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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 7PFV

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00916

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245409**

2.STATE VENDOR OR MEDICAID NO.
(L2) **843242200**

3. NAME AND ADDRESS OF FACILITY
(L3) **MAPLE MANOR NURSING AND REHAB, LLC**
(L4) **1875 19TH STREET NORTHWEST**
(L5) **ROCHESTER, MN** (L6) **55901**

4. TYPE OF ACTION: **7** (L8)

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9) **01/13/2015**

6. DATE OF SURVEY **12/14/2017** (L34)

8. ACCREDITATION STATUS: __ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY **02** (L7)

01 Hospital	**05 HHA**	**09 ESRD**	**13 PTIP**	**22 CLIA**
02 SNF/NF/Dual	**06 PRTF**	**10 NF**	**14 CORF**	
03 SNF/NF/Distinct	**07 X-Ray**	**11 ICF/IID**	**15 ASC**	
04 SNF	**08 OPT/SP**	**12 RHC**	**16 HOSPICE**	

FISCAL YEAR ENDING DATE: (L35)
12/31

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

12.Total Facility Beds **81** (L18)

13.Total Certified Beds **81** (L17)

10.THE FACILITY IS CERTIFIED AS:

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

B. Not in Compliance with Program Requirements and/or Applied Waivers:

And/Or Approved Waivers Of The Following Requirements:
__ 2. Technical Personnel
__ 3. 24 Hour RN
__ 4. 7-Day RN (Rural SNF)
__ 5. Life Safety Code
__ 6. Scope of Services Limit
__ 7. Medical Director
__ 8. Patient Room Size
__ 9. Beds/Room

* Code: **A** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	81			
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS
1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):

17. SURVEYOR SIGNATURE Date :
Marietta Lee, HFE NE II 01/18/2018 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 01/18/2018 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
01/01/1987
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions:
(L44)
B. Rescind Suspension Date:
(L45)

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal
INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
00160
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
12/28/2017
(L33)

DETERMINATION APPROVAL

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

CMS Certification Number (CCN): 245409

January 18, 2018

Mr. Grant Brandon, Administrator
Maple Manor Nursing and Rehabilitation, LLC
1875 19th Street Northwest
Rochester, MN 55901

Dear Mr. Brandon:

The Minnesota Department of Health assists the Centers for Medicare and Medicaid Services (CMS) by surveying skilled nursing facilities and nursing facilities to determine whether they meet the requirements for participation. To participate as a skilled nursing facility in the Medicare program or as a nursing facility in the Medicaid program, a provider must be in substantial compliance with each of the requirements established by the Secretary of Health and Human Services found in 42 CFR part 483, Subpart B.

Based upon your facility being in substantial compliance, we are recommending to CMS that your facility be recertified for participation in the Medicare and Medicaid program.

Effective December 8, 2017 the above facility is certified for:

81 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 81 skilled nursing facility beds.

You should advise our office of any changes in staffing, services, or organization, which might affect your certification status.

If, at the time of your next survey, we find your facility to not be in substantial compliance your Medicare and Medicaid provider agreement may be subject to non-renewal or termination.

Please contact me if you have any questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

cc: Licensing and Certification File

Electronically delivered

January 18, 2018

Mr. Grant Brandon, Administrator
Maple Manor Nursing and Rehabilitation, LLC
1875 19th Street Northwest
Rochester, MN 55901

RE: Project Numbers S5409028, H5409045, F5409026

Dear Mr. Brandon:

On December 7, 2017, we informed you that the following enforcement remedy was being imposed:

- **State Monitoring effective December 12, 2017. (42 CFR 488.422)**

Also on December 7, 2017, as authorized by the CMS Region V Office, we informed you that the following enforcement remedies were being imposed:

- **Civil money penalty for the deficiency cited at F309. (42 CFR 488.430 through 488.444)**

- **Mandatory denial of payment for new Medicare and Medicaid admissions effective January 19, 2018. (42 CFR 488.417 (b))**

Also, we notified you in our letters of December 7, 2017, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from January 19, 2018.

This was based on the deficiencies cited for a standard survey completed on October 19, 2017, and an abbreviated standard survey completed on November 15, 2017. The most serious deficiency was found to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G) whereby corrections were required.

On December 12, 2017, the Minnesota Department of Health and the Minnesota Department of Health, Office of Health Facility Complaints completed Post Certification Revisits (PCR's) and on December 14, 2017 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to the surveys completed on October 18, 2017, October 19, 2017, and November 15, 2017. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of December 8, 2017. As a result of the revisit findings, the Department is discontinuing the Category

1 remedy of state monitoring effective December 12, 2017.

In addition, this Department recommended to the CMS Region V Office the following actions related to the remedies outlined in our letter of December 7, 2017. The CMS Region V Office concurs and has authorized this Department to notify you of these actions:

- **Civil money penalty for the deficiency cited at F309 will remain in effect. (42 CFR 488.430 through 488.444)**

- **Mandatory denial of payment for new Medicare and Medicaid admissions effective January 19, 2018, be rescinded.**

The CMS Region V Office will notify you of their determination regarding the imposed remedies, Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) prohibition.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

cc: Licensing and Certification File

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 7PFV

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(L4) **1875 19TH STREET NORTHWEST**
(L5) **ROCHESTER, MN** (L6) **55901**

4. TYPE OF ACTION: **2** (L8)
1. Initial **2. Recertification**
3. Termination **4. CHOW**
5. Validation **6. Complaint**
7. On-Site Visit **9. Other**
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9) **01/13/2015**

6. DATE OF SURVEY **10/19/2017** (L34)

8. ACCREDITATION STATUS: __ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

01 Hospital	**05 HHA**	**09 ESRD**	**13 PTIP**	**22 CLIA**
02 SNF/NF/Dual	**06 PRTF**	**10 NF**	**14 CORF**	
03 SNF/NF/Distinct	**07 X-Ray**	**11 ICF/IID**	**15 ASC**	
04 SNF	**08 OPT/SP**	**12 RHC**	**16 HOSPICE**	

FISCAL YEAR ENDING DATE: (L35)
12/31

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To (b) :

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___1. Acceptable POC

X B. Not in Compliance with Program Requirements and/or Applied Waivers:

And/Or Approved Waivers Of The Following Requirements:
___ 2. Technical Personnel
___ 3. 24 Hour RN
___ 4. 7-Day RN (Rural SNF)
___ 5. Life Safety Code
___ 6. Scope of Services Limit
___ 7. Medical Director
___ 8. Patient Room Size
___ 9. Beds/Room

* Code: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	81			
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS
1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):

17. SURVEYOR SIGNATURE Date :
Vicky Hamersma, HFE NE II 11/21/2017 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 12/28/2017 (L20)

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

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

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3. Both of the Above :

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01/01/1987
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions:
(L44)
B. Rescind Suspension Date:
(L45)

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal
INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
00160
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
12/28/2017
(L33)

DETERMINATION APPROVAL

Electronically delivered
November 1, 2017

Mr. Grant Brandon, Administrator
Maple Manor Nursing And Rehab, LLC
1875 19th Street Northwest
Rochester, MN 55901

RE: Project Number S5409028

Dear Mr. Brandon:

On October 19, 2017, a standard 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 constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), as evidenced by the electronically delivered CMS-2567 whereby corrections are required.

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.

This letter provides important information regarding your response to these deficiencies and addresses the following issues:

> **Opportunity to Correct - the facility is allowed an opportunity to correct identified deficiencies before remedies are imposed;**
>
> **Electronic Plan of Correction - when a plan of correction will be due and the information to be contained in that document;**
>
> **Remedies - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS) if substantial compliance is not attained at the time of a revisit;**
>
> **Potential Consequences - the consequences of not attaining substantial compliance 3 and 6 months after the survey date; and**

Informal Dispute Resolution - your right to request an informal reconsideration to dispute the attached deficiencies.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

DEPARTMENT CONTACT

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

Gary Nederhoff, Unit Supervisor
Rochester Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
18 Wood Lake Drive Southeast
Rochester, Minnesota 55904-5506
Email: gary.nederhoff@state.mn.us
Phone: (507) 206-2731
Fax: (507) 206-2711

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by November 28, 2017, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by November 28, 2017 the following remedy will be imposed:

- Per instance civil money penalty. (42 CFR 488.430 through 488.444)

ELECTRONIC PLAN OF CORRECTION (ePoC)

An ePoC for the deficiencies must be submitted within **ten calendar days** of your receipt of this letter. Your ePoC must:

- Address how corrective action will be accomplished for those residents found to have

been affected by the deficient practice;

- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;

- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;

- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;

- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,

- Submit electronically to acknowledge your receipt of the electronic 2567, your review and your ePoC submission.

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:

• Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));

• Per day civil money penalty (42 CFR 488.430 through 488.444).

Failure to submit an acceptable ePoC could also result in the termination of your facility's Medicare and/or Medicaid agreement.

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC 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. 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, 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. A Post Certification Revisit (PCR) will occur after the date you identified that compliance was achieved in your plan of correction.

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.

Original deficiencies not corrected

If your facility has not achieved substantial compliance, we will impose the remedies described above. If the level of noncompliance worsened to a point where a higher category of remedy may be imposed, we will recommend to the CMS Region V Office that those other remedies be imposed.

Original deficiencies not corrected and new deficiencies found during the revisit

If new deficiencies are identified at the time of the revisit, those deficiencies may be disputed through the informal dispute resolution process. However, the remedies specified in this letter will be imposed for original deficiencies not corrected. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed.

Original deficiencies corrected but new deficiencies found during the revisit

If new deficiencies are found at the revisit, the remedies specified in this letter will be imposed. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed. You will be provided the required notice before the imposition of a new remedy or informed if another date will be set for the imposition of these remedies.

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

If substantial compliance with the regulations is not verified by January 19, 2018 (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). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the

identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by April 19, 2018 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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: http://www.health.state.mn.us/divs/fpc/profinfo/ltc/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: http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm

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:

Mr. Tom Linhoff, Fire Safety Supervisor
Health Care Fire Inspections
Minnesota Department of Public Safety
State Fire Marshal Division
445 Minnesota Street, Suite 145
St. Paul, Minnesota 55101-5145

Email: tom.linhoff@state.mn.us
Telephone: (651) 430-3012
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

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

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245409	A. BUILDING _____ B. WING _____	10/19/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAPLE MANOR NURSING AND REHAB, LLC	1875 19TH STREET NORTHWEST ROCHESTER, MN 55901

(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 October 16, 17, 18, & 19, 2017, a standard survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with requirements of 42 CFR Part 483, Subpart B, and Requirements for Long Term Care Facilities. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's 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 on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 241 SS=D	DIGNITY AND RESPECT OF INDIVIDUALITY CFR(s): 483.10(a)(1) (a)(1) A facility must treat and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life recognizing each resident's individuality. The facility must protect and promote the rights of the resident. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide care in a dignified manner for 2 of 2 residents (R66 and R145) who were taken due to staff yelling at the resident to take a bath, and not provided clean clothing.	F 241	R145 was assisted in retrieving an adequate clothing supply while in the facility R145 has since discharged from the facility back to his home state R66 care plan was updated	11/28/17

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

Electronically Signed | 11/21/2017

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245409	A. BUILDING _____ B. WING _____	10/19/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAPLE MANOR NURSING AND REHAB, LLC	1875 19TH STREET NORTHWEST ROCHESTER, MN 55901

(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 241	Continued From page 1 Findings include: STAFF YELLING LOUD ENOUGH OTHER RESIDENTS/STAFF/VISITORS COULD HERE CONVERSATION REGARDING CARES: R66's quarterly Minimum Data Set (MDS) dated 6/15/17 indicates that R66 had moderately impaired decision making and total dependence in the area of bathing. In a review of R66's most recent plan of care related to cognitive loss, and disturbed sensory perception indicated that staff will speak to resident in a calm quiet voice and eliminate extraneous noise and stimuli. On 10/19/17, at 7:13 a.m. Registered Nurse (RN)-C was heard shouting at R66 in her room from the hallway and dining room to clearly say, "Your [family member (FM)-A and FM-B] said you smell bad, you are taking a shower!" R66 replied, "No, I'm not." RN-C again shouted a to R66, "Yes you are, your [FM-B] said you need a shower" Shortly after this yelling incident R66 had been witnessed being taken down the hall by RN-C and nursing assistant (NA)-E. On 10/19/17, at 7:22 a.m. R66 had facial expression of distressed/displeasure before stating to NA-E, "I'm not taking a shower!" NA-E did not respond to R66's comment and proceeded to remove R66's nightgown. R66 then stated, "Just hurry it up, no soap!" NA-E then proceeded to spray resident with water and did not use any soap. R66 stated, "Don't get my hair wet" and "that's enough." On asking NA-E in a private setting concerning R66 not wanting a	F 241	Residents have the potential to be affected if their individuality and dignity is not upheld Staff educated on importance of promoting and upholding patient centered care, individuality, and dignity Staff educated on the correct process and acceptable methods of informing Social Services of inadequate clothing supplies for residents 1-2x/week audits for 1 month on verbal and non-verbal speech and treatment toward residents to ensure dignity, respect, and individuality are upheld Audit results to be reviewed at monthly QAPI to evaluate the effectiveness of audit continuation DON/Designee is responsible Corrective Action completed by 11/28/2017	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245409	A. BUILDING _____ B. WING _____	10/19/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAPLE MANOR NURSING AND REHAB, LLC	1875 19TH STREET NORTHWEST ROCHESTER, MN 55901

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shower, NA-E stated she was going to give R66 a bed bath but (RN-C) said the (FM-B) wanted her to have a shower, R66 gets a shower twice a week. On asking about residents choice to not have a bath/shower, NA-E stated residents have a right to refuse and when that happens she goes to get someone "above her" to make the decision.

During an interview on 10/19/17, at 12:11 p.m. RN-C stated the (FM-B) had requested R66 get a shower. RN-C stated she needed to speak loudly as R66 was not wearing her hearing aids. However, NA-E spoke in a quieter tone and R66 heard her and answered questions quickly.

During an interview on 10/19/17, at 12:18 p.m. the director of nursing (DON) verified that the verbal communication from RN-C toward R66 was inappropriate. The DON stated that it is the resident's right to refuse and if it had been her that had been spoken to in this way she would have felt forced to do something she did not want to do. The DON went on to state that education of staff regarding verbal communication is ongoing both through on site in-services and electronic education modules. RN-C had signed that she had attended an in-service on 5/15/17 on resident rights which included content on verbal aggression.

The facility policy entitled Dignity and Respect, revised on 2/3/17, indicated that the facility shall promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition or his or her individuality. The policy included respecting the residents social status, speaking respectfully, listening carefully, treating residents with respect (e.g., addressing the resident with

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the name of the residents choice, not excluding residents from conversations or discussing residents in community setting); and focusing on residents as individuals when they talk to them and addressing residents as individuals when providing care and services.
LACK OF PROVIDING CLEAN CLOTHING FOR A NEWLY ADMITTED RESIDENT:

R145's face sheet, dated 10/12/17, identified a diagnoses of malignant neoplasm (cancer) of the colon and the esophagus and chronic obstructive pulmonary disease (COPD).

R145's care plan, dated 10/13/17, indicated R145 required assistance of one staff for bathing and dressing. R145 should receive a bath or a shower in the AM on Sunday and Thursday.

Facility form, NEW ADMISSION QUESTIONS dated, 10/12/17, identified R145 would like a shower/bath 2 x/week in the a.m. on Sundays and Thursdays.

Facility form, WEST WING SHOWER SCHEDULE indicated that R145 had a shower on Sunday 10/15/17 and Thursday 10/19/17 in the a.m.

Untitled and undated nursing assistant care sheet for R145 indicated assist of 1 person for activities of daily living to include dressing.

On 10/16/17, at 1:11 p.m., R145 was sitting in his wheelchair in his room wearing a red, long-sleeved sweatshirt, plaid pants and blue non-slip socks.

On 10/17/17, at 1:04 P.M., R145 is laying in his

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bed sleeping in his room, wearing the same red, long-sleeved sweatshirt, plaid pants and blue non-slip socks.

On 10/18/17, at 1:14 p.m., R145 observed to be wearing the same red, long-sleeved sweatshirt, plaid pants and blue non-slip socks.

On 10/19/17, at 7:20 a.m., R145 is laying in his bed wearing the same red, long-sleeved sweatshirt, plaid pants and blue non-slip socks.

During interview on 10/19/17, at 8:18 a.m., R145 stated he had not had a shower since Sunday 10/15/17, and at that time they took my clothes, (green slacks, belt and faded short sleeve button up shirt), and "I have not seen them since." R145 further stated he would prefer if someone would help him get dressed and that he has been wearing the same clothes since Sunday.

During interview on 10/19/17, at 8:29 a.m., nursing assistant (NA)-F stated that R145 did not come in with any clothes.

During interview on 10/19/17, at 8:32 a.m. housekeeping (H)-A verified that there is no record that R145 came in with any clothes. Further stated if NAs did not mark a bag of dirty clothes that were sent to the laundry they would have no way of identifying the resident's clothes.

During interview on 10/19/17, at 8:34 a.m., R145 stated he came in with a green pair of dress pants, a faded blue striped shirt and a thin black belt.

During interview on 10/19/17, at 8:50 a.m., social services (SS)-A verified that nothing was reported

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to her about any residents not having any clothes to wear and verified that the green dress pants and faded button shirt found in laundry do belong to R145. SS-A further stated if a resident does not have any clothes to wear it should be reported to me by the NA's and "we would get them some clothes right away." SS-A stated my expectation is for residents to have their clothes changed daily and per their preference.

During interview with R145 on 10/19/17, at 12:02 p.m., R145 stated, "I was not offered a shower this morning. I would prefer a shower." At home I took a shower every other day, so, "this is hard." If they would have offered me a shower today I would have taken one.

During interview on 10/19/17, at 12:11 p.m., nursing assistant (NA)-F stated there was no time to give R145 a shower this morning.

During interview on 10/19/17, at 12:18 p.m., licensed practical nurse (LPN)-A stated I noticed R145 has been wearing the same clothes since Sunday. The NA told me yesterday he didn't have any clothes and I reported it to the administrator. LPN-A further stated, "that is not acceptable ...that would tick me off."

During follow up interview on 10/19/17, at 1:47 p.m., R145 stated they finally gave me a shower. R145 further stated I have had to go out every day this week to get my radiation treatments in the same clothes with no shower, "I plain old felt like a bum!"

Interview on 10/19/17, at 2:12 p.m., director of nursing (DON) stated her expectation in regards to bathing residents is to be offered a

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F 241	Continued From page 6 bath/shower on their day of preference. If it is refused it should be offered 2 more times. If bathing is on their care plan my expectation would be for staff to follow the care plan. DON further stated her expectation for residents is to at least have the option of changing their clothes everyday whether they came in with any clothes or not. The facility policy entitled Dignity and Respect, revised on 2/3/17, indicated that the facility shall promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition or his or her individuality.	F 241		
F 242 SS=E	SELF-DETERMINATION - RIGHT TO MAKE CHOICES CFR(s): 483.10(f)(1)-(3) (f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. (f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. (f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure 4 of 4 residents	F 242	R145 received a bed bath and a shower the same day noted and has since	11/28/17

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F 242	Continued From page 7 (R14, R84, R3, 145) reviewed for choices received baths according to their preferences for bathing frequency. Findings Include: R14 was interviewed on 10/16/17, at 10:09 a.m.; R14 stated I am supposed to have two showers a week. I have not had one for a month. R14 was unaware why he had not had a shower and stated he had spoken to staff about this. Review of the current quarterly Minimum Data Set (MDS) dated 7/12/17, indicated R14's brief interview for mental status BIMS score was 12 out of 15 (meaning cognition is moderately intact) and displayed no behavioral concerns. R14's New Admissions Questions form completed on 2/15/17, indicated R14 preferred a tub bath on Monday and Thursday evenings. Review of the most current plan of care for R74, identified the resident as having self -care deficit related to impaired mobility-hemiplegia, osteoarthritis. Interventions: Provide showers as ordered and as resident allows. Resident has a history of refusals. Staff will continue to provide education for risks and benefits to maintaining shower schedule. Review of the weekly bathing documentation reviewed from 9/3/17 to 10/18/17, revealed the following: R14 had ten opportunities to receive a bath. R14 refused bathing five times, lacked documentation of bathing being offered on scheduled days three times. R14 received a bath one time and was documented as not available for bathing one	F 242	discharged from the facility back to his home state R84 was re-interviewed regarding his bathing preferences and has since passed away R3 was re-interviewed regarding his bathing preferences and his MDS addresses his cognition R14 was re-interviewed regarding his bathing preference and risk and benefits of bathing refusals is current Residents have the potential to be affected if they are not offered bathing preferences or options Resident choice questionnaires to be completed at least quarterly A simplified charting and monitoring process for staff initiated Staff educated on appropriate protocols regarding resident choice, options, and documentation 1-2x/week audits until next survey on bathing and/or refusals to be completed to ensure bathing is offered and/or proper documentation is recorded Audit results to be reviewed at monthly QAPI to evaluate the effectiveness of audit continuation DON/Designee is responsible Corrective Action completed by 11/28/2017	

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time.

On 10/18/17, at 1:09 p.m., nursing assistant (NA)-B stated staff are to approach residents three times during their shift and offering bathing services on their bath day if they are refusing. NA-B stated if R14 refused a bath, staff were to document the refusal in the shower book and computer charting.

R84 was interviewed on 10/16/17, at 10:24 a.m., R84 stated had chosen to have a bath twice a week, but I have never had one twice a week. R84 said that sometimes they forget to give me a bath or shower. I had a shower this past Saturday, but it had been a long time before that that I had one. At least a couple of weeks.

Review of the admission Minimum Data Set (MDS) dated 7/21/17, indicated R84's brief interview for mental status BIMS score was 15 out of 15 (meaning cognition is intact) and displayed no behavioral concerns.

R84's New Admissions Questions undated form indicated R84 did not have a preference for type of bathing, preferred bathing services twice a week and was scheduled for Sunday and Thursday mornings.

Review of the most current plan of care for R84, identified the resident as having self -care deficit related to bilateral BKA (below knee amputations), past stroke with right sided weakness. Interventions: Bathing assist of one, no preference between a bath or shower, would like one two times a week, Sunday and Thursday mornings.

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Review of the weekly bathing documentation reviewed from 9/3/17 to 10/18/17, revealed the following:
R84 had thirteen opportunities to receive a bath, shower or bed bath. R84 refused bathing twice, lacked documentation of bathing being offered on scheduled days four times and received a bathing services seven times.

On 10/18/17, at 1:07 p.m., nursing assistant (NA)-B stated she was not sure of R84's bathing schedule or preferences.

R3 was interviewed on 10/16/17, at 1:02 p.m., R3 stated he received bathing once a week and stated he would like three baths/showers a week. R3 stated he has told staff he would like three baths/showers a week.

Review of the annual Minimum Data Set (MDS) dated 7/14/17; indicated R3 displayed no behavioral concerns. The annual MDS did not address R3's cognition as the questions were left unanswered.

R3's New Admissions Questions form completed on 2/15/17 indicated R3 preferred a shower on Monday, Thursday, and Saturday evenings.

Review of the most current plan of care for R3, identified the resident as having self -care deficit related to hemiplegia. Interventions: bathing assist of one; assist of two with mechanical lift.

Review of the weekly bathing documentation reviewed from 9/3/17 to 10/18/17, revealed the following:
R3 had twenty opportunities to receive a shower. R3 refused showering twice, lacked

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documentation of showering being offered on scheduled days seven times. R3 received a shower eleven times.

On 10/18/17, at 1:00 p.m., nursing assistant (NA)-B stated R3's care guide indicated R3 only gets a bed bath and stated she has never given him a shower or a bath.

On 10/19/17, at 10:00 a.m., nursing assistant (NA)-A stated she completed a first admission questionnaire with residents to determine bathing preferences that included frequency of bathing and type of bathing. NA-A stated she expected staff to ask at least three times if a resident refused their shower. NA-A stated if a resident refused bathing three times during their shift, they were to inform the nurse so the nurse could put in a progress note.

On 10/19/17, at 10:33 a.m., social services (SS)-A stated residents should be asked three times every shift if they would like a bath or a shower. SS-A stated staff should be documenting residents' refusal for bathing. SS-A stated she expected residents to be offered bathing/showers on their scheduled days.

On 10/19/17, at 1:27 p.m., the director of nursing (DON) stated residents are to be offered bathing three times and if they refuse all three times, the nursing assistant is to notify the nurse and the nurse is to make a progress note. The DON stated residents should be offered bathing their scheduled days.
R145's face sheet, dated 10/12/17, identified a diagnoses of malignant neoplasm (cancer) of the colon and the esophagus and chronic obstructive pulmonary disease (COPD).

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R145's care plan, dated 10/13/17, indicated R145 required assistance of one staff for bathing and should receive a bath or a shower in the a.m. on Sunday and Thursday.

Facility form, NEW ADMISSION QUESTIONS dated, 10/12/17, identified R145 would like a shower/bath 2 x/week in the a.m. on Sundays and Thursdays.

Facility form, WEST WING SHOWER SCHEDULE indicated that R145 had a shower on Sunday 10/15/17 and Thursday 10/19/17 in the AM.

During interview on 10/19/17, at 8:18 a.m., R145 stated he had not had a shower since Sunday 10/15/17, and no one has offered to help him wash up since then. R145 stated it has been 5 days since I have been washed up since my shower on Sunday.

During follow up interview on 10/19/17, at 12:02 p.m., R145 stated, "I was not offered a shower this morning. I would prefer a shower." At home I took a shower every other day, so, "this is hard." If they would have offered me a shower today I would have taken one.

During interview on 10/19/17, at 12:11 p.m., nursing assistant (NA)-F stated there was no time to give R145 a shower this morning.

During follow up interview on 10/19/17, at 1:47 p.m., R145 stated they finally gave me a shower. R145 further stated I have had to go out every day this week to get my radiation treatments in the same clothes with no shower, "I plain old felt

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F 242	Continued From page 12 like a bum!" Interview on 10/19/17, at 2:12 p.m., director of nursing (DON) stated her expectation in regards to bathing residents is to be offered a bath/shower on their day of preference. If it is refused it should be offered 2 more times. If bathing is on their care plan my expectation would be for staff to follow the care plan. Bathing policy requested and POLICY & PROCEDURE BATHING dated 8/1/15, directed that the resident will be asked what his/her bathing preferences are regarding bath and shower and number of days of week. The facility will make every effort to meet the resident's needs and preferences.	F 242		
F 250 SS=D	PROVISION OF MEDICALLY RELATED SOCIAL SERVICE CFR(s): 483.40(d) (d) The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure social services were provided to ensure 1 of 1 resident (R145) admission to the facility was properly coordinated, including assurance that appropriate clothing was available following admission to the facility. Findings include: R145's face sheet, dated 10/12/17, identified a diagnoses of malignant neoplasm (cancer) of the	F 250	R145 was assisted in retrieving an adequate clothing supply while in the facility R145 has since discharged from the facility back to his home state Residents without a supply of clothing and/or residents without a support system of family or friends have the potential to be affected if the resident does not admit with clothing supply Facility's Admission Questionnaire now	11/28/17

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F 250	Continued From page 13 colon and the esophagus and chronic obstructive pulmonary disease (COPD). R145's care plan, dated 10/13/17, indicated R145 required assistance of one staff for dressing Untitled and undated nursing assistant care sheet for R145 indicated assist of 1 person for activities of daily living to include dressing. On 10/16/17, at 1:11 p.m., R145 was sitting in his wheelchair in his room wearing a red, long-sleeved sweatshirt, plaid pants and blue non-slip socks. On 10/17/17, at 1:04 P.M., R145 is laying in his bed sleeping in his room, wearing the same red, long-sleeved sweatshirt, plaid pants and blue non-slip socks. On 10/18/17, at 1:14 p.m., R145 observed to be wearing the same red, long-sleeved sweatshirt, plaid pants and blue non-slip socks. On 10/19/17, at 7:20 a.m., R145 is laying in his bed wearing the same red, long-sleeved sweatshirt, plaid pants and blue non-slip socks. During interview on 10/19/17, at 8:18 a.m., R145 stated he had not had a shower since Sunday 10/15/17, and at that time they took my clothes, (green slacks, belt and faded short sleeve button up shirt), and "I have not seen them since." R145 further stated he would prefer if someone would help him get dressed and that he has been wearing the same clothes since Sunday 10/15/17. During interview on 10/19/17, at 8:29 a.m., nursing assistant (NA)-F stated that R145 did not	F 250	includes an area designated to address clothing Staff educated on the correct process and acceptable methods of informing Social Services of inadequate clothing supplies for residents 1-2x/week audits for 1 month on newly admitted residents to occur on clothing inventory to ensure residents have an adequate stock of clothing during their experience at the facility Audit results to be reviewed at monthly QAPI to evaluate the effectiveness of audit continuation DON/Designee is responsible Corrective Action completed by 11/28/2017	

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come in with any extra clothes.

During interview on 10/19/17, at 8:32 a.m. housekeeping (H)-A verified that there is no record that R145 came in with any extra clothes. Further stated if NAs did not mark a bag of dirty clothes that were sent to the laundry they would have no way of identifying the resident's clothes.

During interview on 10/19/17, at 8:34 a.m., R145 stated he came in with a green pair of dress pants, a faded blue striped shirt and a thin black belt.

During interview on 10/19/17, at 8:50 a.m., social services (SS)-A verified that nothing was reported to her about any residents not having any clothes to wear. SS-A stated R145 did come in with extra clothes on admit, and verified the green dress pants and faded button shirt found in laundry do belong to R145. SS-A further stated if a resident does not have any clothes to wear it should be reported to me by the NA's and we would get them some clothes right away." SS-A stated my expectation is for residents to have their clothes changed daily and per their preference.

During interview on 10/19/17, at 12:18 p.m., licensed practical nurse (LPN)-A stated I noticed R145 has been wearing the same clothes since Sunday. The NA told me yesterday R145 didn't have any clothes and I reported it to the administrator. LPN-A further stated, not having clean clothing is not acceptable.

During follow up interview on 10/19/17, at 1:47 p.m., R145 stated I have had to go out every day this week to get my radiation treatments wearing the same soiled clothes and no shower, "I plain

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F 250	Continued From page 15 old felt like a bum!" Interview on 10/19/17, at 2:12 p.m., director of nursing (DON) stated her expectation for residents is to at least have the option of changing their soiled clothes everyday whether they came in with any clothes or not.	F 250		
F 278 SS=D	ASSESSMENT ACCURACY/COORDINATION/CERTIFIED CFR(s): 483.20(g)-(j) (g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. (h) Coordination A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. (i) Certification (1) A registered nurse must sign and certify that the assessment is completed. (2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. (j) Penalty for Falsification (1) Under Medicare and Medicaid, an individual who willfully and knowingly- (i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or (ii) Causes another individual to certify a material	F 278		11/28/17

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F 278	Continued From page 16 and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for each assessment. (2) Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure Minimum Data Set (MDS) was accurately coded for 1 of 1 resident (R135) reviewed for dental services. Also for 1 of 3 residents (R46) reviewed for urinary incontinence. Findings include: R135's admission MDS (an assessment) dated 9/12/17, had identified for oral/dental status no oral concerns were present. R135's teeth were observed on 10/16/17, at 1:28 p.m. and surveyor noted missing teeth. R135's oral/nutritional evaluation dated 9/5/17, indicated R135 had own teeth that were broken or carious. On 10/18/17, at 10:09 a.m. registered nurse (RN)-B stated R135's oral/nutritional evaluation dated 9/5/17, indicated R135 had own teeth that were broken or carious. RN-B stated the admission MDS had been inaccurately coded for R135 and should have been coded to reflect R135 obvious cavity or broken natural teeth. R46's admission MDS dated 6/6/17, had identified R46 for urinary continence as always continent. Review of data from 5/30/17 to 6/6/17, used to completed the MDS, indicated that only	F 278	R135 MDS reflects correct coding through modification R46 MDS reflects correct coding through modification Residents with MDS coding have the potential to be affected if MDS coding is completed incorrectly MDS/Licensed staff educated on importance of correct MDS coding and ramifications if falsified 1-2x/week audit for 1 month to be completed to ensure correct MDS coding occurring Audit results will be reviewed at monthly QAPI to evaluate the effectiveness of audit continuation DON/Designee is responsible Corrective Action completed by 11/28/2017	

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F 278	Continued From page 17 one episode of urinary incontinence had occurred during assessment period. On 10/19/17, at 2:56 p.m. after review of data used for R46's admission MDS dated 6/6/17, RN-B stated admission MDS was coded incorrectly and should have been coded occasionally incontinent. Policy and Procedure for MDS 3.0 Process with revised date of 10/18/17, indicates purpose: To provide guidance to conduct initially and periodically a comprehensive, accurate and standardized reproducible assessment of each resident's functional capacity through utilization of the MDS 3.0 Resident Assessment Instrument user's manual.	F 278		
F 280 SS=D	RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP CFR(s): 483.10(c)(2)(i-ii,iv,v)(3),483.21(b)(2) 483.10 (c)(2) The right to participate in the development and implementation of his or her person-centered plan of care, including but not limited to: (i) The right to participate in the planning process, including the right to identify individuals or roles to be included in the planning process, the right to request meetings and the right to request revisions to the person-centered plan of care. (ii) The right to participate in establishing the expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the plan of care.	F 280		11/28/17

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F 280	Continued From page 18 (iv) The right to receive the services and/or items included in the plan of care. (v) The right to see the care plan, including the right to sign after significant changes to the plan of care. (c)(3) The facility shall inform the resident of the right to participate in his or her treatment and shall support the resident in this right. The planning process must-- (i) Facilitate the inclusion of the resident and/or resident representative. (ii) Include an assessment of the resident's strengths and needs. (iii) Incorporate the resident's personal and cultural preferences in developing goals of care. 483.21 (b) Comprehensive Care Plans (2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the	F 280		

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F 280	Continued From page 19 resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii) Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on interview, observation and document review, the facility failed to revise the comprehensive care plan following recommendations for dental care/services for 1 of 2 residents (R135) reviewed for dental concerns. Findings Include: R135's teeth were observed on 10/16/17, at 1:28 p.m. and surveyor noted missing teeth. R135's Apple Tree Dental Screening dated 9/13/17, indicated R135 had obvious or likely cavity or broken natural teeth. Screening notes: Remaining lower teeth are root tips. Dental Care Referral Recommendations: Routine Dental Referral. Resident has non-urgent dental care	F 280	R135 care plan and care guide has been updated Residents with dental recommendations have the potential to be affected if recommendations are not documented adequately in their care plans Staff educated on importance of follow through and documentation of recommendations based on concerns 1-2x/week audits on dental visits for 1 month to occur on recommendations to ensure adequate documentation recorded Audit results to be reviewed at monthly QAPI to evaluate the effectiveness of audit continuation DON/Designee is responsible Corrective Action completed by	

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F 280	Continued From page 20	F 280	11/28/2017	

needs. Notes to Nursing Staff for follow up/Care Conferences: Monitor for signs of dental pain, swelling or infection. Needs dental visit to assess needs. Will need encouragement reminders to brush.

R135's oral/nutritional evaluation dated 9/5/17, indicated R135 had own teeth that were broken or carious.

R135's admission Minimum Date Set (MDS) (an assessment) dated 9/12/17, had identified for oral/dental status no oral concerns were present.

R135's care plan dated 9/6/17, included, "Self-care deficit r/t [related to]: embolic stroke with right upper extremity weakness, memory loss ...Intervention: Oral care; Has own teeth; A x 1 [assist of one] to brush teeth & gums AM & HS [morning and night]."

R135's care plan did not include Apple Tree Dental Screening recommendations to, "Monitor for signs of dental pain, swelling or infection ...Will need encouragement reminders to brush."

On 10/19/17, at 7:17 a.m., nursing assistant (NA)-C stated R135 will refuse dental cares. NA-C was not aware of any dental recommendation for monitoring of R135 teeth.

On 10/18/17, at 10:09 a.m. registered nurse (RN)-B stated R135's oral/nutritional evaluation dated 9/5/17, indicated R135 had own teeth that were broken or carious. RN-B verified R135's care plan did address the condition of R135's teeth or the Apple Tree Dental Screening recommendations to, "Monitor for signs of dental pain, swelling or infection...Will need

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F 280	Continued From page 21 encouragement reminders to brush." RN-B stated the Apple Tree Dental Screening recommendations should have been care planned and implemented for monitoring of R135's teeth. On 10/17/18, at 2:59 p.m. the director of nurses (DON) stated, "Yes" she expected the Apple Tree Dental screening recommendations for monitoring to be implemented and care planned for R135.	F 280		
F 281 SS=D	SERVICES PROVIDED MEET PROFESSIONAL STANDARDS CFR(s): 483.21(b)(3)(i) (b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to develop a care plan, sufficient to meet the needs of a newly admitted resident for 1 of 1 resident (R144) reviewed for hemodialysis regarding emergency protocols and contact information for dialysis unit/nephrologist, checking for infection and bleeding at port sites. Findings include: R144's temporary care plan developed prior to the Comprehensive Care Plan developed by day 21 following admission (10/2/17) to the facility. The temporary care plan dated 10/12/17,	F 281	R144 care plan was updated R144 has discharged from the facility Residents on dialysis have the potential to be affected if their dialysis sites are not monitored and if they do not have emergency measures addressed in their initial care plan. Staff educated on the importance in completion of the interim care plan and documentation 1-2x/week audits for 1 month on new residents to be completed to ensure residents have interim care plans that address significant care factors and	11/28/17

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F 281	Continued From page 22 indicated a problem area for dialysis and interventions for staff to utilize included; "Monitor shunt site by palpitating for thrill and auscultating for bruit every shift. Notify physician of absence of thrill or bruit." The temporary care plan lacked identification and interventions for monitoring of R144's temporary intravenous catheter access used for dialysis and how staff were to respond to emergency procedures including bleeding from shunt, who to call in an emergency regarding dialysis care, etc. R144 was admitted on 10/2/17 according to face sheet, diagnoses included end stage renal disease and dependence on renal dialysis per the admission record. R144's Physician Orders signed 10/18/17, did not address monitoring of R144's fistula or intravenous catheter site. R144's October 2017, medication administration record (MAR) and treatment administration record (TAR) did not include staff monitoring of the fistula or intravenous catheter access site. R144's record review revealed there was no documentation in progress notes or assessments of monitoring R144's fistula site by palpitating for thrill and auscultating for bruit every shift. There was no document of monitoring R144's intravenous catheter access site. 10/18/17, at 3:03 p.m. the director of nursing (DON) stated she expected staff to chart on R144's dialysis sites daily and to chart post dialysis as well. The DON verified through record review staff were not documenting monitoring of the dialysis site and stated she expected this to	F 281	appropriate documentation Audit results to be reviewed at monthly QAPI to evaluate the effectiveness of audit continuation DON/Designee is responsible Corrective Action completed by 11/28/2017	

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F 281	Continued From page 23 be done. The DON stated this was also a concern because, "they (the facility) usually had a dialysis resident they were taking care of." The DON stated the care plan did not include where R144's dialysis sites were located. The DON stated R144's care plan should have included the fistula as well as the chest catheter and the monitoring to be completed for these sites. The DON confirmed R144's dialysis care plan did not address emergency procedures and stated she expected this to be addressed in the care plan. The DON stated R144's care plan was more general and was not specific enough. The DON stated if a new nurse started, she would not be able to tell where the dialysis site was located for his current dialysis treatment based on the care plan. On 10/19/17, at 5:30 p.m., R144 stated the nursing staff at the facility had not been checking his central line in his chest (intravenous catheter access site) or his fistula in his arm for bruit and thrill. R144 stated they are being monitored at the dialysis center not the facility. R144 had dialysis three times per week. The Dialysis Care policy and procedure dated 8/1/15, included: " ...2. Risk factors related to potential for bleeding, alteration in fluid volume, potential for infection, alteration in nutrition, alteration in skin integrity, risk for adverse medication effects and psychosocial needs should be identified, assessed, and interventions to manage should be addressed in the individualized care plan ...8. Emergency Protocols should be identified and incorporated into the individual care plan."	F 281		
F 309	PROVIDE CARE/SERVICES FOR HIGHEST	F 309		11/28/17

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F 309 SS=D	Continued From page 24 WELL BEING CFR(s): 483.24, 483.25(k)(l) 483.24 Quality of life Quality of life is a fundamental principle that applies to all care and services provided to facility residents. Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, consistent with the resident's comprehensive assessment and plan of care. 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices, including but not limited to the following: (k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. (l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by:	F 309		

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F 309	Continued From page 25 Based on observation, interview and document review, the facility failed to ensure monitoring of dialysis access sites for 1 of 1 resident (R144) reviewed for dialysis; failed to identify, assess, monitor, and treat the great right toe for 1 of 2 residents (R139) reviewed for non-pressure skin conditions; and failed to assess and monitor a non-pressure skin injury for 1 of 1 resident (R44) observed with ear arm skin wounds. Findings include: R144 was admitted on 10/2/17, diagnoses included end stage renal disease and dependence on renal dialysis per the admission record. R144's temporary care plan dated 10/12/17 indicated a problem area for dialysis and interventions for staff to utilize included; "Monitor shunt site by palpitating for thrill and auscultating for bruit every shift. Notify physician of absence of thrill or bruit." The care plan lacked identification and interventions for monitoring of R144's temporary intravenous catheter used for dialysis and emergency procedures. R144's Physician Orders signed 10/18/17 did not address monitoring of R144's fistula or intravenous catheter site. R144's October 2017 medication administration record and treatment administration record did not include staff monitoring of the fistula or intravenous catheter access site. R144's record review revealed there was no documentation in progress notes or assessments of monitoring R144's fistula site by palpitating for	F 309	R139 toe received treatment and is healed R144 care plan was updated and has since discharged from the facility R44 skin sites have healed All residents with skin concerns have the ability to be affected if skin is not assessed, treated, and/or monitored Staff educated on importance of timely reporting, documentation, and monitoring of skin concerns 1-2x/week audit for 2 months to occur on skin concerns to ensure appropriate assessment, treatment, and/or monitoring is completed Audit results to be reviewed at monthly QAPI to evaluate the effectiveness of audit continuation DON/Designee is responsible Corrective Action completed by 11/28/2017	

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F 309	Continued From page 26	F 309		

thrill and auscultating for bruit every shift. There was no document of monitoring R144's intravenous catheter access site. In addition, R144's medical record lacked a memorandum of understanding for dialysis services.

On 10/18/17, at 1:57 p.m. registered nurse (RN)-A stated we will have to put in an order to check the dialysis site for R144. RN-A stated, "For me speaking for myself, I have never observed a dialysis site upon patient return to the facility. Maybe the other nurses are doing it. I will get this fixed and we will start monitoring it tomorrow."

On 10/18/17, at 2:32 p.m., licensed practical nurse (LPN)-A stated monitoring of R144's dialysis sites did not come up on the medication administration record (MAR) or treatment administration record (TAR) for documenting. LPN-A stated he would document in a progress note if, "something was wrong and I would notify the NP [nurse practitioner]." LPN-A stated R144 did not have any physician orders for monitoring the dialysis sites.

10/18/17, at 3:03 p.m. the director of nursing (DON) stated she expected staff to chart on R144's dialysis sites daily and to chart post dialysis as well. The DON verified through record review staff were not documenting monitoring of the dialysis site and stated she expected this to be done. The DON stated this was also a concern because, "they (the facility) usually had a dialysis resident they were taking care of." The DON stated the care plan did not include where R144's dialysis sites were. The DON stated R144's care plan should have included the fistula as well as the chest catheter and the monitoring to be

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F 309	Continued From page 27	F 309		

completed for these sites. The DON confirmed R144's dialysis care plan did not address emergency procedures and stated she expected this to be addressed in the care plan. The DON stated R144's care plan was more general and was not specific enough. The DON stated if a new nurse started, she would not be able to tell where the dialysis site was for his current dialysis treatment based on the care plan.

On 10/19/17, at 2:59 p.m. the administrator stated the facility did not have a copy of the memorandum of understanding for dialysis services at the facility for R144. The administrator stated she was working on getting a copy from dialysis provider. The administrator stated in the future the facility would obtain the memorandum of understanding at the time of admission to the facility for a dialysis resident.

On 10/19/17, at 5:30 p.m., R144 stated the nursing staff at the facility had not been checking his central line in his chest (intravenous catheter access site) or his fistula in his arm for bruit and thrill. R144 stated they are being monitored at the dialysis center not the facility. R144 had dialysis run three times per week.

The Dialysis Care policy and procedure dated 8/1/15, included: " ...2. Risk factors related to potential for bleeding, alteration in fluid volume, potential for infection, alteration in nutrition, alteration in skin integrity, risk for adverse medication effects and psychosocial needs should be identified, assessed, and interventions to manage should be addressed in the individualized care plan ...8. Emergency Protocols should be identified and incorporated into the individual care plan."

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F 309	Continued From page 28 LACK OF NAIL CARE & MONITORING FOR INFECTION OF TOE: R139 had been observed on 10/17/17, at 12:40 p.m., with long untrimmed toenails and right great toenail is loose hanging on by a thin piece of skin and there is a black dusty substance under the nail. On 10/18/17, at 10:24 a.m., R139 observed to be sleeping in his bed with his socks off. Toenails are extremely long and right great toenail is black colored. During interview on 10/19/17, at 11:20 a.m., R139 stated one day he was putting his pants on and his right great toenail caught on his pants. This resulted in nail pulled off nail bed. R139 further stated I have toenail fungus and my toenails need to be clipped, "I haven't clipped them since I have been here." R139 showed this surveyor that he could lift up on his right toenail and stated, "I am going to lose it." During this time R139 stated, I did show one of the nurses here my toenail and she said, "Oh my god!" R139 verified that no one here did anything to help his right great toenail. No follow-up to the nail being blackened and loose form nail bed. Interview on 10/19/17, at 11:34 a.m., registered nurse (RN)-C stated no one told her anything in shift report about R139's right great toenail. Further verified there is no documentation in his chart identifying a blackened, right great toenail that is hanging off for R139. RN-C stated, " ...used to put bacitracin and a band aide on it, but then he started refusing it about a week ago ..." Interview on 10/19/17, at 11:46 a.m., RN-C	F 309		

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verified there no documentation in R139's medical record regarding bacitracin and a band aide to the right great toe.

Interview on 10/19/17, at 1:10 p.m., registered nurse (RN)-A was in R139's room getting ready to clip his toenails. R139 took his right foot out of shoe and yelled, "Don't touch!" "Ow, ow ow ..." RN-A stated, "That one is going to need a podiatrist," as she was first looking at R139's right great toenail and further stated, "It smells like infection." RN-A verifies the skin surrounding the right great toenail is reddened.

Interview on 10/19/17, at 2:06 p.m., director of nursing (DON) stated nail care should be done at least weekly on the resident's bath day. This surveyor told DON that R139's great right toenail was hanging loose and blackened and that there was redness surrounding the nail along with dried blood and that RN-A stated it smelled like infection. DON stated, "Sounds like he needs to see podiatry." And verified there was no documentation in R139's medical record pertaining to his right great toe status.

The resident admission record sheet identifies R139 with a diagnosis of cerebral infarction, encephalopathy and hemiparesis following cerebral infarction affecting dominant right side.

The 14 day Minimum Data Set (MDS) dated 9/25/17, identified to have moderate cognitive impairment and required extensive assist of 1 person for personal hygiene.

The Care Plan dated, 9/11/17, identified R139 with a self-care deficit related to right side hemiparesis (weakness of one side of body).

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Interventions for R139 include an assist of 1 person with grooming.

The nursing assistant care sheet undated, indicates R139 needs 1 assist with activities of daily living skills (ADLs).

Skin monitoring: comprehensive certified nursing assistant (CNA) shower review sheets, dated: 9/11/17, 9/18/17, 9/22/17, 9/29/17, 10/2/17, 10/6/17, 10/13/17, and 10/16/17, all identify that R139 did not get his toenails clipped and no documentation of any problems with right great toenail.

Policy and Procedure for Nail Care dated 7/28/15, revised 3/1/17, revealed: purpose is to clean the nail bed, keep nails trimmed, prevent infections, accidental skin injuries and ensure residents appear clean and well-groomed.
LACK OF MONITORING SKIN WOUND FOR HEALING AND IF CURRENT TREATMENT IS AFFECTIVE:

R44 was admitted to the facility on 8/9/17 according to face sheet, with the diagnoses of other malaise, dementia and glaucoma.

On 10/17/17, at 12:07 p.m. observed a Band-Aid with visible strike-through (wound exudate permeating through a dressing, allowing bacterial ingress through the dressing and colonization of the wound surface) to R44's left ear. It was noted that R44 also had an undated dressing placed on anterior right forearm.

R44's plan of care revised on 8/15/17, indicated the goal is to maintain intact skin integrity through the next review of 11/20/17. No plan for current

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F 309	Continued From page 31 non-pressure skin injury was found in the facilities' electronic health record. A progress noted dated 10/4/17, indicated R44 had scratched the left outer part of her ear, which was cleaned with an alcohol wipe and left open to air. A late entry note on 10/5/17, added that R44 had also sustained a skin tear on her right forearm, both her left ear and right forearm were cleaned with normal saline, left ear left open to air and right forearm skin tear covered with a Mepilex (an absorbent, atraumatic dressing made from polyurethane foam). No other documentation was noted related to the skin injuries. During an interview with the director of nursing (DON) on 10/18/17, at 11:17 a.m. she verified that after 10/5/17 there was no documentation related to the monitoring of the skin injuries and that she would expect this to be addressed on the treatment administration record as well as on the weekly skin assessment The facility Skin Assessment policy dated 1/13/17 indicated skin injuries including skin tears will be assessed every 7 days by a licensed nurse and recorded in the medical record.	F 309		
F 311 SS=D	TREATMENT/SERVICES TO IMPROVE/MAINTAIN ADLS CFR(s): 483.24(a)(1) (a)(1) A resident is given the appropriate treatment and services to maintain or improve his or her ability to carry out the activities of daily living, including those specified in paragraph (b) of this section. This REQUIREMENT is not met as evidenced	F 311		11/28/17

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F 311	Continued From page 32 by: Based on observation, interview, and record review, the facility failed to ensure staff provided toenail care for 1 of 1 resident (R139) reviewed who required assistance with activities of daily living (ADL's). Findings include: On 10/17/17, at 12:40 p.m., observation of R139's toenails were long and the right great toenail was loose and moved easily also there was black colored debris under the loose toenail. On 10/18/17, at 10:24 a.m., R139 observed to be sleeping in his bed with his socks off. Toenails are extremely long and right great toenail is black colored. During interview on 10/19/17, at 11:20 a.m., R139 stated one day he was putting his pants on and his right great toenail caught on his pants pulling it off nail bed and held by thin piece of skin. R139 further stated I have toenail fungus and my toenails need to be clipped, "I haven't clipped them since I have been here." Interview on 10/19/17, at 1:10 p.m., registered nurse (RN)-A stated regarding R139's nail that they are long, and "his toenails do need to be clipped." Interview on 10/19/17, at 2:06 p.m., director of nursing (DON) stated nail care should be done at least weekly on the resident's bath day. DON further verified that according to the last two bath sheets she located there was no documentation of nail care done for R139.	F 311	R139 received fingernail care R139 right great toe has healed R139 care plan was updated to address his smoking status All residents with nails have the potential of being affected if nail care and monitoring is not completed Staff educated on importance of nail care, weekly skin assessments, and licensed/C.NA nail care responsibilities 1-2x/week audit for 1 month to be completed to ensure nail care is being offered and documented appropriately if necessary. Audit results will be reviewed at monthly QAPI to evaluate the effectiveness of audit continuation DON/designee is responsible Corrective Action completed by 11/28/2017	

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F 311	Continued From page 33 The resident admission record sheet identifies R139 with a diagnosis of cerebral infarction, encephalopathy and hemiparesis following cerebral infarction affecting dominant right side. The admission Minimum Data Set (MDS) dated 9/25/17, identified to have moderate cognitive impairment and required extensive assist of 1 person for personal hygiene. The Care Plan dated, 9/11/17, identified R139 with a self-care deficit related to right side hemiparesis (weakness of one side of body). Interventions for R139 include an assist of 1 person with grooming. The nursing assistant care sheet undated, indicates R139 needs 1 assist with activities of daily living skills. . The certified nursing assistant (CNA) shower review sheets, dated: 9/11/17, 9/18/17, 9/22/17, 9/29/17, 10/2/17, 10/6/17, 10/13/17, and 10/16/17, all identify that R139 did not have toenails clipped. Policy and Procedure for Nail Care dated 7/28/15, revised 3/1/17, revealed: purpose is to clean the nail bed, keep nails trimmed, prevent infections, accidental skin injuries and ensure residents appear clean and well-groomed.	F 311		
F 329 SS=D	DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS CFR(s): 483.45(d)(e)(1)-(2) 483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any	F 329		11/28/17

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F 329	Continued From page 34 drug when used-- (1) In excessive dose (including duplicate drug therapy); or (2) For excessive duration; or (3) Without adequate monitoring; or (4) Without adequate indications for its use; or (5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or (6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. 483.45(e) Psychotropic Drugs. Based on a comprehensive assessment of a resident, the facility must ensure that-- (1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; (2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to provide an abnormal involuntary movement (AIMS) assessment for 1 of 1 resident	F 329	R44 has had an AIMS assessment completed All residents on psychotropic drugs have	

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F 329	Continued From page 35 (R44) to ensure baseline monitoring for tardive dyskinesia (a disorder that results in involuntary, repetitive body movements in residents taking antipsychotic medications) when on a psychotropic medication. Findings include: R44 was admitted to the facility on 8/9/17, according to the face sheet, with the diagnoses of other malaise, dementia and glaucoma. On 8/10/17, the most current physicians orders read, Seroquel 6.25 mg (an antipsychotic medication) was initiated to be given one time a day. The medication was discontinued on 8/17/17, and lorazepam (an antianxiety medication) was added as needed up to three times a day. On 9/5/17, Seroquel 12.5 mg was added to be given twice a day. On 10/12/17, an increase to Seroquel 25 mg twice a day was initiated. R44's plan of care related to antipsychotic medication related to anxiety/delirium instructs staff to monitor/document/report adverse side effects including tremors, disturbed gait, increased agitation, restlessness, involuntary movement of the mouth or tongue. A Medication Regimen Review (MRR) report dated 8/17/17, indicated that R44 was recently placed on scheduled Seroquel for management of dementia-related behaviors and to ensure a baseline Abnormal Involuntary Movement Scale (AIMS) exam was completed to assess for tardive dyskinesia side effects. The facility AIMS Assessment policy dated 8/1/15,	F 329	the potential to be affected if AIMS assessments are not completed timely Staff educated on importance of timely AIMS completion and protocol of AIMS completion 1-2x/week audit for 1 month to be completed to ensure AIMS assessments are completed appropriately Audit results will be reviewed at monthly QAPI to evaluate the effectiveness of audit continuation DON/designee is responsible Corrective Action completed by11/28/2017	

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F 329	Continued From page 36 indicated that the AIMS form will be filled out for any resident on the following: Antipsychotic medications, antianxiety medication and/or hypnotic use. The policy goes on to indicate that the AIMS Assessment form provided by the facilities' electronic health record (EHR) should be used. In review of the EHR no AIMS form was located. However, it was noted in the treatment administration record on 10/9/17, and 10/12/17, that an order to complete an AIMS Assessment was signed as other, see progress notes by licensed practical nurse with a progress note that the assessment was completed because R44 was unable to follow commands or respond appropriately to questions. On 10/18/17, at 2:15 p.m. the director of nursing (DON) verified that the AIMS had not been done. The DON stated a more experienced nurse should complete the AIMS.	F 329		
F 334 SS=E	INFLUENZA AND PNEUMOCOCCAL IMMUNIZATIONS CFR(s): 483.80(d)(1)(2) (d) Influenza and pneumococcal immunizations (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	F 334		11/28/17

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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.

(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;

(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

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F 334	Continued From page 38 (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 ensure pneumococcal polysaccharide vaccine (PPSV23) was offered and administered to 3 of 5 residents (R44, R13, R53), reviewed for immunization status. Findings include: R44 was admitted to the facility on 8/9/17, according to the face sheet. No education, consent or administration of PPSV23 has been documented. R13 was admitted to the facility on 9/5/17, according to the face sheet. No education, consent or administration of PPSV23 has been documented. R53 was admitted to the facility on 9/1/15, according to the face sheet. No education, consent or administration of PPSV23 has been documented. In an interview with the director of nursing (DON)	F 334	R44 responsible party has had the opportunity to accept or decline a pneumococcal vaccination R13 has had the opportunity to accept or decline a pneumococcal vaccination R53 has had the opportunity to accept or decline a pneumococcal vaccination Consents and education provided to residents/resident responsible party Consents and education are included in new admission packets All residents have potential to be affected if they are not given the opportunity to accept or refused a pneumococcal vaccination Staff educated on importance of offering vaccinations and appropriate documentation 1-2x/week audit for 1 month on pneumococcal vaccination offer and appropriate documents to be completed to ensure choice and appropriate follow up is initiated Audit results will be reviewed at monthly	

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F 334	Continued From page 39 on 10/19/17, at 4:56 p.m. the DON verified she was unable to provide documentation of education, consent or administration of PPSV23 had been offered to R44, R13, R53, or their representative. The DON did acknowledge that she was aware of the most current update regarding pneumococcal immunization and the nurse practitioner had begun working on reviewing resident records.	F 334	QAPI to evaluate the effectiveness of audit continuation DON/Designee is responsible Corrective Action completed by 11/28/2017	
F 441 SS=D	INFECTION CONTROL, PREVENT SPREAD, LINENS CFR(s): 483.80(a)(1)(2)(4)(e)(f) (a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: (1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards (facility assessment implementation is Phase 2); (2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;	F 441		11/28/17

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F 441	Continued From page 40 (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv) When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi) The hand hygiene procedures to be followed by staff involved in direct resident contact. (4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. (e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. (f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by:	F 441		

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	245409	A. BUILDING _____ B. WING _____	10/19/2017

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F 441	Continued From page 41 Based on interview, and document review, the facility failed to implement a comprehensive infection control program to include analysis and surveillance, and failed to implement a program to prevent Legionella in the facility water systems to prevent cases and outbreak of Legionnaires' disease. This had the potential to affect 64 of 64 residents, staff and visitors. Findings include: LACK OF ANALYSIS AND SURVEILLANCE AS PART OF THE INFECTION CONTROL PROGRAM: Upon review of the facility infection control logs provided by the facility and dated from 3/2017 to 9/2017, the logs identified tracking that included the resident name, room number, date of onset, infection/symptoms, organism, culture date, hospital, in-house, or community acquired treatment and duration, end date and comments/resolved. The logs identified the following: 3/2017 - 1 herpes zoster, 5 pneumonia, 1 Clostridium difficle (C. diff, a stool infection), 7 urinary tract infections (UTIs), 1 impetigo, and 1 methicillin resistant staphylococcus aureus (MRSA) 4/2017 - 1 cough, 5 pneumonia, 2 cellulitis (skin infection) 1 wound infection, and 2 UTIs 5/2017 - 7 pneumonia, 1 lymph infection, 2 C.diff, 1 wound infection, 1 UTI, 1 cough, 1 bronchitis, 1 prophylactic (preventative)	F 441	New tracking of infections initiated including the analysis and surveillance and a legionella program specific to site has been completed Residents living in the facility have the potential of being affected if infections and legionella are not tracked and tested adequately Staff educated on analysis and surveillance of infections and testing for legionella 1-2x/week audit for 2 months to be completed to ensure appropriate analysis and surveillance and legionella testing being competed Audit results will be reviewed at monthly QAPI to evaluate the effectiveness of audit continuation DON/designee is responsible Corrective action completed by 11/28/2017	

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F 441	Continued From page 42 6/2017 - 3 prophylactic, bronchitis, 2 C.diff, 1 sepsis, 1 yeast, 2 UTI, 1 blood infection 7/2017 - 3 pneumonia, 3 UTI, 1 C. diff, 1 infected hardware removal, 1 chronic obstructive pulmonary disease (COPD) exacerbation (flare up). 8/2017 - 5 UTIs, 3 pneumonia 9/2017 - 4 UTIs, 5 pneumonia, 1 septic arthritis During an interview on 10/19/17, at 9:40 a.m. with the director of nursing (DON) it was verified that there was no ongoing analysis or surveillance of the facility's infection control log. An Infection Control Prevention policy was requested but not received. LACK OF DEVELOPING AND OPERATIONALIZE LEGIONELLA PROTOCOL: During an interview on 10/19/17, at 5:12 p.m., the environmental services director (ESD) was asked if the facility had developed policy and procedure in place to reduce the risk of growth and spread of Legionella (Legionella bacteria are microscopic organisms that live in the soil and water and are the most common cause of Legionnaires' disease) and other opportunistic pathogens in building systems. The environmental director stated he had just found out about the requirement during the survey. ESD then provided a CDC guideline,an initial policy titled Water Management Program, as well as an initial incomplete Environmental Assessment of Water Systems.	F 441		

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F 441	Continued From page 43 According to centers for medicare/medicaid services (CMS) Memorandum Summary S&C 17-30 -to include Hospitals/CAHs/NHs dated June 02, 2017, regarding the requirement tor Reduce Legionella Risk in Healthcare Facility Water Systems to Prevent Cases and Outbreaks of legionnaires' Disease (LD). Effective date: Immediately.	F 441		
F 465 SS=D	SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON CFR(s): 483.90(i)(5) (i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. (5) Establish policies, in accordance with applicable Federal, State, and local laws and regulations, regarding smoking, smoking areas, and smoking safety that also take into account non-smoking residents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure 1 of 2 refrigerator's reviewed, containing resident nutritional supplements were maintained in a clean and sanitary condition. Findings include: On 10/17/17, at 3:37 p.m., during tour of the medication room on the North hall, the refrigerator with a #9 on it held the residents nutritional supplements. The refrigerator was noted to have a dried brown substance on the	F 465	The North medication fridge has been cleaned Fridges in the facility were checked and are clean Residents on the North Wing have the potential to be affected if storage sites are not clean Refrigerator cleanliness monitoring has been assigned to the overnight nurse routine task Staff educated on importance of clean storages sites for resident material 1-2x/week audit for 1 month to be	11/28/17

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F 465	Continued From page 44 bottom shelf on the inside. The freezer portion of the fridge was noted to have at a minimum 1 inch thick layer of ice build-up. The outside of refrigerator #9 was a sheet entitled, "Refrigerator/Freezer cleaning schedule." Below the caption it stated, "Nurses on night shift: Defrost/clean medication room refrigerator's every 2 weeks." The initials, "DA" were put in next to the date of April 10, 2016. During interview with registered nurse (RN)-D on 10/17/17, at 3:52 p.m., verified routine cleaning had not been documented with the last recorded date of April, 2016. Further RN-D verified there is a large amount of ice buildup on the freezer portion of the fridge. 10/19/17, at 5:54 p.m., director of nursing (DON) verified routine cleaning was not routinely documented with last date of April, 2016. The DON was informed #9 refrigerator has debris on the floor and ice build-up. Requested policy for maintenance and cleaning of medication storage refrigerator's and received a policy entitled, "Policy and Procedure Medication Refrigerator Cleaning." Policy reads: Medication refrigerator will be kept on a routine cleaning schedule to ensure there is no contamination from spills. Spills should be wiped up promptly as as not to become stuck to the refrigerator surfaces.	F 465	completed to ensure medication fridges are sanitary Audit results will be reviewed at monthly QAPI to evaluate the effectiveness of audit continuation DON/Designee is responsible Corrective Action completed by 11/28/2017	
F 520 SS=E	QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS CFR(s): 483.75(g)(1)(i)-(iii)(2)(i)(ii)(h)(i) (g) Quality assessment and assurance.	F 520		11/28/17

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F 520	Continued From page 45 (1) A facility must maintain a quality assessment and assurance committee consisting at a minimum of: (i) The director of nursing services; (ii) The Medical Director or his/her designee; (iii) At least three other members of the facility's staff, at least one of who must be the administrator, owner, a board member or other individual in a leadership role; and (g)(2) The quality assessment and assurance committee must : (i) Meet at least quarterly and as needed to coordinate and evaluate activities such as identifying issues with respect to which quality assessment and assurance activities are necessary; and (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; (h) Disclosure of information. A State or the Secretary may not require disclosure of the records of such committee except in so far as such disclosure is related to the compliance of such committee with the requirements of this section. (i) Sanctions. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the	F 520	An Ad Hoc QAPI was held with root	

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F 520	Continued From page 46 facility failed to ensure the Quality Assurance and Assessment (QA&A) effectively sustained ongoing compliance related to repeat citation form past surveys in regards to bathing choices. This had the potential to effect all 64 resident residing in the facility. Findings include: See F242: Based on interview and document review, the facility failed to ensure 4 of 4 residents (R14, R84, R3, 145) reviewed for choices received baths according to their preferences for bathing frequency On 10/19/17, 4:05 p.m. the administrator was interviewed about their quality assurance (QA) program. The administrator stated their QA committee meets monthly, and identified who attended as well, as how they would identify issues in the facility. The administrator recognized the repeated deficiencies regarding resident choice in bathing and will be addressed.	F 520	cause analysis conducted and proactive plans initiated All residents have the potential to be affected if they are not provided the assistance of bathing and/or documentation of refusals are inadequately recorded Resident choice questionnaires to be completed at least quarterly, highlighting resident bathing preferences and individual bathing patterns New simplified charting system initiated Staff educated on importance of ADLs, documentation, and the repeat survey presence of this deficiency 1-2x/week audits until next survey on bathing and/or refusals to be completed to ensure bathing is offered and/or proper documentation is recorded Audit results to be reviewed at monthly QAPI to evaluate the effectiveness of audit continuation DON/Designee is responsible Corrective Action completed by 11/28/2017	

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K 000	INITIAL COMMENTS FIRE SAFETY 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. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey, Edenbrook - Rochester 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) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K TAGS) TO: HEALTH CARE FIRE INSPECTIONS STATE FIRE MARSHAL DIVISION 445 MINNESOTA STREET, SUITE 145	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		11/10/2017

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

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K 000	Continued From page 1 ST. PAUL, MN 55101-5145, or By e-mail to both: Marian.Whitney@state.mn.us and Angela.Kappenman@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency Edenbrook - Rochester is a 1-story building with a partial basement. The building was constructed at 2 different times. The original building was constructed in 1964 and was determined to be of Type II(111) construction. In 1974, addition was constructed to the East wing that was determined to be of Type II(111) construction. Because the original building and the addition are of the same type of construction and meet the construction type allowed for existing buildings, the facility was surveyed as one building. The building is fully fire sprinkler protected and has a fire alarm system with smoke detection in the corridors and spaces open to the corridors that is monitored for automatic fire department notification.	K 000		

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K 000	Continued From page 2 The facility has a capacity of 81 beds and had a census of 65 at the time of the survey. The requirement at 42 CFR Subpart 483.70(a) is NOT MET.	K 000		
K 133 SS=F	NFPA 101 Multiple Occupancies - Construction Type Multiple Occupancies - Construction Type Where separated occupancies are in accordance with 18/19.1.3.2 or 18/19.1.3.4, the most stringent construction type is provided throughout the building, unless a 2-hour separation is provided in accordance with 8.2.1.3, in which case the construction type is determined as follows: * The construction type and supporting construction of the health care occupancy is based on the story in which it is located in the building in accordance with 18/19.1.6 and Tables 18/19.1.6.1 * The construction type of the areas of the building enclosing the other occupancies shall be based on the applicable occupancy chapters. 18.1.3.5, 19.1.3.5, 8.2.1.3 This STANDARD is not met as evidenced by: Based on observations and staff interview, it was revealed that the two hour fire separation was found not in compliance with NFPA 101 "The Life Safety Code" 2012 edition (LSC) sections 19.1.3.3. These deficient conditions could allow the products of combustion to travel from one building to another, which could negatively affect 65 of 65 residents, as well as an undetermined number of staff, and visitors.	K 133	-A new closure and latch handle to be purchased and installed -Corrective Action completed by 11/19/17 -Facility Maintenance Director responsible for correction and monitoring to prevent a reoccurrence of deficiency	11/19/17

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K 133	Continued From page 3 Findings include: On facility tour between 11:00 a.m. to 4:00 p.m. on 10/18/2017, observations revealed that in the 2 hour fire rated wall separating the North wing and the main dining room there is a a 90 minute fire rated door between the serving side and the dining room that did not have a closing device that was being held closed by a slide bolt hasp. This deficient condition was verified by a Maintenance Supervisor.	K 133		
K 211 SS=C	NFPA 101 Means of Egress - General Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 This STANDARD is not met as evidenced by: Based on observation and interview, the facility had 1 of several exit corridors that did not meet the requirements of NFPA 101 "The Life Safety Code" 2012 edition, sections 7.1.10 and 19.2.1. This deficient practice could affect 20 of 65 residents, as well as an undetermined number of staff, and visitors. Findings include: On facility tour between 11:00 a.m. to 4:00 p.m. on 10/18/2017, observations revealed that the beauty shop was working in an alternate location and had been using bonnet style hair dryers in	K 211	-Understanding by beautician and management that this occurrence is not an appropriate accommodating location and is not to be utilized in the future. -Corrective Action completed by 11/19/17 -Facility Maintenance Director responsible for correction and monitoring to prevent a reoccurrence of deficiency	11/19/17

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K 211	Continued From page 4 the exit corridor. The beautician removed the hair dryers and discontinued the use of the exit corridor for beauty shop use at the time the deficient condition was identified. This deficient condition was verified by a Maintenance Supervisor.	K 211		
K 271 SS=F	NFPA 101 Discharge from Exits Discharge from Exits Exit discharge is arranged in accordance with 7.7, provides a level walking surface meeting the provisions of 7.1.7 with respect to changes in elevation and shall be maintained free of obstructions. Additionally, the exit discharge shall be a hard packed all-weather travel surface in accordance with CMS Survey and Certification Letter 05-38. 18.2.7, 19.2.7, S&C 05-38 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to provide a means of egress in accordance with the following requirements of the NFPA 101 "The Life Safety Code" 2012 edition (LSC) sections 7.1.6.2 and 7.1.7. This deficient practice could affect 65 of 65 residents, as well as an undetermined number of staff, and visitors. Findings include: On facility tour between 11:00 a.m. to 4:00 p.m. on 10/18/2017, observations revealed that there are elevation changes greater than 1/2 inch at the following exits discharges: 1. From East exit which had a 1 inch drop in elevation at the threshold of the exit door.	K 271	-Facility referring two options for compliancy. Facility is waiting to hear back from the City Fire Marshal. Corrective action will be either to install new sloping concrete to make the door and sidewalk flush or to use consultation of City Fire Marshal of no longer promoting the existing door as a means of exit through dry walling and signage removal. -Corrective Action completed by 11/19/17 -Facility Maintenance Director responsible for correction and monitoring to prevent a reoccurrence of deficiency	11/19/17

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K 271	Continued From page 5 2. From the North exit by the North Dining room which had a 1 inch drop in elevation at the threshold of the exit door. This deficient condition was verified by a Maintenance Supervisor.	K 271		
K 291 SS=F	NFPA 101 Emergency Lighting 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 STANDARD is not met as evidenced by: Based on observations and an interview with staff, the facility has failed to ensure that emergency lighting has been tested and maintained in accordance with the NFPA 101 "The Life Safety Code" 2012 edition (LSC) section 7.9.3. This deficient practice could affect 65 of 65 residents, as well as an undetermined number of staff, and visitors in the event of an emergency evacuation during a power outage. Findings include: On facility tour between 11:00 a.m. to 4:00 p.m. on 10/18/2017, observation during a review of all available testing and maintenance documentation and an interview with the Maintenance Supervisor revealed that the facility had not conducted the 90 minute annual test of the battery operated emergency lights found within the facility. This deficient condition was verified by a Maintenance Supervisor.	K 291	-Log created in electronic maintenance system 'TELS' for routine monthly inspection prompts -Corrective Action completed by 11/19/17 -Facility Maintenance Director responsible for correction and monitoring to prevent a reoccurrence of deficiency	11/19/17

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 321 SS=D	NFPA 101 Hazardous Areas - Enclosure Hazardous Areas - Enclosure 2012 EXISTING Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4-hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) This STANDARD is not met as evidenced by: Based on observations and staff interview, it was revealed that the facility has failed to provide proper protection for 1 of several hazardous areas located throughout the facility in accordance with NFPA 101 "The Life Safety Code" 2012 edition (LSC) section 19.3.2.1. This deficient conditions could in the event of a fire,	K 321	-Fire caulk applied where pipes come through the wall for sealing -Corrective Action completed by 11/19/17 -Facility Maintenance Director responsible for correction and monitoring to prevent a reoccurrence of deficiency	11/19/17

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K 321	Continued From page 7 allow smoke and flames to spread throughout the effected corridors and areas making them untenable, which could negatively affect 10 of 65 residents as well as an undetermined number of staff, and visitors. Findings include: On facility tour between 11:00 a.m. to 4:00 p.m. on 10/18/2017, observations revealed that the lower level storage room L-19 had a 2 inch opening inside the room above the door leading to the corridor. This deficient condition was verified by a Maintenance Supervisor.	K 321		
K 331 SS=D	NFPA 101 Interior Wall and Ceiling Finish Interior Wall and Ceiling Finish 2012 EXISTING Interior wall and ceiling finishes, including exposed interior surfaces of buildings such as fixed or movable walls, partitions, columns, and have a flame spread rating of Class A or Class B. The reduction in class of interior finish for a sprinkler system as prescribed in 10.2.8.1 is permitted. 10.2, 19.3.3.1, 19.3.3.2 Indicate flame spread rating(s). This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to provided interior finish materials that meets the NFPA Life Safety Code 101 2012 edition sections 19.3.3.1, 19.3.3.2, and 10.2.3. This deficient practice could effect residents as	K 331	-Material has been removed from stairwell -Corrective Action completed by 11/19/17 -Facility Maintenance Director responsible for correction and monitoring to prevent a	11/19/17

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K 331	Continued From page 8 well as an undetermined number of staff, and visitors. Findings include: On facility tour between 11:00 a.m. to 4:00 p.m. on 10/18/2017, it was observed that the facility has 4 by 8 foot sheets of wood paneling attached to one of the walls located in the exit stairwell in the north wing across from resident room 29. At the time of the inspection it could not be verified that the wood paneling was treated with a fire retardant finish. This deficient condition was verified by a Maintenance Supervisor.	K 331	reoccurrence of deficiency	
K 345 SS=F	NFPA 101 Fire Alarm System - Testing and Maintenance 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. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This STANDARD is not met as evidenced by: Based on staff interview and a review of the available documentation, the facility has not maintained the fire alarm system testing and maintenance documentation in accordance with	K 345	-Facility's fire alarm test documentation now addresses a detailed list of the devices tested and the results of the testing	11/19/17

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K 345	Continued From page 9 NFPA 72 National Fire Alarm Code 2010 edition. This deficient practice could affect 65 of 65 residents,as well as an undetermined number of staff, and visitors to the facility. Findings include: On facility tour between 11:00 a.m. to 4:00 p.m. on 10/18/2017, during a review of all available fire alarm maintenance and testing documentation for the last 12 months, and an interview with the Maintenance Supervisor revealed the following deficient conditions: 1. At the time of the inspection the facility's fire alarm test documentation did not contain a detailed list of all the devices that had been tested and the results of the testing completed on the devices. 2. At the time of the inspection the facility could not produce a copy of the most current smoke detector sensitivity testing for the smoke detectors located throughout the facility. This deficient condition was verified by a Maintenance Supervisor.	K 345	-The most recent sensitivity test was gathered from Custom Alarm and will be provided timely in the future for our onsite record. -Corrective Action completed by 11/19/17 -Facility Maintenance Director responsible for correction and monitoring to prevent a reoccurrence of deficiency	
K 346 SS=F	NFPA 101 Fire Alarm System - Out of Service Fire Alarm - Out of Service Where required fire alarm system is out of services for more than 4 hours in a 24-hour period, the authority having jurisdiction shall be notified, and the building shall be evacuated or an approved fire watch shall be provided for all parties left unprotected by the shutdown until the	K 346		11/19/17

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K 346	Continued From page 10 fire alarm system has been returned to service. 9.6.1.6 This STANDARD is not met as evidenced by: Based on a record review and staff interview, the facility has failed to provide a complete and acceptable written policy containing procedures to be followed in the event that the Fire Alarm system has to be placed out-of-service for four or more hours in a 24 hour period. This deficient practice could affect the facility's ability for early response and notification of a fire and would affect the safety of 65 of 65 residents as well as an undetermined number of staff, and visitors to the facility . Findings include: On facility tour between 11:00 a.m. to 4:00 p.m. on 10/18/2017, during a records review and an interview with the Maintenance Supervisor, the facility did not have an acceptable fire alarm system out of service policy that included the contact information for the Deputy State Fire Marshal Division representative, fire alarm company in the event of the fire alarm being out of service and the need for a fire watch to be initiated This deficient condition was verified by a Maintenance Supervisor.	K 346	-The policy & procedure has been updated to include necessary missing components outlined -Corrective Action completed by 11/19/17 -Facility Maintenance Director responsible for correction and monitoring to prevent a reoccurrence of deficiency	
K 354 SS=F	NFPA 101 Sprinkler System - Out of Service Sprinkler System - Out of Service Where the sprinkler system is impaired, the extent and duration of the impairment has been determined, areas or buildings involved are	K 354		11/19/17

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K 354	Continued From page 11 inspected and risks are determined, recommendations are submitted to management or designated representative, and the fire department and other authorities having jurisdiction have been notified. Where the sprinkler system is out of service for more than 10 hours in a 24-hour period, the building or portion of the building affected are evacuated or an approved fire watch is provided until the sprinkler system has been returned to service. 18.3.5.1, 19.3.5.1, 9.7.5, 15.5.2 (NFPA 25) This STANDARD is not met as evidenced by: Based on a record review and staff interview, the facility has failed to provide a complete and acceptable written policy containing procedures to be followed in the event that the automatic fire sprinkler system has to be placed out-of-service for four or more hours in a 24 hour period. This deficient practice could affect the facility's ability for early response and notification of a fire and would affect the safety of 65 of 65 residents as well as an undetermined number of staff, and visitors to the facility . Findings include: On facility tour between 11:00 a.m. to 4:00 p.m. on 10/18/2017, during a records review and an interview with the Maintenance Supervisor, the facility did not have an acceptable fire sprinkler system out of service policy that included the contact information for the Deputy State Fire Marshal Division representative, fire sprinkler company in the event of the fire alarm being out of service and the need for a fire watch to be initiated This deficient condition was verified by a	K 354	-Policy and procedures created to include necessary components outlined -Corrective Action completed by 11/19/17 -Facility Maintenance Director responsible for correction and monitoring to prevent a reoccurrence of deficiency	

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K 354	Continued From page 12 Maintenance Supervisor.	K 354		
K 355 SS=C	NFPA 101 Portable Fire Extinguishers 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 STANDARD is not met as evidenced by: Based on observations and staff interview, it was determined that the facility failed to maintain portable fire extinguishers in accordance with the NFPA 101 "The Life Safety Code" 2012 edition (LSC) sections 9.7.3.2, 19.3.5.6 and the NFPA 10 "Standard for Portable Fire Extinguishers" 2010 edition, section 1-6.6. This deficient practice could affect residents, as well as an undetermined number of staff, and visitors. Findings include: On facility tour between 11:00 a.m. to 4:00 p.m. on 10/18/2017, observation and staff interviews revealed that the fire extinguisher located in the north wing by resident room 36 was found to be blocked by a several pieces of medical equipment. The medical equipment was moved by the maintenance supervisor and other nursing staff member at the time that it was identified during the inspection. This deficient condition was verified by a Maintenance Supervisor.	K 355	-Staff education completed and routine 2-3x weekly audits to be completed for 1 month to ensure compliance -Corrective Action completed by 11/19/17 -Facility Maintenance Director responsible for correction and monitoring to prevent a reoccurrence of deficiency	11/19/17
K 363 SS=D	NFPA 101 Corridor - Doors	K 363		11/19/17

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K 363	Continued From page 13 Corridor - Doors 2012 EXISTING Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas shall be substantial doors, such as those constructed of 1-3/4 inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Doors shall be provided with a means suitable for keeping the door closed. There is no impediment to the closing of the doors. Clearance between bottom of door and floor covering is not exceeding 1 inch. Roller latches are prohibited by CMS regulations on corridor doors and rooms containing flammable or combustible materials. Powered doors complying with 7.2.1.9 are permissible. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. This STANDARD is not met as evidenced by: Based on observation and interview, the facility had 1 of several corridor doors that did not meet the requirements of NFPA 101 "The Life Safety Code" 2012 edition. This deficient practice could	K 363	-The proper latch was installed at this door -Corrective Action completed by 11/19/17 -Facility Maintenance Director responsible	

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K 363	Continued From page 14 affect 10 of 65 residents, as well as an undetermined number of staff, and visitors if smoke from a fire were allowed to enter the exit access corridors making it untenable. Findings include: On facility tour between 11:00 a.m. to 4:00 p.m. on 10/18/2017, observations revealed that the beauty shop corridor door did not fully close and positively latch into the door frame. This deficient condition was verified by a Maintenance Supervisor.	K 363	for correction and monitoring to prevent a reoccurrence of deficiency	
K 372 SS=D	NFPA 101 Subdivision of Building Spaces - Smoke Barrie Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS. This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain 1 of multiple smoke barrier walls in accordance with the requirements of NFPA 101 "The Life Safety Code" 2012 edition sections 19-3.7.3 and 8.3. This deficient practice	K 372	-All smoke penetrations noted were sealed with fire proofing caulk -Corrective Action completed by 11/19/17 -Facility Maintenance Director responsible for correction and monitoring to prevent a	11/19/17

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K 372	Continued From page 15 could affect 24 of 64 residents as well as an undetermined number of staff, and visitors by allowing smoke to propagate from one smoke compartment to another. Findings include: On facility tour between 11:00 a.m. to 4:00 p.m. on 10/18/2017, observations revealed that there were penetrations found around a pipe and a small bundle of communication cables above the smoke barrier doors by the east nurses station. This deficient condition was verified by a Maintenance Supervisor.	K 372	reoccurrence of deficiency	
K 511 SS=C	NFPA 101 Utilities - Gas and Electric Utilities - Gas and Electric Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NFPA 70, National Electric Code. Existing installations can continue in service provided no hazard to life. 18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2 This STANDARD is not met as evidenced by: Based on observation and interview with the staff the facility had a deficient condition affecting the facility's electrical system that were not in accordance with the NFPA 101 "The Life Safety Code" 2012 edition (LSC) section 9.1.2 and the NFPA 70 "National Electrical Code" 2011 edition. This deficient practice could affect the 10 of 65	K 511	-Missing outlet cover was replaced -Corrective Action completed by 11/19/17 -Facility Maintenance Director responsible for correction and monitoring to prevent a reoccurrence of deficiency	11/19/17

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K 511	Continued From page 16 residents, as well as an undetermined number of staff, and visitors. Findings include: On facility tour between 11:00 a.m. to 4:00 p.m. on 10/18/2017, observations revealed that there is an electrical outlet that is located in the lower level corridor by the physical therapy room that is missing a cover plate. This deficient condition was verified by the Maintenance Supervisor.	K 511		
K 531 SS=D	NFPA 101 Elevators Elevators 2012 EXISTING Elevators comply with the provision of 9.4. Elevators are inspected and tested as specified in ASME A17.1, Safety Code for Elevators and Escalators. Firefighter's Service is operated monthly with a written record. Existing elevators conform to ASME/ANSI A17.3, Safety Code for Existing Elevators and Escalators. All existing elevators, having a travel distance of 25 feet or more above or below the level that best serves the needs of emergency personnel for firefighting purposes, conform with Firefighter's Service Requirements of ASME/ANSI A17.3. (Includes firefighter's service Phase I key recall and smoke detector automatic recall, firefighter's service Phase II emergency in-car key operation, machine room smoke detectors, and elevator lobby smoke detectors.) 19.5.3, 9.4.2, 9.4.3 This STANDARD is not met as evidenced by:	K 531		11/19/17

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K 531	Continued From page 17 Based on observations and staff interview, it was revealed that the facility has failed to limit storage in elevator equipment rooms in accordance with NFPA 101 "The Life Safety Code" 2012 edition (LSC). This deficient conditions could in the event of a fire, allow smoke and flames to spread throughout the effected corridors and areas making them untenable, which could negatively affect the 65 of 65 residents as well as an undetermined number of staff, and visitors. Findings include: On facility tour between 11:00 a.m. to 4:00 p.m. on 10/18/2017, observations revealed that there are combustible items being stored in the elevator equipment room. This deficient condition was verified by the Maintenance Supervisor.	K 531	-Staff understanding of storage error. Items removed and room is known not to be an appropriate storage location for combustible items. -Corrective Action completed by 11/19/17 -Facility Maintenance Director responsible for correction and monitoring to prevent a reoccurrence of deficiency	
K 711 SS=F	NFPA 101 Evacuation and Relocation Plan Evacuation and Relocation Plan There is a written plan for the protection of all patients and for their evacuation in the event of an emergency. Employees are periodically instructed and kept informed with their duties under the plan, and a copy of the plan is readily available with telephone operator or with security. The plan addresses the basic response required of staff per 18/19.7.2.1.2 and provides for all of the fire safety plan components per 18/19.2.2. 18.7.1.1 through 18.7.1.3, 18.7.2.1.2, 18.7.2.2, 18.7.2.3, 19.7.1.1 through 19.7.1.3, 19.7.2.1.2, 19.7.2.2, 19.7.2.3	K 711		11/19/17

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K 711	Continued From page 18 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility has failed to provide a complete and current fire evacuation policy in accordance with the NFPA 101 "The Life Safety Code" 2012 edition (LSC) section 19.7.2.2. This deficient practice could affect 65 of 65 residents, as well as an undetermined number of staff, and visitors. Findings include: On facility tour between 11:00 a.m. to 4:00 p.m. on 10/18/2017, during the documentation review it was revealed that the facility's Fire Emergency Evacuation Plan did not address all nine element as outlined in the NFPA 101 "The Life Safety Code" 2012 edition (LSC) sections 19.7.2.2. The element that was not provided in the plan presented at the time of the inspection was the evacuation of the smoke compartment and the preparation of the floors and building for evacuation. This deficient condition was verified by the Maintenance Supervisor.	K 711	-Evacuation Plan completed to address all nine elements -Corrective Action completed by 11/19/17 -Facility Maintenance Director responsible for correction and monitoring to prevent a reoccurrence of deficiency	
K 712 SS=F	NFPA 101 Fire Drills Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at 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. Responsibility for planning and conducting drills is assigned only to competent	K 712		11/19/17

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K 712	Continued From page 19 persons who are qualified to exercise leadership. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 18.7.1.4 through 18.7.1.7, 19.7.1.4 through 19.7.1.7 This STANDARD is not met as evidenced by: Based on review of reports, records and staff interview, it was determined that the facility failed to conduct 7 of 12 fire drills in accordance with the NFPA 101 "The Life Safety Code" 2012 edition (LSC) section 19.7.1.6, during the last 12-month period. This deficient practice could affect 65 of 65 residents, as well as an undetermined number of staff, and visitors. Findings include: On facility tour between 11:00 a.m. to 4:00 p.m. on 10/18/2017, during the review of all available fire drill documentation and interview with the Maintenance Supervisor the following deficient conditions were found 1. The fire drill conducted in April 2017 did not have the names of the staff that participated in the fire drill. 2. The facility could not provide any documentation for a day shift fire drill in the first calendar quarter. 3. The facility could not provide any documentation for an evening fire drill in the second calendar quarter. This deficient condition was verified by the	K 712	-A new paper record system initiated to record drills completed -Corrective Action completed by 11/19/17 -Facility Maintenance Director responsible for correction and monitoring to prevent a reoccurrence of deficiency	

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K 712	Continued From page 20 Maintenance Supervisor.	K 712		
K 751 SS=D	NFPA 101 Draperies, Curtains, and Loosely Hanging Fabr Draperies, Curtains, and Loosely Hanging Fabrics Draperies, curtains including cubicle curtains and loosely hanging fabric or films shall be in accordance with 10.3.1. Excluding curtains and draperies: at showers and baths; on windows in patient sleeping room located in sprinklered compartments; and in non-patient sleeping rooms in sprinklered compartments where individual drapery or curtain panels do not exceed 48 square feet or total area does not exceed 20 percent of the wall. 18.7.5.1, 18.3.5.11, 19.7.5.1, 19.3.5.11, 10.3.1 This STANDARD is not met as evidenced by: Based on observations there are privacy curtains in the facility that do not meet the requirements for Furnishing, Bedding, and Decorations for use in health care occupancies in accordance with provisions of the NFPA 101 "The Life Safety Code" 2012 edition (LSC) section 19.7.5.1 and the NFPA 13 "The Standard for the Installation of Sprinkler Systems" 2010 edition. This deficient condition is causing a decrease in the fire protection system capability in the event of an emergency that could affect 24 of 65 residents, as well as an undetermined number of staff, and visitors. Findings Include: On facility tour between 11:00 a.m. to 4:00 p.m. on 10/18/2017, observations revealed that the privacy divider curtain located in resident rooms 23 and 37 did not have any labeling attached to it	K 751	-In house audit completed. An order for complaint privacy curtains has been placed for delivery -Corrective Action completed by 11/19/17 -Facility Maintenance Director responsible for correction and monitoring to prevent a reoccurrence of deficiency	11/19/17

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K 751	Continued From page 21 stating that it is "inherently fire retardant". This deficient condition was verified by the Maintenance Supervisor.	K 751		
K 791 SS=F	NFPA 101 Construction, Repair, and Improvement Operati Construction, Repair, and Improvement Operations Construction, repair, and improvement operations shall comply with 4.6.10. Any means of egress in any area undergoing construction, repair, or improvements shall be inspected daily to ensure its ability to be used instantly in case of emergency and compliance with NFPA 241. 18.7.9, 19.7.9, 4.6.10, 7.1.10.1 This STANDARD is not met as evidenced by: Based on observations and staff interview the major renovation and construction projects are not maintained in compliance with NFPA 101 "The Life Safety Code" 2012 edition sections 4.6.10 and NFPA 214 the Standard for safeguarding Construction, Alteration, and Demolition Operations 2009 edition, section 8.6. The failure to maintain required safe construction operations could allow a decrease in the fire protection and life safety capability in the event of an emergency that could affect 10 of 65 residents, as well as an undetermined number of staff, and visitors. Findings include: On facility tour between 11:00 a.m. to 4:00 p.m. on 10/18/2017, observations revealed that there was portion of the lower level that had construction in progress that was not provided	K 791	-Construction Company aided in the installation of appropriate fire rated construction separation to replace existing construction structure -Corrective Action completed by 11/19/17 -Facility Maintenance Director responsible for correction and monitoring to prevent a reoccurrence of deficiency	11/19/17

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K 791	Continued From page 22 with the required fire rated construction separations. At the time of the inspection the area had a layer of poly affixed to wood 2 x 4 framing as their construction separation. This deficient condition was verified by a Maintenance Supervisor.	K 791		
K 901 SS=F	NFPA 101 Fundamentals - Building System Categories Fundamentals - Building System Categories Building systems are designed to meet Category 1 through 4 requirements as detailed in NFPA 99. Categories are determined by a formal and documented risk assessment procedure performed by qualified personnel. Chapter 4 (NFPA 99) This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility has failed to provide a complete and current facility Risk Assessment in accordance with the NFPA 99 "Health Care Facilities Code" 2012 edition section 4.1. This deficient practice could affect 65 of 65 residents, as well as an undetermined number of staff, and visitors. Findings include: On facility tour between 11:00 a.m. to 4:00 p.m. on 10/18/2017, during the documentation review and an interview with the Maintenance Supervisor it was revealed that the facility has a risk	K 901	-Chapters 10 & 11 of the NFPA 99 "Health Care Facilities Code" 2012 edition consulted. Facility compliant with categories necessary being included -Corrective Action completed by 11/19/17 -Facility Maintenance Director responsible for correction and monitoring to prevent a reoccurrence of deficiency	11/19/17

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K 901	Continued From page 23 assessment document but upon reviewing the document it was found that the assessment was incomplete. The current risk assessment did not account for all of the systems that are identified in chapters 10 and 11 of the NFPA 99 "Health Care Facilities Code" 2012 edition. This deficient condition was verified by the Maintenance Supervisor.	K 901		
K 914 SS=F	NFPA 101 Electrical Systems - Maintenance and Testing Electrical Systems - Maintenance and Testing Hospital-grade receptacles at patient bed locations and where deep sedation or general anesthesia is administered, are tested after initial installation, replacement or servicing. Additional testing is performed at intervals defined by documented performance data. Receptacles not listed as hospital-grade at these locations are tested at intervals not exceeding 12 months. Line isolation monitors (LIM), if installed, are tested at intervals of less than or equal to 1 month by actuating the LIM test switch per 6.3.2.6.3.6, which activates both visual and audible alarm. For LIM circuits with automated self-testing, this manual test is performed at intervals less than or equal to 12 months. LIM circuits are tested per 6.3.3.3.2 after any repair or renovation to the electric distribution system. Records are maintained of required tests and associated repairs or modifications, containing date, room or area tested, and results. 6.3.4 (NFPA 99) This STANDARD is not met as evidenced by: Based on observations and staff interview, that the electrical testing and maintenance was not	K 914	-This task added to TELS system and a tester was purchased	11/19/17

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K 914	Continued From page 24 maintained in accordance with NFPA 99 Standards for Health Care Facilities 2012 edition, section 6.3.4. This could negatively affect 65 of 65 residents as well as an undetermined number of staff, and visitors to the facility. Findings include: On facility tour between 11:00 a.m. to 4:00 p.m. on 10/18/2017, during a records review and an interview with the Maintenance Supervisor, the facility could not provide any documentation for the completion of the annual electrical outlet inspection and testing for the electrical outlets located in the patient/resident rooms located throughout the facility. This deficient condition was verified by the Maintenance Supervisor.	K 914	-Corrective Action completed by 11/19/17 -Facility Maintenance Director responsible for correction and monitoring to prevent a reoccurrence of deficiency	
K 918 SS=F	NFPA 101 Electrical Systems - Essential Electric Syste 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	K 918		11/19/17

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K 918	Continued From page 25 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 and readily identifiable. 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 STANDARD is not met as evidenced by: Based on documentation review and staff interview, the facility failed to test and maintain the emergency generator in accordance with the requirements of the NFPA 101 "The Life Safety Code" 2012 edition (LSC) sections, 9.1.3 and NFPA 110 "Standard for Emergency and Standby Power Systems 6-4, 6-4.1, and 6-4.2.2. This deficient practice could affect the safety of 65 of 65 residents as well as an undetermined number of staff, and visitors to the facility . Findings include: On facility tour between 11:00 a.m. to 4:00 p.m. on 10/18/2017, during the review of all available emergency generator maintenance documentation and an interview with the Maintenance Supervisor it was revealed that the facility did not have a letter of reliable service for their natural gas fuel supply from the fuel	K 918	-Fuel Company notified and a copy of the letter is being sent to the facility -Corrective Action completed by 11/19/17 -Facility Maintenance Director responsible for correction and monitoring to prevent a reoccurrence of deficiency	

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K 918	Continued From page 26 company. This deficient condition was verified by the Maintenance Supervisor.	K 918		