Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
March 21, 2024

Administrator
Good Shepherd Lutheran Home
800 Home Street, Box 747
Rushford, MN 55971

RE: CCN: 245393
Cycle Start Date: January 25, 2024

Dear Administrator:

On March 19, 2024, the Minnesota Departments of Health and Public Safety completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Correction of the Life Safety Code deficiency cited under K374 at the time of the January 25, 2024 survey, has not yet been verified. Your plan of correction for this deficiency, including your request for a temporary waiver with a date of completion of May 20, 2024, has been forwarded to the Region V Office of the Centers for Medicare and Medicaid Services (CMS) for their review and determination. Failure to come into substantial compliance with this deficiency by the date indicated in your plan of correction may result in the imposition of enforcement remedies.

Feel free to contact me if you have questions.

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

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
February 7, 2024

Administrator
Good Shepherd Lutheran Home
800 Home Street, Box 747
Rushford, MN 55971

RE: CCN: 245393
Cycle Start Date: January 25, 2024

Dear Administrator:

On January 25, 2024, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

Within **ten (10) calendar days** after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved.

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

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

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

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

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

DEPARTMENT CONTACT

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

Jennifer Kolsrud Brown, RN, Unit Supervisor
Rochester District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
18 Wood Lake Drive Southeast
Rochester, Minnesota 55904-5506
Email: jennifer.kolsrud@state.mn.us
Office: (507) 206-2727 Mobile: (507) 461-9125

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 April 25, 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 July 25, 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,

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245393	A. BUILDING _____ B. WING _____	C 01/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SHEPHERD LUTHERAN HOME	800 HOME STREET, BOX 747 RUSHFORD, MN 55971

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS On 1/22/24 to 1/25/24, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was NOT compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. In addition to the recertification survey, the following complaints were reviewed: The following complaint was reviewed with no deficiency issued. H53938891C (MN87599). 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 554 SS=D	Resident Self-Admin Meds-Clinically Approp CFR(s): 483.10(c)(7) §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to assess resident for safety and the ability to self-administer	F 554	Corrective Action: Facility Self-Administration of Medications and Bedside Medications policy and	2/29/24

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

Electronically Signed — 02/16/2024

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 554	Continued From page 1 medications (SAM) for 1 of 1 resdient (R99) with nebulizer treatment. Findings include: R99's medical diagnoses indicate R99 with hemiplegia and hemiparesis following cerebral infarction affecting right dominant side (paralysis of right dominant side due to a stroke), dysphagia (inability to swallow food or liquid), aphasia (damage to the speaking or language areas of the the brain), depression, diabetes, and chronic obstructive pulmonary disease. R99's physician orders indicate R99 admitted to facility on 1/5/24, start date of 1/5/24 for, "Ipratropium-Albuterol Inhalation Solution 0.5-2.5 (3) MG[milligram]/3 ML[milligram] 3 ml inhale orally four times a day related to CHRONIC OBSTRUCTIVE PULMONARY DISEASE. During an observation on 1/22/24 at 3:19 p.m., R99 was in bed with nebulizer treatment mask being held in her left hand away from her face as nebulizer machine was running. At 3:20 p.m., the nebulizer mask was on her bedside table while the machine was running with liquid observed in the nebulizer cup attached to the mask and tubing. During observation and interview with the licensed practical nurse (LPN)-B on 1/22/24 at 3:35 p.m., LPN-B walked with surveyor to R99's room and assessed the nebulizer. The nebulizer machine was running with the mask on the bedside table. LPN-B stated the medication was finished and turned off the machine. LPN-B stated, "I did leave the room while I administered it. She did remove the mask also this morning, so	F 554	procedure was reviewed for accuracy. R99 had been assessed by the RN Care Coordinator on 1/10/24 for desire to self-administer her medications. There was no desire expressed by the resident to self-administer any of her medications. Facility staff were to administer all medications including her nebulizer. Staff were re-educated on the fact there was not a self-administration order listed in her orders and that they are all required to stay with her during her nebulizer treatments. Identification: Reviewed all current residents with an order for a nebulizer. All resident's orders for a nebulizer treatment were reviewed to determine if they have/do not have a self-administration assessment/order. Measures: All nursing home staff will be re-educated during the mandatory plan of corrections inservice on the current self-administration policy and the need to stay with any resident that does not have the desire to self-administer their medications and/or have been assessed as not being competent enough to administer themselves. Emphasis will be made on administration of nebulizer treatments when a resident does not have an order to self-administer. Monitoring: Random audits/monitoring will be conducted by the Director of Nursing weekly x 4 weeks then biweekly x 1	

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F 554	Continued From page 2 I do not know how much of the medication she [R99] received.". LPN-B stated she did not know if R99 had a SAM assessment to determine if R99 was safe or competent to administer her nebulizer treatment. During interview with LPN-C on 1/22/24 at 3:45 p.m., LPN-C stated, "someone is not with her [R99] the whole time to watch her take that med. She is not getting all of her medications if she takes it off and we don't know how much of the med she has taken." During interview with the unit case manager and registered nurse (RN)-A on 1/22/24 at 3:45 p.m., RN-A stated R99, "is not appropriate for self-administration of meds. If she pulls off the mask then there is no way to make sure she is taking the complete dose of the medication." During interview with RN-B on 1/23/24 at 12:27 p.m., RN-B stated she was assigned to care for R99 on 1/21/24 during the evening shift. RN-B stated R99, "sometimes pulls it off [nebulizer mask] and I will re-put it back on. I have left the room before and come back and it is still running so I have to put back on her. I try to stay in her room. If she pulls off the mask she is not getting the full dose." RN-B stated R99 did not have a SAM order to safely administer her own medications. During interview with LPN-D on 1/23/24 at 1:58 p.m., LPN-D stated she was familiar with R99 and stated R99 will take off the nebulizer mask "several times during the administration of it.". LPN-D stated she reminded R99 to keep the mask on and, "when I walk past her room the face mask is on the floor [while still running]".	F 554	month. Results will be brought to the Quality Assurance Committee. Further monitoring as needed based on results.	

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F 554	Continued From page 3 LPN-D stated, "if you are busy with 5 other patients then she [R99] won't get it put back on." LPN-D stated, "My thought is that staff should be in there during the full administration [of the nebulizer]." LPN-D also stated R99 was not competent to SAM the nebulizer. During an interview on 1/24/24 at 1:00 p.m., director of nursing (DON) stated R99 was "not competent to administer the scheduled nebulizer treatment because she takes it off." DON stated the SAM assessment is to be completed by the nurse manager at every admission, quarterly, or significant change Minimum Data Set (MDS) timing. DON stated R99 admitted to facility on 1/5/24 and had not had the SAM completed. Facility policy titled Self-Administration of Medications and Bedside Medications Policy and Procedure revised 11/22 state: "Residents may choose to administer their own medication. Residents will be asked on admission if the do/do not wish to self-administer their own medications. Residents who wish to do so will be assessed by a minimum of three members of the health care plan team and the attending physician."	F 554		
F 759 SS=D	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record	F 759	Corrective Action:	2/29/24

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F 759	Continued From page 4 review, the facility failed to ensure a medication administration error rate of less than 5 percent (%). Six medication administration errors occurred out of 26 opportunities resulting in a 23.08 % medication error rate for 1 of 4 residents (R99) observed during medication pass. Findings include: R99's admission Minimum Data Set (MDS) assessment dated 1/11/24, indicated R99 had severely impaired cognition and was diagnosed with kidney disease, diabetes, depression, chronic obstructive pulmonary disease (COPD-incurable lung disease causing breathlessness, frequent coughing, and chest tightness), hypertension, a heart dysrhythmia, and a stroke. R99's Order Summary Report dated 1/24/24, indicated R99's medications should have be crushed separately, dissolved in 15 milliliters (mL) of water each, and administered separately. The report indicated the following medications were to be administered via the gastric tube: 81 milligrams (mg) of aspirin daily, 25 mg of chlorthalidone (treat high blood pressure) daily, 25 mg of carvedilol (treat high blood pressure and heart failure) two times a day, 2.5 mg of apixaban (used to prevent serious blood clots from forming due to a certain irregular heartbeat) two times a day, 10 mg of escitalopram (used to treat depression and anxiety) daily, and 20 mg of lisinopril (used to treat high blood pressure) daily. During an observation and interview on 1/23/24 at 10:12 a.m., licensed practical nurse (LPN)-E was observed removing the aspirin, chlorthalidone, carvedilol, apixaban, escitalopram, and lisinopril from its packaging and placing them in the same	F 759	When DON was made aware that the Pharmacy Consultants did not review a new admission's medications to ensure they could be safely crushed, diluted and administered together through a gastric tube, R99's orders were updated to direct nurses to crush each medication separately and administer each one separately through the resident's gastric tube. Identification: Pharmacy Consultants were instructed to review each resident receiving a tube feeding for possible medication incompatibility issues as indicated in the Institute for Safe Medication Practices article titled Preventing errors when preparing and administering medications via enteral tube. Facility policy was reviewed and updated with current guidelines. Measures: A template was created for all residents receiving medications through a gastric tube directing nurses to crush each medication individually and administer them one at a time. Nurses were educated on the policy update and directed to follow the templated instructions when administering medications via gastric tube. Monitoring: Random audits/monitoring will be conducted by the Director of Nursing weekly x 4 weeks then biweekly x 1 month. Results will be brought to the	

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F 759	Continued From page 5 medication cup. The medications were then transferred to a clear medication bag and crushed together using a manual levered machine. LPN-E then transferred the crushed medications to a small cup and entered R99's room. LPN-E diluted the medications in the cup with water set them on the side table and left the resident room to gather more supplies. LPN-E stated that she had not seen an order in the medical record indicating she could safely crush, dilute, and administer the medications together. LPN-E stated she expected the pharmacist to review the medications on admission and add a note to the resident orders if she could not crush, dilute, and administer them together and had not noted this in R99's chart. LPN-E then called the director of nursing (DON) per her report, to confirm she could administer the medications together. LPN-E stated the DON said as long as an order was not in the chart to administer the medications separately, she could combine and give them together through R99's gastric tube. LPN-E re-entered R99's room, flushed the gastric tube with water, and administered the combined medication solution through the gastric tube, and then again, flushed the tube with water. During an interview on 1/23/24 at 2:52 p.m., the consulting pharmacist (CP) stated when a resident was admitted to the facility, he completed a medication reconciliation but he did not assess whether nursing staff could safely dilute and administer medications together through a gastric tube. CP stated if the nursing staff had questions regarding the safe administration of medications through a gastric tube, he would have been able to assist them with this but did not recall anyone asking for assistance with this recently. CP stated if	F 759	Quality Assurance Committee. Further monitoring as needed based on results.	

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F 759	Continued From page 6 medications were crushed, diluted, and administered together, he would worry about a possible compatibility issue between the medications and the adverse effects this could have on a resident. During an interview on 1/24/24 at 8:25 a.m., the DON stated she expected the pharmacist and physician to review the medications on admission to ensure they could have been safely crushed, diluted, and administered together through a gastric tube. The DON stated she had received a message from the pharmacist yesterday indicating he did not review the medications to ensure they could be crushed, diluted, and given together through a g-tube and she was "surprised" by this. The DON stated she would be concerned the medications should not have been mixed and could adversely affect the resident. During an interview on 1/24/24 at 12:48 p.m., the medical director (MD) stated he was not aware of an order or a policy indicating nursing staff could combine and administer medications together through a g-tube. The MD stated if this was the current policy, it should have been updated to indicate nursing staff should not mix medications together like this and instead administer the medications separately. The Institute for Safe Medication Practices article titled "Preventing Errors When Preparing and Administering Medications Via Enteral Feeding Tubes" dated 11/17/22, indicated that multiple medications should not be mixed and given at once through an enteral tube because of possible medication incompatibility issues. The facility Administration of Medication Via	F 759		

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F 759	Continued From page 7 Feeding Tube dated 12/22, indicated that medications administered via a feeding tube could be mixed and administered together unless specific instructions not to were received.	F 759		

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	245393	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**01/24/2024**

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GOOD SHEPHERD LUTHERAN HOME	**800 HOME STREET, BOX 747** **RUSHFORD, MN 55971**

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K 000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety Code survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 01/24/2024. At the time of this survey, GOOD SHEPARD LUTHERAN HOME was found NOT in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: IF PARTICIPATING IN THE E-POC PROCESS, A PAPER COPY OF THE PLAN OF CORRECTION	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		02/16/2024

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
	245393	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**01/24/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SHEPHERD LUTHERAN HOME	**800 HOME STREET, BOX 747** **RUSHFORD, MN 55971**

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K 000	Continued From page 1 IS NOT REQUIRED. Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR By email to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A detailed description of the corrective action taken or planned to correct the deficiency. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. 4. Identify who is responsible for the corrective actions and monitoring of compliance. 5. The actual or proposed date for completion of the remedy. GOOD SHEPHARD LUTHERAN HOME is a 1 story building with partial basement. The original building was constructed at 2 different times. The original building, 1 story with partial basement, was constructed in 1965 and was determined to be of Type II (111) construction. In	K 000		

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K 000	Continued From page 2 1982, a 1 story addition with no basement was constructed and was determined to be of Type II (111) construction. Because the original building and addition are of the same type of construction allowed for existing buildings, the facility was surveyed as one building, Type III (111). The facility is fully protected throughout by an automatic sprinkler system and has a fire alarm system with smoke detection in corridors and spaces open to the corridors that is monitored for automatic fire department notification. The facility has a capacity of 65 beds and had a census of 47 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidence by:	K 000		
K 291 SS=D	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 observation and staff interview, the facility failed to maintain, test, and inspect the emergency lighting fixtures per NFPA 101 (2012 edition) Life Safety Code, sections 19.2.9.1, 7.9.3. This deficient finding could have an isolated impact on the residents within the facility. Findings include:	K 291	Emergency Lighting: Emergency Light located in Basement found to be non-functional when Fire Marshal pressed button. Norman's Electric inspected light fixture and was "OKAY" and functioning according to manufacturers guidelines on 2-9-23.	2/9/24

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K 291	Continued From page 3 On 01/24/2024 between 11:30 AM and 4:30 PM, it was revealed by observation that the emergency light located in the Basement Stairwell leading to the Boiler Room was found to be non-functional upon testing. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 291		
K 324 SS=D	Cooking Facilities CFR(s): NFPA 101 Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2 This REQUIREMENT is not met as evidenced by:	K 324		3/1/24

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K 324	Continued From page 4 Based on observation and staff interview, the facility failed to maintain proper safety and security measures related to a residential cooking device in accordance with NFPA 101 (2012 edition), Life Safety Code, section 19.3.2.5.3(9). This deficient condition could have an isolated impact on the residents within the facility. Findings Include: On 01/24/2024 between 11:30 AM and 4:30 PM, it was revealed by observation that the cooking device located in the Activities Area did not have the proper lock-out, timeout, and disconnect hardware connected to the device. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 324	Cooking Facilities: Cooking device in Activity Area did not have the proper lock-out, time-out, disconnect. Norman's electric will install when parts arrive. Parts ordered on 2-15-24. Norman's Electric has committed to installing the new part within two weeks of receiving the parts.	
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 documentation review and staff interview, the facility failed to maintain the fire alarm system per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.4.1, 9.6.1.3, and NFPA 72 (2010 edition), National Fire Alarm and Signaling Code, section 14.4.5.3. This deficient	K 345	The Fire Alarm System: A sensitivity test was completed on 2/14/24. Dates of the required testing will be reviewed bi-monthly at the Safety Committee Meetings.	2/14/24

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K 345	Continued From page 5 finding could have a widespread impact on the residents within the facility. Findings include: On 01/24/2024 between 11:30 AM and 4:30 PM, it was revealed by a review of available documentation that there was no documentation presented to confirm that sensitivity testing of fire alarm system devices is occurring. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 345		
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 any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on observation, documentation review, and	K 353	Sprinkler System: 5 -Year Inspection was	2/16/24

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K 353	Continued From page 6 staff interview the facility failed to inspect and maintain the sprinkler system in accordance with NFPA 101 (2012 edition), Life Safety Code, sections 4.6.12, 9.7.5, 9.7.6, NFPA 25 (2011 edition) Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, section(s), 4.1.1, 4.3, 4.4, 5.1, 5.2. These deficient findings could have a widespread impact on the residents within the facility. Findings include: 1. On 01/24/2024 between 11:30 AM and 4:30 PM, it was revealed by observation that fire sprinkler system riser gages identified that the most recent 5-year inspection was completed in 2018. During documentation review, no documentation was presented to confirm a 2018 - 5-year inspection, and no documentation was presented to confirm a current 5-year inspection had been completed. 2. On 01/24/2024 between 11:30 AM and 4:30 PM, it was revealed during documentation review that no documentation was presented for review to confirm the 2023 Annual Inspection. 3. On 01/24/2024 between 11:30 AM and 4:30 PM, it was revealed during documentation review that no documentation was presented for review to confirm that a quarterly inspection had occurred in Q1 of 2023. An interview with the Maintenance Director verified these deficient findings at the time of discovery.	K 353	completed on 2/5/24. 2023 Annual Inspection was completed by Fire Protection Specialists on 5/3/23. Quarterly Inspection was completed on 2-16-23 in the first quarter of the year. Quarterly inspections were completed 2-16-23, 5-3-23, 8-22-23, 11-13-23. All inspections are going to be reviewed bi-monthly at the Safety Committee Meetings.	
K 355 SS=D	Portable Fire Extinguishers CFR(s): NFPA 101	K 355		2/9/24

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K 355	Continued From page 7 Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to properly inspect fire extinguishers per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.5.12, 9.7.4.1, and NFPA 10 (2010 edition), Standard for Portable Fire Extinguishers, section 7.1.1, 7.2, 7.2.1.2, 7.2.4, 7.3.3. This deficient finding could have an isolated impact on the residents within the facility. Findings include: On 01/24/2024 between 11:30 AM and 4:30 PM, it was revealed by observation, that visual inspection of the fire extinguisher located in the Basement - Elevator Room had not been inspected monthly since the vendor inspection in 03/2023. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 355	Portable Fire Extinguishers: Elevator Room had not been inspected since annual vendor inspection in 3/2023. Documentation of the fire extinguishers from the Annual Vendor Inspection was compared to the monthly checklist to ensure all extinguishers are being inspected each month. This checklist will be audited yearly after the annual vendor inspection to ensure all extinguishers are being inspected.	
K 374 SS=F	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Doors 2012 EXISTING Doors in smoke barriers are 1-3/4-inch thick solid bonded wood-core doors or of construction that resists fire for 20 minutes. Nonrated protective plates of unlimited height are permitted. Doors are permitted to have fixed fire window assemblies per 8.5. Doors are self-closing or automatic-closing, do	K 374		5/20/24

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K 374	Continued From page 8 not require latching, and are not required to swing in the direction of egress travel. Door opening provides a minimum clear width of 32 inches for swinging or horizontal doors. 19.3.7.6, 19.3.7.8, 19.3.7.9 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain the smoke barrier doors per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.7.8 and 8.5.4.1. These deficient findings could have a widespread impact on the residents within the facility. Findings include: On 01/24/2024 between 11:30 AM and 4:30 PM, it was revealed by observation on the Main Floor - adjacent to stairwell door 104, that the smoke barrier doors exhibited a vertical door-to-door gap greater than 1/8 inch. An interview with the Maintenance Director verified these deficient findings at the time of discovery.	K 374	Subdivision of Building Spaces: Fire door by upper employee entrance smoke door exhibited a vertical door gap greater than 1/8 inch. LaCrosse Glass and Overhead Door assessed the door on 2/16/24. LaCrosse Glass and Overhead reported these doors are custom and require a 6-8 week lead time. A waiver has been completed and submitted.	
K 923 SS=F	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	K 923		2/9/24

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K 923	Continued From page 9 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 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 observation and staff interview, the facility failed to maintain proper medical gas storage and management per NFPA 99 (2012 edition), Health Care Facilities Code, sections 9.3.7, 9.3.7.5.3, 11.3.2.3, 11.6.5. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 01/24/2024 between 11:30 AM and 4:30 PM, it	K 923	Gas Equipment: Cylinder and Container Storage: ADD O2 storage has been rearranged to remove all combustibles from the storage area. A Sign was placed reminding employees to remove all combustible materials and that additional storage of combustible materials is not allowed.	

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K 923	Continued From page 10 was revealed by observation in the Med Gas (O2) Storage Room that there was storage of combustibles. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 923		