Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
December 12, 2024

Administrator
Charter House Inc
211 Northwest Second Street
Rochester, MN 55901

RE: CCN: 245282
Cycle Start Date: October 16, 2024

Dear Administrator:

On December 5, 2024, 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

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

October 29, 2024

Administrator
Charter House Inc.
211 Northwest Second Street
Rochester, MN 55901

RE: CCN: 245282
Cycle Start Date: October 16, 2024

Dear Administrator:

On October 16, 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 isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D), 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 January 16, 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 April 16, 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,

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
	245282	A. BUILDING _____ B. WING _____	10/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHARTER HOUSE INC	211 NORTHWEST SECOND STREET ROCHESTER, MN 55901

(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 10/14/24-10/16/24, a standard recertification survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with requirements of 42 CFR Part 483, Subpart B, Requirements for Long Term Care Facilities. Your facility was NOT in compliance. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. 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 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 and control program (IPCP) that must include, at a minimum, the following elements:	F 880		11/22/24

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

Electronically Signed | 11/07/2024

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 880	Continued From page 1 §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 §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents	F 880		

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F 880	Continued From page 2 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 record review the facility failed to ensure transmission-based precautions (TBP) were initiated for 1 of 1 resident (R64) suspected of having clostridioides difficile (c-diff-a highly contagious bacteria that causes significant diarrhea, often attributed to antibiotic use). Findings include: R64's admission Minimum Data Set (MDS) dated 9/24/24, indicated mild cognitive impairment, no behaviors, substantial assist with activities of daily living (ADL's), transferring, and bed mobility. It also indicated incontinence. R64's diagnosis list includes incontinence and urinary tract infection's. R64's care plans included R64 required an assist of 1 for transfers, bed mobility, toileting, toilet hygiene, and ADLs. During interview and observation on 10/14/24 at 3:41 p.m., R64 stated diarrhea episodes started "a couple days ago". No indication of	F 880	R64 was placed on transmission-based precautions on 10/15/24. On 10/16/24, c-diff was ruled out and the transmission-based precautions were discontinued. R64 discharged from the community. All residents had potential to be affected by this. Re-education on the Isolation Precautions: Modified Contact Procedure will be completed for the nurses and CNAs by the interim Director of Health Services or designee. Weekly audits will be conducted by the interim Director of Health Services or designee to monitor for ongoing compliance to the Isolation Precautions: Modified Contact Procedure for three months. The audits will be taken to the QAPI Meetings. The QAPI Committee will review the audits at the monthly meeting for three months. Any further action needed during or after the audit period, based on the audit results, will be determined by the	

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F 880	Continued From page 3 transmission-based precaution noted on door. No personal protective equipment (PPE) noted outside room. During interview on 10/15/24 at 2:09 p.m., nursing assistant (NA)-A stated occupational therapy assists R64 with getting ready for the day and nursing staff assist R64 with cares and toileting the rest of the day. Nursing assistants also assist the nurses with positioning during dressing changes. NA-A stated R64 had loose stools for at least the past two days and received antibiotics for a urinary tract infection. NA-A stated loose stools are immediately reported to the nurse. During interview and observation on 10/15/24 at 2:12 p.m., R64 reported having loose stools for "the past couple days" that were loose enough to have occasional bowel incontinence. R64 was told by the facility medical provider the morning of 10/15/24 a stool sample was going to be collected. No indication of transmission-based precautions noted on resident's door. No PPE noted outside room. Progress notes indicated R64 was started on cefdinir (antibiotic) for UTI on 10/9/24. On 10/10/24, R64's antibiotics were changed from cefdinir to Augmentin. A large loose stool was noted on 10/11/24. R64 refused antibiotics due to having loose stools on 10/13/24. Two medium loose stools were documented on 10/14/24. October medication administration record (MAR) confirmed R64 received cefdinir on 10/9-10/11 and Augmentin 10/10/24-10/15/24. A provider order dated 10/14/24 indicated:	F 880	QAPI Committee.	

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F 880	Continued From page 4 "-stool sample to rule out C-diff -hold Miralax, senna [stool softeners] if [R64] is having loose stools -given antimicrobial resistance on recent urine culture, would prefer to not change antibiotic at this time and would encourage [R64] to take Augmentin if [R64] is willing." Provider progress notes dated 10/15/24 indicated R64 had loose stools and C-diff/stool assessment was ordered 10/14/24 but not yet obtained. It also indicated R64 refusal to take prescribed antibiotic. During interview 10/15/24 at 2:48 p.m., registered nurse (RN)-A stated R64 has had several loose stools and was recently placed on Augmentin. RN-A stated the interdisciplinary team (IDT) met and discussed R64's loose stools, orders for stool sample, and placing R64 on C-Diff precautions. During interview on 10/15/24 at 4:41 p.m., the infection preventionist (IP) stated there is an IDT meeting every day however did not attend that morning due to a quality improvement meeting. The IP stated progress notes are reviewed every morning for documentation of any infection related issue. Residents are placed on TBP when suspected of having symptoms outside of their baseline and prior to when ordered labs are obtained. IP stated the provider did not want to adjust R64's antibiotics due to history of antibiotic resistance and wanted to rule out C-Diff. During observation on 10/15/24 at 4:29 p.m., no TBP or PPE were noted outside R64's room. During interview and observation on 10/15/24 at 4:49 p.m., the IP confirmed the facility received	F 880		

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F 880	Continued From page 5 an order for C-diff testing on 10/14/24, was processed the afternoon on 10/14/24. IP confirmed R64 should be on TBP pending lab results. IP stated an email was sent to the care coordinator and nurse manager the morning of 10/15/24 indicated R64 is to be on precautions. IP confirmed there was no TBP or PPE located outside of R64's room. IP stated a clarification email was sent the morning of 10/15/24 confirming R64 should be on TBP while waiting for lab sample to be obtained. During interview on 10/16/24 at 12:25 p.m., the director of nursing (DON) stated if staff request orders from providers for testing for gastrointestinal illness, the expectation would be for resident's to immediately be placed on transmission-based precautions. This is necessary to prevent the spread of potential infections to other residents and staff. A policy titled "Isolation Precautions: Modified Contact Procedure- Mayo clinic Health System, Rochester" dated 7/8/24, indicated a purpose of "provide personnel with the direction to safely care for a patient requiring Modified Contact Precautions to prevent the transmission of diseases spread by contact, specifically Clostridiodes difficile (C. Difficile), C. auris, or norovirus infections." Section titled "Procedure" indicated "use Modified contact Precautions for suspected or confirmed Clostridiodes difficile (C. difficile), C. auris, or norovirus infections because these organisms require cleaning with bleach. A policy titled "Clostriodioides Difficile (C-diff) guideline-Rochester" dated 7/3/23 indicated "Suspected infections of clostridium difficile will be verified by culture or by evidence of positive	F 880		

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F 880	Continued From page 6 cytotoxin assay. Nursing should be alert to isolate residents with any symptoms when suspected and prior to obtaining confirmatory lab results".	F 880		
F 883 SS=D	Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2) §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. §483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal	F 883		11/22/24

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F 883	Continued From page 7 immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure 3 of 5 (R5, R114, R9) residents were appropriately vaccinated against pneumococcal disease upon admission and/or offered updated vaccination per Centers for Disease Control (CDC) vaccination recommendations. Findings include: R5 was 87 years old, admitted 10/1/24. R5 received PCV-13 on 6/8/15 and PPSV-23 on 9/19/17. There was no documentation to support R5 had a discussion with a medical provider regarding the PCV-20 vaccine, according to current CDC guidance for vaccines.	F 883	R5, R114 and R9 were offered the PCV-20 vaccine by the charge nurse. All residents had potential to be affected by this. An audit was completed by the RN Unit Manager of current residents and indicated that they have been offered the PCV-20 vaccine. Re-education on the Vaccination of Resident□s Policy-Rochester will be completed for the nurses by the interim Director of Health Services or designee. Weekly audits will be conducted by the interim Director of Health Services or designee to monitor for ongoing compliance to the Vaccination of	

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F 883	Continued From page 8 R9 was 81 years old, admitted on 9/13/24. R9 received PCV-13 on 4/26/17 and PCV-23 on 12/3/18. There was no documentation to support R9 had a discussion with a medical provider regarding the PCV-20 vaccine, according to current CDC guidance for vaccines. R114 was 92 years old, admitted on 10/4/24. R114 received PCV-13 on 1/29/16 and PPSV-23 on 10/1/99. There was no documentation to support R114 had a discussion with a medical provider regarding the PCV-20 vaccine, according to current CDC guidance for vaccines. During interview on 10/15/24 at 2:26 p.m., the IP stated immunizations are reviewed upon admission for COVID, pneumococcal, respiratory syncytial virus (RSV) and influenza. If residents have had PCV-13 and PPSV-23, they are deemed fully vaccinated and not triggered to receive PCV-20. IP stated she would ask facility providers if resident's were evaluated for eligibility of PCV-20. During interview on 10/16/24 at 9:30 a.m., the IP stated facility providers reported immunizations were generally deferred to the residents' outside primary care provider due to residents' stay being short term. IP reviewed medical records and confirmed R9, R114, and R5 were eligible to receive PCV-20 however, the records lack any documentation the vaccines were offered or evaluated for appropriateness. During interview on 10/16/24 at 12:25 p.m., the DON stated she would expect vaccines to be offered to residents who are eligible.	F 883	Resident□s Policy-Rochester. The audits will be taken to the QAPI Meetings. The QAPI Committee will review the audits at the monthly meeting for three months. Any further action needed during or after the audit period, based on the audit results, will be determined by the QAPI Committee.	

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F 883	Continued From page 9 A policy titled "Vaccination of Resident's Policy-Rochester" dated 7/2/24 indicated "All residents will be assessed for current vaccination status prior to admission. Vaccinations will be offered annually or as indicated, unless medically contraindicated." "Policy notes" section of the policy states "Vaccinations are offered to short Term Rehabilitation Center residents on admission, annually, and as needed." CDC pneumococcal guidelines located at https://www.cdc .gov/vaccines/vpd/pneumo/hcp/pneumo-vaccine-timing.html, identified for adults 65 years of age or older, staff were to offer and/or provide based off previous vaccination status as shown below: .....Received PCV-13 at Any Age AND PPSV-23 AFTER Age 65 Years: aa) Use shared clinical decision-making to decide whether to administer PCV-20. If so, the dose of PCV-20 should be administered at least 5 years after the last pneumococcal vaccine.	F 883		

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	245282	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**10/15/2024**

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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 10/15/2024. At the time of this survey, CHARTER HOUSE was found NOT in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: IF PARTICIPATING IN THE E-POC PROCESS, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED.	K 000		

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

Electronically Signed | 11/07/2024

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 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. CHARTER HOUSE is a 24-story building with full basement. The building was constructed in 1985 and was determined to be of Type I (322) construction. The SNF is located on the 3rd floor only. Kitchens are located on the 2nd and 22nd floor. 3rd floor has a warming / serving kitchen only	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 via Mayo Clinic Security Central The facility has a capacity of 32 beds and had a census of 11 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET.	K 000		
K 345 SS=C	Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This REQUIREMENT is not met as evidenced by: Based on review of available documentation and staff interview, the facility failed provide documentation associated to the fire alarm system per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.4.1, 19.3.4.2, 9.6.1.3, and NFPA 72 (2010 edition), National Fire Alarm and Signaling Code, section 14.6. These deficient findings could have a patterned impact on the residents within the facility. Findings include:	K 345	The annual fire alarm system inspection and fire alarm system sensitivity test will be completed by an approved fire alarm vendor. The semi-annual test was scheduled for and completed on 11/6/2024 by Custom Communication Inc. We are currently awaiting results. Re-education on NFPA 101 fire alarm system- testing and maintenance will be completed for the maintenance department	11/29/24

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K 345	Continued From page 3 1. On 10/15/2024 between 9:00 AM and 11:30 AM, it was revealed by a review of available documentation that documentation was unavailable to review associated to the most recent Annual and Semi-Annual Fire Alarm System inspections. 2. On 10/15/2024 between 9:00 AM and 11:30 AM, it was revealed by a review of available documentation that documentation was unavailable to review associated to the most recent Annual Fire Alarm System Sensitivity. An interview with the Maintenance Director verified these deficient findings at the time of discovery.	K 345	by the Director of Facilities. The annual and semi-annual fire alarm system inspections and the annual fire alarm system sensitivity test are in the PM maintenance system on reoccurring schedules. Charter House maintenance supervisor will maintain responsibility for future corrective actions and monitoring.	
K 353 SS=C	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.	K 353		11/29/24

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K 353	Continued From page 4 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on review of available documentation and staff interview, the facility failed provide documentation associated to the sprinkler system documentation in accordance with NFPA 101 (2012 edition), Life Safety Code, sections 4.6.12, 9.7.5, 9.7.6 and NFPA 25 (2011 edition) Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, section, 3.3.1.9. These deficient findings could have an isolated impact on the residents within the facility. Findings include: 1. On 10/15/2024 between 9:00 AM and 11:30 AM, it was revealed by a review of available documentation that documentation was unavailable to review associated to the most recent Annual Sprinkler System testing. 2. On 10/15/2024 between 9:00 AM and 11:30 AM, it was revealed by a review of available documentation that documentation was unavailable to review associated to 2-of-3 Sprinkler System Quarterly testing. An interview with the Maintenance Director verified these deficient findings at the time of discovery.	K 353	The Annual sprinkler system testing was completed on 2/20/2024 by Olympic Fire Protection Corp an approved sprinkler company vendor. Quarterly sprinkler system tests were completed on 3/4/2024, 5/14/2024 & 8/9/2024. Quarter 4 will be tested per our PM schedule to be completed by the end of November. Re-education on PM schedule along with maintenance and testing and will be completed for the maintenance department by the Director of Facilities. The annual and quarterly sprinkler testing are in the PM maintenance system on reoccurring schedules. Charter House maintenance supervisor will maintain responsibility for completing quarterly monitoring.	
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	K 355		11/29/24

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K 355	Continued From page 5 This REQUIREMENT is not met as evidenced by: Based on review of available documentation and staff interview, the facility failed provide documentation associated to the 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. These deficient findings could have a widespread impact on the residents within the facility. Findings include: 1. On 10/15/2024 between 9:00 AM and 11:30 AM, it was revealed by a review of available documentation that documentation was unavailable to review associated to the most recent Annual Fire Extinguisher vendor report. 2. On 10/15/2024 between 9:00 AM and 11:30 AM, it was revealed by a review of available documentation that documentation was unavailable to review associated to the past 12-months of on-site fire extinguisher inspections. An interview with the Maintenance Director verified these deficient findings at the time of discovery.	K 355	The annual fire extinguisher vendor report was completed the first week, 2024. Monthly onsite fire extinguisher inspections have been completed by an approved fire sprinkler contractor for all of 2024, the most recent inspection was on 10/17/24. Re-education on maintaining documentation for NFPA 101 portable fire extinguishers will be completed for the maintenance department by the Director of Facilities. The annual fire extinguisher vendor report and monthly fire extinguisher checks are in the PM maintenance system on reoccurring schedules. Charter House maintenance department will maintain responsibility for future corrective actions and monitoring.	
K 761 SS=C	Maintenance, Inspection & Testing - Doors CFR(s): NFPA 101 Maintenance, Inspection & Testing - Doors Fire doors assemblies are inspected and tested annually in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives. Non-rated doors, including corridor doors to patient rooms and smoke barrier doors, are routinely inspected as part of the facility maintenance	K 761		11/29/24

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K 761	Continued From page 6 program. Individuals performing the door inspections and testing possess knowledge, training or experience that demonstrates ability. Written records of inspection and testing are maintained and are available for review. 19.7.6, 8.3.3.1 (LSC) 5.2, 5.2.3 (2010 NFPA 80) This REQUIREMENT is not met as evidenced by: Base Based on review of available documentation and staff interview, the facility failed provide documentation associated to the inspection and testing of doors per NFPA 101 (2012 edition), Life Safety Code, sections 7.2.1.15, and NFPA 80 (2010 edition), sections 5.2.1. This deficient condition could have a widespread impact on the residents within the facility. Findings include On 10/15/2024 between 9:00 AM and 11:30 AM, it was revealed by a review of available documentation that documentation was unavailable to review associated to the most recent Annual Fire / Smoke Barrier Door Inspection. An interview with Maintenance Director verified this deficient finding at the time of discovery.	K 761	The annual fire/smoke barrier door inspections were completed by the maintenance department between 9/3/2024 and 9/6/2024. Re-education on maintaining documentation NFPA 101 maintenance, inspections & testing-doors will be completed for the maintenance department by the Director of Facilities. The annual fire/smoke barrier door inspections are in the PM maintenance system on a reoccurring schedule. Charter House maintenance department will maintain responsibility for future corrective actions and monitoring.	
K 914 SS=C	Electrical Systems - Maintenance and Testing CFR(s): NFPA 101 Electrical Systems - Maintenance and Testing Hospital-grade receptacles at patient bed locations and where deep sedation or general anesthesia is administered, are tested after initial installation, replacement or servicing. Additional testing is	K 914		11/29/24

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K 914	Continued From page 7 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. 6.3.4 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on review of available documentation and staff interview, the facility failed provide documentation associated to electrical receptacle testing in resident rooms per NFPA 99 (2012 edition), Health Care Facilities Code, section(s) 6.3.3.2, 6.3.4, 6.3.4.1.3, 6.3.4.2. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 10/15/2024 between 9:00 AM and 11:30 AM, it was revealed by a review of available documentation that documentation was unavailable to review associated to the most recent Annual Resident Room Electrical Outlet testing. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 914	The annual resident room electrical outlet testing will be completed by maintenance department. Testing for room receptacle was completed on 11/4/2024 per PM procedure guidelines by in house maintenance staff. GFCI testing was completed on 2/19/2024. Re-education on storage of NFPA 101 electrical systems maintenance and testing documentation will be completed for the maintenance department by the Director of Facilities. The annual resident room electrical outlet testing is in the PM maintenance system on a reoccurring schedule. Charter House maintenance department will maintain responsibility for future corrective actions and monitoring.	

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K 918 SS=C	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 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 review of available documentation and	K 918	The weekly generator inspection was	11/29/24

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K 918	Continued From page 9 staff interview, the facility failed provide documentation associated to the weekly inspection and monthly testing of the emergency generator system per NFPA 99 (2012 edition), Health Care Facilities Code, section 6.4.4.1.1.3, 6.4.4.2 and NFPA 110 (2010 edition), Standard for Emergency and Standby Power Systems, 8.3.4, 8.3.4.1, 8.4.9, 8.4.9.2. These deficient findings could have a widespread impact on the residents within the facility. Findings include: 1. On 10/15/2024 between 9:00 AM and 11:30 AM, it was revealed by a review of available documentation that documentation was unavailable to review associated to the most recent Weekly Inspection records of EG1 - Prospect Gen Set. 2. On 10/15/2024 between 9:00 AM and 11:30 AM, it was revealed by a review of available documentation that documentation was unavailable to review associated to the most recent Monthly Inspection and Testing records of EG1 - Prospect Gen Set. An interview with the Maintenance Director verified these deficient findings at the time of discovery.	K 918	most recently completed on 10/28/2024 and the monthly inspection was completed on 10/3/2024 by the Mayo's Utility Operations Team, these are on a routine schedule with this department and have been completed for all of 2024. Inspections were completed by Franklin and Prospect utility plant operation staff. Documentation is sent to us at the being of the month for the prior month tests. Re-education on maintaining documentation for weekly and monthly generator inspections and testing records will be completed for the maintenance department by the Director of Facilities. The weekly and monthly generator inspections and testing records are in the PM maintenance system on a reoccurring schedule. Charter House maintenance department will maintain responsibility for future corrective actions and monitoring.	