Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
March 15, 2024

Administrator
Glenoaks Senior Living Campus
100 Glen Oaks Drive
New London, MN 56273

RE: CCN: 245360
Cycle Start Date: March 6, 2024

Dear Administrator:

On March 6, 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:

Judy Loecken, Unit Supervisor
St. Cloud B District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Midtown Square
3333 Division Street, Suite 212
Saint Cloud, Minnesota 56301-4557
Email: judy.loecken@state.mn.us
Office: (320) 223-7300 Mobile: (320) 241-7797

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 June 6, 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 September 6, 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
State Fire Safety Supervisor
Health Care & Correctional Facilities
MN Department of Public Safety-Fire Marshal Division
445 Minnesota St., Suite 145
St. Paul, MN 55101
Email: travis.ahrens@state.mn.us
Web: www.sfm.dps.mn.gov
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
	245360	A. BUILDING _____ B. WING _____	C 03/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GLENOAKS SENIOR LIVING CAMPUS	100 GLEN OAKS DRIVE NEW LONDON, MN 56273

(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 3/4/24 to 3/6/24, a survey for compliance with Appendix Z, Emergency Preparedness Requirements for Long Term Care facilities, §483.73 was conducted during a standard recertification survey. The facility was not IN compliance. 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. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulation has been attained.	E 000		
E 041 SS=F	Hospital CAH and LTC Emergency Power CFR(s): 483.73(e) §482.15(e) Condition for Participation: (e) Emergency and standby power systems. The hospital must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section and in the policies and procedures plan set forth in paragraphs (b)(1)(i) and (ii) of this section. §483.73(e), §485.625(e), §485.542(e) (e) Emergency and standby power systems. The [LTC facility CAH and REH] must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section. §482.15(e)(1), §483.73(e)(1), §485.542(e)(1),	E 041		3/11/24

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

Electronically Signed | 03/25/2024

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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E 041	Continued From page 1 §485.625(e)(1) Emergency generator location. The generator must be located in accordance with the location requirements found in the Health Care Facilities Code (NFPA 99 and Tentative Interim Amendments TIA 12-2, TIA 12-3, TIA 12-4, TIA 12-5, and TIA 12-6), Life Safety Code (NFPA 101 and Tentative Interim Amendments TIA 12-1, TIA 12-2, TIA 12-3, and TIA 12-4), and NFPA 110, when a new structure is built or when an existing structure or building is renovated. 482.15(e)(2), §483.73(e)(2), §485.625(e)(2), §485.542(e)(2) Emergency generator inspection and testing. The [hospital, CAH and LTC facility] must implement the emergency power system inspection, testing, and [maintenance] requirements found in the Health Care Facilities Code, NFPA 110, and Life Safety Code. 482.15(e)(3), §483.73(e)(3), §485.625(e)(3),§485.542(e)(2) Emergency generator fuel. [Hospitals, CAHs and LTC facilities] that maintain an onsite fuel source to power emergency generators must have a plan for how it will keep emergency power systems operational during the emergency, unless it evacuates. *[For hospitals at §482.15(h), LTC at §483.73(g), REHs at §485.542(g), and and CAHs §485.625(g):] The standards incorporated by reference in this section are approved for incorporation by reference by the Director of the Office of the Federal Register in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. You may obtain the	E 041		

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E 041	Continued From page 2 material from the sources listed below. You may inspect a copy at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202-741-6030, or go to: http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html. If any changes in this edition of the Code are incorporated by reference, CMS will publish a document in the Federal Register to announce the changes. (1) National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02169, www.nfpa.org, 1.617.770.3000. (i) NFPA 99, Health Care Facilities Code, 2012 edition, issued August 11, 2011. (ii) Technical interim amendment (TIA) 12-2 to NFPA 99, issued August 11, 2011. (iii) TIA 12-3 to NFPA 99, issued August 9, 2012. (iv) TIA 12-4 to NFPA 99, issued March 7, 2013. (v) TIA 12-5 to NFPA 99, issued August 1, 2013. (vi) TIA 12-6 to NFPA 99, issued March 3, 2014. (vii) NFPA 101, Life Safety Code, 2012 edition, issued August 11, 2011. (viii) TIA 12-1 to NFPA 101, issued August 11, 2011. (ix) TIA 12-2 to NFPA 101, issued October 30, 2012. (x) TIA 12-3 to NFPA 101, issued October 22, 2013. (xi) TIA 12-4 to NFPA 101, issued October 22, 2013. (xiii) NFPA 110, Standard for Emergency and Standby Power Systems, 2010 edition, including TIAs to chapter 7, issued August 6, 2009..	E 041		

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E 041	Continued From page 3 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to test and maintain the on-site emergency generator system per NFPA 99 (2012 edition), Health Care Facilities Code, section 6.4.1.1, 6.4.4.1.1.4, 6.4.4.2, and NFPA 110 (2010 edition), Standard for Emergency and Standby Power Systems, section, 5.6.5.2, 8.3, 8.3.7, 8.4. These deficient findings could have a widespread impact on the residents within the facility. Findings include: 1. On 03/06/2024 between 10:00 AM and 3:30 PM, it was revealed by a review of available documentation that no documentation was presented to confirm that weekly and monthly inspection and testing of the generator is occurring. 2. On 03/06/2024 between 10:00 AM and 3:30 PM, it was revealed by documentation review and observation that the generator battery had not been replaced - battery installed in 2021. Battery install / age was noted in the vendor annual inspection records. 3. On 03/06/2024 between 10:00 AM and 3:30 PM, it was revealed by observation that the remote emergency stop switch for the generator exhibited damage. Electrical contractor on-site at time of survey confirmed that the device was damaged and in need to repair or replacement. An interview with the Maintenance Director verified these deficient findings at the time of discovery.	E 041	E 041: 1. Weekly and Monthly Generator logs are being utilized to document inspections by Maintenance Director. Generator Inspection Checklist was completed by Interstate Power Systems on March 11, 2024. 2. New Generator battery was installed on March 11, 2024 and date punched on battery tag to verify date of installation for documentation. 3. Emergency Stop Switch on outside of generator enclosure was replaced with new switch on March 11, 2024. " All residents of the facility have the potential to be affected by the deficient practice. " To monitor the corrective actions and prevent recurrance, Audits of weekly generator logs will be done weekly for 8 weeks and monthly generator Audits for 2 months and reviewed at facility QAPI meeting on compliance. " Maintenance Director will be responsible for ensuring continued compliance. " Date of correction: March 11, 2024	

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F 000	Continued From page 4	F 000		
F 000	INITIAL COMMENTS On 3/4/24 to 3/6/24, 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 cited: H53601260C/MN00097835 H53601199C/MN00097754 The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulations has been attained.	F 000		
F 578 SS=D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate.	F 578		3/25/24

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F 578	Continued From page 5 §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure advanced directives for emergency care and treatment were accurately reflected in all areas of the resident's medical record to ensure residents wishes would be implemented correctly in case of an emergency for 1 of 17 residents (R15) reviewed for advanced directives.	F 578	F578- Glen Oaks does ensure that all residents advanced directives are correct with orders and care planning. At Glen Oaks all residents have the potential to be affected by inaccurate advanced directives. (R15) advanced directives were corrected for accuracy The facility has conducted an audit to	

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F 578	Continued From page 6 Findings include: R15's admission Minimum Data Set (MDS) dated 1/21/24, identified R15 had severe cognitive impairment and required assistance with all activities of daily living (ADL)'s. R15's diagnoses included cerebral infarction, coronary artery disease, heart failure, aphasia, hemiplegia/hemiparesis, depression, restless leg syndrome, muscle weakness, difficulty in walking, unspecified lack of coordination and abnormal posture. Review of R15's electronic medical record (EMR) identified the following: -R15's Order Summary Report identified Advance Directive: DNR (do not resuscitate) -R15's dashboard profile (viewed on computer screen) identified Advance Directive: DNR -R15's care plan revised on 1/18/24, identified R15's advance directives were Full Code. Review of R15's paper chart identified the following: -R15's Provider Orders for Life-Sustaining Treatment (POLST) Form signed 2/9/24, identified Full Code - Resident and/or legal representative does want resident to be resuscitated. This resident is considered a "Full Code" status. During interview on 3/5/24 at 11:22 a.m., trained medication aide (TMA)-A stated she would look for a resident's code status on the banner in the EHR. R15's EMR banner indicated DNR During interview on 3/5/24 at 11:26 a.m., licensed practical nurse (LPN)-B stated a resident's code states could be found on the banner in the HER	F 578	accurately reflect resident's wishes in all areas of the medical record. Social Services Director was educated on the process for ensuring the accuracy of advanced directives. Staff will perform a check of both the PCC and paper charts to ensure that all residents have the correct documentation. An audit will be conducted by the Social Services Designee weekly for 4 weeks, and monthly for three months results forwarded to the QAA committee for review. Responsible Party: Social Services Director/ Designee Alleged Compliance Date 3/25/24	

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F 578	Continued From page 7 and also on a report, that was printed every night, and hung on a clipboard in the nurse's station. LPN-B confirmed R15's code status stated DNR on the printed report and on the EHR. During interview on 3/5/24 at 11:36 a.m., R15's daughter stated R15's code status remained full code as was stated on the POLST that signed on 2/9/24. During interview on 3/5/24 at 2:57 p.m., director of nursing (DON) stated nurses accessed code status by looking at the banner in the ERH, orders in the EHR, a report that hung on a clipboard in the nurse's station, and/or in the resident's hard medical chart. DON stated on 2/23/24, R15's daughter brought in power of attorney paperwork, at which time DON thought R15's daughter had stated she wanted R15 to be DNR. At that time, DON changed R15's code status in the EHR to DNR. The facility policy titled Advance Directives revised 12/2016, identified the plan of care for each resident would be consistent with his or her documented treatment preferences and/or advance directive. The policy further identified changes or revocations of a directive must be submitted in writing to the Administrator. The Administrator may require new document if changes were extensive. The Care Plan Team would be informed of such changes and/or revocations so that appropriate changes could be made in the resident assessment (MDS) and care plan. The policy lacked guidance on the facility forms used and the multiple places resident code status may be identified.	F 578		
F 582 SS=D	Medicaid/Medicare Coverage/Liability Notice	F 582		3/25/24

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F 582	Continued From page 8 CFR(s): 483.10(g)(17)(18)(i)-(v) §483.10(g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and (ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this section. §483.10(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate. (i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible. (ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change. (iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident	F 582		

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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
F 582	Continued From page 9 representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements. (iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility. (v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to provide the required Skilled Nursing Facility Advanced Beneficiary Notice (SNFABN) to 1 of 3 residents (R94) reviewed whose Medicare A coverage ended and then remained in the facility. Findings include: R94's Centers for Medicare and Medicaid Services (CMS)-10123 signed as received on 10/23/23, identified a last covered day (LCD) of 10/23/23. R94's undated Census Records listing identified on 10/24/23, R94's payer source changed from Medicare Part A to "Private Pay," and remained in the facility. R94's medical record was reviewed and lacked any evidence a SNFABN had been provided to explain the estimated cost per day or provide rationale or explanation of the extended care	F 582	F582 □ Glen Oaks does provide Advanced Beneficiary Notice to residents and/or representatives when services are ending. At Glenoaks all residents have the potential to be affected when an Advanced Beneficiary Notice is not provided. Resident (R94) representative was informed of the ABN process and voiced satisfaction with the ending of services and signed ABN The facility will provide all skilled residents and their families an Advanced Beneficiary Notice when the service stops and they decide to stay long term. Social Services Director was educated on the ABN process	

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	245360	A. BUILDING _____ B. WING _____	C 03/06/2024

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F 582	Continued From page 10 services or items to be furnished, reduced, or terminated. When interviewed on 03/05/24 at 4:16 p.m., the social services designee (SSD)-A stated she was responsible for providing the Medicare non-coverage notices within the facility but had missed providing the SNFABN to R94 at the time Medicare payment was ending. The SSD-A stated the importance of the SNFABN was to inform a resident who was planning on staying after Medicare stopped paying so they were fully informed of their daily rates and potential costs of living in the facility. A Beneficiary Notice policy was requested but not provided.	F 582	The Social Services Designee will complete an audit weekly for 3 months to ensure compliance results forwarded to the QAA committee for review. Responsible Party: Social Services Director/Designee	
F 684 SS=D	Quality of Care CFR(s): 483.25 § 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. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility failed to complete neurological assessments following falls for 2 of 3 residents (R15 and R21) who had unwitnessed falls. Findings include:	F 684	F684 □ Glen Oaks does perform neurologic assessments on resident with unwitnessed falls or when a resident is known to hit their head. All residents have the potential to be affected	3/25/24

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F 684	Continued From page 11 R15's admission Minimum Data Set (MDS) dated 1/21/24, identified R15 had severe cognitive impairment and required assistance with all activities of daily living (ADL)'s. R15's diagnoses included cerebral infarction, coronary artery disease, heart failure, aphasia, hemiplegia/hemiparesis, depression, restless leg syndrome, muscle weakness, difficulty in walking, unspecified lack of coordination and abnormal posture. R15's record lacked evidence neurological assessments were initiated and completed after R15's unwitnessed falls on: 1/17/24, 1/19/24, 1/19/24, 1/25/24, 1/26/23, 2/1/24. 2/1/24, 2/8/24, 2/12/24, 2/13/24, and 2/23/24. R21's admission Minimum Data Set (MDS) dated 1/7/24, identified R21 had intact cognitive impairment and required assistance with all activities of daily living (ADL)'s. R21's diagnoses included spinal stenosis, heart failure, hypertension, anxiety disorder, depression, respiratory failure, pulmonary hypertension, acute pulmonary edema, fibromyalgia and pulmonary fibrosis. R21's record lacked evidence neurological assessments were completed after R21's unwitnessed fall on 3/2/24. During an interview on 3/6/24 at 11:33 a.m., assistant director of nursing (ADON) stated when a resident fell staff alerted the nurse who would obtain vitals and assess for injury. ADON stated when a fall was unwitnessed that neurological checks are done every 15 minutes for the first hour, every 30 minutes for the next two hours and then every 30 minutes for an hour. ADON	F 684	All residents will receive appropriate nursing services with accurate assessment, timely intervention for neurological changes and timely notification to physician of changes. Neurologic assessments have been completed for (R15) and (R21) and both residents are at baseline. The Neurological Assessments process was reviewed with all nurses and a policy was placed in a binder in the nurse□s station. Facility implemented a paper documentation process for Neurological Assessments. These assessments will be uploaded in each resident□s chart after completion. Nursing Leadership will complete an audit daily for 2 weeks and weekly for 4 weeks and then monthly for 3 months to ensure neurological assessments are being completed per process results forwarded to the QAA committee for review. Responsible Party: DON/Designee	

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F 684	Continued From page 12 confirmed that neurological assessments for R15's and R21's fall were not completed. ADON stated neurological assessments were important to make sure there were no cognitive deficit and resident was at baseline. A facility Neurological Assessment policy, dated 11/28/21, indicated the purpose of this procedure is to provide guidelines for a neurological assessment: 1) upon physician order; 2) when following an unwitnessed fall; 3) subsequent to a fall with a suspected head injury; or 4) when indicated by resident condition. When assessing neurological status, always include frequent vital signs. Particular attention should be pain to widening pulse pressure (difference between systolic and diastolic pressures). This my ay be indicative of increasing intracranial pressure (ICP).	F 684		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs	F 758		3/25/24

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F 758	Continued From page 13 unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to monitor orthostatic blood pressures with the use of an antipsychotic medication for 1 of 3 resident (R12) reviewed for unnecessary medications. Findings include:	F 758	F758- Glen Oaks does perform orthostatic blood pressures on residents taking antipsychotic medications. At Glenoaks all residents have the potential to be affected by orthostatic blood pressures fluctuations while taking antipsychotic medications.	

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F 758	Continued From page 14 R12's quarterly Minimum Data Set (MDS) dated 12/16/23, identified R12 had moderate cognitive impairment and required assistance with activities of daily living (ADL)'s. R12's diagnoses included schizoaffective disorder, diabetes mellitus, seizure disorder, anxiety disorder, depression, bipolar disorder, and obsessive-compulsive disorder. R12's medication and treatment record, print date of 3/5/24, indicated R12 had a potential for psychotropic drug adverse drug reaction (ADR's) related to daily use of psychotropic medications, and included to monitor for postural hypotension (blood pressure drops when you go from lying down to sitting up, or sitting to standing). R12's physician orders included orders for Risperidone (antipsychotic) 2 milligram (MG) by mouth two times daily for Schizophrenia and Obsessive-Compulsive disorder. R12's medical record was reviewed and lacked any evidence orthostatic blood pressures had been obtained for R1 in the past six months. During interview on 3/6/24 at 11:47 a.m., assistant director of nursing (ADON) stated she was not aware of resident needing orthostatic blood pressures. ADON stated orthostatic blood pressures are important to ensure resident was not having a significant difference in his blood pressures that could lead to falls or fainting episodes due to the side effects of his prescribed medication. During interview on 3/6/24 at 1:21 p.m., ADON stated R12's orthostatic blood pressures were not	F 758	Orthostatic blood pressures have been added to all residents who are taking antipsychotic medication□s monthly. All nurses were educated on ensuring orthostatic bp□s are completed monthly and added to the MAR with any new antipsychotic orders. Nursing leadership will audit all antipsychotics on admission and monthly times 3 months results forwarded to the QAA committee for review. Alleged Compliance Date 3/25/24	

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F 758	Continued From page 15 obtained and/or monitored. ADON stated that staff observe every shift for postural hypotension but that no actual blood pressures are obtained. During interview on 3/6/24 at 1:51 p.m., consultant pharmacist stated any resident on an antipsychotic medication should have orthostatic blood pressures obtained monthly and facility should reach out to resident's provider with any concerns in blood pressure readings. Pharmacist stated orthostatic blood pressures consist of obtaining a blood pressure when resident is lying, sitting, and then standing within the same timeframe. Pharmacist stated orthostatic blood pressures were important to monitor due to postural hypotension being one of the major side effects, especially in an older person, and would put the resident at a higher risk for falls when taking these medications. A facility Psychotropic Medications policy, dated 11/28/21, indicated purpose is to assure each resident receiving psychotropic medication is monitored, evaluated, and assessed for reduction opportunities on a regular basis. All residents receiving psychotropic medications will be monitored for side effects and appropriate action shall be taken upon identification of said side effects.	F 758		
F 883 SS=E	Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2) §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative	F 883		3/25/24

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F 883	Continued From page 16 receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. §483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (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:	F 883		

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F 883	Continued From page 17 (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 5 of 5 residents (R3, R8, R11, R13 and R19) reviewed for immunizations were offered and/or provided the pneumococcal vaccine series as recommended by the Centers for Disease Control (CDC) to help reduce the risk of associated infection(s). Findings include: A CDC Pneumococcal Vaccine Timing for Adults feature, dated 3/15/2023, identified various tables when each (or all) of the pneumococcal vaccinations should be obtained. This identified when an adult over 65 years old had received the complete series (i.e., PPSV23 and PCV13; see below) then the patient and provider may choose to administer Pneumococcal 20-valent Conjugate Vaccine (PCV20) for patients who had received Pneumococcal 13-valent Conjugate Vaccine (PCV13) at any age and Pneumococcal Polysaccharide Vaccine 23 (PPSV23) at or after 65 years old. R3's face sheet dated 3/6/24, indicated she was 86 years old. The immunization record dated 3/6/24, indicated she received a PPSV23 on 6/12/2007 followed by the PCV13 on 10/19/2016. The record lacked evidence of shared clinical	F 883	F883- At Glen Oaks the facility offers residents who are eligible to receive the pneumo vac series. The facility also updates the immunization tab when vaccines are administered, consents or refusals are documented in residents charts. At Glen Oaks all residents have the potential to be affected when pneumococcal vaccine series is not offered or administered as recommended by the CDC. Pneumonia vaccine consents and refusals have been obtained. Process is in place to administer vaccinations. The pneumococcal vaccine will be offered to all residents who are eligible. Nursing Leadership will conduct an audit of each residents immunizations to determine eligibility. The frequency of this process will be upon admission, weekly for four weeks, and monthly for three months results forwarded to the QAA committee for	

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F 883	Continued From page 18 decision making with the physician for PCV20 at least 5 years after the last pneumococcal dose. The record lacked evidence that R3 was offered or received PCV20. R8's face sheet dated 3/6/24, indicated she was 85 years old. The immunization record dated 3/6/24, indicated she received a PPSV23 on 11/25/2013 followed by the PCV13 on 2/2/2016. The record lacked evidence of shared clinical decision making with the physician for PCV20 at least 5 years after the last pneumococcal dose. The record lacked evidence that R8 was offered or received PCV20. R11's face sheet dated 3/6/24, indicated he was 79 years old. The immunization record dated 3/6/24, indicated he received a PPSV23 on 9/3/2015 followed by a PCV13 on 11/8/2016. The record lacked evidence of shared clinical decision making with the physician for PCV20 at least 5 years after the last pneumococcal dose. The record lacked evidence that R11 was offered or received PCV20. R13's face sheet dated 3/6/24, indicated she was 97 years old. The immunization record dated 3/6/24, indicated she received a PPSV23 on 1/7/2008 followed by a PCV13 on 6/14/2016. The record lacked evidence of shared clinical decision making with the physician for PCV20 at least 5 years after the last pneumococcal dose. The record lacked evidence that R13 was offered or received PCV20. R19's face sheet dated 3/6/24, indicated she was 71 years old. The immunization record dated 3/6/24, indicated he had not received a PPSV23, PCV13 and/or the PCV20. The record lacked	F 883	review. Responsible Party: DON/Designee	

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F 883	Continued From page 19 evidence of shared clinical decision making with the physician for PCV20 at least 5 years after the last pneumococcal dose. The record lacked evidence that R19 was offered or received PPSV23, PCV13 and/or the PCV20. During an interview on 3/6/2024 at 11:10 a.m., the infection preventionist (IP) stated immunizations were reviewed upon admission through MIIC (Minnesota Immunization Information Connection). IP stated residents and/or their families were asked about vaccines that were eligible and available. When resident and/or their families consented to a vaccine, facility would obtain the vaccine, administer, and update immunization record in resident's electronic health record. IP stated she used the Centers of Disease Control and Prevention (CDC) pneumococcal vaccine recommendations, dated 4/2022 for eligibility of pneumococcal immunizations. IP verified R3, R8, R11, R13 and R19's pneumococcal immunizations as listed above. IP stated that IP was not aware of the recommendation of the PCV20. IP verified they had not offered or provided education on PCV20. IP verified there had been no shared clinical decision making with the provider regarding pneumococcal immunizations for R3, R8, R11, R13 and R19. IP stated it was important to ensure residents are offered all available vaccinations to prevent the risk of developing symptoms to lead to acute illness. A facility policy titled "Pneumococcal Vaccine" with a review date of 9/21/21 was provided. Policy indicated: All residents will be offered pneumococcal vaccines to aid in preventing pneumonia/pneumococcal infections. Prior to or upon admission, residents will be assessed for	F 883		

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F 883	Continued From page 20 eligibility to receive the pneumococcal vaccine series, and when indicate, will be offered the vaccine series within thirty days of admission to the facility unless medically contraindicated or the resident has already been vaccinated. Administration of the pneumococcal vaccines or revaccinations will be made in accordance with current Centers for Disease Control and Prevention (CDC) recommendations at the time of the vaccination.	F 883		

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K 000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety Code survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 03/06/2024. At the time of this survey, GLENOAKS SENIOR LIVING CAMPUS 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 IS NOT REQUIRED.	K 000		

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

Electronically Signed | 03/25/2024

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245360	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**03/06/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GLENOAKS SENIOR LIVING CAMPUS	**100 GLEN OAKS DRIVE** **NEW LONDON, MN 56273**

(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 000	Continued From page 1 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. GLENOAKS SENIOR LIVING CAMPUS is a 1-story building with a partial basement. The building was constructed at 4 different times. The original building was constructed in 1964 and was determined to be of Type II (000) construction. In 1993 and addition was added to the south of the Service Wing that was determined to be of Type II (000) construction. In 1996 and addition was added to the north of	K 000		

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K 000	Continued From page 2 the Service Wing that was determined to be of Type II (000) construction. In 1999 and addition was added to the south of the 1993 addition that was determined to be of Type II (000) construction. The building is fully fire sprinkler protected and has a fire alarm system with smoke detection in the corridors and spaces open to the corridor that is monitored for automatic fire department notification. The facility has a licensed capacity of 52 beds and had a census of 40 at the time of the survey. At the time of this survey, the requirements of 42 CFR, Subpart 483.70(a), are NOT MET.	K 000		
K 211 SS=D	Means of Egress - General CFR(s): NFPA 101 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 REQUIREMENT is not met as evidenced by: Based on observation and staff interview the facility failed to maintain means of egress reliability requirements per NFPA 101 (2012 edition), Life Safety Code sections 19.2.1, 7.1.10 This deficient finding could have an isolated impact on the residents within the facility. Findings include:	K 211	K- 211: 1. Access to the Exit Door #32 was cleared of the obstruction of the cleaning cart on March 6, 2024. The egress is clear of obstructions and will be monitored daily by visual means. Housekeeping and Laundry were educated on the regulation and importance of keeping the	3/7/24

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K 211	Continued From page 3 On 03/06/2024 between 10:00 AM and 5:30 PM, it was revealed by observation that access to Exit Door #32 was fully obstructed. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 211	egress clear in event of an emergency to exit the building through door #32. " All residents of the facility have the potential to be affected by the deficient practice. " To monitor the corrective actions and prevent recurrence, random visual inspection of the egress path to Exit Door #32 will be performed by Maintenance Director and Administrator. Housekeeping and Laundry staff were educated on the regulation and importance of keeping the egress clear in event of an emergency to exit the building through Door # 32 and all exit doors. " Maintenance Director and Administrator will be responsible for ensuring continued compliance. " Date of correction: 03/06/2024.	
K 324 SS=F	Cooking Facilities CFR(s): NFPA 101 Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under	K 324		4/5/24

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K 324	Continued From page 4 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain proper inspection and safety measures associate to the commercial and residential cooking devices in accordance with NFPA 101 (2012 edition), Life Safety Code, section 19.3.2.5.3(9)(10) and the Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, NFPA 96-2014, section 11.2. These deficient findings could have a widespread impact on the residents within the facility. Findings Include: 1. On 03/06/2024 between 10:00 AM and 5:30 PM, it was revealed by observation that the all-residential cooktop and wall ranges located neighborhood kitchenettes were not outfitted with lock-out, disconnect, 120 min max timeout hardware. 2. On 03/06/2024 between 10:00 AM and 5:30 PM, it was revealed during documentation review that no documentation was presented for review to confirm the Ansul type fire suppression system was current in its 6-month inspection(s).	K 324	K- 324 1. The residential cooktop in the therapy room will have lock-out tag-out disconnects with 120 minute max timeout hardware installed by licensed electrician. Date of correction to be completed by April 5, 2024. 2. Summit Fire Systems will verify completion of inspections on extinguisher and ansul system in the kitchen. Scheduled to arrive on 3/22/2024 to complete. " All residents have the potential to be affected by the deficient practice. " Therapy staff were educated on March 8, 2024 on the requirements. " Maintenance Director will monitor for compliance that inspections occur. " Date of correction: April 5, 2024.	

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K 324	Continued From page 5 An interview with the Maintenance Director verified these deficient findings at the time of discovery.	K 324		
K 345 SS=F	Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain and test the fire alarm system per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.4.1, 9.6.1.3, and NFPA 72 (2010 edition), National Fire Alarm and Signaling Code, section 14.4.5.3, 14.4.5.3.2. These deficient findings could have a widespread impact on the residents within the facility. Findings include: 1. On 03/06/2024 between 10:00 AM and 5:30 PM, it was revealed during documentation review that most recent annual fire alarm system testing was completed on 02/03/2023. 2. On 03/06/2024 between 10:00 AM and 5:30 PM, it was revealed by observation that the mag-hold assemblies for the following fire doors were found to be non-operational: Kitchen door;	K 345	K-345 1. Annual fire alarm system testing was completed on March 15, 2024. 2. Nationwide Glass has been contacted to order and install the mag-hold assemblies for the fire doors in the kitchen and dishwashing room doors. The damaged fire door leading into the dining area will be replaced. " All residents have the potential to be affected by the deficient practice. " Maintenace Director and Dietary Director educated on the proper operation of mag-hold assemblies for fire doors on March 15, 2024. " Maintenance Director will monitor and verify for compliance. " Date of correction: 04/30/2024.	4/30/24

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K 345	Continued From page 6 Dishwashing Room door. An interview with the Maintenance Director verified these deficient findings at the time of discovery.	K 345		
K 347 SS=F	Smoke Detection CFR(s): NFPA 101 Smoke Detection 2012 EXISTING Smoke detection systems are provided in spaces open to corridors as required by 19.3.6.1. 19.3.4.5.2 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to document and test the resident room smoke detectors per NFPA 101 (2012 edition), Life Safety Code sections 19.3.6.1, 19.3.4.5.2 and 9.6.2.10. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 03/06/2024 between 10:00 AM and 5:30 PM, it was revealed by a review of available documentation that the documentation presented for review did not contain individual assessment or information associated to each of the resident room smoke detectors. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 347	K-347 " All residents have the potential to be affected by the deficient practice. " To prevent the deficient practice from recurring, Individual resident room smoke detectors will be tested and assessed individually for each room and documented on spreadsheet to verify results and compliance. " Maintenance Director will monitor and verify for compliance, " Date of correction: March 31, 2024. " All residents have the potential to be affected by the deficient practice. " To prevent the deficient practice from recurring, Individual resident room smoke detectors will be tested and assessed individually for each room and documented on spreadsheet to verify results and compliance. " Maintenance Director will monitor and verify for compliance, " Date of correction: March 31, 2024.	3/31/24

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K 353 SS=F	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on observation, documentation review, and staff interview the facility failed to inspect and maintain the sprinkler system in accordance with NFPA 101 (2012 edition), Life Safety Code, sections 4.6.12, 9.7.5, 9.7.6, NFPA 25 (2011 edition) Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, section(s), 4.4, 5.2.1.1.1. These deficient findings could have a widespread impact on the residents within the facility. Findings include: 1. On 03/06/2024 between 10:00 AM and 5:30 PM, it was revealed during documentation review that the no documentation was present for review	K 353	K-353 1. Summit Fire contacted to review and confirm quarterly sprinkler system testing in Q1, Q2, Q3 and Q4 for 2024. Summit Fire has been contacted to conduct system testing. Maintenance Director will monitor for compliance. Date of correction: March 31, 2024. 2. Activity storage closet and PT/OT closets were cleared of items that were closer than 18 to the sprinkler head. Activity Director and Therapy Director will monitor for continued compliance. Date of correction: March 6, 2024. 3. A replacement for the missing escutcheon cover in Room 124 was	3/31/24

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K 353	Continued From page 8 to confirm that sprinkler system quarterly inspection occurred in Q1 and Q3 - 2023. 2. On 03/06/2024 between 10:00 AM and 5:30 PM, it was revealed by observation that in the following locations that items were stacked vertically closer than 18 inches to the sprinkler head: Activities storage closet and P.T. / O.T. storage closet. 3. On 03/06/2024 between 10:00 AM and 5:30 PM, it was revealed by observation that in RM 124 the sprinkler head was physically retracted into the wall and was missing an escutcheon cover. An interview with the Maintenance Director verified these deficient findings at the time of discovery.	K 353	replaced on March 21, 2024. " All residents have the potential to be affected by the deficient practice. " To prevent deficient practice from recurring, Activity Staff and Therapy Staff were educated on the requirement to keep space clear in closets from 18 to the sprinkler head to allow safe operation in event of a fire. " Quarterly Sprinkler system testing will be confirmed by Summit Fire to ensure continued compliance. " Random visual inspections of the sprinkler escutcheons in rooms will be conducted by Maintenance Director to ensure covers are in place on sprinkler heads. " Maintenance Director will verify the completion of the installation and monitor for compliance. " Date of correction: April 10, 2024	
K 355 SS=F	Portable Fire Extinguishers CFR(s): NFPA 101 Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to properly inspect, and maintain documentation of portable fire extinguishers in accordance with NFPA 101 (2012 edition), Life Safety Code, sections 19.3.5.12, 9.7.4.1, and	K 355	K-355 1. The fire extinguisher located on the Maintenance Shop that was freestanding on the floor has been secured to the wall by a bracket. This was completed on	3/29/24

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K 355	Continued From page 9 NFPA 10 (2010 edition), Standard for Portable Fire Extinguishers, section 7.2, 7.2.1, 7.2.4, 7.3.1, 6.1.3.8.3. These deficient findings could have a widespread impact on the residents within the facility. Findings include: 1. On 03/06/2024 between 10:00 AM and 3:30 PM, it was revealed by observation, that the fire extinguisher located in the Maintenance Shop was found to be freestanding on the floor. 2. On 03/06/2024 between 10:00 AM and 3:30 PM, it was revealed by observation, that in the partial basement of the facility that fire extinguishers had last been inspected in JAN 2024. An interview with the Maintenance Director verified these deficient findings at the time of discovery.	K 355	March 7, 2024. 2. The fire extinguishers in the partial basement of the facility were checked as functional and full and initialed to verify proper inspection for the month. This was completed on March 7, 2024. New sets of inspection tags will arrive on March 29, 2024 that will be used for future months as the existing inspection tags are filled up with initials. " All residents have the potential to be affected by the deficient practice. " To prevent the deficient practice from recurring, the new Maintenance Director has been educated on all locations of fire extinguishers in the building and new inspection tags are being installed for initializing inspection dates and educated on the proper securing of fire extinguishers. " Maintenance Director will be responsible to verify for compliance. " Date of correction: March 29, 2024	
K 374 SS=F	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Doors 2012 EXISTING Doors in smoke barriers are 1-3/4-inch thick solid bonded wood-core doors or of construction that resists fire for 20 minutes. Nonrated protective plates of unlimited height are permitted. Doors are permitted to have fixed fire window assemblies per 8.5. Doors are self-closing or automatic-closing, do not require latching, and are not required to swing in the direction of egress travel. Door opening provides a minimum	K 374		4/30/24

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K 374	Continued From page 10 clear width of 32 inches for swinging or horizontal doors. 19.3.7.6, 19.3.7.8, 19.3.7.9 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain the smoke barrier doors per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.7.8 and 8.5.4.1. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 03/06/2024 between 10:00 AM and 3:30 PM, it was revealed by observation that Oak Lane smoke barrier doors did not self-close and seal the opening upon testing. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 374	K-374 Nationwide contacted on March 18, 2024 and arrived on-site. Nationwide inspected and will replace smoke barrier door on Oak Lane as unable to repair existing door to properly seal the opening upon testing. Door is being ordered, with anticipated arrival date of 4 weeks, and then installed. " All residents have the potential to be affected by the deficient practice. " To prevent recurrence, the Maintenance Director will verify completion and compliance and conduct random inspections of the door operations during daily rounding of the facility. " Maintenance Director will be responsible to verify compliance. " Date of correction: April 30, 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.	K 712		3/31/24

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K 712	Continued From page 11 19.7.1.4 through 19.7.1.7 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to conduct fire drills per NFPA 101 (2012 edition), Life Safety Code, sections 19.7.1. These deficient findings could have a widespread impact on the residents within the facility. Findings include: On 03/06/2024 between 10:00 AM and 3:30 PM, it was revealed by review of available documentation that no documentation was presented to confirm that fire drills were conducted in 1st Quarter for 1st, 2nd, and 3rd shifts. An interview with Maintenance Director verified this deficient finding at the time of discovery.	K 712	K-712 Fire drills will be completed and documented for Q1 for 1st, 2nd and 3rd shifts per NFPA 101, Life Safety Code sections 19.7.1. " All residents have the potential to be affected by the deficient practice. " To prevent recurrence, Maintenance Director and Administrator will verify completion and compliance. Audits on Quarterly Fire Drills will be completed in Q1 and Q2 in 2004 to verify compliance with drills having occurred on all three shifts. Summit Fire logs verifying the alerts for fire drills will serve as proof the drills occurred on the shifts that were identified. " Maintenance Director will be responsible to ensure compliance. " Date of correction: March 31, 2024.	
K 761 SS=F	Maintenance, Inspection & Testing - Doors CFR(s): NFPA 101 Maintenance, Inspection & Testing - Doors Fire doors assemblies are inspected and tested annually in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives. Non-rated doors, including corridor doors to patient rooms and smoke barrier doors, are routinely inspected as part of the facility maintenance program. Individuals performing the door inspections and testing possess knowledge, training or experience that demonstrates ability. Written records of inspection and testing are	K 761		3/11/24

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K 761	Continued From page 12 maintained and are available for review. 19.7.6, 8.3.3.1 (LSC) 5.2, 5.2.3 (2010 NFPA 80) This REQUIREMENT is not met as evidenced by: Based on document review and staff interview the facility failed to inspect and test doors per NFPA 101 (2012 edition), Life Safety Code, sections 7.2.1.15, and NFPA 80 (2010 edition), sections 5.2.1. This deficient condition could have a widespread impact on the residents within the facility. Findings include: On 03/06/2024 between 10:00 AM and 3:30 PM, it was revealed by review of available documentation that there was no documentation presented to confirm that the facility is conducting annual maintenance, inspection and testing of doors. An interview with Maintenance Director verified this deficient finding at the time of discovery.	K 761	K-761 " All residents have the potential to be affected by the deficient practice. " Annual inspection of swinging fire door assemblies was completed on March 11, 2024 and documented by Maintenance Director to verify they were working properly. " Maintenance Director will monitor and verify for annual compliance. " Date of correction; 3/11/2024.	
K 914 SS=F	Electrical Systems - Maintenance and Testing CFR(s): NFPA 101 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	K 914		3/21/24

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	245360	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**03/06/2024**

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K 914	Continued From page 13 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 REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to conduct electrical receptacle testing in resident rooms per NFPA 99 (2012 edition), Health Care Facilities Code, section(s) 6.3.3.2, 6.3.4, 6.3.4.2. These deficient findings could have a widespread impact on the residents within the facility. Findings include: On 03/06/2024 between 10:00 AM and 3:30 PM, it was revealed by review of available documentation that there was no documentation presented to confirm that the facility is conducting electrical outlet receptacle testing in resident rooms. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 914	K-914 " All residents have the potential to be affected by the deficient practice. " All Electrical receptacle testing in resident rooms and documentation of testing was completed and documented as of March 21, 2024, by Maintenance Director. " Maintenance Director will monitor and verify for annual compliance. " Date of correction: 3/21/2024.	
K 918 SS=F	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing	K 918		4/15/24

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	245360	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**03/06/2024**

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K 918	Continued From page 14 The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to test and maintain the on-site emergency generator system per NFPA 99 (2012 edition), Health Care Facilities Code, section 6.4.1.1, 6.4.4.1.1.4, 6.4.4.2, and NFPA 110 (2010	K 918	K-918 1. Weekly visual inspection of emergency power generator was completed on March 18, 2024 and will be documented of weekly inspections going	

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K 918	Continued From page 15 edition), Standard for Emergency and Standby Power Systems, section, 5.6.5.2, 8.3, 8.3.7, 8.4. These deficient findings could have a widespread impact on the residents within the facility. Findings include: 1. On 03/06/2024 between 10:00 AM and 3:30 PM, it was revealed by a review of available documentation that no documentation was presented to confirm that weekly and monthly inspection and testing of the generator is occurring. 2. On 03/06/2024 between 10:00 AM and 3:30 PM, it was revealed by documentation review and observation that the generator battery had not been replaced - battery installed in 2021. Battery install / age was noted in the vendor annual inspection records. 3. On 03/06/2024 between 10:00 AM and 3:30 PM, it was revealed by observation that the remote emergency stop switch for the generator exhibited damage. Electrical contractor on-site at time of survey confirmed that the device was damaged and in need to repair or replacement. An interview with the Maintenance Director verified these deficient findings at the time of discovery.	K 918	forward. Monthly inspection and testing of the generator will be conducted by Maintenance Director. Maintenance Director is being trained on monthly generator testing on April 15, 2024. 2. Generator battery was replaced with new battery on March 18, 2024. New battery was punch stamped to verify date of installation. 3. Remote emergency generator stop switch that was noted to be damaged was replaced with a new switch by licensed electrical contractor. This was completed on March 18, 2024. " All residents have the potential to be affected by the deficient practice. " To prevent recurrence of the deficient practice, weekly and monthly visual inspections of emergency power generator will be completed and documented of weekly inspections going forward. Training on the monthly inspection testing of the generator will also be conducted by Interstate Power Systems to the Maintenance Director on April 1, 2024. " Maintenance Director will be responsible for ensuring compliance. " Date of correction: April 15, 2024.	
K 920 SS=D	Electrical Equipment - Power Cords and Extens CFR(s): NFPA 101 Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable	K 920		4/10/24

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K 920	Continued From page 16 patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to manage usage electrical devices in accordance with NFPA 99 (2012 edition), Health Care Facilities Code, section 10.2.3.6, 10.2.4, 10.5.2.3 and NFPA 70, (2011 edition), National Electrical Code, sections 110.3(B), 400.8 (1) and UL 1363. This deficient finding could have a isolated impact on the residents within the facility. Findings include: On 03/06/2024 between 10:00 AM and 3:30 PM, it was revealed by observation that in the Payroll Office that two appliances were found connected to relocatable power tap.	K 920	K-920 The relocatable power tap in the payroll office that had two appliances connected to it was disconnected to have only one appliance connected to it. This was completed on March 6, 2024. Business office manager and Human Resource manager will monitor for continued compliance and all-staff will be educated at scheduled All-Staff education on April 10, 2024 on the proper use of relocatable power strips to only have one appliance plugged into it at a time. " All residents and people in the building have the potential to be affected by the deficient practice. " To prevent recurrence of the deficient	

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K 920	Continued From page 17 An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 920	practice, random visual inspections will be done on power taps in offices throughout the facility to ensure that multiple appliances are not being plugged into a single power tap unit. " Business Office Manager and Human Resources Manager and Administrator will be responsible for continued compliance. " Date of correction: April 10, 2024.	
K 923 SS=F	Gas Equipment - Cylinder and Container Storag CFR(s): NFPA 101 Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited- combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES)	K 923		3/27/24

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K 923	Continued From page 18 STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain proper medical gas storage and management per NFPA 99 (2012 edition), Health Care Facilities Code, section 5.1.3.3.2(2), 11.3.2. These deficient finding could have a widespread impact on the residents within the facility. Findings include: 1. On 03/06/2024 between 10:00 AM and 3:30 PM, it was revealed by observation that the Med Gas (O2) Room was found unsecured. 2. On 03/06/2024 between 10:00 AM and 3:30 PM, it was revealed by observation that in the Med Gas (O2) Room combustible storage was found. An interview with the Maintenance Director verified these deficient findings at the time of discovery.	K 923	K-923 " The Med Gas room for oxygen storage was properly secured by lock on March 6, 2024. Date of correction: March 6, 2024. " The Med Gas room combustible storage containing cardboard and paper that is combustible, was all removed from the room on March 20, 2022 and the room then securely locked. " All residents have the potential to be affected by the deficient practice. " To ensure the deficient practice does not recur, staff education on proper locking and to not be storing combustible paper in a Med Gas room will be conducted on March 27, 2024. Administrator and Maintenance Director will conduct random visual inspections of the Gas storage room to ensure continued compliance. " Administrator and Maintenance Director will be responsible for ensuring the deficient practice does not recur. " Date of correction: March 27, 2024	