*Protecting, Maintaining and Improving the Health of All Minnesotans*

Electronically delivered
July 1, 2022

CMS Certification Number (CCN): 245332

Administrator
The Estates At Excelsior LLC
515 Division Street
Excelsior, MN 55331

Dear Administrator:

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

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

Effective April 20, 2022 the above facility is certified for:

56 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 56 skilled nursing facility beds.

You should advise our office of any changes in staffing, services, or organization, which might affect your certification status. If, at the time of your next survey, we find your facility to not be in substantial compliance your Medicare and/or Medicaid provider agreement may be subject to non-renewal or termination.

Please contact me if you have any questions.

Sincerely,

Kamala Fiske-Downing

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

*P r o t e c t i n g , M a i n t a i n i n g a n d I m p r o v i n g t h e H e a l t h o f A l l M i n n e s o t a n s*

Electronically Delivered
July 1, 2022

Administrator
The Estates At Excelsior LLC
515 Division Street
Excelsior, MN 55331

RE: CCN: 245332
Cycle Start Date: April 20, 2022

Dear Administrator:

On June 22, 2022, the Minnesota Department(s) of Health and Public Safety, completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Feel free to contact me if you have questions.

Sincerely,

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

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July 1, 2022

Administrator
The Estates At Excelsior LLC
515 Division Street
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Sincerely,

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Health Regulation Division
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Email: Kamala.Fiske-Downing@state.mn.us

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Electronically delivered

July 1, 2022

Administrator
The Estates At Excelsior LLC
515 Division Street
Excelsior, MN 55331

Re: Reinspection Results
Event ID: A2JK12

Dear Administrator:

On June 22, 2022 survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on Aoril 4, 2022. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

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

Electronically delivered
May 11, 2022

Administrator
The Estates At Excelsior LLC
515 Division Street
Excelsior, MN 55331

RE: CCN: 245332
Cycle Start Date: April 20, 2022

Dear Administrator:

On April 20, 2022, 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 a pattern of deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level E), 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:

Jamie Perell, Unit Supervisor
Metro B District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
85 East Seventh Place, Suite 220
P.O. Box 64900
Saint Paul, Minnesota 55164-0900
Email: jamie.perell@state.mn.us
Office: (651) 245-8094

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 July 20, 2022 (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 October 20, 2022 (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:

William Abderhalden, Fire Safety Supervisor
Deputy State Fire Marshal
Health Care/Corrections Supervisor – Interim
Minnesota Department of Public Safety
445 Minnesota Street, Suite 145
St. Paul, MN 55101-5145
Cell: (507) 361-6204
Email: william.abderhalden@state.mn.us
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

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

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245332 | A. BUILDING ______ B. WING ______ | C 04/20/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **THE ESTATES AT EXCELSIOR LLC** | **515 DIVISION STREET EXCELSIOR, MN 55331** |

| (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<br><br>On 4/18/22, to 4/20/22, a survey for compliance with Appendix Z, Emergency Preparedness Requirements, §483.73(b)(6) was conducted during a standard recertification survey. The facility was IN compliance.<br><br>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<br><br>On 4/18/22, through 4/20/22, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was found to be NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities.<br><br>The following complaints were found to be UNSUBSTANTIATED:<br>H5332079C (MN00082495), H5332080C (MN00082214), H5332081C (MN0007622), and H5332082C (MN00075966)<br><br>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.<br><br>Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to | F 000 | | |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed

TITLE:

(X6) DATE: 05/20/2022

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<br>validate that substantial compliance with the regulations has been attained. | F 000 | | |
| F 730<br>SS=C | Nurse Aide Peform Review-12 hr/yr In-Service<br>CFR(s): 483.35(d)(7)<br><br>§483.35(d)(7) Regular in-service education.<br>The facility must complete a performance review of every nurse aide at least once every 12 months, and must provide regular in-service education based on the outcome of these reviews. In-service training must comply with the requirements of §483.95(g).<br>This REQUIREMENT is not met as evidenced by:<br>Based on interview and document review, the facility failed to complete annual performance reviews for 3 of 4 nursing assistants (NA-A, NA-B, and NA-C) whose employee files were reviewed. This had the potential to affect all 22 residents who resided at the facility.<br><br>Findings include:<br><br>A facility provided unnamed document (undated) identified NA-A was hired on 9/8/08, NA-B was hired on 4/1/19, and NA-C was hired on 12/14/98.<br><br>Performance reviews were requested from the respective employee files of NA-A, NA-B, and NA-C, however, not provided by the facility.<br><br>During interview on 4/20/22, at 10:11 a.m. administrator stated performance reviews may not have been completed over the past three years for NA-A, NA-B, and NA-C as the facility had not had a steady director of nursing (DON). The administrator stated they should have been done each year to evaluate the need for training. | F 730 | F730 Nurse Aide Performance Review<br>Immediate Corrective Action:<br>NA-A, NA-B and NA-C all have scheduled reviews initiated on 5/18/22<br><br>Corrective Action as it applies to others:<br>Health care academy will continue to be assigned to all new hires, and current employees quarterly and annually.<br>Facility created policy that reviews will be completed on anniversary dates for all employees. If direct supervisor is unavailable or vacant, designated positions will complete these.<br>All Employees will be educated on annual review policy.<br>Facility will ensure annual reviews are completed as necessary.<br>Date of Compliance: 6/20/22<br>Recurrence will be prevented by:<br>Audits will be completed to ensure all current employee�s reviews are up to date will be conducted weekly x 4 weeks and then monthly x 2 months to assure | 6/20/22 |

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| F 730 | Continued From page 2<br><br>During interview on 4/20/22, at 10:24 a.m. human resources representative (HR) stated the facility had at least four or five DONs over the previous two years with large gaps in between, therefore performance reviews were likely not completed.<br><br>An excerpt from the facility handbook (undated) indicated staff would receive performance reviews at a time consistent with their position. The manager would review the job progress within the company and help you set new job performance goals. New employees would also be reviewed at the end of their introductory period.<br><br>Policies pertaining to specific review schedules were requested but not provided. | F 730 | reviews are being completed that are due. Results will be shared with the facility QAPI Committee for input on the need to increase, decrease, or discontinue the audits | |
| F 812 SS=E | Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2)<br><br>§483.60(i) Food safety requirements.<br>The facility must -<br><br>§483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities.<br>(i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations.<br>(ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices.<br>(iii) This provision does not preclude residents from consuming foods not procured by the facility.<br><br>§483.60(i)(2) - Store, prepare, distribute and | F 812 | | 6/20/22 |

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| F 812 | Continued From page 3<br>serve food in accordance with professional standards for food service safety.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview, and document review, the facility failed to consistently monitor dish machine temperatures to ensure proper sanitation of dishware to prevent the potential for food-borne illness and could affect 21 of 22 residents who received meals prepared and served by the facility.<br><br>Findings include:<br><br>Review of the Food Code 2017 included, "Adequate cleaning and sanitization of dishes and utensils using a ware-washing machine is directly dependent on the exposure time during the wash, rinse, and sanitizing cycles. Failure to meet manufacturer and Code requirements for cycle times could result in failure to clean and sanitize. For example, high temperature machines depend on the buildup of heat on the surface of dishes to accomplish sanitization. If the exposure time during any of the cycles is not met, the surface of the items may not reach the time-temperature parameter required for sanitization. Contact time is also important in ware-washing machines that use a chemical sanitizer since the sanitizer must contact the items long enough for sanitization to occur. In addition, a chemical sanitizer will not sanitize a dirty dish; therefore, the cycle times during the wash and rinse phases are critical to sanitization."<br><br>The Dish Machine Temperature Log Sheet (undated) identified the wash cycle temperatures should be a minimum of 150 degrees Fahrenheit (°F) and the Rinse temperatures should be a | F 812 | F812 Food Procurement, Store, Prepare, Serve-Sanitary<br>Immediate Corrective Action:<br>Dishwasher Temp log was placed immediately to monitor temperatures of dish runs.<br><br>Corrective Action as it applies to others:<br>Culinary staff educated on use of dish machine temperature log.<br>Facility will ensure dish temps are being recorded per policy.<br><br>Date of Compliance: 6/20/220<br>Recurrence will be prevented by:<br>Audits that dish wash temperatures are recorded appropriately will be conducted weekly x 4 weeks and then monthly x 2 months to assure temps are being recorded and dish machine is running at the correct temps. Results will be shared with the facility QAPI Committee for input on the need to increase, decrease, or discontinue the audits | |

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| F 812 | Continued From page 4 | F 812 | | |

minimum of 180°F.

During interview on 4/19/22, at 10:41 a.m. director of dietary services (DDS) stated the dish washing machine temperature gauge should indicate 155-160°F during the wash cycle and 180°F or more for the rinse cycle. Upon review of the Dish Machine Temperature Log Sheets, DDS acknowledged the undated form, presumably for 4/2022, lacked temperature reading for 48 of 58 meals and indicated a temperature of less than 180°F for 2 of the 8 documented rinse temperatures. DDS stated temperatures needed to be documented at each meal to identify if the the machine sanitized properly and to ensure it was clean and safe for everyone to use and prevent foodborne illness. He stated he was not sure why the log was not completed, and suggested the kitchen staff ran out of the log forms when he was not onsite in previous weeks.

During interview on 4/20/22, at 11:59 a.m. corporate culinary certified dietary manager stated the facility had a high temperature dish machine and staff should be monitoring it every meal and writing the temperatures in the logbook. She stated if they noted low temperatures, they needed to stop using it and use other means of sanitation or disposables until fixed. She stated if temperature documentation was missing staff needed to be trained to complete it to ensure proper sanitation of dishware.

The AM Select Dishwashers Instructions dated 10/2010, indicated the minimum wash temperature was 150°F and the minimum rinse temperature was 180° F.

The facility policy Dishwashing Machine Use

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| F 812 | Continued From page 5<br>dated 3/2010, indicated dishwashing machines that use hot water to sanitize must maintain a wash solution temperature of 150°F for stationary rack, dual temperature machines and rinse temperature of 180°F for all machines other than stationary rack, single temperature machines. | F 812 | | |
| F 882 SS=C | Infection Preventionist Qualifications/Role<br>CFR(s): 483.80(b)(1)-(4)(c)<br><br>§483.80(b) Infection preventionist<br>The facility must designate one or more individual(s) as the infection preventionist(s) (IP)(s) who are responsible for the facility's IPCP. The IP must:<br><br>§483.80(b)(1) Have primary professional training in nursing, medical technology, microbiology, epidemiology, or other related field;<br><br>§483.80(b)(2) Be qualified by education, training, experience or certification;<br><br>§483.80(b)(3) Work at least part-time at the facility; and<br><br>§483.80(b)(4) Have completed specialized training in infection prevention and control.<br><br>§483.80 (c) IP participation on quality assessment and assurance committee.<br>The individual designated as the IP, or at least one of the individuals if there is more than one IP, must be a member of the facility's quality assessment and assurance committee and report to the committee on the IPCP on a regular basis.<br>This REQUIREMENT is not met as evidenced by:<br>Based on interview and document review, the | F 882 | F882- Infection Preventionist | 6/20/22 |

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| **THE ESTATES AT EXCELSIOR LLC** | **515 DIVISION STREET EXCELSIOR, MN 55331** |

| (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 |
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| F 882 | Continued From page 6<br>facility failed to ensure the acting infection preventionist (IP) had completed specialized training in infection prevention and control. This had the potential to affect all 22 residents who resided at the facility.<br><br>Findings include:<br><br>An interview on 4/20/22, at 2:18 p.m. the interim director of nursing (DON) verified she was working in the IP role, but had no specialized training in infection control. The DON further stated the corporate IP comes to the facility to help.<br><br>An interview on 4/20/22, at 2:45 p.m. the administrator stated the corporate IP was supposed to be in facility this week. The administrator further stated she was not sure when he had been out last to the building as he does cover 42 facilities.<br><br>A schedule of time the corporate IP was in the facility was requested but was not received.<br><br>A facility policy titled directed the infection control program was coordinated and overseen by the IP. Furthermore, the IP in conjunction with the facility quality team was responsible for reviewing data, identify trends, and update policies. | F 882 | Qualifications/Role<br>Immediate Corrective Action:<br>Infection Preventionist has been completed and is specialized in training in infection prevention and control.<br>Corrective Action as it applies to others:<br>Interim DON who was hired has the proper Infection control education completed.<br>When a new DON or interim is assigned facility will ensure they have the education completed.<br>Infection Preventionist will continue to assist at The Estates of Excelsior for infection prevention and control process and procedures.<br><br>Date of Compliance: 6/20/22<br>Recurrence will be prevented by:<br>Director of Nursing/Designee will be responsible for conducting audits weekly x4 and then monthly x2. Audit results will be reviewed by the QAPI committee for further review and recommendations. | |
| F 883 SS=B | Influenza and Pneumococcal Immunizations<br>CFR(s): 483.80(d)(1)(2)<br><br>§483.80(d) Influenza and pneumococcal immunizations<br>§483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that-<br>(i) Before offering the influenza immunization, | F 883 | | 6/20/22 |

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| F 883 | Continued From page 7<br>each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization;<br>(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;<br>(iii) The resident or the resident's representative has the opportunity to refuse immunization; and<br>(iv)The resident's medical record includes documentation that indicates, at a minimum, the following:<br>(A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and<br>(B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal.<br><br>§483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that-<br>(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;<br>(ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized;<br>(iii) The resident or the resident's representative has the opportunity to refuse immunization; and<br>(iv)The resident's medical record includes documentation that indicates, at a minimum, the | F 883 | | |

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| F 883 | Continued From page 8<br>following:<br>(A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and<br>(B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal.<br>This REQUIREMENT is not met as evidenced by:<br>Based on interview and document review, the facility failed to ensure education regarding the benefits and potential side effects of influenza vaccine was provided and/or an influenza vaccination was offered for 4 of 5 residents (R2, R7, R17, R21) reviewed for immunizations.<br><br>Findings include:<br><br>R2's quarterly Minimum Data Set (MDS) dated 3/29/22, indicated R2 was cognitively intact and had diagnoses of dementia, high blood pressures, and diabetes.<br><br>R2's immunization audit report dated 10/18/21, indicated R2 had received the influenza vaccine. The report further indicated in section titled education given, "no" was documented.<br><br>R7's quarterly MDS dated 1/18/22, indicated R7 was cognitively impaired and had diagnoses of Alzheimer's disease and vascular disease.<br><br>R7's medical record lacked evidence R7 was offered an influenza vaccine or educated on the risks or benefits for 2021.<br><br>R17's quarterly MDS dated 2/18/22, indicated | F 883 | F883- Influenza and Pneumococcal Immunizations<br>Immediate Corrective Action:<br>R2, R7, R17 and R21 have had education regarding the benefits and potential side effects of the influenza vaccine.<br>Corrective Action as it applies to others:<br>Residents will have education regarding the benefits and potential side effects of the influenza vaccine during Influenza season.<br><br>Date of Compliance: 6/20/22<br>Recurrence will be prevented by:<br>DON or designee will complete audits weekly x4 and then monthly x2 to ensure all residents are educated on side effects of vaccines. Audit results will be reviewed by QAPI Committee for further recommendations. | |

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| F 883 | Continued From page 9<br>R17 was cognitively impaired and had diagnoses of dementia, high blood pressure, and cancer.<br><br>R17's immunization audit report dated 10/18/21, indicated R2 had received the influenza vaccine. The report further indicated in section titled education given, "no" was documented.<br><br>R21's quarterly MDS dated 3/11/22, indicated R21 was cognitively intact and had diagnoses of delusional disorders, high blood pressure, and kidney disease.<br><br>R21's immunization audit report dated 10/18/22, indicated R21 had refused the influenza vaccine. The report further indicated in section titled education given, "no" was documented.<br><br>During an interview on 4/20/22, at 1:37 p.m. registered nurse (RN)-A stated the care coordinator or director of nursing (DON) completed education and obtained consent with the residents before vaccines were ordered. The orders were placed and then nursing gave the vaccine. RN-A further verified no education handouts were given to residents when a vaccine was administered.<br><br>During an interview on 4/20/22, at 1:45 p.m. the interim DON stated she expected an assessment of vaccine status to be completed upon admission and during influenza season for all residents. A vaccine needed to be offered to any resident who was due. Furthermore, the DON stated nurses should provide education to residents when the vaccine was administered, but was not sure how the prior DON's process was. The interim DON verified the process was not ideal and verified no benefits/risk of side effect | F 883 | | |

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| F 883 | Continued From page 10<br>documentation was found for R2, R7, R17 and R21.<br><br>A facility policy titled Influenza and Influenza like Illness revised 12/8/21, directed prior to vaccination, the resident or resident representative are provided information and education regarding benefits and potential side effects of the vaccine. The education will be documented in the resident's medical record. | F 883 | | |

*P r o t e c t i n g , M a i n t a i n i n g a n d I m p r o v i n g t h e H e a l t h o f A l l M i n n e s o t a n s*

Electronically delivered
May 11, 2022

Administrator
The Estates At Excelsior LLC
515 Division Street
Excelsior, MN 55331

Re: State Nursing Home Licensing Orders
Event ID: A2JK11

Dear Administrator:

The above facility was surveyed on April 18, 2022 through April 20, 2022 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

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

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html. The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the

"Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute or rule after the statement, "This MN Requirement is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

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

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

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

Jamie Perell, Unit Supervisor
Metro B District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
85 East Seventh Place, Suite 220
P.O. Box 64900
Saint Paul, Minnesota 55164-0900
Email: jamie.perell@state.mn.us
Office: (651) 245-8094

You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.

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

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program

Health Regulation Division
Telephone: (651) 201-4112  Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

Minnesota Department of Health

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 00988 | A. BUILDING: ______ B. WING ______ | C 04/20/2022 |

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| 2 000 | Initial Comments | 2 000 | | |

*****ATTENTION******

NH LICENSING CORRECTION ORDER

In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected.

You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.

INITIAL COMMENTS:
On 4/18/22, through 4/20/22, a standard licensing survey was conducted completed at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was found NOT in compliance with the MN State Licensure. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the

Minnesota Department of Health

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| 2 000 | Continued From page 1<br>date when they will be completed.<br><br>The following complaints were found to be UNSUBSTANTIATED:<br>H5332079C/ MN00082495,<br>H5332080C/MN00082214,<br>H5332081C/MN0007622,<br>H5332082C/MN00075966<br><br>Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyor ' s findings are the Suggested Method of Correction and Time Period for Correction.<br><br>You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm. The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "CORRECTED" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to | 2 000 | | |

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| 2 000 | Continued From page 2<br>the Minnesota Department of Health. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form.<br><br>PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. | 2 000 | | |
| 21015 | MN Rule 4658.0610 Subp. 7 Dietary Staff Requirements- Sanitary conditi<br><br>Subp. 7. Sanitary conditions. Sanitary procedures and conditions must be maintained in the operation of the dietary department at all times.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and document review, the facility failed to consistently monitor dish machine temperatures to ensure proper sanitation of dishware to prevent the potential for food-borne illness and could affect 21 of 22 residents who received meals prepared and served by the facility.<br><br>Findings include:<br><br>Review of the Food Code 2017 included, "Adequate cleaning and sanitization of dishes and utensils using a ware-washing machine is directly dependent on the exposure time during the wash, rinse, and sanitizing cycles. Failure to meet manufacturer and Code requirements for cycle times could result in failure to clean and sanitize. | 21015 | Corrected | 6/20/22 |

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| 21015 | Continued From page 3 | 21015 | | |

For example, high temperature machines depend on the buildup of heat on the surface of dishes to accomplish sanitization. If the exposure time during any of the cycles is not met, the surface of the items may not reach the time-temperature parameter required for sanitization. Contact time is also important in ware-washing machines that use a chemical sanitizer since the sanitizer must contact the items long enough for sanitization to occur. In addition, a chemical sanitizer will not sanitize a dirty dish; therefore, the cycle times during the wash and rinse phases are critical to sanitization."

The Dish Machine Temperature Log Sheet (undated) identified the wash cycle temperatures should be a minimum of 150 degrees Fahrenheit (°F) and the Rinse temperatures should be a minimum of 180°F.

During interview on 4/19/22, at 10:41 a.m. director of dietary services (DDS) stated the dish washing machine temperature gauge should indicate 155-160°F during the wash cycle and 180°F or more for the rinse cycle. Upon review of the Dish Machine Temperature Log Sheets, DDS acknowledged the undated form, presumably for 4/2022, lacked temperature reading for 48 of 58 meals and indicated a temperature of less than 180°F for 2 of the 8 documented rinse temperatures. DDS stated temperatures needed to be documented at each meal to identify if the the machine sanitized properly and to ensure it was clean and safe for everyone to use and prevent foodborne illness. He stated he was not sure why the log was not completed, and suggested the kitchen staff ran out of the log forms when he was not onsite in previous weeks.

During interview on 4/20/22, at 11:59 a.m.

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| 21015 | Continued From page 4<br>corporate culinary certified dietary manager stated the facility had a high temperature dish machine and staff should be monitoring it every meal and writing the temperatures in the logbook. She stated if they noted low temperatures, they needed to stop using it and use other means of sanitation or disposables until fixed. She stated if temperature documentation was missing staff needed to be trained to complete it to ensure proper sanitation of dishware.<br><br>The AM Select Dishwashers Instructions dated 10/2010, indicated the minimum wash temperature was 150°F and the minimum rinse temperature was 180° F.<br><br>The facility policy Dishwashing Machine Use dated 3/2010, indicated dishwashing machines that use hot water to sanitize must maintain a wash solution temperature of 150°F for stationary rack, dual temperature machines and rinse temperature of 180°F for all machines other than stationary rack, single temperature machines.<br><br>SUGGESTED METHOD OF CORRECTION: The administrator, certified dietary manager, or designee could develop, review, and/or revise policies and procedures to ensure dishwasher temperatures were maintained, educate staff regarding policies and procedures, and develop monitoring systems to ensure ongoing compliance.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days. | 21015 | | |
| 21426 | MN St. Statute 144A.04 Subd. 3 Tuberculosis Prevention And Control | 21426 | | 6/20/22 |

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| 21426 | Continued From page 5<br>(a) A nursing home provider must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in CDC's Morbidity and Mortality Weekly Report (MMWR). This program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, residents, and volunteers. The Department of Health shall provide technical assistance regarding implementation of the guidelines.<br><br>(b) Written compliance with this subdivision must be maintained by the nursing home.<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and document review the facility failed to ensure screening for tuberculosis (TB) risk factors and symptoms according to the Centers for Disease Control & Prevention (CDC) guidelines was completed for 5 of 5 residents (R2, R7, R8, R9, R17) reviewed for TB prevention and management. Further, the facility failed to ensure TB history and symptom screening, a two-step tuberculin skin test (TST), TB blood test, or a chest x-ray was completed for 3 of 5 staff (DA-A, RN-A) per CDC guidelines. This had the potential to affect all 22 residents who resided at the facility.<br><br>Findings include: | 21426 | corrected | |

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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) COMPLETE DATE |
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| 21426 | Continued From page 6 | 21426 | | |

The Facility Tuberculosis (TB) Risk Assessment Instructions and Worksheet for Health Care Settings Licensed by MDH (Minnesota Department of Health)* dated by facility staff on 8/18/21, indicated baseline screening for TB included assessing for current symptoms of active TB disease, TB history, and testing for the presence of infection with by administering a two-step TST or single blood test.

The Facility TB Risk Assessment Worksheet for Health Care Settings Licensed by MDH (Minnesota Department of Health)* dated 8/18/21, indicated baseline TB screening of all health care personnel, including staff who worked in nursing and culinary departments, was required at time of hire. The document also identified baseline TB screening was required for all residents at time of admission.

R2's Admission Record dated 4/20/22, indicated R2's admission date was October 2020.
R7's Admission Record dated 4/20/22, indicated R7's admission date was July 2019.
R8's Admission Record dated 4/20/22, indicated R7's admission date was July 2021.
R9's Admission Record dated 4/20/22, indicated R7's admission date was January 2021.
R17's Admission Record dated 4/20/22, indicated R7's admission date was July 2021.

The Order Summary Reports for R2, R7, R8, R9, and R17, dated 4/20/22, each included an order for Standing Orders: May Use Standing Orders per the facility's corporate policy.

The facility Standing Orders for Skilled Nursing Facilities dated 1/2021, directed staff to administer two-step Mantoux (TST) unless history

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|---|---|---|---|
| | 00988 | A. BUILDING: ___ B. WING ___ | C 04/20/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| **THE ESTATES AT EXCELSIOR LLC** | **515 DIVISION STREET EXCELSIOR, MN 55331** |

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| 21426 | Continued From page 7<br>of TB or positive PPD (TST).<br><br>The medical records of R2, R7, R8, R9, and R17 lacked evidence of assessment of baseline TB risk factors and symptom screening was completed.<br><br>An unnamed facility staff list (undated) identified dietary aide (DA)-A was hired on 7/20/21. DA-A's TB Baseline Screening Tool for Health Care Worker dated 7/20/21, indicated he completed step one of a two-step TST on 7/23/21. The record lacked documentation of a second-step TST.<br><br>An unnamed facility staff list (undated) identified registered nurse (RN)-A was hired on 8/7/19. RN-A's TB Baseline Screening Tool for Health Care Worker dated 8/7/19, lacked evidence of TB symptom and history screening.<br><br>During interview on 4/20/22, at 1:05 p.m. RN-C stated staff should not be providing resident care until the results of the first step pf the TST are known. She stated if they had a previous TST, TB blood test, or chest x-ray during the months prior to hire, those results should be maintained in the employee record.<br><br>During interview on 4/20/22, at 1:07 p.m. director of nursing (DON) stated residents had orders for a two-step TST upon admission. Upon review of the electronic order, DON confirmed the standing nursing order directed staff to "Administer [tuberculin skin test] per Manufacturer Directions. Complete MHM-TB symptom and Hx [history] evaluation version 2 form in PCC [electronic health record] and record administration/information under immunization tab." DON stated she expected staff to complete | 21426 | | |

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| 21426 | Continued From page 8 | 21426 | | |

the testing and the symptom evaluation form, and staff needed to be re-educated to complete it. DON confirmed DA-A did not have a second step TST, RN-A lacked TB history and symptom screening. She stated TB screening and testing were required to protect residents because TB is a highly infectious disease.

The Facility policy Tuberculosis Screening - Resident dated 11/20/22, indicated the facility shall perform baseline TB screening within 72 hours of admission/readmission or within 90 days prior to admission for all residents. Baseline TB screwing consists of three components, including assessing the residents risk factors and current symptoms of TB.

The facility policy Tuberculosis Screwing - Health Care Worker dated 11/20/20, indicated all paid and unpaid health care workers (HCW), prior to duty assignment in the facility, will receive baseline TB screening. The baseline screening consists of 3 components: assessing for current symptoms of active TB disease, TB history, and testing the presence of infection with Mycobacterium tuberculosis by administering either a two-step tuberculin skin test (TST) or a single Interferon Gamma Release Assay (IGRA [a TB blood test]). Further, a HCW may begin working with residents after a negative TB symptom screen AND a negative IGRA or TST dated within 90 days before. The second TST may be performed after the HCW starts working with residents. If the 2nd step is not completed within 3 weeks, the process will need to be restarted. Before first full scheduled shift with resident contact, the employee will show proof of negative Mantoux (TST) with baseline TB screening.

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| 21426 | Continued From page 9<br><br>SUGGESTED METHOD OF CORRECTION: The director of nursing or designee could review and update systems for resident and employee tuberculosis screenings. The director of nursing or designee could educate all appropriate staff and monitor to ensure ongoing compliance with tuberculosis policy and procedures.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days. | 21426 | | |

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|---|---|---|---|
| | 245332 | A. BUILDING **01 - MAIN BUILDING 01**<br>B. WING ______ | **04/20/2022** |

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| **THE ESTATES AT EXCELSIOR LLC** | **515 DIVISION STREET**<br>**EXCELSIOR, MN 55331** |

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| K 000 | INITIAL COMMENTS<br><br>FIRE SAFETY<br><br>An annual Life Safety recertification survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 04/20/2022. At the time of this survey, The Estates At Excelsior 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.<br><br>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.<br><br>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.<br><br>PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO:<br><br>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 | | 05/20/2022 |

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.

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

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|---|---|---|---|
| | **245332** | A. BUILDING **01 - MAIN BUILDING 01**<br>B. WING ______ | **04/20/2022** |

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| **THE ESTATES AT EXCELSIOR LLC** | **515 DIVISION STREET**<br>**EXCELSIOR, MN 55331** |

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| K 000 | Continued From page 1<br>Healthcare Fire Inspections<br>State Fire Marshal Division<br>445 Minnesota St., Suite 145<br>St. Paul, MN 55101-5145, OR<br><br>By email to:<br>FM.HC.Inspections@state.mn.us<br><br>THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION:<br><br>1. A detailed description of the corrective action taken or planned to correct the deficiency.<br><br>2. Address the measures that will be put in place to ensure the deficiency does not reoccur.<br><br>3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained.<br><br>4. Identify who is responsible for the corrective actions and monitoring of compliance.<br><br>5. The actual or proposed date for completion of the remedy.<br><br>The Estates at Excelsior is a 1-story building with a partial basement that was built in 1962 and was determined to be of Type II(222) construction. The facility is divided into four smoke compartments. This facility is fully protected throughout by an automatic fire sprinkler system and has a fire alarm system with smoke detection in the corridors and spaces open to the corridors, that are monitored for automatic fire department notification. | K 000 | | |

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| | 245332 | A. BUILDING **01 - MAIN BUILDING 01**<br>B. WING ______ | **04/20/2022** |

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| K 000 | Continued From page 2<br>The facility has a capacity of 56 beds and had a census of 21 at the time of the survey.<br><br>The requirements at 42 CFR, Subpart 483.70(a), are NOT MET as evidenced by: | K 000 | | |
| K 914<br>SS=C | Electrical Systems - Maintenance and Testing<br>CFR(s): NFPA 101<br><br>Electrical Systems - Maintenance and Testing<br>Hospital-grade receptacles at patient bed locations and where deep sedation or general anesthesia is administered, are tested after initial installation, replacement or servicing. Additional testing is performed at intervals defined by documented performance data. Receptacles not listed as hospital-grade at these locations are tested at intervals not exceeding 12 months. Line isolation monitors (LIM), if installed, are tested at intervals of less than or equal to 1 month by actuating the LIM test switch per 6.3.2.6.3.6, which activates both visual and audible alarm. For LIM circuits with automated self-testing, this manual test is performed at intervals less than or equal to 12 months. LIM circuits are tested per 6.3.3.3.2 after any repair or renovation to the electric distribution system. Records are maintained of required tests and associated repairs or modifications, containing date, room or area tested, and results.<br>6.3.4 (NFPA 99)<br>This REQUIREMENT is not met as evidenced by:<br>Based on a review of available documentation and staff interview, the facility failed to test and inspect electrical receptacles in resident sleeping rooms per NFPA 99 (2012 edition), Health Care Facilities Code, sections 6.3.4.1.3 and 6.3.3.2.1 through 6.3.3.2.4. This deficient finding could | K 914 | K914- Electrical Systems:<br>Immediate Corrective Action:<br>The correct form was immediately put into place.<br>Corrective Action as it applies to others:<br>Facility will utilize all recommended and | 6/20/22 |

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| K 914 | Continued From page 3<br>have a widespread impact on the residents within the facility.<br><br>Findings include:<br><br>On 04/20/2022, between 10:00 AM and 12:30 PM, it was revealed by a review of available documentation that the test and inspection records for the receptacles at patient bed locations did not indicate visual, physical integrity, or continuity of grounding was performed.<br><br>An interview with the Regional Director of Facility Maintenance verified this deficient finding at the time of discovery. | K 914 | required forms for the life safety book.<br><br>Date of Compliance: 6/20/22<br>Recurrence will be prevented by:<br>FMD or designee will audit weekly x4 and then monthly x2 to ensure all residents are educated on side effects of vaccines. Audit results will be reviewed by QAPI Committee for further recommendations. | |