sixty (60) days after receiving this letter, by mailing to the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
(202) 565-9462

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Tamika Brown, Principal Program Representative by phone at (312) 353-1502 or by e-mail at Tamika.Brown@cms.hhs.gov.

INFORMAL DISPUTE RESOLUTION (IDR) / INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

In accordance with 42 CFR 488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to:

Nursing Home Informal Dispute Process
Minnesota Department of Health
Health Regulation Division
P.O. Box 64900
St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: https://mdhprovidercontent.web.health.state.mn.us/ltc_idr.cfm

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

Questions regarding all documents submitted as a response to the Life Safety Code deficiencies (those preceded by a "K" tag) i.e., the plan of correction, request for waivers, should be directed to:

William Abderhalden, Fire Safety Supervisor
Deputy State Fire Marshal
Health Care/Corrections Supervisor – Interim
Minnesota Department of Public Safety
445 Minnesota Street, Suite 145
St. Paul, MN 55101-5145
Cell: (507) 361-6204
Email: william.abderhalden@state.mn.us
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Joanne Simon, Enforcement Specialist
Minnesota Department of Health
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
	245500	A. BUILDING _____ B. WING _____	10/21/2021

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 10/18/21 through 10/21/21, a survey for compliance with Appendix Z, Emergency Preparedness Requirements, §483.73(b)(6) was conducted during a standard recertification survey. The facility was 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 10/18/21 through 10/21/21, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. 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 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 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents.	F 689		12/1/21

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

Electronically Signed | 11/22/2021

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F 689	Continued From page 1 The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to implement intervenitons for fall prevention for 1 of 1 residents (R51) reviewed for falls. Findings include: R51's quarterly minimum data set (MDS) dated 10/4/21, indicated R51 was cognitively impaired, did not ambulate and required assistance from two staff with activities of daily living (ADL's) including transfers, toileting and personal hygiene. R51's diagnoses included weakness and encephalopathy (a disease which affects brain structure or function and causes altered mental state and confusion). R51's care plan dated 7/8/21, indentifed R51 was at risk for falls related to confusion, pain and weakness. The care plan directed staff to implement interventions which included to ensure R51 had a touch pad call light placed on the edge of the bed when resident was in bed. R51's incident report dated 10/17/21, identified at 8:20 p.m. R51 was found on the floor and leaning against the wall. R51's call light was within reach but the touch pad call light was hanging on the bed rail and not been placed on the bed. The report further indicated the nursing assistant	F 689	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. F-689 SS=D 1. All staff were re-educated by DNS and designees as to the care plan of resident R51 and the requirement and proper use of touchpad call light to help prevent falls. 2. All residents who use touch pad call lights as a to help mitigate fall risk are at risk of fall and injury due to their care plan not being followed in regards to the use of the touch pad call light. 3. The DNS reviewed all care plans for	

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F 689	Continued From page 2 stated she forgot to place the touch pad call light under R51 when she had assisted him to bed earlier that evening. During interview on 10/21/21, at 9:15 a.m. registered nurse (RN)-C stated R51's touch pad call light was supposed to be placed next him on the edge of the bed. The touch pad call light was placed at the edge of the bed to alert staff the resident was moving. -At 10:17 a.m. nursing assistant (NA)-C and RN-D were interviewed together. NA-C stated R51 had a touch pad call light that was supposed to be placed on the edge of the bed. Touch pad call light's were used to alert staff when the resident was moving and were not used to prevent a resident from falling. RN-D stated touch pad call light's were used to help prevent a resident from falling by alerting staff when a resident was moving so the staff were able to assist the resident prior to self transferring. -At 12:18 p.m. NA-A stated since R51's admission to facility R51 was supposed to have a touch pad call light on the edge of the bed when he was in bed. The alarm was used to alert staff that the resident was moving so staff could attend to the resident prior to self transferring. On 10/17/21, she assisted R51 to bed and forgot to place the touch pad call light on the bed next to R51. Later that evening R51 was found on the floor. - At 3:13 p.m. the director of nursing (DON) stated NA-A assisted R51 to bed the evening of 10/17/21. NA-A forgot to place the touch pad call light under R51. R51 had not turned on the call light, self transferred and fell, staff were not	F 689	the use of touch pad call lights to reduce falls, and audited all of those residents to ensure that their use of touch pad call lights was appropriate and that they were in place. All staff were re-educated on the requirement and proper use of a touchpad call light to help prevent falls through one on one education by the DNS or designee. 4. DNS or designee will audit 3 residents who use touch pad call lights to help prevent falls 3 times a week for 6 weeks. They will report their findings to the QAPI committee after which the results of the audits will be reviewed by the QAPI committee and they will give direction for any further needed action. 5. Corrected by 12/1/2021	

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F 689	Continued From page 3 following his care plan. The touch pad call light were used to alert staff a resident was moving and were not used to prevent falls from happening. The facility Fall Prevention and Management policy revised 9/17/21, identified the risk of falling for residents in long-term care locations substantially increases due to decreased mobility, frailty, muscle weakness, gait disturbance and disease progression. After a fall, a resident may experience lifestyle changes due to impaired function, decrease mobility and lost independence. It is the facilities obligation to provide the safest environemnt possible for the residents trusted to the facilities care. The policy directs staff to identify fall risk factors, care plan appropriate interventions (including personalizing all areas), communicate fall risks and interventions per the 24-hour report, care plan and kardex, daily stand-up meeting, and/or fall committee meetings, as well as communicate any identified environmental changes and/or referral needs.	F 689		
F 880 SS=D	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	F 880		12/1/21

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F 880	Continued From page 4	F 880		

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.
(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

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GOOD SAMARITAN SOCIETY - BETHANY	804 WRIGHT STREET BRAINERD, MN 56401

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F 880	Continued From page 5 by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure hand hygiene was performed during personal cares and after touching their personal protective equipment (PPE) for 1 of 3 residents (R46) observed during personal cares. Findings include: R46's quarterly minimum data set (MDS) dated 9/27/21, indicated R46 was cognitively impaired and required assistance with activities of daily living including personal cares. On 10/20/21, at 8:04 a.m. nursing assistant (NA)-B was observed completing morning cares for R46. NA-B washed R46's peri area with a wet wash cloth and then placed the dirty wash cloth in the wash basin on the table next to the bed. NA-B's face mask slid down below the tip of her nose. With same dirty, wet gloved hand, NA-B reached and pulled her own face mask up over her nose and stated her face mask slipped down.	F 880	F-880 SS=D 1. All staff were re-educated as to proper hand hygiene and hand washing policy including sanitizing hands after doffing and before donning gloves as well as before and after touching PPE. 2. All residents are at risk of infection due to improper hand hygiene. 3. An RCA was performed by QAPI coordinator, Administrator, DNS/Infection Preventions. The result of the RCA was that the location of hand sanitizers by the door was not always easy to access when preforming cares. All nursing staff received a personal bottle of hand sanitizer to have as part of their uniform for easy access to hand sanitizer during cares. Additionally all staff were re-educated as to proper hand hygiene and hand washing policy including	

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 _____	10/21/2021

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

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F 880	Continued From page 6 NA-B completed R46's cares, removed the soiled gloves and did not complete hand hygiene. NA-B then proceeded to fasten R46's brief and pull up their pants. NA-B exited R46's room and did not perform hand hygiene. - At 8:28 a.m. NA-B re-entered R46's room and did not perform hand hygiene and put on a clean pair of gloves. Using both hands NA-B emptied R46's catheter urine into a receptacle, clamped catheter tubing, stood and with same dirty gloved hands pulled up her own face mask and stated "I just touched my mask with that hand, that was gross." NA-B entered the bathroom, emptied urine receptacle, removed their gloves and washed their hands with soap and water. NA-A adjusted R46's catheter tubing and bag. NA's face mask slid down to the tip of her nose again. NA-B stood, reached up and adjusted her dirty face mask by pulling it up over her nose and then wheeled R46 out of the room and down the hallway. NA did not use hand sanitizer upon exiting residents room. During interview on 10/20/21, at 8:43 a.m. NA stated she did not perform hand hygiene after providing peri care to R46, prior to or after adjusting her face mask up, or prior to exiting R46's room. Staff were expected to use hand sanitizer every time they remove gloves, between dirty and clean procedures and upon entering or exiting a residents room. During interview on 10/21/21, at 3:13 p.m. the director of nursing (DON) stated staff were expected to perform hand hygiene before entering a residents room, before putting on and taking off gloves, prior to/after dirty to clean tasks, and upon exiting a residents room. Staff were	F 880	sanitizing hands after doffing and before donning gloves as well as before and after touching PPE. 4. Audits will be performed on 3 staff every shift for a week by the DNS and/or designee to ensure that staff are performing proper hand hygiene. After which the results of the audits will be reviewed by the QAPI committee and they will give direction for any further needed action. 5. Corrected by 12/1/2021	

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F 880	Continued From page 7 expected to wash hands their when they were visible dirty. The Hand Hygiene and Handwashing policy revised 4/6/21, indicated regular handwashing with soap and warm, not hot, water is one of the best ways to remove germs, avoid getting sick and prevent the spread of germs to others. The policy directed staff to wash hands or use alcohol-based hand rub during patient care.	F 880		

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
November 16, 2021

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

Re: Event ID: 4Z5311

Dear Administrator:

The above facility survey was completed on October 21, 2021 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted no violations of these rules promulgated under Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10.

Electronically posted is the Minnesota Department of Health order form stating that no violations were noted at the time of this survey. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Please disregard the heading of the fourth column which states, "Provider's Plan of Correction." This applies to Federal deficiencies only. There is no requirement to submit a Plan of Correction.

Please feel free to call me with any questions.

Sincerely,

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

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00087	A. BUILDING: _____ B. WING _____	10/21/2021

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GOOD SAMARITAN SOCIETY - BETHANY	804 WRIGHT STREET BRAINERD, MN 56401

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 10/18/21 through 10/21/21, a licensing survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was found NOT in compliance with the MN State Licensure and the following correction orders are issued. Please indicate in your electronic plan of correction you have reviewed	2 000		

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2 000	Continued From page 1 these orders and identify the date when they will be completed. Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY.	2 000		

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2 000	Continued From page 2 THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000		

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	245500	A. BUILDING **01 - MAIN BUILDING** B. WING _____	**10/20/2021**

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K 000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety recertification survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division. 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:	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		11/23/2021

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

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K 000	Continued From page 1 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. 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	K 000		

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K 000	Continued From page 2 determined to be of Type II(111) construction and are separated with 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 106 beds and had a census of 56 at the time of the survey. The requirements at 42 CFR, Subpart 483.70(a) are NOT MET as evidenced by:	K 000		

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K 132 SS=E	Multiple Occupancies - Contiguous Non-Health CFR(s): NFPA 101 Multiple Occupancies - Contiguous Non-Health Care Occupancies Non-health care occupancies that are located immediately next to a Health Care Occupancy, but are primarily intended to provide outpatient services are permitted to be classified as Business or Ambulatory Health Care Occupancies, provided the facilities are separated by construction having not less than 2-hour fire resistance-rated construction, and are not intended to provide services simultaneously for four or more inpatients. Outpatient surgical departments must be classified as Ambulatory Health Care Occupancy regardless of the number of patients served. 18.1.3.4.1, 19.1.3.4.1 This REQUIREMENT is not met as evidenced by: Based on observations and staff interview, it was revealed that the two of the two-hour fire separations were found not in compliance with NFPA 101 (2012) The Life Safety Code, sections 8.3.3.1 and NFPA 80 (2010 edition), the Standard for Fire Doors and Other Opening Protectives, sections 5.2.14.1, 6.1.4.3.1, and 6.3.1.7.1. These deficient findings could have a widespread impact on the residents within the facility. Findings include: 1. On 10/20/2021, at 12:19 PM, it was revealed by observation that the 90-minute fire-rated doors located at the South wing entry to rooms 131 through 144 had a 1/4 inch gap between the door leaves when measured in the closed position.	K 132	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 centers allegation of compliance in accordance with section 7305 of the State Operations Manual.	11/24/21

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K 132	Continued From page 4 2. On 10/20/2021, at 12:35 PM, it was revealed by observation that the 90-minute fire-rated doors located at the by resident room 230 in station 2 had one of the door leaves that had a loose door hinge causing the door to hang at an angle, causing it to catch against the side of the other door leaf not allowing the double doors to fully close. An interview with the Maintenance Supervisor verified these deficient findings at the time of discovery.	K 132	K-132 NFPA 101, Life Safety Code, 2012 edition, section 8.3.3.1 Multiple Occupancies – Contiguous Non-Health CFR(s) 1. Purchased new door brush sweeps an Installed on deficient location. Maintenance will perform monthly visual inspections of fire doors and repair as necessary. 2. One on One education was provided to nurse-managers in regards to clean linen storage areas (area of concern). During weekly egress audits and visual inspections doors will be checked and education will be given if re-occurrence happens. Completion Date: 1. November 24, 2021; 2. Ongoing Monthly. Responsible Person: Matthew Bugnacki – Ancillary Services Supervisor	
K 291 SS=F	Emergency Lighting CFR(s): NFPA 101 Emergency Lighting Emergency lighting of at least 1-1/2-hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to test the battery operated emergency light per NFPA 101 (2012 edition) The Life Safety Code, section 7.9.3.1.1. This deficient finding could have a widespread impact on the residents within the	K 291	K291 NFPA 101, Life Safety Code, 2012 edition, section 7.9, 18.2.9.1, 19.2.9.1 Emergency Lighting A new Battery-Operated Emergency Light will be installed in the station 3 Generator	11/24/21

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K 291	Continued From page 5 facility. Findings include: On 10/20/2021, at 10:45 AM, a review of available battery operated emergency lighting testing documentation and interview with the Maintenance Supervisor it was observed that the facility could not provide information or documentation for the monthly 30 second and annual 90 minute test/inspection for the batter powered emergency light that is located within the unit 3 generator/boiler room. An interview with the Maintenance Supervisor verified this deficient finding at the time of discovery.	K 291	room. Contractor Holden Electric has been scheduled and will install new light. Light will have a self-diagnostic/ self-testing function. Maintenance team will perform monthly visual Inspections and they will be logged in both LSC Code Manual and in the TELS online PM software. Completion Date: 11/24/2021 Responsible Person: Matthew Bugnacki – Ancillary Services Supervisor	
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 a review of available documentation and staff interview, the facility failed to test and maintain the fire alarm system per NFPA 101 (2012 edition), Life Safety Code, section 9.6.1.3, and NFPA 72 (2010 edition), National Fire Alarm	K 345	K 345 NFPA 101, Life Safety Code, 2012 edition, section 9.6.1.3 Fire Alarm System – Testing and Maintenance	10/31/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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K 345	Continued From page 6 and Signaling Code, sections 14.5.2 and 14.6.2.4. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 10/20/2021, at 11:41 AM, during a review of all available fire alarm test and inspection documentation and an interview with the Maintenance Supervisor, it was revealed that the facility could not provide any current documentation verifying that a semiannual inspection of all initiating devices had been completed. An interview with the Maintenance Supervisor verified this deficient finding at the time of discovery.	K 345	Fie Alarms were scheduled to be inspected the week of the survey. That inspection was completed. Semi-Annual Inspection was scheduled at the time of the survey for April 2022 to be performed by Brothers Fire & Security. Completion Date: 10/31/2021 and 04/30/2022 Responsible Person: Matthew Bugnacki – Ancillary Services Supervisor	
K 353 SS=F	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for	K 353		10/22/21

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	245500	A. BUILDING **01 - MAIN BUILDING** B. WING _____	**10/20/2021**

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GOOD SAMARITAN SOCIETY - BETHANY	**804 WRIGHT STREET** **BRAINERD, MN 56401**

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K 353	Continued From page 7 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 observations, staff interview and a review of the available fire sprinkler test and inspection documentation, the automatic sprinkler system is not maintained in accordance with NFPA 101 (2012 edition) The Life Safety Code, section 9.7.1.1, and NFPA 25 (2011 edition) the Standard for the Inspection, Testing, and Maintenance of Water Based Fire Protection Systems, section 5.2.5. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 10/20/2021, at 11:45 AM, a review of all available fire sprinkler test and inspection documentation and interview with the Maintenance Supervisor it was revealed that the facility could not provide any documentation verifying the completion of quarterly flow test and inspection of the fire sprinkler system. An interview with the Maintenance Supervisor verified this deficient finding at the time of discovery.	K 353	K 353 NFPA 101, Life Safety Code, 2012 edition, section 9.7.5, 9.7.7, 9.7.8 Quarterly Flow tests were performed in October 2021 and scheduled at the end of the Survey to be conducted starting in January 2022, April 2022, July 2022, October 2022. Quarterly Flow Tests will be done by Brothers Fire & Security Company. Completion Date: 10/22/21 Responsible Person: Matthew Bugnacki □ Ancillary Services Supervisor	
K 521 SS=F	HVAC CFR(s): NFPA 101 HVAC Heating, ventilation, and air conditioning shall comply with 9.2 and shall be installed in	K 521		11/24/21

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	245500	A. BUILDING **01 - MAIN BUILDING** B. WING _____	**10/20/2021**

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K 521	Continued From page 8 accordance with the manufacturer's specifications. 18.5.2.1, 19.5.2.1, 9.2 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to test and inspect the fire and smoke damper systems per NFPA 101 (2012 edition) Life Safety Code, sections 9.2 and 19.5.2.1, NFPA 80 (2010 edition) the Standard for Fire Doors and Other Opening Protectives, sections 19.4.9, 19.4.10 and 19.5.5, NFPA 90A (2012 edition) the Standard for the Installation of Air-Conditioning and Ventilating Systems, section 5.4.8.1, and NFPA 105 (2010 edition) the Recommended Practice for the Installation of Smoke-Control Door Assemblies, sections 6.5.11, 6.5.12 and 6.6.6. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 10/20/2021 at 11:36 AM, during a review of all available fire damper test and inspection documentation and an interview with the Maintenance Supervisor, it was revealed that the facility could not provide any current documentation verifying that the fire and smoke damper testing and inspections have been completed within the last 4 years. An interview with the Maintenance Supervisor verified this deficient finding at the time of	K 521	K 521 NFPA 101, Life Safety Code, 2012 edition, section 9.2 and 19.5.2.1 HVAC Brothers Fire and Security Company will be onsite 11/24/2021 to perform 4 year Smoke and damper test and inspection. Completion Date: 11/24/2021 Responsible Person: Matthew Bugnacki – Ancillary Services Supervisor	

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	245500	A. BUILDING **01 - MAIN BUILDING** B. WING _____	**10/20/2021**

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K 521	Continued From page 9 discovery.	K 521		
K 712 SS=F	Fire Drills CFR(s): NFPA 101 Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to conduct fire drills per NFPA 101 (2012 edition), Life Safety Code, sections 19.7.1.2 and 19.7.1.4. These deficient findings could have a widespread impact on the residents within the facility. Findings include: 1. On 10/20/2021, at 10:00 AM., during the review of all available fire drill documentation and interview with the Maintenance Supervisor, it was revealed that the facility did not conduct a fire drill for the evening shift in the second calendar quarter within the last 12 months. 2. On 10/20/2021, at 10:00 AM., during the review of all available fire drill documentation and interview with the Maintenance Supervisor, it was revealed that the facility did not conduct a fire drill	K 712	K 712 NFPA 101, Life Safety Code, 2012 edition, section 19.7.1.2 and 19.7.1.4 Fire Drills Ancillary Services Supervisor created an annual schedule for fire drills known only to maintenance personnel. Alarms are scheduled each quarter for each of the 3 shifts and will be documented in both the LSC Binder as well as the TELS electronic Monitoring System. System will create PM's weekly and monthly to better track Fire Drills. Two drills were conducted to date one on 10/28/2021 and one on 11/11/2021. Completion Date: 11/24/21 Responsible Person: Matthew Bugnacki – Ancillary Services Supervisor	11/24/21

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K 712	Continued From page 10 for the overnight shift in the third calendar quarter within the last 12 months. 3. On 10/20/2021, at 10:00 AM., during the review of all available fire drill documentation and interview with the Maintenance Supervisor, it was revealed that the facility did not verify that a fire alarm signal had been transmitted to the fire alarm monitoring company for the two missed fire drills within the last 12 months. An interview with the Maintenance Supervisor verified these deficient findings at the time of the discovery.	K 712		
K 761 SS=F	Maintenance, Inspection & Testing - Doors CFR(s): NFPA 101 Maintenance, Inspection & Testing - Doors Fire doors assemblies are inspected and tested annually in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives. Non-rated doors, including corridor doors to patient rooms and smoke barrier doors, are routinely inspected as part of the facility maintenance program. Individuals performing the door inspections and testing possess knowledge, training or experience that demonstrates ability. Written records of inspection and testing are maintained and are available for review. 19.7.6, 8.3.3.1 (LSC) 5.2, 5.2.3 (2010 NFPA 80) This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to conduct the fire door inspections per NFPA 101 (2012	K 761	K 761 NFPA 101, Life Safety Code, 2012 edition, section 8.3.3.1 and 19.7.6 Maintenance, Inspection & Testing -	11/23/21

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K 761	Continued From page 11 edition), Life Safety Code, sections 8.3.3.1, 19.7.6, and NFPA 80 (2010 edition), Standard for Fire Doors and Other Opening Protectives, section 5.2.1. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 10/20/2021, at 10:40 AM, during the review of all available fire door test and inspection documentation and an interview with the Maintenance Supervisor, it was revealed that the facility could not provide any current documentation verifying that the fire door inspection had been completed within the last 12 months. An interview with the Maintenance Supervisor verified this finding at the time of discovery.	K 761	Doors Annual Fire Door Inspection will be conducted on 11/23/2021. Documentation will be scanned and Uploaded to TELS Electronic Monitoring System and physical copies will be help in both the Life Safety Code Binder and In Managers Files. Date will be documented at the time of Inspection. Completion Date: 11/23/2021 Responsible Person: Matthew Bugnacki - Ancillary Services Supervisor	
K 918 SS=F	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36	K 918		11/30/21

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K 918	Continued From page 12 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This REQUIREMENT is not met as evidenced by: Based on documentation review and staff interview, the facility failed to test and maintain the emergency generator per NFPA 101 (2012 edition) The Life Safety Code, section, 9.1.3 and NFPA 110 (2010 edition) the Standard for Emergency and Standby Power Systems, sections 8.4.1, 8.4.2, and 8.4.9.5.1. These deficient findings could have a widespread impact on the residents within the facility. Findings include: 1. On 10/20/2021, at 10:35 AM, during the review of all available emergency generator maintenance documentation and an interview with the Maintenance Supervisor, it was revealed that the facility could not provide documentation	K 918	Provided training to staff on how to perform the monthly 3ph – 30-minute test and document. Testing was conducted on 10/25/21 and 11/23/2021 for both generators. A continuous 4-Hour test is scheduled and was completed on 12/1/2021 by Northern Generator Service. Weekly Visual Inspections will continue to be performed and have been completed on the following dates: 8/21/2021,8/28/2021, 9/4/2021, 9/11/2021, 9/18/2021, 9/25/2021, 10/2/2021, 10/9/2021, 10/16/2021, 10/23/2021, 10/30/2021, 11/6/2021, 11/13/2021, 11/20/2021, 11/27/2021, 12/4/2021, 12/11/2021.	

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K 918	Continued From page 13 for 41 of 52 weekly inspections for both of the facility's emergency generators. 2. On 10/20/2021, at 10:35 AM, during the review of all available emergency generator maintenance documentation and an interview with the Maintenance Supervisor, it was revealed that the facility could not provide detailed documentation annotating that the emergency generators have been tested monthly at 30 percent of the rated capacity. An interview with the Maintenance Supervisor verified these findings at the time of discovery.	K 918	Completion Date: Monthly Load tests are ongoing by the end of the month and 4 hour test was completed on 12/1/2021. Responsible Person: Matthew Bugnacki - Ancillary Services Supervisor	
K 923 SS=D	Gas Equipment - Cylinder and Container Storag CFR(s): NFPA 101 Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited- combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be	K 923		11/30/21

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K 923	Continued From page 14 stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observations and staff interview, the facility failed to store oxygen cylinders per NFPA 99 (2012 edition), Health Care Facilities Code, sections 11.6.5.2 and 11.6.5.3. This deficient condition could have an isolated impact on the residents within the facility. Findings include: On 10/20/2021 at 1:10 PM, it was revealed by observation that in the main oxygen storage room, there are three oxygen cylinders that were not properly tagged to avoid confusion nor separated by full and empty status at the time of the inspection. An interview with the Maintenance Supervisor verified this deficient finding at the time of discovery.	K 923	K 923 NFPA 101, Life Safety Code, 2012 edition, section 5.1.3.3.2 and 5.1.3.3.3 Gas Equipment Cylinder and Container Storage Maintenance Staff will perform Monthly Visual Compliance inspections of all Med-Gas storage Areas. Maintenance will record Inspections in TELS monitoring system and paper copies will be maintained in LSC binder. To help ongoing compliance new Oxygen Storage signs will be placed by 11/30/2021 and education given when non-compliance is determined. Completion Date: 11/30/2021 and ongoing. Responsible Person: Matthew Bugnacki - Ancillary Services Supervisor	

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