Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
August 26, 2024

Administrator
Barrett Care Center Inc
800 Spruce Avenue
Barrett, MN 56311

RE: CCN: 245575
Cycle Start Date: August 15, 2024

Dear Administrator:

On August 15, 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, Regional Operations Supervisor
St. Cloud B District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
4140 Thielman Lane
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 November 15, 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 February 15, 2025 (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,

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245575	A. BUILDING _____ B. WING _____	C 08/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BARRETT CARE CENTER INC	800 SPRUCE AVENUE BARRETT, MN 56311

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E 000	Initial Comments On 8/12/24 through 8/15/2024, a survey for compliance with Appendix Z, Emergency Preparedness Requirements, §483.73 was conducted during a standard recertification survey. The facility was IN compliance. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	E 000		
F 000	INITIAL COMMENTS On 8/12/2024 through 8/15/2024, 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 complaint was reviewed with NO deficiencies cited: H55754222 (MN101204). 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 568 SS=D	Accounting and Records of Personal Funds CFR(s): 483.10(f)(10)(iii)	F 568		9/3/24

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

Electronically Signed | 08/30/2024

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

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F 568	Continued From page 1 §483.10(f)(10)(iii) Accounting and Records. (A) The facility must establish and maintain a system that assures a full and complete and separate accounting, according to generally accepted accounting principles, of each resident's personal funds entrusted to the facility on the resident's behalf. (B) The system must preclude any commingling of resident funds with facility funds or with the funds of any person other than another resident. (C)The individual financial record must be available to the resident through quarterly statements and upon request. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure resident trust account statements were provide on at least a quarterly basis for 1 of 1 residents (R8) reviewed for personal fund accounts. Findings include: R8's quarterly minimum data set (MDS) dated 4/2/24, indicate R8 was cognitively intact. During interview on 8/14/24 at 12:52 p.m., R8 stated she did not receive any kind of statements from the facility. R8 stated she made her own decisions, but her daughter took care of the bills. R8 then called her daughter on speaker phone and asked if she received any financial statements from the facility. R8's daughter stated she received monthly billing statements, however, she did not receive a statement for R8's personal funds account. During interview on 8/14/24 at 1:11 p.m.,	F 568	The allegation of compliance is met as evidence by the following: All Resident trust statements will be mailed out to Residents/Representative every quarter starting on 9/03/2024 and each subsequent quarter following. An audit will be completed 1 time following statements being sent out to assure compliance. This will be presented to the QAPI committee for review and ongoing compliance. Person responsible: Office Manager	

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F 568	Continued From page 2 business office manager (BM) stated the facility had a separate account set up for personal funds. BM stated bank statements were sent to her and she would balance each personal account against the bank statements. BM stated she used an excel spreadsheet to track resident personal fund accounts and cognitive residents who wanted to know their balance could ask her for that information. BM went on to state if a resident requested a statement, she would print it but did not routinely provide personal account statements to residents or families. Facility policy Resident Personal Funds indicated to comply with regulations regarding the management of resident personal funds the facility will set as a fiduciary of the residents' funds and hold, safeguard, manage, and account for the personal funds of the residents' funds. The policy further indicated records of receipts, disbursements, balances, and notices would be open to the resident or guardian or Department of Health upon request. The policy lacked information on frequency of issuing statements.	F 568		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention	F 880		9/3/24

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F 880	Continued From page 3 and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed	F 880		

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F 880	Continued From page 4 by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure proper handwashing and glove usage was implemented for 1 of 1 resident (R16) observed for wound cares. Findings include: R16's face sheet dated 8/14/24, identified diagnoses including hereditary spastic paraplegia (genetic inability to move limbs/body), neuromuscular dysfunction of the bladder (bladder dysfunction-requires catheterization), weakness, and dementia. R16's quarterly minimum data set (MDS) dated 7/9/24, identified R16 had moderate cognitive impairment, and was completely dependent for mobility and self-cares. R16's Order Summary Report dated 8/15/24, indicated wound care orders for a stage three pressure ulcer to the coccyx (lower back-area just	F 880	The allegation of compliance is met as evidence by the following: RN-B and NA-A were re-educated on hand hygiene, review of policy and procedure for hand hygiene also completed with all staff on 9/11/2024. Audits for following policy and procedure for hand hygiene are being conducted by ADON, Inservice RN, and DON to assure hand hygiene is completed at appropriate times during resident cares. Random audits will continue for 8 weeks. Audit findings will be reviewed by the QAPI committee to ensure ongoing compliance. Person Responsible: Director of Nursing	

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F 880	Continued From page 5 above buttocks) which stated the following: Cleanse with wound cleaner, apply skin prep to peri wound and apply a foam bordered dressing 3x (3 times) a week and as needed (PRN). On 8/14/24 at 11:48 a.m., registered nurse (RN)-B completed a dressing change on R16's wound site. RN-B was wearing gloves and removed the soiled dressing from R16's wound. RN-B did not change gloves or perform hand hygiene. RN-B proceeded to apply wound cleaner and cleaned the wound with soiled gloves. After cleansing of the wound, RN-B removed gloves and preformed hand hygiene. RN-B placed the new dressing. RN-B removed gloves, however, did not preform hand hygiene. The wound was covered. RN-B turned R16 on to their back and placed a clean split gauze over R16's super pubic catheter site (open area in the pelvic skin that allows for the catheter to pass to the bladder instead of through the urethra) prior to performing hand hygiene or donning gloves.. On 8/14/24 at 12:06 p.m., nursing assistant (NA)-A, who had been assisting RN-B with R16 dressing change, removed their gown and gloves. NA-A exited the room with the resident and assisted R16 to the dining room to eat lunch, however NA-A did not preform hand hygiene after providing resident cares. On 8/14/24 at 12:07 p.m., RN-B stated staff were expected to wash hands when entering or exiting a room, taking off gloves, hands are visibly soiled, and doing cares. RN-B stated they had not worn gloves because the tape used to secure the gauze stuck to the gloves. RN-B stated they should have completed hand hygiene every time gloves were removed.	F 880		

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F 880	Continued From page 6 On 8/14/24 at 12:09 p.m., NA-A stated they were expected to wash hands when entering or exiting a room, taking off gloves, and doing cares. NA-A stated they had brought the resident to the dining room and had washed their hands after exiting the dining room. NA-A confirmed they should have washed their hands prior to exiting the resident's room. On 8/14/24 at 12:34 p.m., the infection preventionist (RN)-A stated staff were expected to wash their hands after cares, taking off gloves, during dressing changes, and when hands were visibly soiled. RN-A confirmed during dressing changes, after removing gloves, and when leaving the resident's room, hand hygiene should have been completed to prevent the spread of infection. On 8/15/24 at 09:49 a.m., the director of nursing (DON) (O)-A expected staff to preform hand hygiene before and after cares, and when visibly soiled. The DON confirmed hand hygiene should have been completed after removing the soiled dressings during a dressing change and before moving to a different site to prevent the spread of infection. Further, hand hygiene should have been performed prior to exiting a resident's room. The undated Standard Precaution-Hand Hygiene Policy indicated the following: Hand hygiene should be preformed during the, but not limited to the following situations: -Coming on duty -When hands are visibly soiled -Before and after: Direct resident contact	F 880		

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F 880	Continued From page 7 Performing invasive procedures Entering isolation settings Eating or handling food Assisting residents with meals Assisting resident with personal cares Inserting indwelling catheters Handing catheters and invasive devices Changing a dressing Assisting a resident with toileting	F 880		

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K 000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety Code recertification survey was conducted on 08/13/2024 by the Minnesota Department of Public Safety, Fire Marshal Division. At the time of this survey, Barrett Care Center Bldg 01 was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care 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 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. IF OPTING TO USE AN EPOC, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K TAGS) TO:	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		08/30/2024

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

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K 000	Continued From page 1 HEALTH CARE FIRE INSPECTIONS STATE FIRE MARSHAL DIVISION 445 MINNESOTA STREET, SUITE 145 ST. PAUL, MN 55101-5145, or By e-mail 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. Barrett Care Center is a 1-story building with a partial basement. The original building was constructed in 1967, has a partial basement, and was determined to be of Type II(111) construction with monolithic ceilings throughout. In 1982, additions were added to the south of the dining room and to the east wing that is not separated from the original building and was determined to be of Type II(111) construction. In 2000 an addition was constructed to the West Wing for	K 000		

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K 000	Continued From page 2 administration offices and PT that was determined to be Type V(111) construction. In 2002 an addition was constructed to the North Wing is Type II (111) construction. The building is fully sprinkler protected and has a manual fire alarm system with smoke detection in the corridors of the 1982 edition, at all cross corridor doors that are held open, and in spaces open to the corridors and common living areas that is monitored for automatic fire department notification. The facility has a capacity of 45 beds and had a census of 36 at the time of the survey. The requirements at 42 CFR, Subpart 483.70(a) are NOT MET as evidenced by:	K 000		
K 000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety Code recertification survey was conducted on 08/13/2024 by the Minnesota Department of Public Safety, Fire Marshal Division. At the time of this survey, Barrett Care Center Bldg 02 was found NOT in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care 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	K 000		

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	245575	A. BUILDING **01, 02** B. WING _____	**08/13/2024**

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K 000	Continued From page 3 SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. IF OPTING TO USE AN EPOC, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K TAGS) TO: HEALTH CARE FIRE INSPECTIONS STATE FIRE MARSHAL DIVISION 445 MINNESOTA STREET, SUITE 145 ST. PAUL, MN 55101-5145, or By e-mail 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	K 000		

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K 000	Continued From page 4 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. Barrett Care Center Bldg 2 In 2015 an addition (bldg 2) was constructed off the northeast corner and is a one-story building with no basement. This wing consists of 6 resident rooms and office spaces. The building construction was determined to be of Type V (III) construction and is separated by a two-hour fire barrier. This building is sprinkled throughout and has smoke detectors in the corridors spaces open to the corridors and sleeping rooms. The facility has a capacity of 45 beds and had a census of 36 at the time of the survey. The requirements at 42 CFR, Subpart 483.70(a) are NOT MET as evidenced by:	K 000		
K 321 SS=F	Hazardous Areas - Enclosure CFR(s): NFPA 101 Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting	K 321		8/27/24

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K 321	Continued From page 5 partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain doors to hazardous rooms per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.2.1 and 7.2.1.15 and 7.2.1.15.8. These deficient findings could have a widespread impact on the residents within the facility. Findings include: On 08/13/2024 between 9:15 and 11:15 AM, it was revealed by observation that the doors to the following hazardous areas did not latch properly when closed: Storage N-3, Linen N, and Storage E-2.	K 321	The allegation of compliance is met as evidence by the following: On 8/16/2024 all doors including Storage N-3, Linen N, and Storage E-2 were fixed and springs were tightened and replaced to ensure the complete closure of all doors. All doors within the building will be checked monthly and ongoing as a part of our maintence program and to ensure compliance. The findings will be reviewed at the quarterly QA meeting. Person responsible: Maintenance Director	

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K 321	Continued From page 6 An interview with the Administrator and Maintenance Director verified these deficient findings at the time of discovery.	K 321	and Administrator	
K 353 SS=E	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, review of available documentation, and staff interview, the facility failed to maintain the fire sprinkler system per NFPA 101 (2012 edition), Life Safety Code, section 9.7.5, and NFPA 25 (2011 edition), Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, sections 4.7, 5.2.1.1.1, and 5.2.1.1.2(5). These deficient findings could a patterned impact on residents within the facility.	K 353	The allegation of compliance is met as evidence by the following: On 8/26/2024 The 3 sprinker heads in the Furnace room and the 2 sprinkler heads in the tub room were cleaned and the lint was removed from the sprinkler heads. The 1 escutcheon plate was replaced in the older section of the building. All sprinler heads will be checked monthly to assure that all sprinkler heads are free	8/27/24

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K 353	Continued From page 7 Findings include: 1. On 08/13/2024 between 9:15 and 11:15 AM it was revealed by observation that there was a build-up of lint on two sprinkler heads in the Therapy Tub Room, and 3 sprinkler heads in the Furnace Room in the basement. 2. On 08/13/2024 between 9:15 and 11:15 AM it was revealed by observation that an escutcheon plate was missing from a sprinkler head in the older section of the building by the smoke barrier door separating the older section of the building from the 2015 addition. An interview with the Administrator and Maintenance Director verified these deficient findings at the time of discovery.	K 353	from lint and in good working order and all parts are present and to ensure compliance ongoing. The findings will be reviewed at the quarterly QA meeting. Person responsible: Maintenance Director and Administrator	
K 374 SS=D	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 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:	K 374		8/27/24

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K 374	Continued From page 8 Based on observation and staff interview, the facility failed to maintain 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 an isolated impact on the residents within the facility. Findings include: On 08/13/2024 between 9:15 and 11:15 AM, it was revealed by observation that the smoke barrier doors between the dining room and hallway did not close completely leaving a gap between the door leaves when released from the magnetic hold-open device. An interview with the Administrator and Maintenance Director verified this deficient finding at the time of discovery.	K 374	The allegation of compliance is met as evidence by the following: On 8/16/2024 The door that creates a smoke barrier between the dining room and hallway was fixed and springs were tightened with stripping to ensure the complete closure of door when released from magnetic hold-open device. All doors within the building will be checked monthly and ongoing as a part of our maintence program and to ensure compliance. The findings will be reviewed at the quarterly QA meeting. Person responsible: Maintenance Director and Administrator	
K 374 SS=D	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 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	K 374		8/27/24

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K 374	Continued From page 9 by: Based on observation and staff interview, the facility failed to maintain 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 an isolated impact on the residents within the facility. Findings include: On 08/13/2024 between 9:15 and 11:15 AM, it was revealed by observation that the smoke barrier doors between the 2015 addition and the older building did not close completely leaving a gap between the door leaves when released from the magnetic hold-open device. An interview with the Administrator and Maintenance Director verified this deficient finding at the time of discovery.	K 374	The allegation of compliance is met as evidence by the following: On 8/16/2024 The door that creates a smoke barrier and 2015 addition was fixed and springs were tightened with stripping to ensure the complete closure of door. All doors within the building will be checked monthly and ongoing as a part of our maintence program and to ensure compliance ongoing. The findings will be reviewed at the quarterly QA meeting. Person responsible: Maintenance Director and Administrator	
K 918 SS=F	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test	K 918		8/26/24

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K 918	Continued From page 10 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 a review of available documentation and staff interview, the facility failed to maintain generators per NFPA 99 (2012 edition), Health Care Facilities Code, section 6.4.4.1.1.3, and NFPA 110 (2010 edition), Standard for Emergency and Standby Power Systems, sections 8.3, 8.3.4.1, and 8.4.1. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 08/13/2024 between 9:15 and 11:15 AM, it was revealed by a review of available documentation that at the time of the survey the facility could not provide documentation showing that weekly inspections of the emergency generator occurred from April 2-May 5, and May	K 918	The allegation of compliance is met as evidence by the following: On 8/16/2024 The door that creates a smoke barrier and 2015 addition was fixed and springs were tightened with stripping to ensure the complete closure of door. All doors within the building will be checked monthly and ongoing as a part of our maintence program to ensure compliance. The findings will be reviewed at the quarterly QA meeting. Person responsible: Maintenance Director and Administrator	

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K 918	Continued From page 11 7-August 13 of 2024. An interview with the Administrator and Maintenance Director verified this deficient finding at the time of discovery.	K 918	The documentation was presented and emailed to Fire Marshall that did include and verify that the Generator tests were in fact performed during the specified timeframe that was required weekly inspections were performed April 2- May 5 and May 7-August 13 of 2024.	
K 918 SS=F	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and	K 918		8/26/24

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K 918	Continued From page 12 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 a review of available documentation and staff interview, the facility failed to maintain generators per NFPA 99 (2012 edition), Health Care Facilities Code, section 6.4.4.1.1.3, and NFPA 110 (2010 edition), Standard for Emergency and Standby Power Systems, sections 8.3, 8.3.4.1, and 8.4.1. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 08/13/2024 between 9:15 and 11:15 AM, it was revealed by a review of available documentation that at the time of the survey the facility could not provide documentation showing that weekly inspections of the emergency generator occurred from April 2-May 5, and May 7-August 13 of 2024. An interview with the Administrator and Maintenance Director verified this deficient finding at the time of discovery.	K 918	The allegation of compliance is met as evidence by the following: On 8/16/2024 The door that creates a smoke barrier and 2015 addition was fixed and springs were tightened with stripping to ensure the complete closure of door. All doors within the building will be checked monthly and ongoing as a part of our maintenance program and to ensure ongoing compliance. The findings will be reviewed at the quarterly QA meeting. Person responsible: Maintenance Director and Administrator The documentation was presented and emailed to Fire Marshall that did include and verify that the Generator tests were in fact performed during the specified timeframe that was required weekly inspections were performed April 2- May 5 and May 7-August 13 of 2024.	