Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
January 10, 2025

Administrator
Good Samaritan Society - Comforcare
1201 17th Street Ne
Austin, MN 55912

RE: CCN: 245317
Cycle Start Date: November 7, 2024

Dear Administrator:

On January 3, 2025, the Minnesota Departments 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.

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

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
November 26, 2024

Administrator
Good Samaritan Society - Comforcare
1201 17th Street NE
Austin, MN 55912

RE: CCN: 245317
Cycle Start Date: November 7, 2024

Dear Administrator:

On November 7, 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:

Jennifer Kolsrud Brown, RN, Regional Operations Supervisor
Rochester District Office
Health Regulation Division
Minnesota Department of Health
3425 40th Avenue NW, Suite 115
Rochester, MN 55901
Email: jennifer.kolsrud@state.mn.us
Office: (507) 206-2727

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 February 7, 2025 (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 May 7, 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)

In accordance with 42 CFR 488.331 **and Minnesota Statute 144A.10 subd 15**, 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: https://forms.web.health.state.mn.us/form/NHDisputeResolution

This request must be sent within the same ten calendar days you have for submitting an ePoC for the cited deficiencies. 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.

A copy of the Department's informal dispute resolution policies is posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

In accordance with 42 CFR § 488.431 and Minnesota Statute 144A.10 subd 16, when a CMP subject to being collected and placed in an escrow account is imposed, you have one opportunity to question cited deficiencies through an Independent IDR process. You may also contest scope and severity assessments for deficiencies which resulted in a finding of SQC or immediate jeopardy. 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:

https://forms.web.health.state.mn.us/form/NHDisputeResolution

A facility may not use both IDR and independent IDR for the same deficiency citation(s) arising from the same survey unless the IDR process was completed prior to the imposition of the CMP. This request must be sent within ten calendar days of receipt of this offer. An incomplete Independent IDR process will not delay the effective date of any enforcement action.

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

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

Feel free to contact me if you have questions.

Sincerely,

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245317	A. BUILDING _____ B. WING _____	11/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - COMFORCARE	1201 17TH STREET NE AUSTIN, MN 55912

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS On 11/4/24 to 11/7/24, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were reviewed with NO deficiencies cited: H53171002C (MN00105648) H53171005C (MN00105492) H53171003C (MN00100595) H53171004C (MN00099883) H53171006C (MN00099690). 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 582 SS=D	Medicaid/Medicare Coverage/Liability Notice CFR(s): 483.10(g)(17)(18)(i)-(v) §483.10(g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in	F 582		12/20/24

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

Electronically Signed | 12/09/2024

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 582	Continued From page 1 nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and (ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this section. §483.10(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate. (i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible. (ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change. (iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements. (iv) The facility must refund to the resident or resident representative any and all refunds due	F 582		

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F 582	Continued From page 2 the resident within 30 days from the resident's date of discharge from the facility. (v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure the Skilled Nursing Facility Advanced Beneficiary Notice-Centers for Medicare and Medicaid-10055 (SNFABN-CMS-10055) was provided to 2 of 3 residents (R99, R100) reviewed for beneficiary notices. Findings include: R99's discharge Minimum Data Set (MDS) dated 8/15/24, indicated R99 was admitted 7/8/24 and discharged 8/15/24. R99's Notice of Medicare non-coverage form CMS-10123 (NOMNC-CMS-10123), undated, indicated R99's services would end 7/29/24. However, R99 remained in the facility until 8/15/24. R99's medical record lacked evidence the SNFABN-CMS-10055 was provided to R99 or their representative as required. R100's discharge MDS dated 8/14/24, indicated R100 was admitted 7/24/24 and discharged 8/14/24. R100's NOMNC-CMS-10123, undated, indicated R100's services would end 8/12/24. However, R100 remained in the facility until 8/14/24.	F 582	Preparation and execution of this response and plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. For the purposes of any allegation that the center is not in substantial compliance with federal requirements of participation, this response and plan of correction constitutes the center's allegation of compliance in accordance with section 7305 of the State Operations Manual. F582 Medicaid/Medicare Coverage/Liability Notice 1. R99 and R100 have discharged from the facility. 2. An audit was completed of all residents who came off of skilled care, but remained in the facility for the last 3 months. There were no issues found. 3. To ensure systemic changes are sustained, the "SNF Medicare Part A Advance Beneficiary Notice of Non-Coverage" policy was reviewed with the Social Services Director and Business Office Manager. 4. Audits will be conducted by the	

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F 582	Continued From page 3 R100's medical record lacked evidence the SNFABN-CMS-10055 was provided to R100 or their legal representative as required. During interview on 11/6/24 at 10:46 a.m., social worker (SW)-A stated he had a flow sheet to aide with figuring out which forms to provide for residents prior to discharge. They stated R99 was probably provided with the NOMNC-CMS-10123 before they were aware the SNFABN-CMS-10055 also needed to be provided for residents who stayed in the facility after services ended. The discharge for R100 was delayed due to coordination with the assisted living facility R100 was being discharged too. Therefore, R100 stayed after services ended. During interview on 11/6/24 at 11:14 a.m., administrator stated the SNFABN-CMS-10055 should be given if a resident remains in the facility after being discharged from Medicare services. The administrator confirmed R99 was discharged from services on 7/29/24 and remained in the facility until 8/15/24 and the SNFABN-CMS-10055 should have been completed if Medicare days remained. The administrator confirmed R100 was discharged from services on 8/12/24 and remained in the facility until 8/14/24 and the SNFABN-CMS-10055 should have been completed if Medicare days remained. The administrator stated it was important to provide the SNFABN-CMS-10055 so residents would be aware of the private pay charges. Email provided by office manager (OM)-B sent 11/6/24 at 12:43 p.m., confirmed both R99 and R100 had remaining Medicare days when they were discharged from services.	F 582	Quality Assurance Coordinator or designee weekly x 4 and monthly x 2 to ensure ABNs are issued to residents coming off of skilled care but remaining in the facility. 5. 12/20/24	

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F 582	Continued From page 4 Facility policy titled SNF Medicare Part A Advanced Beneficiary Notice of Non-Coverage (SNFABN) included the SNFABN-CMS-10055 would be completed with the beneficiary to notify them that the extended care services would no longer be covered by Medicare before those services are provided and the beneficiary would be personally responsible for payment of services furnished.	F 582		
F 584 SS=D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition;	F 584		12/20/24

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F 584	Continued From page 5 §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure necessary maintenance services were performed for 1 of 5 residents (R4) reviewed for a home-like environment. Findings include: R4's quarterly Minimum Data Set (MDS) dated 10/02/24, indicated R4 had intact cognition , required assistance with catheter care and was on hospice. During an interview and observation on 11/04/24 at 2:49 p.m., R4 stated her window shade had not worked for several months, and she told staff she would like it fixed. Further, R4 stated the last time she had her urinary catheter replaced; the nurse had to put a blanket over the window because the window shade would only go down enough to cover the top half of the window. R4 stated the broken window shade didn't bother her too much during the day, but it bothered her a night	F 584	F584 Safe/Clean/Comfortable/Homelike Environment 1. Resident R4's window shade was replaced on 11/05/24. 2. An audit was completed of all resident room blinds on 11/19/24, to ensure they properly function. If additional blinds are found not properly functioning, they will be functional by 12/20/24. 3. To ensure systemic changes are sustained, TELS work order system was integrated on 11/6/24 and all staff were informed of the process change on 11/6/24. The Maintenance Supervisor will oversee tasks in TELS and ensure work orders are completed and documented 4. Audits will be conducted by the Quality Assurance Coordinator or designee to weekly x 4 and monthly x 2 to ensure resident room blinds are in functioning order. Audit results will be brought to the monthly QA meeting for further recommendations.	

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F 584	Continued From page 6 because she didn't know if someone was outside her window looking in. R4 stated her daughter had called the administrator about this prior but couldn't remember the date. R4's bed was positioned with the head of the bed facing the ground-level window. During an interview and observation on 11/05/24 at 3:09 p.m., nursing assistant (NA)-A stated R4's window shade had been broken for a while. NA-A stated they had to cover it with a blanket at the last catheter change. NA-A attempted to lower the window shade and confirmed the shade could not be lowered further than the middle of the window. During an interview and observation on 11/05/24 at 3:11 p.m., the administrator stated she was not aware R4 had a broken window shade. The administrator entered R4's room, confirmed the broken window shade, and requested maintenance to come to the room via walkie talkie. The administrator stated the facility did not have a maintenance tracking system; maintenance requests or issues were discussed during daily interdisciplinary team (IDT) meetings, during resident care conferences, during resident council, and during quality assurance and performance improvement (QAPI) meetings. During an observation on 11/05/24 at 3:16 p.m., maintenance (M)-A arrived to R4's room and confirmed the window shade was broken. During an interview on 11/05/24 at 3:20 p.m., M-A stated staff notify him of issues via walkie talkie. He stated he was unaware the window shade was broken until today. During an interview on 11/7/24 at 8:45 a.m., the	F 584	5. 12/20/24	

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F 584	Continued From page 7 hospice nurse stated she replaced R4's catheter on 10/10/24 and confirmed the shade was not working properly. She reported the broken shade to a nursing assistant but could not remember who. A policy regarding maintenance requests titled Environmental Services Overview, Resource packet was received; the policy did not address an expected timeline for completing maintenance requests.	F 584		

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	245317	A. BUILDING **02 - BUILT IN 2007** B. WING _____	**11/07/2024**

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K 000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety Code survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 11/07/2024. At the time of this survey, GOOD SAMARITAN SOCIETY COMFORTCARE was found NOT in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: IF PARTICIPATING IN THE E-POC PROCESS, A PAPER COPY OF THE PLAN OF CORRECTION	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		12/09/2024

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245317	A. BUILDING **02 - BUILT IN 2007** B. WING _____	**11/07/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - COMFORCARE	**1201 17TH STREET NE AUSTIN, MN 55912**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	Continued From page 1 IS NOT REQUIRED. Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR By email to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A detailed description of the corrective action taken or planned to correct the deficiency. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. 4. Identify who is responsible for the corrective actions and monitoring of compliance. 5. The actual or proposed date for completion of the remedy. GOOD SAMARITAN SOCIETY COMFORTCARE is a 1 story building, with no basement. The building was constructed was constructed in 2007 and was determined to be of Type II (111) construction.	K 000		

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K 000	Continued From page 2 The building is protected by a full fire sprinkler system. The facility has a fire alarm system with full corridor smoke detection and spaces open to the corridors that is monitored for automatic fire department notification. The facility has a capacity of 45 beds and had a census of 42 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 271 SS=F	Discharge from Exits CFR(s): NFPA 101 Discharge from Exits Exit discharge is arranged in accordance with 7.7, provides a level walking surface meeting the provisions of 7.1.7 with respect to changes in elevation and shall be maintained free of obstructions. Additionally, the exit discharge shall be a hard packed all-weather travel surface. 18.2.7, 19.2.7 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed provide approved discharge walking surfaces as identified per NFPA 101 (2012 edition), Life Safety Code, section 19.2, 7.1.6, 7.1.7. This deficient condition could have a patterned impact on the residents within the facility. Findings include: On 11/07/2024 between 9:30 AM and 1:00 PM, it was revealed by observation that Wing 200 / 300 / 400 exit sidewalks exhibited a slab-to-slab vertical displacement great-than one-half inch, presenting a trip and fall hazard.	K 271	Preparation and execution of this response and plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. For the purposes of any allegation that the center is not in substantial compliance with federal requirements of participation, this response and plan of correction constitutes the center's allegation of compliance in	12/20/24

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K 271	Continued From page 3 An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 271	accordance with section 7305 of the State Operations Manual. K271 – Discharge from Exits 1. The exit sidewalks from the 200, 300, and 400 neighborhoods were filled in to ensure the vertical displacement at the transition was less than one-half inch. 2. All exit slabs were audited on 11/15/24 for their vertical displacement and filled in as necessary to ensure that there is no greater than one-half inch displacement. 3. Audits will be conducted by the Quality Assurance Coordinator or designee to weekly x 4 and monthly x 2 to ensure resident room blinds are in functioning order. Audit results will be brought to the monthly QA meeting for further recommendations. 4. 12/20/24	
K 355 SS=C	Portable Fire Extinguishers CFR(s): NFPA 101 Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to properly documentation of portable fire extinguishers in accordance with NFPA 101 (2012 edition), Life Safety Code, sections 19.3.5.12, 9.7.4.1, and NFPA 10 (2010 edition), Standard for Portable Fire Extinguishers, section 7.2.4.1. This deficient finding could have a widespread impact on the residents within the facility.	K 355	K355 Portable Fire Extinguishers 1. Documentation was obtained by the vendor for the service completed in December 2023 (scheduled again for December 2024). 2. New process was created for documentation forms for our facility, mailed to the vendor and educated maintenance supervisor on 12/9/24.	12/20/24

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K 355	Continued From page 4 Findings include: On 11/07/2024 between 9:30 AM and 1:00 PM, it was revealed by a review of available documentation that the most current vendor documentation presented for review was dated 12/2022 An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 355	3. Audits will be conducted by the Quality Assurance Coordinator or designee to weekly x 4 and monthly x 2 to ensure resident room blinds are in functioning order. Audit results will be brought to the monthly QA meeting for further recommendations. 4. 12/20/24	
K 372 SS=F	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS. This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to maintain, test, and inspect the facility smoke dampers system per NFPA 101 (2012 edition), Life Safety Code, sections 8.5.5, 8.5.5.2, 8.5.5.4.2, and NFPA 105 (2010 edition), Standard for Smoke Door Assemblies and Other Opening Protectives, section 6.5.2 This deficient finding could have a widespread impact on the residents within the	K 372	K372 Subdivision of Building Spaces – Smoke Barrier 1. Smoke Damper maintenance/inspection was completed on 11/20/24. 2. Education provided to Maintenance Supervisor on the regulation and timing on 11/07/2024. A task in TELS was created for ongoing maintenance tasks in accordance with this regulation.	12/20/24

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K 372	Continued From page 5 facility. Findings include: On 11/07/2024 between 9:30 AM and 1:00 PM, it was revealed by review of available documentation that the most current vendor documentation presented for review was dated 08/05/2020 associated to inspection / testing of the facility fire / smoke dampers. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 372	3. Audits will be conducted by the Quality Assurance Coordinator or designee to weekly x 4 and monthly x 2 to ensure resident room blinds are in functioning order. Audit results will be brought to the monthly QA meeting for further recommendations. 4. 12/20/2024	
K 923 SS=F	Gas Equipment - Cylinder and Container Storag CFR(s): NFPA 101 Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited-combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled	K 923		12/20/24

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K 923	Continued From page 6 with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain proper medical gas storage and management per NFPA 99 (2012 edition), Health Care Facilities Code, sections 11.3.2.3, 11.6.5, 11.6.5.2, 11.6.5.3. These deficient findings could have a widespread impact on the residents within the facility. Findings include: On 11/07/2024 between 9:30 AM and 1:00 PM, it was revealed by observation that in the Med Gas (O2) Storage Rooms there was mixed storage of empty / full cylinders. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 923	K293 Gas Equipment – Cylinder and Container Storage 1. Full and empty cylinders were separated in the oxygen storage room on 11/9/24. 2. Full and empty cylinders were separated in the oxygen storage room on 11/9/24 and new signs were hung in the oxygen storage room indicating where full and empty tanks are to be placed. 3. To ensure systemic changes are sustained, all nursing staff will be re-educated on the facility's life safety code policy "Medical Gas Protection, Including Oxygen." 4. Audits will be conducted by the Quality Assurance Coordinator or designee to weekly x 4 and monthly x 2 to ensure full and empty oxygen cylinders are separated in the oxygen storage rooms. 5. 12/20/24	

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