DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

February 29, 2024

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

Re: Reinspection Results
Event ID: 56N012

Dear Administrator:

On February 1, 2024 survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on December 20, 2023. At this time these correction orders were found corrected.

Please feel free to call me with any 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
February 29, 2024

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

RE: CCN: 245500
Cycle Start Date: December 20, 2024

Dear Administrator:

On January 12, 2024, we notified you a remedy was imposed. On February 1, 2024 the Minnesota Departments of Health and Public Safety completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of February 1, 2024.

As authorized by CMS the remedy of:

- Mandatory denial of payment for new Medicare and Medicaid admissions effective March 20, 2024 did not go into effect. (42 CFR 488.417 (b))

In our letter of January 12, 2024, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from March 20, 2024, due to denial of payment for new admissions. Since your facility attained substantial compliance on February 1, 2024, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded. However, this does not apply to or affect any previously imposed NATCEP loss.

The CMS Region V Office may notify you of their determination regarding any imposed remedies.

Feel free to contact me if you have questions.

Sincerely,

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
January 2, 2024

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

RE: CCN: 245500
Cycle Start Date: December 20, 2023

Dear Administrator:

On December 20, 2023, 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, Unit Supervisor
Bemidji District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
705 5th Street NW, Suite A
Bemidji, MN 56601-2933
Email: Jennifer.bahr@state.mn.us
Office: (218) 308-2104 Mobile: (218) 368-3683

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for 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 March 20, 2024 (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 June 20, 2024 (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

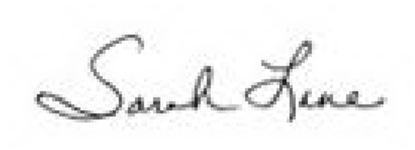
Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

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
Interim State Fire Safety Supervisor
Health Care & Correctional Facilities/Explosives
MN Department of Public Safety-Fire Marshal Division
445 Minnesota St., Suite 145
St. Paul, MN 55101
travis.ahrens@state.mn.us
Cell: 1-507-308-4189

Feel free to contact me if you have questions.

Sincerely,



Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697
Email: sarah.lane@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 12/20/2023

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 12/18/23-12/20/23, a survey for compliance with Appendix Z, Emergency Preparedness Requirements, §483.73 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 12/18/23 -12/20/23, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was not in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were reviewed with no deficiencies cited: H55007805C (MN96078) H55007806C (MN98019) H55007807C (MN98907) H55007808C (MN97293) H55007809C (MN98998) H55007810C (MN96745) H55007811C (MN96743) H55007812C (MN96805) 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.	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		01/10/2024

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 000	Continued From page 1 Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulations has been attained.	F 000		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to use the ordered wound care to promote wound healing for 1 of 1 resident (R37) reviewed for pressure ulcers. Findings include: R37's significant change Minimum Data Set (MDS) dated 11/24/23, identified R37 was at risk for pressure ulcers and had a stage II pressure ulcer. R37's care plan revised 12/11/23, identified R37 had a coccyx pressure ulcer. The care plan	F 686	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,	2/1/24

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F 686	Continued From page 2 directed to educate R37/R37's family as to causes of skin breakdown, including: transfer/positioning requirements; importance of taking care during ambulating/mobility; good nutrition and frequent repositioning; avoid positioning R37 on her back, R37 was resistive to repositioning; reposition every 2 hours while in bed and every 1 hour when in chair, encourage R37 to eat protein foods; and notify nurse of any new areas of skin breakdown. R37's Order Summary Report dated 12/2/23, identified right buttock wound: cleanse with wound cleanser and pat dry. Apply silver alginate (an antimicrobial ointment) to cover wound and some of the intact skin. Secure with Mepilex border 3x3. Change every other day. If dressings do not stay in place, may change back to Triad hydrophilic wound filler at least two times day application. R37's Treatment Record dated December 2023, identified nursing applied silver alginate and a Mepilex dressing on 12/2/23, 12/4/23, 12/6/23, 12/8/23, 12/10/23, 12/12/23, 12/14/23, 12/16/23 and 12/18/23. The medical record failed to identify if the dressing failed to stay in place. R37's nursing progress notes dated 12/2/23 at 6:43 a.m., identified R37 was evaluated by the wound care provider and new wound care orders were transcribed. R37 was signed off from wound care unless hospice requested additional follow up. R37's failed to identify documentation R37's dressing would not stay in place, if nursing had requested a change in wound treatment order and/or if the provider had been informed.	F 686	this response and plan of correction constitutes the center's allegation of compliance in accordance with section 7305 of the State Operations Manual. F686 SS=D The resident's orders were immediately clarified with their primary, corrected and nurse staff were reeducated on the importance of following orders as written in the TAR. A whole house sweep was done of all residents in the facility with pressure injuries and there treatment orders in the TAR were verified and all nurse staff were reeducated on the importance of following orders as written in the TAR. Nurse station managers will be educated that going forward they will be expected to regularly monitor care of pressure injuries and ensure that the TAR matches orders. All residents with pressure injuries with be audited 1x every week for 6 weeks to ensure that their TAR matches the original orders and that the wound care that they are receiving matches what is stated in the TAR. Audits will be reviewed by the QAPI committee and they will give direction for any further needed action. Completed by: February 1, 2024	

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F 686	Continued From page 3 R37's Wound Data Collection V2 identified the following: - On 12/2/23, R37's wound was assessed. The wound was cleansed and stoma power and Triad were applied. - On 12/4/23, R37's wound was assessed. The wound was cleansed and Triad cream was applied. R37's wound was left open to air. - On 12/5/23, R37's wound was assessed. Triad was applied and R37 was offloaded. - On 12/6/23, R37's wound was assessed. Triad was applied and R37 was offloaded. - On 12/10/23, R37's wound was assessed. Triad was applied and R37 was offloaded. - On 12/12/23, R37's wound was assessed. The document did not identify the treatment provided. - On 12/13/23, R37's wound was assessed. The document did not identify the treatment provided. - On 12/14/23, R37's wound was assessed. Triad was applied and R37 was offloaded. - On 12/15/23, R37's wound was assessed. Triad was applied and R37 was offloaded when she allowed. - On 12/16/23, R37's wound was assessed. Triad was applied. - On 12/17/23, R37's wound was assessed. Triad was applied and R37 was offloaded. - On 12/19/23, R37's wound was assessed. Triad was applied. - On 12/20/23, R37's wound was assessed. Triad was applied and R37 was offloaded. During an observation on 12/19/23 at 11:38 a.m., registered nurse (RN)-A and nursing assistant (NA)-A provided incontinence care to R37. R37 was rolled onto her left side, her incontinence brief was unfastened, and her right buttock wound was exposed. The wound was open to air and a white colored substance covered the	F 686		

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F 686	Continued From page 4 surrounding skin. NA-A washed the wound with a warm, wet washcloth and dabbed the area dry with a towel. RN-A then applied ointment to the wound and stated it was "Triad". A Mepilex wound dressing nor silver alginate were applied. During an interview on 12/19/23 at 1:45 p.m., RN-A stated there was no "normal dressing" for R37's wound. The Mepilex wound dressing was tried, but kept coming off. RN-A stated she was unsure if the Mepilex wound dressing not adhering to R37's skin had been communicated to the hospice or wound care provider. When RN-A reviewed R37's wound order, RN-A stated the order was scheduled for every other day and would not show on R37's treatment record for 12/20/23, because it was an off day. RN-A did not review R37's wound care order prior to applying Triad and was "going by memory". There was no documentation in R37's EHR regarding the use of Mepilex for R37. Documentation was important to ensure order accuracy and to allow the ordering provider to be able to adjust orders as needed. During an interview on 12/20/23 at 1:47 p.m. RN-B stated staff tried Mepilex wound dressings, zinc oxide and/or Triad ointment for R37's wound. It really depended on how it looked that day what treatment RN-B would use. The facility's medical providers were very "liberal" with wound care orders and were at the facility every week. Because of this, staff could just ask for what they wanted when it came to wound care. During an interview on 12/20/23 at 2:31 p.m., the director of nursing (DON) stated she would always expected staff to refer to the wound care orders and not go by memory. This was important to ensure staff were doing the correct care	F 686		

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F 686	Continued From page 5 according to the physician's orders. Upon review of R37's wound care order, the DON stated because the order read staff could use Triad if the Mepilex wound dressing did not work for R37, nursing should have contacted either the wound care provider or the hospice to have the order updated. Additionally, the DON expected nursing staff to document the wound care treatment and, also, document failed treatments. During an interview on 12/20/23 at 3:43 p.m., RN-C stated she did not know why staff had not documented the silver alginate and Mepilex wound dressing did not work. Hospice should have been informed as well. RN-C expected staff to review R37's treatment order and even print out the treatment record to review to bring with them, if needed. Staff were expected to always follow the wound care order because, in R37's case, the wound care provider was the subject matter expert. Documentation allowed the provider to fully assess R37 for the best possible treatment. If a treatment was not working for a wound, the wound care provider needed to know all available information to adjust their plan. The facility policy Pressure Ulcer/Wound Care Resource Packet revised 5/30/23, identified the Pressure Ulcer/Wound Care Resource Packet was designed to provide staff with the resources and tools needed to provide care and services for residents who were at risk for skin breakdown or had skin integrity issues. Based on the comprehensive assessment of a resident, the facility must ensure that a resident having pressure sores received necessary treatment and services to promote healing, prevent infection, and prevent new sores from developing.	F 686		

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F 883	Continued From page 6	F 883		
F 883 SS=E	Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2) §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. §483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization;	F 883		2/1/24

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F 883	Continued From page 7 (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to provide the most recent Centers for Disease and Prevention (CDC) education regarding the potential risks and benefits of the pneumococcal vaccine for 3 of 5 residents (R32, R36, R49) reviewed for pneumococcal immunizations. Findings include: R32's significant change Minimum Data Set (MDS) dated 11/27/23, identified R32 was 64 years old and had diagnoses that included hypertension, Alzheimer's disease, and Parkinson's disease. R32's Minnesota Immunization Report dated 12/20/23, identified R32 had not received a pneumococcal immunization.	F 883	F883 SS=E The DNS contacted the Medical director to ensure guidance for giving Pneumococcal Immunizations in relation to COVID-19 status. They also contacted the pharmacy to ensure a supply of Pneumococcal Immunizations was available for us. Affected residents are receiving vaccinations as soon as their consent from families (when needed) and COVID-19 status allow. The DNS or designee have performed a whole house sweep of all residents, checking there pneumococcal immunizations status and all residents who require immunization will receive it as soon as their consent from families (when	

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	245500	A. BUILDING _____ B. WING _____	C 12/20/2023

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 883	Continued From page 8 R32's electronic health record (EHR) failed to identify if R32 had received pneumococcal immunization education and/or a declination. R36's quarterly MDS dated 9/20/23, identified R36 was 64 years old and had diagnoses that included a history of traumatic brain injury, seizer disorder, and transient cerebral ischaemic attack (temporary blockage of blood flow to the brain). R36's Minnesota Immunization Report dated 12/20/23, identified R36 had received a pneumococcal polysaccharide vaccine (PPSV23) on 5/16/17. R32's electronic health record (EHR) failed to identify if R32 had received pneumococcal immunization booster education and/or a declination. R49's significant change MDS dated 10/12/23, identified R49 was 65 years old and had diagnoses that included renal insufficiency and diabetes. R49's Minnesota Immunization Report dated 12/20/23, identified R49 had not received a pneumococcal immunization. R32's electronic health record (EHR) failed to identify if R49 had received pneumococcal immunization education and/or a declination. During an interview with the director of nursing (DON) on 12/19/23 at 3:07 p.m., the DON stated resident immunizations were reviewed upon admission. The Health Information Management (HIM) reviewed the resident's immunization record and entered the information into the	F 883	needed) and COVID-19 status allow. All nurse managers have been educated to a new system of monitoring immunization status by DNS and the expectations relating to it going forward. The DNS or designees will audit pneumococcal immunizations status of all residents in the facility 1x weekly for 6 weeks to ensure that they have either declined immunizations or have received appropriate immunizations as allowed by COVID-19 status. Audits will be reviewed by the QAPI committee and they will give direction for any further needed action. Completed: February 1, 2024	

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F 883	Continued From page 9 resident's EHR. The unit manager would then review the resident's EHR to determine what immunizations were recommended to be administered. The resident would receive education and the administration or declination would be documented in the resident's EHR. The DON was aware new pneumococcal immunization booster recommendations were available and had created a spreadsheet to begin the process, but had not completed a review of resident immunization records nor offered pneumococcal immunizations. The facility policy Immunizations/Vaccinations for Residents, Pneumococcal, Influenza, COVID-19 revised 9/21/23, identified resident would be provided the opportunity to receive immunizations as they fit into the resident's healthcare goals. Upon admission, each resident and/or resident representative would receive the Vaccination Information Statement (VIS) for influenza and pneumococcal vaccines. If the resident and/or resident representative chose not to be vaccinated after discussion of benefits, staff were to document declination.	F 883		

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
January 2, 2024

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

Re: State Nursing Home Licensing Orders
Event ID: 56N011

Dear Administrator:

The above facility was surveyed on December 18, 2023 through December 20, 2023 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

To assist in complying with the correction order(s), a "suggested method of correction" has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the order within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html. The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered to you electronically. The 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 number and the corresponding text of 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 that are in violation of the state statute or rule after the statement, "This MN Requirement is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.

THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.

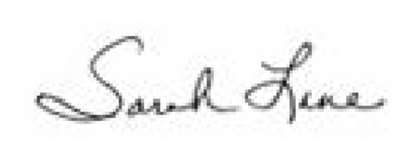
Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact:

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

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.

Please feel free to call me with any questions.

Sincerely,



Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697
Email: sarah.lane@state.mn.us

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 _____	C 12/20/2023

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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 12/18/23-12/20/23, a licensing survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was 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 these orders and	2 000		

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2 000	Continued From page 1 identify the date when they will be completed. The following complaints were reviewed during the survey and no licensing orders were issued: H55007805C (MN96078) H55007806C (MN98019) H55007807C (MN98907) H55007808C (MN97293) H55007809C (MN98998) H55007810C (MN96745) H55007811C (MN96743) H55007812C (MN96805) 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	2 000		

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2 000	Continued From page 2 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. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. 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		
2 900	MN Rule 4658.0525 Subp. 3 Rehab - Pressure Ulcers Subp. 3. Pressure sores. Based on the comprehensive resident assessment, the director of nursing services must coordinate the development of a nursing care plan which provides that: A. a resident who enters the nursing home without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates, and a physician authenticates, that they were unavoidable; and B. a resident who has pressure sores receives necessary treatment and services to promote healing, prevent infection, and prevent new sores from developing. This MN Requirement is not met as evidenced	2 900		2/1/24

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2 900	Continued From page 3 by: Based on observation, interview and document review, the facility failed to use the ordered wound care to promote wound healing for 1 of 1 resident (R37) reviewed for pressure ulcers. Findings include: R37's significant change Minimum Data Set (MDS) dated 11/24/23, identified R37 was at risk for pressure ulcers and had a stage II pressure ulcer. R37's care plan revised 12/11/23, identified R37 had a coccyx pressure ulcer. The care plan directed to educate R37/R37's family as to causes of skin breakdown, including: transfer/positioning requirements; importance of taking care during ambulating/mobility; good nutrition and frequent repositioning; avoid positioning R37 on her back, R37 was resistive to repositioning; reposition every 2 hours while in bed and every 1 hour when in chair, encourage R37 to eat protein foods; and notify nurse of any new areas of skin breakdown. R37's Order Summary Report dated 12/2/23, identified right buttock wound: cleanse with wound cleanser and pat dry. Apply silver alginate (an antimicrobial ointment) to cover wound and some of the intact skin. Secure with Mepilex border 3x3. Change every other day. If dressings do not stay in place, may change back to Triad hydrophilic wound filler at least two times day application. R37's Treatment Record dated December 2023, identified nursing applied silver alginate and a Mepilex dressing on 12/2/23, 12/4/23, 12/6/23, 12/8/23, 12/10/23, 12/12/23, 12/14/23, 12/16/23	2 900	Corrected	

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2 900	Continued From page 4 and 12/18/23. The medical record failed to identify if the dressing failed to stay in place. R37's nursing progress notes dated 12/2/23 at 6:43 a.m., identified R37 was evaluated by the wound care provider and new wound care orders were transcribed. R37 was signed off from wound care unless hospice requested additional follow up. R37's failed to identify documentation R37's dressing would not stay in place, if nursing had requested a change in wound treatment order and/or if the provider had been informed. R37's Wound Data Collection V2 identified the following: - On 12/2/23, R37's wound was assessed. The wound was cleansed and stoma power and Triad were applied. - On 12/4/23, R37's wound was assessed. The wound was cleansed and Triad cream was applied. R37's wound was left open to air. - On 12/5/23, R37's wound was assessed. Triad was applied and R37 was offloaded. - On 12/6/23, R37's wound was assessed. Triad was applied and R37 was offloaded. - On 12/10/23, R37's wound was assessed. Triad was applied and R37 was offloaded. - On 12/12/23, R37's wound was assessed. The document did not identify the treatment provided. - On 12/13/23, R37's wound was assessed. The document did not identify the treatment provided. - On 12/14/23, R37's wound was assessed. Triad was applied and R37 was offloaded. - On 12/15/23, R37's wound was assessed. Triad was applied and R37 was offloaded when she allowed. - On 12/16/23, R37's wound was assessed. Triad was applied. - On 12/17/23, R37's wound was assessed. Triad	2 900		

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2 900	Continued From page 5 was applied and R37 was offloaded. - On 12/19/23, R37's wound was assessed. Triad was applied. - On 12/20/23, R37's wound was assessed. Triad was applied and R37 was offloaded. During an observation on 12/19/23 at 11:38 a.m., registered nurse (RN)-A and nursing assistant (NA)-A provided incontinence care to R37. R37 was rolled onto her left side, her incontinence brief was unfastened, and her right buttock wound was exposed. The wound was open to air and a white colored substance covered the surrounding skin. NA-A washed the wound with a warm, wet washcloth and dabbed the area dry with a towel. RN-A then applied ointment to the wound and stated it was "Triad". A Mepilex wound dressing nor silver alginate were applied. During an interview on 12/19/23 at 1:45 p.m., RN-A stated there was no "normal dressing" for R37's wound. The Mepilex wound dressing was tried, but kept coming off. RN-A stated she was unsure if the Mepilex wound dressing not adhering to R37's skin had been communicated to the hospice or wound care provider. When RN-A reviewed R37's wound order, RN-A stated the order was scheduled for every other day and would not show on R37's treatment record for 12/20/23, because it was an off day. RN-A did not review R37's wound care order prior to applying Triad and was "going by memory". There was no documentation in R37's EHR regarding the use of Mepilex for R37. Documentation was important to ensure order accuracy and to allow the ordering provider to be able to adjust orders as needed. During an interview on 12/20/23 at 1:47 p.m. RN-B stated staff tried Mepilex wound dressings, zinc oxide and/or Triad ointment for R37's wound.	2 900		

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2 900	Continued From page 6 It really depended on how it looked that day what treatment RN-B would use. The facility's medical providers were very "liberal" with wound care orders and were at the facility every week. Because of this, staff could just ask for what they wanted when it came to wound care. During an interview on 12/20/23 at 2:31 p.m., the director of nursing (DON) stated she would always expected staff to refer to the wound care orders and not go by memory. This was important to ensure staff were doing the correct care according to the physician's orders. Upon review of R37's wound care order, the DON stated because the order read staff could use Triad if the Mepilex wound dressing did not work for R37, nursing should have contacted either the wound care provider or the hospice to have the order updated. Additionally, the DON expected nursing staff to document the wound care treatment and, also, document failed treatments. During an interview on 12/20/23 at 3:43 p.m., RN-C stated she did not know why staff had not documented the silver alginate and Mepilex wound dressing did not work. Hospice should have been informed as well. RN-C expected staff to review R37's treatment order and even print out the treatment record to review to bring with them, if needed. Staff were expected to always follow the wound care order because, in R37's case, the wound care provider was the subject matter expert. Documentation allowed the provider to fully assess R37 for the best possible treatment. If a treatment was not working for a wound, the wound care provider needed to know all available information to adjust their plan. The facility policy Pressure Ulcer/Wound Care Resource Packet revised 5/30/23, identified the	2 900		

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2 900	Continued From page 7 Pressure Ulcer/Wound Care Resource Packet was designed to provide staff with the resources and tools needed to provide care and services for residents who were at risk for skin breakdown or had skin integrity issues. Based on the comprehensive assessment of a resident, the facility must ensure that a resident having pressure sores received necessary treatment and services to promote healing, prevent infection, and prevent new sores from developing. SUGGESTED METHOD OF CORRECTION: The DON or designee, should review all residents at risk for pressure ulcers to assure they are receiving the necessary treatment/services to prevent pressure ulcers from developing and to promote healing of pressure ulcers. The DON or designee should conduct measurable audits for a specific amount of time of the delivery of care to residents affected and those who have the potential to be affected to ensure appropriate care and services are implemented and reduce the risk for pressure ulcer development. The DON or designee should bring all audit information to the Quality Assurance Performance Improvement (QAPI) committee to determine compliance or the need for further monitoring. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 900		

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	245500	A. BUILDING **01 - MAIN BUILDING** B. WING _____	**12/20/2023**

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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K 000	INITIAL COMMENTS An annual Life Safety recertification survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 12/20/2023. 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 | 01/10/2024

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245500	A. BUILDING **01 - MAIN BUILDING** B. WING _____	**12/20/2023**

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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 69 at the time of the survey. The requirements at 42 CFR, Subpart 483.70(a) are NOT MET as evidenced by:	K 000		
K 712 SS=C	Fire Drills CFR(s): NFPA 101	K 712		1/3/24

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K 712	Continued From page 3 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 19.7.1.6. This deficient findings could have a isolated impact on the residents within the facility. Findings include: On 12/20/2023 at 10:00 AM, it was revealed by a review of available documentation the facility did not perform the required fire drill on the third shift of the second quarter. An interview with the Environmental Service Supervisor verified this deficient finding at the time of discovery.	K 712	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. K712 SS=C On 12/28/23 a calendar was made of all the fire dill dates and times for the next year by the Director of Environmental Services and privately shared with the	

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K 712	Continued From page 4	K 712	Administrator and the Senior Quality Analyst. On 1/3/24 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. Completed: 1/3/24	
K 741 SS=D	Smoking Regulations CFR(s): NFPA 101 Smoking Regulations Smoking regulations shall be adopted and shall include not less than the following provisions: (1) Smoking shall be prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area shall be posted with signs that read NO SMOKING or shall be posted with the international symbol for no smoking. (2) In health care occupancies where smoking is prohibited and signs are prominently placed at all major entrances, secondary signs with language that prohibits smoking shall not be required. (3) Smoking by patients classified as not	K 741		1/19/24

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K 741	Continued From page 5 responsible shall be prohibited. (4) The requirement of 18.7.4(3) shall not apply where the patient is under direct supervision. (5) Ashtrays of noncombustible material and safe design shall be provided in all areas where smoking is permitted. (6) Metal containers with self-closing cover devices into which ashtrays can be emptied shall be readily available to all areas where smoking is permitted. 18.7.4, 19.7.4 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to implement smoking regulations per NFPA 101 (2012 edition), Life Safety Code, section 19.7.4. These deficient findings could have an isolated impact on the residents within the facility. Findings include: On 12/20/2023 at 9:20 AM, it was revealed by observation that a resident in a wheelchair was smoking near the front doors of the facility. Upon documentation review and an interview with the Environmental Service Supervisor the facility is a non smoking facility and all smoking is to be done at the street or on a pathway away from the building that is on public property. There were discarded cigarettes on the ground in the mulch and in planters with fertilizer at the entrance. An interview with the Environmental Service Supervisor verified this deficient finding at the time of discovery.	K 741	K741 SS=D On 1/3/24 a stainless steel “Smokers Outpost” was ordered for the facility for the collection and extinguishing of cigarette butts. It is scheduled to arrive at the facility 1/8/24 and will be set in place by 1/12/24. The Director of Environmental Services or designee will be in charge of empting and maintaining the “Smokers Outpost” weekly. The Director of Environmental Services will audit the grounds weekly for 6 weeks for cigarette butts not in the “Smokers Outpost.” The Director of Environmental Services will be in charge of education residents and visitors as to the need to use the “Smokers Outpost” for the disposal of butts. Audits will be reviewed by the QAPI committee and they will give direction for any further needed action. Completed: 1/19/24	
K 918 SS=F	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101	K 918		1/5/24

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K 918	Continued From page 6 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to test their	K 918	K918 SS=F	

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K 918	Continued From page 7 Emergency Power Supply System (EPSS) per NFPA 99 (2012 edition), Health Care Facilities Code, section 6.4.4.1.1.3, and NFPA 110 (2010 edition), Standard for Emergency and Standby Power Systems, sections 8.3.4, 8.3.4.1, 8.4.1, 8.4.9, 8.4.9.1, and 8.4.9.2. These deficient findings could have a widespread impact on the residents within the facility. Findings include: 1. On 12/20/2023 between 09:00 AM and 1:30 PM, it was revealed by a review of available documentation, the facility could not provide documentation showing monthly inspection of the emergency generator was completed for the months of June 2023 and October 2023 for the Diesel Generator and July 2023 for the Natural Gas Generator. 2. On 12/20/2023 between 09:00 AM and 1:30 PM, it was revealed by a review of available documentation, the facility could not provide documentation showing weekly inspections of the emergency generators were completed between 05/31/23 to 07/12/2023 for both the Natural Gas and Diesel Generator. An interview with the Environmental Service Supervisor verified this deficient finding at the time of discovery.	K 918	On 12/20/23 The Director of Environmental Services downloaded and printed the Fire Marshal recommended generator log and instructed maintenance staff in its proper usage. Maintenance staff has since then been using the new log correctly and entering the information into TELS. To ensure sustainability of this process change the Director of Environmental Services will audit the generator log weekly for 6 weeks and then audits will be reviewed by the QAPI committee and they will give direction for any further needed action. Completed: 1/5/2024	