Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

February 12, 2024

Administrator
The North Shore Estates, LLC
7700 Grand Avenue
Duluth, MN 55807

RE: CCN: 245483
Cycle Start Date: February 1, 2024

Dear Administrator:

On February 1, 2024, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

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

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

DEPARTMENT CONTACT

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

Alex Warren, Unit Supervisor
Duluth District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
11 East Superior Street, Suite 290
Duluth, MN 55082
Email: Alex.Warren@state.mn.us
Cell: 651-279-5375 Office: 218-302-6186

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

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

If substantial compliance with the regulations is not verified by May 1, 2024 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by August 1, 2024 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

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

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

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

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

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

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

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

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

Feel free to contact me if you have questions.

Sincerely,

Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
Orville L. Freeman Building | HRD 3A 3rd Floor
PO Box 64900
625 Robert Street North
St. Paul, MN 55155
Office: 651-201-4384
Email: holly.zahler@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245483	A. BUILDING _____ B. WING _____	C 02/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE NORTH SHORE ESTATES LLC	7700 GRAND AVENUE DULUTH, MN 55807

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments On 1/29/24 to 2/1/24, a survey for compliance with Appendix Z, Emergency Preparedness Requirements, §483.73 was conducted during a standard recertification survey. The facility was IN compliance. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	E 000		
F 000	INITIAL COMMENTS On 1/29/24 to 2/1/24, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were reviewed with NO deficiencies: H54837534C MN98121 H54837537C MN92784 H54837535C MN94549 H54837536C MN93740 H54837541C MN92704 The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance.	F 000		

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

Electronically Signed | 02/19/2024

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

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F 000	Continued From page 1 Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulations has been attained.	F 000		
F 554 SS=D	Resident Self-Admin Meds-Clinically Approp CFR(s): 483.10(c)(7) §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility failed to ensure medications were not left unattended at bedside for 1 of 1 resident (R16) reviewed for self-administration of medication. Findings include: R16's quarterly Minimum Data Set (MDS) dated 12/13/23, indicated R16 was cognitively intact with the diagnosis of cataracts, cognitive impairment of unknown origin and cardiac diagnosis. R16's undated care plan did not include a plan for self-administration of medication. R16's care conference note dated 1/6/24, indicated R16's medication preference was "medication administered by the LN [licensed nurse] and to take pills whole." R16's medical record lacked evidence that R16 had been assessed to safely have their medications at bedside for self-administration.	F 554	Immediate Corrective Action: A self-administration of medication assessment was completed on R16. Corrective Action as it applies to others: The facilities self-administration of medication policy was reviewed and remains current. All residents were reviewed for self-administration of medications. All licensed nurses and TMA's received education on leaving medication in resident rooms, and the need for the self-administration of medication assessment needing to be completed. Date of Compliance: 2/22/2024 Recurrence will be prevented by: Medication pass will be watched on 5	2/22/24

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F 554	Continued From page 2 During an observation on 1/29/24 at 5:18 p.m., R16 had medications in a cup on her dinner tray. R16 stated they got their medications dropped off during breakfast and in the evening. During a follow-up observation on 1/29/24 at 5:23 p.m., the pill cup on R16's meal tray contained 4 pills. R16 stated "they leave my pills at breakfast and dinner for me to take with my meal." During an observation on 1/31/24 at 8:33 a.m., the medication nurse entered R16's room and observed R16 take their medications before leaving. During an interview on 2/01/24 08:43 a.m., R16 confirmed that the nurse had stayed in her room while she took her meds. During an interview on 2/1/24 at 8:57 a.m., licensed practical nurse (LPN)-A stated residents that could self-administer their medications would have an order in their chart, otherwise residents needed to be observed when they received their medications. During an interview on 2/01/24 at 12:56 p.m., registered nurse (RN)-C confirmed R16 did not have an assessment or order in place for self-medication administration. When a resident has not been cleared for self-administration, it is expected that staff would not leave a resident until they witnessed the resident take their medication. R16 should not have had pills left at the bedside. During an interview on 2/1/24 at 1:37 p.m., the director of nursing (DON) stated if a resident did	F 554	residents weekly x4 weeks, and monthly x2 months to appropriate administration, and the need for resident to self-administer medications assessment completion. Audits and findings will be reported to QAPI committee for further recommendations.¿ Corrections will be monitored by: Director of Nursing or Designee	

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F 554	Continued From page 3 not have an order for/and assessment in place for self-medication administration they expected the nurse to administer and observe the resident taking their medications before they left the resident's side. This was important to ensure the resident took their medications, for swallow observation, and for safety. Medication Self-Administration policy requested and not received.	F 554		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to accurately code Minimum Data Set (MDS) for 1 of 4 residents (R25) reviewed for MDS accuracy. Findings include: R25's quarterly MDS dated 12/14/23, identified R25 had moderately impaired cognition, and diagnoses which included anemia, congestive heart failure, end-stage renal disease, diabetes mellitus, depression, and respiratory failure. R25 was coded for unstageable pressure ulcers due to coverage of wound bed by slough and/or eschar. R25's medical record dated 8/16/23, identified R25's left great toe wound was related to poor arterial blood flow to lower extremity. Vascular surgeon stated wound was unlikely to heal and	F 641	Immediate Corrective Action: MDS for R25 was modified to reflect an arterial ulcer on the left great toe. Corrective Action as it applies to others: The Resident Assessment Instrument Policy was reviewed and remains current. All residents with skin concerns will have their MDS assessments reviewed from the last 30 days to ensure that all sections are filled out accurately. Education will be completed with all leadership that complete MDS sections regarding the Resident Assessment Instrument Policy with specific regards to completing the skin concerns section	2/22/24

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F 641	Continued From page 4 diagnosed R25 with peripheral artery disease. Review of R25's medical record identified wound care weekly notes starting on 6/28/23 through 1/31/24. On 11/1/23, R43's diagnosis changed from left great toe pressure ulcer to arterial ulcer of great left toe. During interview on 1/31/24 at 8:44 a.m., nurse practitioner (NP)-D confirmed R25's current diagnosis was arterial ulcer of great toe left. During interview on 2/1/24 at 9:50 a.m., registered nurse (RN)-B confirmed having completed R25's quarterly MDS, dated 12/14/23. RN-B indicated using medical record review to collect data to complete the MDS. RN-B confirmed was unaware of R25's diagnosis change on 11/1/23 from left great toe pressure ulcer to arterial ulcer great toe left. RN-B confirmed R25's quarterly MDS dated 2/14/23, should have been coded for an arterial ulcer and not a pressure ulcer. RN-B stated having accurate information on the MDS was important because it guides required treatments. During interview on 2/1/24 at 1:32 p.m., administrator stated diagnoses changes should be updated on the next quarterly MDS. Administrator stated this was important because it will impact quality measures. An MDS policy was requested from the facility and was not provided. The facility stated they follow the Resident Assessment Instrument (RAI) Manual for MDS assessments. The Long-Term Care Facility Resident Assessment Instrument (RAI) User's Manual for	F 641	accurately. Date of Compliance: 2/22/2024 Recurrence will be prevented by: 5 residents will have their skin concerns section of their MDS assessment reviewed weekly x4 weeks, and monthly x2 months to ensure that all sections have been completed accurately. Audits and findings will be reported to QAPI committee for further recommendations.¿ Corrections will be monitored by: Director of Nursing or Designee	

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F 641	Continued From page 5 Version 3.0 dated 10/23, was published by the Centers for Medicare & Medicaid Services (CMS). CMS's goal was to disseminate information broadly to facilitate accurate and effective resident assessment practices in long-term care facilities.	F 641		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review the facility failed to ensure provider orders for a c-pap (continuous positive airway pressure) [a machine that provides breathing support for individuals that experience pauses in breathing when they sleep] were followed for 1 of 1 resident (R206) reviewed for respiratory care. Findings include: R206's admission Minimum Data Set (MDS) dated 1/22/24, identified R206 was cognitively intact with the diagnoses of chronic obstructive lung disease (COPD) and end stage renal disease (ESRD). R206's Order Summary dated 2/1/24, included the following active orders as of 2/1/24:	F 695	Immediate Corrective Action: R206□s CPAP was cleaned. R206□s orders were reviewed and updated to reflect the need to clean the water chamber, hose, and mask weekly, and to empty water chamber and dry daily. Corrective Action as it applies to others: The manufacturers□ guidelines for all residents with CPAP/BiPAP□s were reviewed. All residents with a CPAP/BiPAP had their machines cleaned and their orders reviewed to ensure following of the manufacturer's guidelines for cleaning.	2/22/24

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F 695	Continued From page 6 -C-pap on at night and bedtime. -Clean mask and tubing with gentle soap and warm water let air dry one time a day. -Clean c-pap chamber with gentle soap and air-dry weekly every day shift every Sat. -Fill c-pap water chamber with distilled water to fill line. Empty and dry out chamber daily one time a day. -Inspect and wash c-pap head gear with gentle soap and warm water weekly one time a day every Thursday. R206's care plan dated 2/1/24, identified an alteration in oxygen/gas exchange, and instructed staff to perform supportive tasks and monitoring to support R206's respiratory status. During an observation on 1/29/24 at 6:10 p.m., R206 stated the water in their c-pap was from yesterday. They don't dump it, and clean the water out, and only one nurse cleaned the tubing when they were working. R206's c-pap water chamber was noted to have water in it just below the full line. During an observation on 1/30/24 at 10:58 a.m., R206's c-pap machine was on the bedside table. The water chamber was full. During an interview on 1/30/24 at 3:53 p.m., R206 stated the water in their c-pap chamber was left over from the night before. Staff were supposed to empty the chamber and rinse the c-pap mask when they got up for the day, but it hadn't been done. During an observation on 1/31/24 at 12:02 p.m., R206's c-pap water chamber had water in the chamber. R206 stated nothing had been cleaned	F 695	Education will be completed with all nurses, TMAs, and CNAs on cleaning a CPAP/BiPAP, and emptying water chamber daily, Date of Compliance: 2/22/2024 Recurrence will be prevented by: All residents with CPAP/BiPAP will be reviewed weekly x4 weeks, and monthly x2 months to ensure that the CPAP/BiPAP are being cleaned appropriately, and the water chamber is emptied daily. Audits and findings will be reported to QAPI committee for further recommendations.¿ Corrections will be monitored by: Director of Nursing or Designee	

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F 695	Continued From page 7 or emptied yet, it was still from the night before. During an interview on 2/1/24 at 12:47 p.m., registered nurse (RN)-C reviewed R206's c-pap care orders and confirmed R206's c-pap water chamber should be emptied and dried each morning, and then refilled with water in the evening before R206 went to bed. The water chamber should be emptied in the morning to prevent bacteria growth and illness. During an interview at 2/01/24 at 1:35 p.m., the director of nursing (DON) stated they expected mask care and the c-pap water chamber to be emptied and cleaned by the day shift in the morning. In addition to emptied, the c-pap water chamber should be dried to prevent bacteria build up that can occur in sitting water or an environment with moisture. The undated, facility CPAP CARE employee pass/fail competency directed staff to check the treatment administration record for order and client specific instructions. The competency did not include test off for tubing and water chamber cleaning/management, but it did include pass/fail for wash mask daily with antibacterial soap, rinse well and then air dry. The ResMed AirCurve10 manufacturer instructions dated 2021, identified it was important to regularly clean the c-pap tubing, mask, and water chamber to ensure optimal therapy and to prevent the growth of germs that could adversely affect health. The instructions indicated the water chamber and tubing should be cleaned once a week with mild detergent and allowed to air dry, and each mask's insert should be followed for mask cleaning.	F 695		

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F 698 SS=D	Dialysis CFR(s): 483.25(l) §483.25(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: Based on observation, interview, and document review, the facility failed to ensure post-dialysis access site monitoring was consistently completed to provide continuity of care and reduce the risk of complication (i.e., bleeding, clotting) for 1 of 1 residents (R33) reviewed for dialysis care. Findings include: R33's quarterly Minimum Data Set (MDS) dated 12/13/2023, identified R33 was cognitively intact and receiving dialysis (process of removing excess water and waste products from the blood when kidneys can no longer perform that function adequately). In addition, R33's MDS identified diagnoses of stage 4 chronic kidney disease (severe), dependence on renal dialysis, arteriovenous fistula (special connection that is made by joining a vein onto an artery that can be used for dialysis), peripheral vascular disease (abnormal narrowing of arteries), chronic heart failure (chronic condition in which the heart doesn't pump blood as well as it should), and chronic obstructive pulmonary disease (progressive lung disease with long-term symptoms such as shortness of breath and coughing).	F 698	Immediate Corrective Action: R33’s dialysis site was assessed for bruit and thrill, for bleeding, and vital signs were obtained. Corrective Action as it applies to others: The Hemodialysis Policy was reviewed and remains current. Education will be completed with all Licensed Nurses on completing a post-dialysis assessment in accordance with our policies and procedures. Date of Compliance: 2/22/2024 Recurrence will be prevented by: All residents with dialysis will be reviewed weekly x4 weeks, and monthly x2 months to ensure that the dialysis site is assessed in a timely manner. Audits and findings will be reported to QAPI committee for further recommendations.¿ Corrections will be monitored by:	2/22/24

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F 698	Continued From page 9 R33's care plan dated 1/11/2024, identified R33 had a left arm fistula. Interventions included dialysis per schedule, treatment and dressing protocol to dialysis site per medical doctor (MD) order, no blood pressure (BP) to left arm, and to call 911 for uncontrolled bleeding at dialysis site. Physician's orders for R33 included no blood draws, BPs, and no intravenous fluids in R33's left arm, monitor fistula for bruit (whooshing sound) and thrill (a powerful pulse felt at the top of the fistula) every shift, vital signs after dialysis, and to monitor dialysis site for bleeding. During a continuous observation on 1/30/2024, the following was observed: -1:18 p.m., R33 was observed to be in room, was wearing winter coat, was finishing lunch tray, and had been back from dialysis center for a short time. When interviewed, R33 stated the nurse had not been in to check dialysis access site. -2:04 p.m., door closed on R33's room. No staff in or out of room. -2:39 p.m., R33 left room and went outside to smoke. R33 wearing same winter coat. -2:44 p.m., R33 sitting outside in chair. No staff observed to interact with R33. -3:22 p.m., R33 returned to room and closed door. No staff were observed to interact with R33 when he was out of his room. -3:32 p.m., trained medication aide (TMA)-A entered R33's room, measured his blood sugar, checked blood pressure using wrist blood	F 698	Director of Nursing or Designee	

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F 698	Continued From page 10	F 698		

pressure machine, and gave pain medication and a multivitamin. R33 was still wearing winter coat.

During interview on 1/30/2024 at 3:35 p.m., registered nurse (RN)-A stated she did not assess dialysis site for R33 when resident returned from dialysis center. RN-A further stated, "think the TMA checked vital signs" on R33 after return from dialysis center. The expectation is R33 will tell staff if dialysis site was bleeding. RN-A also stated R33 should have dialysis site checked for bruit and thrill and assessed for bleeding after return from dialysis center.

During interview on 2/1/2024 at 10:38 a.m., registered nurse (RN)-C stated training on dialysis for nurses was part of orientation and was conducted on the unit. RN-C further stated expectation of nurses should check vital signs, check dialysis site for bruit and thrill, and to check for bleeding after a resident returns from dialysis center.

During interview on 2/1/2024 at 11:03 a.m., director of nursing (DON) stated expectation when a resident on dialysis returns to the facility nurses would check dialysis communication form from dialysis center, check dialysis site, test site for bruit and thrill, and check vital signs of the resident. DON further stated checking dialysis site was important to ensure the site was accessible, to monitor for adverse reactions, and to monitor for bleeding.

During interview on 2/1/2024 at 11:40 a.m., DON stated the facility does not have any formal training on dialysis upon hire and dialysis training is not part of any annual training. DON further stated she expected nurses were trained on

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F 698	Continued From page 11 dialysis care in their nursing program. Hemodialysis policy dated 11/22/19, identified "resident will be monitored for complications before and after dialysis treatment." Policy also identified "ongoing assessment/evaluation of the resident's condition and monitoring for complications should occur before and after dialysis treatments (i.e. infection and patency of fistula or graft)." Policy further identified "documentation should include, but is not limited to, pre and post dialysis assessment/observation, daily check of the access site (fistula, graft, or external catheter), evaluation for signs and symptoms of infection"	F 698		
F 761 SS=E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and	F 761		2/22/24

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F 761	Continued From page 12 Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure that temperature-controlled medications were properly stored for 3 of 8 residents (R3, R9, R33) and any resident needing medications from the pharmacy-provided emergency kit. Findings include: R3's Admission Record dated 2/1/24, identified an admission date of 8/9/17, and a diagnosis of diabetes mellitus (type two diabetes). R3's provider orders dated 1/15/24, included an order for semaglutide (an antihyperglycemic injectable medication) 0.25 milligrams (mg) weekly on Tuesdays. R9's Admission Record dated 2/1/24, identified an admission date of 12/29/23, and a diagnosis of type two diabetes. R9's provider orders dated 1/24/24, included an order for Lispro (a fast-acting type of insulin) injections per sliding scale instructions with meals and at bedtime, and Trulicity (an antihyperglycemic injectable medication) 1.5 mg weekly on Mondays. R33's Admission Record dated 2/1/24, identified an admission date of 9/7/23, and a diagnosis of type two diabetes.	F 761	Immediate Corrective Action: R3, R9, and R33's medications were disposed of. The emergency kit was returned to the pharmacy to be disposed of. Correction Action as it applies to others: Education will be completed with all licensed nurses and TMA's on the storage of refrigerated medications and ensuring the temperature of the refrigerator is within the appropriate range. Date of Compliance: 2/22/2024 Recurrence will be prevented by: Medication refrigerators will be audited 5x a week x4 weeks, and monthly x2 months to ensure that the refrigerator temp is within guidelines. Audits and findings will be reported to QAPI committee for further recommendations.¿ Corrections will be monitored by: Director of Nursing or Designee	

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F 761	Continued From page 13 R33's provider orders dated 9/19/23, included an order for NovoLog (also called insulin aspart, a fast-acting type of insulin) injections before meals and at bedtime, per sliding scale instructions. The Polaris pharmacy emergency kit contained the following medications which required refrigeration: -lispro insulin, one pen -humulin R (fast-acting insulin), one pen -humulin N (intermediate-acting insulin), one pen -humulin 70/30 (mixture of 70% intermediate-acting and 30% short-acting insulin), one pen -humalog 75/25 (a combination insulin), one pen -insulin detemir (long-acting insulin), one pen -insulin aspart (fast-acting insulin), one pen During an interview on 2/1/24 at 12:11 p.m., licensed practical nurse (LPN)-A stated they record the temperature of the medication refrigerator on the first floor during the overnight shift. If the fridge was out of range, 36-46 degrees Fahrenheit (F), they would contact maintenance. LPN-A confirmed the thermometer on the door read 51 degrees F. During an interview on 2/1/24 at 12:53 p.m., LPN-A confirmed the temperature in the medication refrigerator on the first floor was 49 degrees F. During an interview on 2/1/24 at 12:58 p.m., the administrator stated she would get a new thermometer and have maintenance come take the temperature with a temperature gun to see what the reading was now.	F 761		

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F 761	Continued From page 14 During an observation on 2/1/24 at 1:08 p.m., maintenance personnel (MP)-A obtained a reading of 48 to 49 degrees F with a temperature gun in the first-floor medication refrigerator. During an interview on 2/1/24 at 1:11 p.m., the director of nursing (DON) stated they would replace all the resident's insulin and get a different refrigerator now. The DON stated her expectation would be for nursing staff to monitor the temperature in the refrigerator daily and for staff to notify management of any issues. The DON further explained it was important to have proper refrigerator temperatures so that the medications were safe and work properly. During an interview on 2/1/24 at 3:07 p.m., the Polaris pharmacy consultant stated since we do not know when the fridge stopped being cold enough, she advised all those medications be replaced. The consultant also added it was important to keep medication at proper temperatures so that we can have safe medications. Review of facility document, Temperature Log for Medication Refrigerator for January 2024, revealed temperatures taken and recorded on 15 of 31 days. The document identified the temperature danger zone as being below 36 degrees F or above 46 degrees F. On 1/7, 1/9, 1/10, and 1/13 the recorded temperature was 46 degrees F and on 1/14/23 the "action" line of the form indicated the temperature was turned down. The manufacturer's instructions for semaglutide indicated prior to first use, semaglutide should be stored in a refrigerator between 36- and 46-degrees F.	F 761		

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F 761	Continued From page 15 The manufacturer's instructions for NovoLog (also called insulin aspart) indicated it should be stored in a refrigerator between 36- and 46-degrees F. The patient instructions for Trulicity indicated to store in the refrigerator between 36- and 46-degrees F. The manufacturer's instructions for Lispro indicated to keep unused pens in the refrigerator between 36- and 46-degrees F. A policy and procedure regarding the process for temperature monitoring and reporting was requested but not received.	F 761		
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals	F 880		2/22/24

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F 880	Continued From page 16 providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens.	F 880		

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F 880	Continued From page 17 Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure proper personal protective equipment use and hand sanitization occurred during food preparation. This had the ability to affect all residents, staff, and visitors who consumed food in the facility. Findings include: During a continuous observation on 1/31/2024 starting at 11:13 a.m. and ending at 12:20 p.m., the following was observed: -11:13 a.m., cook (C)-A was observed wearing face mask and gloves to start food preparation. -11:21 a.m., C-A used gloved hand to move face mask down to talk with culinary aide. C-A moved face mask back over mouth and did not remove gloves, perform hand hygiene, or change gloves. C-A continued to scoop tuna salad onto plates and pick up sandwiches and plate them. -11:23 a.m., C-A wearing same face mask and same gloves moved tray of sandwiches. C-A while wearing same gloves moved face mask down to speak with surveyors. C-A did not remove gloves, perform hand hygiene, or put on new gloves. C-A continued to scoop tuna salad onto plates and pick up sandwiches and place	F 880	Immediate Corrective Action: Correction Action as it applies to others: The Hand Hygiene Policy was reviewed and remains current. All staff received education on hand hygiene and hand hygiene with mask usage. Date of Compliance: 2/22/2024 Recurrence will be prevented by: Hand hygiene will be audited 5x a week x4 weeks, and monthly x2 months to ensure that hand hygiene is completed appropriately. Audits and findings will be reported to QAPI committee for further recommendations. Corrections will be monitored by: Director of Nursing or Designee	

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F 880	Continued From page 18 them on the plate with the same gloved hands. -11:28 a.m., C-A placed alternate meal items into freezer and adjusted face mask while wearing same gloves. C-A did not remove gloves, perform hand hygiene, or put on new gloves. C-A continued to scoop tuna salad onto plates and pick up sandwiches and plate them. -11:37 a.m., C-A spoke with kitchen staff. C-A moved face mask down wearing the same gloves. C-A did not remove gloves, perform hand hygiene, or put on new gloves. C-A continued to scoop tuna salad onto plates and pick up sandwiches and plate them. -11:46 a.m., C-A wiped down countertop and adjusted face mask while wearing the same gloves. C-A did not remove gloves, perform hand hygiene, or put on new gloves. C-A continued to scoop tuna salad onto plates and pick up sandwiches and plate them. -11:53 a.m., C-A plated food while wearing face mask and same gloves. C-A touched uncovered food while wearing same gloves and plating food. C-A did not remove gloves, perform hand hygiene, or put on new gloves. C-A continued to scoop tuna salad onto plates and pick up sandwiches and plate them. -12:01 p.m., C-A removed plates from cooler and adjusted face mask while wearing the same gloves. C-A did not remove gloves, perform hand hygiene, or put on new gloves. -12:18 p.m., C-A removed pureed food from freezer and adjusted face mask while wearing same gloves. C-A did not remove gloves, perform	F 880		

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F 880	Continued From page 19 hand hygiene, or put on new gloves. C-A continued to scoop tuna salad onto plates and pick up sandwiches and plate them. -12:20 p.m., C-A finished plating food. C-A adjusted face mask and removed gloves. During interview on 2/1/2024 at 11:15 a.m., director of nursing (DON) proper personal protective equipment use and hand sanitization during food preparation were important for infection control. DON further stated all staff should be wearing face masks and staff should wear gloves when preparing food. DON also stated kitchen staff were expected to remove gloves when switching tasks or after touching face or mask, complete hand hygiene, and put on new gloves before handling food again. During interview on 2/1/2024 at 12:18 p.m., culinary services director (CSD) stated staff were expected to wear face masks and to wear gloves when preparing food. CSD further stated staff were expected to remove gloves after touching face mask, perform hand hygiene, and put on new gloves before handling food again. During interview on 2/1/2024 at 12:26 p.m., administrator stated staff were expected to wear face masks all the time and wear gloves during food preparation. Administrator further stated staff expected to remove gloves, perform hand hygiene, and put on new gloves after touching face mask. Administrator stated the facility follows Centers for Disease Control (CDC) guidelines for mask use. Facility policy on hand hygiene requested and not provided.	F 880		

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F 880	Continued From page 20 Hand Hygiene (publication from the CDC) dated 8/29/2022, identified handwashing as important "before, during, and after preparing and eating food" and "before and after touching your eyes, nose, mouth, or face mask".	F 880		
F 883 SS=D	Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2) §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. §483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure	F 883		2/23/24

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F 883	Continued From page 21 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 (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 follow the most recent Centers for Disease Control (CDC) standards for offering and educating on pneumococcal vaccinations for 2 of 5 residents (R11, R29) reviewed for immunizations. This had the potential to affect all residents who were eligible for the pneumococcal booster. Findings include: R11's quarterly Minimum Data Set (MDS) dated 12/30/23, identified R11 was 90 years old and diagnoses included hypertension, renal	F 883	Immediate Corrective Action: R29 and R11 were given the pneumococcal booster. Correction Action as it applies to others: All residents were reviewed for the need of a pneumococcal vaccine or booster. All licensed nurses received education on the pneumococcal vaccine. Date of Compliance: 2/23/2024	

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F 883	Continued From page 22 insufficiency, and non-Alzheimer's dementia. R11's immunization record undated, identified R11 received the pneumococcal polysaccharide vaccine (PPSV23) on 1/9/03, and a Prevnar 13 on 3/11/2015. R11's medical record did not include evidence R11 or R11's representative received education regarding pneumococcal vaccine booster and there was no indication R11 was offered the pneumococcal vaccine per CDC guidance. R29's quarterly Minimum Data Set (MDS) dated 1/3/24, identified R29 was 68 years old and diagnoses included malnutrition, anemia, and coronary artery disease. R29's immunization record undated, identified R29 received the pneumococcal polysaccharide vaccine (PPSV23) on 3/28/12. R29's medical record did not include evidence R29 or R29's representative received education regarding pneumococcal vaccine booster and there was no indication R29 was offered the pneumococcal vaccine per CDC guidance. During interview on 1/31/24 at 2:35 p.m., registered nurse (RN)-D reviewed R11 and R29's Minnesota Immunization Information Connection (MIIC) record. Upon review, RN-D stated R11 was "up to date" and was not offered a pneumococcal booster and R29 was "due for a booster" and "should have been offered one." RN-D indicated per current CDC recommendations R11 and R29 should have been offered a pneumococcal booster. The facility policy Pneumococcal dated 4/6/22, identified all eligible residents shall be offered and	F 883	Recurrence will be prevented by: 5 residents will be audited weekly x4 weeks, and monthly x2 months to ensure that the pneumococcal vaccination is up to date. Audits and findings will be reported to QAPI committee for further recommendations.¿ Corrections will be monitored by: Director of Nursing or Designee	

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	245483	A. BUILDING _____ B. WING _____	C 02/01/2024

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F 883	Continued From page 23 educated on the pneumococcal vaccine. The facility will refer to the current CDC recommended adult immunization schedule to determine recommended vaccines.	F 883		
F 921 SS=F	Safe/Functional/Sanitary/Comfortable Environ CFR(s): 483.90(i) §483.90(i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure kitchen equipment was kept in a clean and sanitary manner. This had the potential to affect all 54 residents, staff, and visitors who consumed food prepared in and/or served from the kitchen. Findings include: On 2/1/2024 at 8:30 a.m., kitchen tour with culinary service director (CSD) was completed. The small mixer in kitchen was under a plastic cover. Plastic cover was stuck to mixer by food residue. Small mixer observed to have light white-brown colored food remnants on sides and under the mixing head. Toaster was found to have a reddish brown grease-like substance on trim. Crumbs were around toaster on the countertop. Large mixer was under a plastic cover. Large mixer had light brown colored food remnants stuck to the body of mixer and under the mixing head. Protective guard around mixing bowl had white powdery spots. Cabinet next to large mixer had food remnants of the same light brown color as large mixer. Cooler had red sticky	F 921	Immediate Corrective Action: The small mixer was cleaned. The toaster was cleaned. The large mixer was cleaned. Protective guard around the mixing bowl was cleaned. Cabinet next to the large mixer was cleaned. The cooler was cleaned. Correction Action as it applies to others: All cupboards, coolers, and equipment in the kitchen were cleaned. Date of Compliance: 2/22/2024 Recurrence will be prevented by:	2/22/24

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F 921	Continued From page 24 substance on bottom of door seal and down the front vents. During interview on 2/1/2024 at 9:08 a.m., CSD stated she was not sure of the exact details of how and when the kitchen and equipment was cleaned as the kitchen was on "an informal cleaning schedule" and cleaning was not assigned to any staff in particular. All kitchen staff were expected to help clean the kitchen and were expected to clean kitchen equipment after use. CSD also stated a cleaning log for staff to sign after cleaning was started on 1/29/2024, during the recertification survey. CSD confirmed clean kitchen equipment was important to prevent food-borne illness and to prevent any contamination of food. During interview on 2/1/2024 at 12:29 p.m., administrator stated staff were expected to clean kitchen equipment after use. Administrator also stated expectation clean and ready to use kitchen equipment to be under a protective plastic cover. Administrator confirmed clean kitchen equipment was important to prevent food-borne illness and prevent any contamination of food.	F 921	The kitchen equipment will be audited 5x weekly x4 weeks, and monthly x2 months to ensure that all equipment has been cleaned appropriately. Audits and findings will be reported to QAPI committee for further recommendations.¿ Corrections will be monitored by: Culinary Director or designee	

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	245483	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**01/29/2024**

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K 000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety recertification survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 01/29/2024. At the time of this survey, The North Shores Estates LLC was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: IF PARTICIPATING IN THE E-POC PROCESS, A PAPER COPY OF THE PLAN OF CORRECTION	K 000		

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

Electronically Signed | 02/20/2024

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

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K 000	Continued From page 1 IS NOT REQUIRED. Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR By email to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A detailed description of the corrective action taken or planned to correct the deficiency. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. 4. Identify who is responsible for the corrective actions and monitoring of compliance. 5. The actual or proposed date for completion of the remedy. The North Shores Estates LLC is a two-story building with a full basement. The building was constructed at two different times. The original building was constructed in 1971 with an addition built in 2005. Both buildings are of Type II(111) construction. Because the original building and the addition(s) meet the construction type allowed for existing buildings, the facility was surveyed as one	K 000		

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K 000	Continued From page 2 building, the 2005 building is support services only. The facility is fully protected throughout by an automatic fire sprinkler system. The facility also have a fire alarm system with smoke detection in the corridors and spaces open to the corridors that is monitored for automatic fire department notification. The two resident sleeping floors are each divided into three separate smoke compartments.	K 000		
K 372 SS=F	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 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 REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain their smoke barrier per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.7.1, 19.3.7.3, 8.5.2.2, and 8.5.6.5. These deficient findings could have a widespread impact on the residents within the facility. Findings include: On 01/29/2024, between 9:30am and 12:30pm, it was revealed by observation that there was a	K 372	The penetration above the door, on the lower level by the stairwell was sealed. There were no other penetrations identified. In order to protect all residents, the maintenance director or designee will audit the facility for penetrations in the smoke barriers weekly x4 weeks and monthly x2 months. Audits and findings will be reported to the QAPI committee for further	2/22/24

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K 372	Continued From page 3 penetration running from one smoke compartment to another above doors on lower level by center stairwell. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 372	recommendations. Date of Compliance: 2/22/2024	
K 712 SS=F	Fire Drills CFR(s): NFPA 101 Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to conduct fire drills under varied times and conditions per NFPA 101 (2012 edition), Life Safety Code, sections 19.7.1.6, 4.7.4, and 4.6.1.1. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 01/29/2024, between 9:30am and 12:30pm, it was revealed by a review of available documentation that fire drills were not completed: third shift missing second quarter (April - June) and fourth quarter (October - December) drills completely.	K 712	A drill for the third shift was completed. There were no other missing shifts for fire drills. In order to protect all residents, the Administrator or designee will audit the facility for fire drill completion on the appropriate shift monthly for 6 months. Audits and findings will be reported to the QAPI committee for further recommendations. Date of Compliance: 2/22/2024	2/22/24

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K 712	Continued From page 4 An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 712		
K 918 SS=F	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations.	K 918		3/6/24

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K 918	Continued From page 5 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to install and maintain generators per NFPA 99 (2012 edition), Health Care Facilities Code, section 6.4.4.1.1.3, 6.4.1.1.16.2 and 6.4.1.1.17, and NFPA 110 (2010 edition), Standard for Emergency and Standby Power Systems, sections 5.6.5.2, 5.6.5, 5.6.5.6, 5.6.5.6.1, 5.6.6, 8.3.8,8.4.1, 8.4.2.1, 8.4.2.3,8.4.9, 8.4.9.1, 8.4.9.2 and 8.4.9.5.1. These deficient findings could have a widespread impact on the residents within the facility. Findings include: On 01/29/2024, between 9:30am and 12:30pm, it was revealed by a review of available documentation of the emergency generator maintenance and testing requirements for a 36 month 4 hour load bank test was not available at time of document review. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 918	The 4-hour load bank testing was completed on the generator. There was no other missing generator load-bank testing. In order to protect all residents, the Administrator or designee will audit the facility for generator load-bank testing completion monthly for 6 months. Audits and findings will be reported to the QAPI committee for further recommendations. Date of Compliance: 3/6/2024	