DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
September 19, 2023

Administrator
Bayshore Residence & Rehab Ctr
1601 St Louis Avenue
Duluth, MN 55802

RE: CCN: 245227
Cycle Start Date: June 23, 2023

Dear Administrator:

On August 3, 2023, we notified you a remedy was imposed. On August 23, 2023 the Minnesota Department(s) of Health and Public Safety completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of August 18, 2023.

As authorized by CMS the remedy of:

- Mandatory denial of payment for new Medicare and Medicaid admissions effective September 23, 2023 did not go into effect. (42 CFR 488.417 (b))

In our letter of August 3, 2023, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from September 23, 2023 due to denial of payment for new admissions. Since your facility attained substantial compliance on August 18, 2023, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded. However, this does not apply to or affect any previously imposed NATCEP loss.

The CMS Region V Office may notify you of their determination regarding any imposed remedies.

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Health Regulation Division
Telephone: (651) 201-4112
Email: Kamala.Fiske-Downing@state.mn.us

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
August 2, 2023

Administrator
Bayshore Residence & Rehab Ctr
1601 St Louis Avenue
Duluth, MN 55802

RE: CCN: 245227
Cycle Start Date: June 23, 2023

Dear Administrator:

On June 23, 2023, 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, Unit Supervisor
Rochester District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
18 Wood Lake Drive Southeast
Rochester, Minnesota 55904-5506
Email: jennifer.kolsrud@state.mn.us
Office: (507) 206-2727 Mobile: (507) 461-9125

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 September 23, 2023 (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 December 23, 2023 (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
Interim State Fire Safety Supervisor
Health Care & Correctional Facilities/Explosives
MN Department of Public Safety-Fire Marshal Division
445 Minnesota St., Suite 145
St. Paul, MN 55101
Cell: 1-507-308-4189

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Health Regulation Division
Telephone: (651) 201-4112
Email: Kamala.Fiske-Downing@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245227	A. BUILDING _____ B. WING _____	C 06/23/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BAYSHORE RESIDENCE & REHAB CTR	1601 ST LOUIS AVENUE DULUTH, MN 55802

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments On 6/20/23-6/23/23, a survey for compliance with Appendix Z, Emergency Preparedness Requirements, §483.73(b)(6) was conducted during a standard recertification survey. The facility was NOT in compliance. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulation has been attained.	E 000		
E 041 SS=C	Hospital CAH and LTC Emergency Power CFR(s): 483.73(e) §482.15(e) Condition for Participation: (e) Emergency and standby power systems. The hospital must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section and in the policies and procedures plan set forth in paragraphs (b)(1)(i) and (ii) of this section. §483.73(e), §485.625(e), §485.542(e) (e) Emergency and standby power systems. The [LTC facility CAH and REH] must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section. §482.15(e)(1), §483.73(e)(1), §485.542(e)(1), §485.625(e)(1)	E 041		8/18/23

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

Electronically Signed | 08/08/2023

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

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

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E 041	Continued From page 2 inspect a copy at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202-741-6030, or go to: http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html. If any changes in this edition of the Code are incorporated by reference, CMS will publish a document in the Federal Register to announce the changes. (1) National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02169, www.nfpa.org, 1.617.770.3000. (i) NFPA 99, Health Care Facilities Code, 2012 edition, issued August 11, 2011. (ii) Technical interim amendment (TIA) 12-2 to NFPA 99, issued August 11, 2011. (iii) TIA 12-3 to NFPA 99, issued August 9, 2012. (iv) TIA 12-4 to NFPA 99, issued March 7, 2013. (v) TIA 12-5 to NFPA 99, issued August 1, 2013. (vi) TIA 12-6 to NFPA 99, issued March 3, 2014. (vii) NFPA 101, Life Safety Code, 2012 edition, issued August 11, 2011. (viii) TIA 12-1 to NFPA 101, issued August 11, 2011. (ix) TIA 12-2 to NFPA 101, issued October 30, 2012. (x) TIA 12-3 to NFPA 101, issued October 22, 2013. (xi) TIA 12-4 to NFPA 101, issued October 22, 2013. (xiii) NFPA 110, Standard for Emergency and Standby Power Systems, 2010 edition, including TIAs to chapter 7, issued August 6, 2009.. This REQUIREMENT is not met as evidenced by:	E 041		

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E 041	Continued From page 3 Based on a review of available documentation and staff interview, the facility failed to install and maintain generators per NFPA 99 (2012 edition), Health Care Facilities Code, section 6.4.4.1.1.3, 6.4.1.1.16.2 and 6.4.1.1.17, and NFPA 110 (2010 edition), Standard for Emergency and Standby Power Systems, sections 5.6.5.2, 5.6.5, 5.6.5.6, 5.6.5.6.1, 5.6.6, 8.3.8,8.4.1, 8.4.2.1, 8.4.2.3,8.4.9, 8.4.9.1, 8.4.9.2 and 8.4.9.5.1. These deficient findings could have a widespread impact on the residents within the facility. Findings include: On 06/22/2023, between 9:30am and 12:30pm, it was revealed by a review of available documentation that the four (4) Hour load bank test was not completed. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	E 041	E 041 A generator test was performed on 06/27/2023. A load bank was completed with Total Energy Systems for 06/27/2023. Monthly, the generator test will be completed per policy and an annual load test will be performed yearly per facility policy. There were no ill effects experienced from this deficient practice. The Maintenance Director will be in-serviced on the NFPA 110 Generator TELS Master□s procedure for performing and recording monthly generator testing. A load bank test will be performed in May of each year and results of this test will be placed in the TELS electronic facility work order platform. The Maintenance Director and/or designee is responsible for compliance. Audits on monthly generator testing will begin monthly x 3 months to ensure compliance. Audit results will be reviewed by the Administrator and taken to QAPI for review and recommendation. Compliance: 08/18/2023	
F 000	INITIAL COMMENTS On 6/20/23-6/23/23, 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. In addition to the recertification survey, the following complaints were reviewed with no deficiency issued.	F 000		

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F 000	Continued From page 4 H52272837C (MN91609) H52272840C (MN91151) H52272839C (MN89955) H52272838C (MN89808) H52272838C (MN89551) H52279141C (MN86908) H52279142C (MN85139) H52279140C (MN86526) H52272841C (MN84437) H52272994C (MN94587) 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 that substantial compliance with the regulations has been attained.	F 000		
F 567 SS=E	Protection/Management of Personal Funds CFR(s): 483.10(f)(10(i)(ii) §483.10(f)(10) The resident has a right to manage his or her financial affairs. This includes the right to know, in advance, what charges a facility may impose against a resident's personal funds. (i) The facility must not require residents to deposit their personal funds with the facility. If a resident chooses to deposit personal funds with the facility, upon written authorization of a resident, the facility must act as a fiduciary of the	F 567		8/18/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 567	Continued From page 5 resident's funds and hold, safeguard, manage, and account for the personal funds of the resident deposited with the facility, as specified in this section. (ii) Deposit of Funds. (A) In general: Except as set out in paragraph (f)(l0)(ii)(B) of this section, the facility must deposit any residents' personal funds in excess of $100 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.) The facility must maintain a resident's personal funds that do not exceed $100 in a non-interest bearing account, interest-bearing account, or petty cash fund. (B) Residents whose care is funded by Medicaid: The facility must deposit the residents' personal funds in excess of $50 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.) The facility must maintain personal funds that do not exceed $50 in a noninterest bearing account, interest-bearing account, or petty cash fund. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure residents had reasonable access to their personal fund accounts for 5 of 5 residents (R12, R33, R19, R5, R34) reviewed for personal funds. This had the potential to affect 57 residents who had a personal fund account at the facility. Findings include:	F 567	F 567 R 12, R 33, R 19, R5 and R 34 met with the Business Office Manager (BOM) to review the current amount of their resident funds. A grievance form will be completed for R 12, R 33, R 19, R5 and R 34 with plan and resolution documented. All current residents and future residents who funds are managed by the facility will have	

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F 567	Continued From page 6 R12's quarterly minimum data set (MDS) assessment dated 3/15/23, indicated R12 had moderate cognitive impairment with diagnoses of anxiety, depression, and HTN. When interviewed on 6/20/23 at 12:29 p.m., R12 stated he was supposed to be able to get fifty dollars a day, but a woman from the business office had told him he was going through too much money. R12 stated there was now some confusion on how much money he could get each day. R33's significant change MDS assessment dated 5/28/23, indicated R33 was cognitively intact with diagnoses of major depression. When interviewed on 6/20/23, at 1:36 p.m., R33 stated she could not access her resident funds anytime she wanted and explained she could only access her money between 1:30 p.m. and 3:30 p.m. during the week. R33 stated she did not have access to her money in the evening or on the weekends. R19's quarterly MDS assessment dated 5/18/23, showed R19 was cognitively intact with diagnoses of dementia, alcohol dependence, and pain. During an observation and interview on 6/20/23 at 2:09 p.m., R19 was in his room. There was a sign on the dresser that read: Money 1:30 to 3:30 at front desk M-F $10.00. R19 stated you used to be able to get money anytime but now you could only get money for just a couple hours Monday through Friday from 1:30 p.m. to 3:30 p.m. R19 stated he had to plan to have money for the weekend, because you could not get money on	F 567	their amounts reviewed and the resident/representative will be notified that resident funds will be available as soon as possible but no later than the same day for amounts less than $100 ($50 for Medicaid) residents and amounts greater than $100 ($50 for Medicaid) resident are available within 3 banking days. The BOM was in-serviced on the Deposit Resident Funds Policy with focus on item #1 c on having funds available upon resident request and at the specified time periods. The residents will also be notified of this policy and procedure and timeframes in which funds care available will be explained at the next resident council meeting tentatively scheduled for 08/10/2023. The Administrator and/or designee is responsible for compliance. Audits on resident funds request, timely disbursement and weekend fund requests will begin 2x week for 4 weeks then monthly to ensure sustained compliance. Audits will be reviewed by the Administrator and the Administrator will take the audit results to QAPI for review and recommendation. Compliance: 08/18/2023	

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F 567	Continued From page 7	F 567		

the weekend. R19 went on to say if he needed to get something big, he had to plan and request money each day to get up to $50.00.

R5's significant change MDS assessment dated 6/8/23 indicated R5 was cognitively intact with diagnoses of major depressive disorder, diabetes type 2 and fibromyalgia.

When interviewed on 6/20/23 at 2:43 p.m. R5 stated she did have access to her personal funds, but it was hard to get sometimes. R5 said at first, she could only get $10.00 a day, but it was changed so she could get $20.00 a day at the reception desk. R5 indicated some days if you ask for $50.00 you can get it, but other times you can't get $50.00 until the next day. To get more than $50.00, R5 stated she would have to ask permission and then wait to get her money. R5 stated it takes about 3 to 5 days to get more than $50.00 but she said she has had to wait two weeks in the past to get $200.00 or more. R5 stated she felt this happened because the owner had to sign the checks.

R34's quarterly MDS assessment dated 3/23/23 indicated R34 was cognitively intact with diagnoses of depression.

When interviewed on 6/20/23 at 3:33 p.m., R34 stated $20.00 was the maximum amount that could be taken from personal funds each day. R34 stated there was not a way to get money on the weekend or at 7 p.m. during the week.

When interviewed on 6/22/23 at 7:15 a.m., registered nurse (RN)-A stated she would direct a resident to the business office if they asked to withdraw funds from their personal account. RN-A

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BAYSHORE RESIDENCE & REHAB CTR	1601 ST LOUIS AVENUE DULUTH, MN 55802

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F 567	Continued From page 8	F 567		

stated on the weekend the facility had petty cash on the first floor for the residents.

When interviewed on 6/22/23 at 8:43 a.m., nursing assistant (NA)-E stated residents can access money during the week at the reception desk and if a resident needed money on the weekend, the charge nurse would take care of it.

When interviewed on 6/22/23 at 1:22 p.m., the health unit coordinated (HUC)-F stated if a resident needed money on the weekend, the nurse supervisor would get the money from a lock box on the nursing unit.

When interviewed on 6/22/23 at 1:26 p.m., RN-F stated she did not know when residents could get money during the week or on the weekend, but she could get the information from the business office if needed.

When interviewed on 6/23/23 at 8:19 a.m., licensed practical nurse (LPN)-C stated residents could get money anytime. LPN-C explained during the week she would have residents go to the business office, and on the weekend the residents would get money from the supervisor.

When interviewed on 6/23/23 at 9:09 a.m., LPN-A stated he would contact the social worker if a resident asked for help getting money out of their account.

When interviewed on 6/23/23 at 8:50 a.m. RN-G stated the facility used to keep a locked cash box at the first-floor nursing station and a nurse would have to be tracked down to get the money. To be more efficient the facility moved the cash box to the reception desk and set hours of 1:30 to 3:00

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F 567	Continued From page 9	F 567		

p.m. At that time residents were notified. Residents don't have any issue getting money during this time unless the receptionist is out doing mail. RN-G stated she was not aware how residents got money on the weekend, but she could find out if needed.

When interviewed on 6/23/23 at 10:15 a.m. receptionist (R)-E explained each day the business office manager (BOM) gave her the petty cash box with a printout of who had an account, and how much they could get. R-E explained some residents had caps and some residents had a financial power of attorney (POA) that may cap when and how much money a resident could get. R-E stated the cash limit was $50.00 a day from petty cash, but residents could ask the BOM for more money. R-E stated the designated time for residents to get money was Monday through Friday from 1:30 p.m. to 3:30 p.m. R-E stated she would not give money out before or after the designated time and explained some residents had asked her to bend the rules, but she let them know they would have to come back the next day to withdraw money. R-E confirmed she did not work weekends and stated if a resident needed money on the weekend, they would have to talk to the BOM.

When interview on 6/23/23 at 11:27 a.m., the BOM stated she has informed residents can get money at any time, however for the benefit of some residents in the facility, the facility had implemented, and adhered to specific time frames and dollar amounts for those residents to get money. The BOM explained a POA may also put limitations on how much money a resident could ask for. The BOM confirmed the facility did not have petty cash on the weekends. The BOM

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F 567	Continued From page 10 explained weekend money was discussed at resident council, and the resident council agreed residents did not need to get money on the weekend so petty cash was removed from the nursing unit. The BOM stated she believed all residents knew to get money ahead of time for the weekend. The BOM stated facility hours for residents to access their funds were in place when she started about a year ago and indicated the set hours were Monday through Friday between 1:30 p.m. and 3:30 p.m. The BOM confirmed money was only disbursed during established hours at the reception desk, but indicated residents knew they could ask her for money anytime. The BOM stated if a resident wanted money for a soda or something on the weekend, she would return to the facility and disburse the requested funds. The BOM stated some residents might say they could not access funds anytime because of a POA or because some specific residents could only get money at specific times. The BOM explained if a resident was limited to a specific time or amount, it was for their benefit. For example, if a routine was better for the resident, they would stick to only disbursing money during the set time. The limitations were agreed upon and the limits were more about mental status and routine and structure. The BOM thought there may be three or four residents with restrictions and explained the team had decided the restrictions would benefit the residents and suggested the administrator could better explain the benefits. The ROM went on to say R33 did not have a cap on how much money she could get, but the facility preference was to have her set-up to only get money between 130-3:30 p.m. We are payee representative for R12 and a restriction of $50.00 was put into place for him because he had money	F 567		

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F 567	Continued From page 11 all over in his room, and there was a concern he would lose the money so for his safety the restriction was put into place. The BOM stated R19 had a guardian-imposed cap on his funds, but R5 and R34 did not have any restrictions on their resident funds. During a follow-up interview on 6/23/23 at 12:31 p.m., the BOM stated she or the administrator could be called in at any time if a resident requested money outside of business hours or on the weekend. The BOM stated to the best of her knowledge there had never been an issue with a resident needing money on a weekend. When interviewed on 6/23/23 at 1:57 p.m., the administrator verified the facility had set weekday hours for residents to access personal funds. The administrator stated they had gone to resident council and suggested resident fund access be changed to be more like banking hours. The council members at that time had not objected to the proposed change, so the proposed (current) hours were implemented. The administrator indicated the set hours were for everyone, but residents could still get money anytime they wanted. The administrator stated they did however have some residents that may be limited on when and how much money they could take out. The administrator stated this may be in place because of a POA or for example so a resident would have money to use throughout the month instead of using it all at once. The administrator stated the system had been working, and they had not experienced any issues with money being requested on the weekend. All polices related to resident funds were requested and none were received.	F 567		

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F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to update resident care plan with post fall interventions and to include residents fluid restriction for 2 of 2 (R28, R32) residents reviewed for care planning. Findings included,	F 657	F 657 R 28 risk management incident will be reopened and thoroughly reviewed. R 28 will have a new fall assessment, ADL care plan and fall care plan interventions updated. R 32 will have updated order placed for fluid restriction amounts for nursing and dietary and fluids consumed	8/18/23

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F 657	Continued From page 13 R28's significant change Minimum Data Set (MDS) assessment dated 6/6/23, indicated R28 was cognitively intact and had diagnoses of arthritis and hemiplegia. (paralysis of one side of the body). R28 requires an extensive assist of two staff for transfers. The MDS indicated R28 had one fall since admission. The Care Assessment Area (CAA)-the section of the MDS indicated resident needed specialized focus care for, visual function, ADL(activity of daily living) functional and falls as areas to specifically address in the plan of care. R28's care plan dated 7/27/22, indicated R28 was a moderate risk for falls related to post stroke hemiplegia and an above the knee amputation. The goal was resident would be free of falls with the intervention would keep call light within reach encourage to use it and resident needs prompt response to all requests. No other interventions were in place. R28's fall report dated 5/31/23 at 7:18 a.m., indicated R28 was transferred to the shower chair by staff, missed the chair and had to be assisted to the floor by staff. Interventions initiated included nursing to assure shoe is on with all transfers and occupational therapy (OT) evaluation indicated R28 needed an 18 inch or 20 inch shower chair. During an interview on 6/20/23 at 3:24 p.m., R28 stated he had a fall about four weeks ago and the staff did not tell him anything after it happened. During an interview on 6/23/23 at 10:23 a.m., nurse assistant (NA)-C stated R28 was an extensive assist of 1-2 staff for transfers. She stated all interventions were listed on the care	F 657	will be recorded in the resident electronic medical record. R 32 care plan will include current fluid restriction. The MD for both R 28 and R 32 will be notified of this occurrence and the MD response will be recorded in the resident All current and future residents will have fluid restriction orders with shift amount breakdown recorded in the resident electronic medical record and indicated in the resident care plan. All existing residents who experienced falls from survey exit until present will have their risk management incidents thoroughly reviewed, root cause established, and interventions implemented. Future residents who fall or have fluid restrictions will have fall interventions and fluid restrictions added to the respective care plan. Nursing and dietary staff will be in-serviced on the Encouraging/Restricting Fluid policy with emphasis on ensuring there is a physician order, care plan indication and fluid recording accuracy. Nursing staff will also be in-serviced on the Fall Risk Management policy with focus on item #5 that staff will implement new and/or document if approach to fall remains relevant. Director of Nursing and/or designee is responsible for compliance. Audits on dietary fluid restriction orders, care plan updates and fluid consumption will begin weekly x 2 weeks, then monthly. Audits on initiation of new and/or documentation of relevance of fall care plan intervention post fall and root cause	

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F 657	Continued From page 14 sheets that the NA's carried with them. NA-C reviewed the care sheets and acknowledged the care sheets did not talk about R28 needed shoes on when up and did not mention the need for the 18-20 inch shower chair. NA-C said the care sheets should mention both of those items to make the staff aware of how to work with R28. During an interview on 6/23/23 at 11:02 a.m., registered nurse (RN)-C stated any interventions that the NA's needed to be aware of would be on the care plan and on the care sheets. RN-C reviewed the care sheets and care plan and acknowledge the interventions for the post fall assessment was not on the care plan or the care sheets. During an interview on 6/23/23 at 1:34 p.m., the assistant director of nursing (ADON) stated an expectation is all interventions would be placed on the care plan, so staff knew how to provide the best care for the residents and keep the residents safe. R32 R32's significant change Minimum Data Set (MDS) assessment dated 5/17/23, indicated R32 was cognitively intact. Diagnoses included heart failure and end stage renal disease. R32 received dialysis services due to her end stage renal disease. The Care Assessment Area (CAA) summary indicated nutritional status was a specialized area of concern but did not address fluid maintenance as an area of concern. R32's care plan dated 3/1/23, indicated risk for fluid volume overload with interventions to included monitor and document intake as per	F 657	identification will begin weekly x 2 weeks then monthly to ensure compliance. Audits will be reviewed by the Administrator and the Administrator will take the audit results to QAPI for review and recommendation. Compliance: 08/18/2023	

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F 657	Continued From page 15 facility protocol. The care plan lacked information related to a fluid restriction of 1200 milliliters (ml) every 24 hours. R32's care sheet undated lacked information related to a fluid restriction or the need to document fluid intakes. R32's Order Summary Report (OSR) dated 3/24/23, indicated a provider order for 1200 ml per 24 hours was entered. The OSR lacked orders to keep track of intakes daily. During an interview on 6/22/23 at 9:04 a.m., nurse assistant (NA)-D stated they found out in morning report with the nurses who was a fluid restriction and who needed intakes reported. NA-D stated at that time they did not have any residents that were on fluid restrictions and needed intakes recorded. During an interview on 6/22/23 at 12:32 p.m., licensed practical nurse (LPN)-B stated staff would look at the care plan to find out who was on a fluid restriction and then report it off to the NAs. LPN-B stated the only way we knew who was on fluid restrictions was through nurse-to-nurse report and on the care plan if it would be a new order. During an interview on 6/22/23 at 12:54 p.m., registered nurse (RN)-C stated R32 was on a fluid restriction but the only way staff new about it was through report with the nurse in the beginning of the shift. Fluid restrictions may or may not have been on the care plan. During an interview on 6/22/23 at 1:33 p.m., the kitchen manager stated any resident that had a	F 657		

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F 657	Continued From page 16 fluid restriction would be placed on the care plan so all staff would know how many ml's of fluid they would be able to have in a 24 hour period. During an interview on 6/23/23 at 1:14 p.m., the assistant director of nursing (ADON) stated an expectation that fluid restrictions were placed on the care plan so staff would be able to keep the residents safe. The facilities care plan policy was requested but not provided.	F 657		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility failed to ensure an overhead trapeze (a triangle-shaped metal bar, which hangs from a metal frame and aids in positioning attached to the bed or free-standing) was assessed, evaluated and maintained for individual safety for 1 of 1 resident (R12) reviewed for accident hazards. Findings include: R12's quarterly Minimum Data Set (MDS) assessment dated 3/15/23, indicated R12 was cognitively intact, and required extensive	F 689	F 689 R 12 trapeze bar was adjusted by the maintenance director on 6/23/2023. All other residents who utilize trapeze bars were assessed for safety and changed out as needed. Future residents who require trapeze bar will have their bar applied and tested for safety prior to use. Maintenance Director, therapy staff, licensed nurses and nurse aides will be in-serviced on the Assistive Device Policy and Procedure with emphasis on item #6C that equipment is maintained on schedule and if equipment is faulty, a	8/18/23

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F 689	Continued From page 17 assitance with bed mobility and total dependence with transfers. R12's Diagnosis Report, indicated diagnoses of paraplegia (paralysis of the legs and lower body), anxiety, hemiplegia (paralysis of one side of the body) affecting left dominant side, morbid obesity, depression, chronic pain syndrome, and epilepsy. R12's care plan dated 11/4/22, indicated R12 had a self care deficit and would maintain his current level of function. Interventions indicated R12 required extensive assistance of one staff to turn and reposition in bed. In addition, R12 was totally dependent on two staff to move between surfaces. R12's Order Summary Report date initiated 3/1/22, indicated R12 had an order for grab bars to assist with bed mobility and positioning. During an observation on 6/20/23 at 12:49 p.m., R12 pulled on his overhead trapeze grad bar shaped like a triangle to adjust in the bed, the trapeze set up wobbled and unstable. The trapeze was free standing with it's legs under the bed. During an observation on 6/22/23 at 7:01 a.m., R12 was lying in bed leaning toward the left side of his bed. The overbed trapeze was in place with it's legs under the bed. The right leg of the trapeze was not straight out, it was pointed inward toward the left leg and was slightly bent. During an interview on 6/22/23 at 8:24 a.m., registered nurse (RN)-A stated she had seen R12 use his trapeze and verified the set up wobbled when R12 used it.	F 689	maintenance request must be initiated and placed in lock-out/tag out status. In addition, a new task was entered into the electronic maintenance request system that will prompt quarterly to have trapeze bars assessed for safety. Maintenance Director and/or designee is responsible for compliance. Audits on trapeze bar safety checks will begin weekly x 2 weeks, monthly x 3 months to ensure compliance. Audits will be reviewed by the Administrator and the Administrator will take the audit results to QAPI for review and recommendation. Compliance: 08/18/2023	

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F 689	Continued From page 18 During an interview on 6/22/23 at 8:41 a.m., physical therapy assistant/director (PTA)-B stated R12 had never had an evaluation for trapeze use nor had she ever seen him use it. On 6/22/23 at 8:45 a.m., PTA-B looked under the bed at the free standing trapeze set up and verified the right leg was turned inward toward the left leg and was bent slightly. PTA-B stated both legs should be straight out. She was unsure what amount of weight the trapeze could support. PTA-B told R12 she was going to have maintenance look at his trapeze set up and said she didn't want R12 to use it until maintenance looked at it. PTA-B placed the trapeze grad bar out of R12's reach preventing any use of the trapeze. During an observation on 6/22/23 at 12:08 p.m., R12 was sleeping in his bed, the right leg of the free standing trapeze was straight out but remained slightly bent toward the left. During an interview on 6/22/23 at 12:06 p.m., PTA-B stated maintenance had looked at R12's free standing trapeze and fixed the right lower leg. PTA-B stated the trapeze was rated for weights up to 400 pounds. During an interview on 6/22/23 at 12:46 p.m., the assistant director of nursing (ADON) stated he would expect staff to notice if a trapeze was wobbling and would expect staff to stop allowing the resident to use it and would expect staff to fill out a repair slip for maintence. During an interview on 6/23/23 at 9:17 a.m., R12 was eating his breakfast, he pulled on the trapeze	F 689		

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F 689	Continued From page 19 to straighten more in bed, there was no longer a wobble. R12 said it was feeling more stable when he used it. Both legs were straight under the bed and there was no longer a bend in the right leg. During an interview on 6/23/23 at 9:48 a.m., maintenance director (MD)-A stated he had not been made aware the free standing trapeze was wobbling during use. MD-A stated when he checked the free standing trapeze set up he found the right leg was bent and turned toward the left. MD-A stated the right leg was missing a clip that would hold the leg straight out in the proper position and prevent the leg from turning inward toward the left. MD-A verified the right leg was also slightly bent. MD-A stated the trapeze set up was unstable and thought maybe staff had hit the right leg when pushing mechanical lift under R12's bed. The facility policy Assistive Devices and Equipment dated 2/7/22, indicated the facility would address the following factors to the extent possible to decrease the risk of avoidable accidents associated with devices and equipment; appropriateness for the resident's condition, personal fit, device condition, and staff practices. Manufacturer's information on Temco free standing trapeze was requested but not provided.	F 689		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to	F 690		8/18/23

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F 690	Continued From page 20 maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to perform urinary catheter care based on current standards of practice and infection prevention for 1 of 2 residents (R292) reviewed for catheter care. Findings include:	F 690	F 690 R 292 has since discharged from the facility. All existing residents who have urinary catheters will have their catheter care plan reviewed and updated as needed. Future residents will have a catheter care plan initiated and catheter	

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F 690	Continued From page 21 R292's admission record, indicated an admission date of 6/12/23 with diagnoses of obstructive and reflux uropathy (when urine cannot drain through the urinary tract and backs up into the kidneys), urinary tract infection (UTI), sepsis and severe sepsis without shock. R292's care plan, dated 6/12/23, indicated R292 needed assistance with dressing, grooming, and bathing. R292 needed extensive assistance for bed mobility and eating. The care plan lacked information regarding the urinary catheter or catheter care. R292's provider orders, indicated catheter care every shift, clean drainage bag daily with vinegar and water. During an observation on 6/22/23 at 8:51 a.m., nursing assistant (NA)-F provided morning care to R292, including washing his hands, face, and brushing teeth. NA-F emptied the standard urinary collection bag attached to R292's catheter, then disconnected that bag and attached a new leg collection bag. Used alcohol swabs to clean all connections. NA-F unfastened R292's brief to check inside, then reattached the tabs on the same brief R292 had been wearing. During an interview on 6/22/23 at 10:16 a.m., NA-F stated the usual process for providing catheter care would be to empty the urinary collection bag and change it from the standard bag to a leg bag. Clean all connections with an alcohol swab. NA-F would use a washcloth and soap to clean the catheter where it exits the body. NA-F stated he realized he didn't do that with R292, but normally would have.	F 690	care performed per facility catheter care policy. Nurse aides will be in-serviced, and competency performed on catheter care procedures with emphasis on the care procedure washing resident□s private areas with soap and water, use a clean washcloth with soap and water to cleanse and rinse the catheter from insertion site to approximately for inches outward. Assistant Director of Nursing and/or designee is responsible for compliance. Audits on catheter care plan care frequency and catheter care competency will begin 2x week for 2 weeks, weekly x 4 weeks then monthly to ensure compliance. Audits will be reviewed by the Administrator and the Administrator will take the audit results to QAPI for review and recommendation. Compliance: 08/18/2023	

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F 690	Continued From page 22 During an interview on 6/22/23 at 1:59 p.m., registered nurse (RN)-F, stated the expectation was that catheter care is provided daily with hygiene at the insertion site and the first few inches of the tubing where it exits the body. RN-F stated staff would know to do this because it was on their care sheets. During an interview on 6/23/23 at 10:59 a.m., the assistant director of nursing (ADON) stated he would expect catheter care to be done every shift as it was important for infection control. A facility policy titled, Catheter Care-Urinary dated 11/1/21, indicated the purpose of providing catheter care is to prevent catheter-associated urinary tract infections. Catheter care, according to the procedure, will be done with a basin with warm water washing the resident's genitalia and perineum thoroughly with soap and water. Rinse the area well and towel dry. For a male resident male: Use a washcloth with warm water and soap to cleanse around the meatus. Cleanse the glands using circular strokes from the meatus outward. Change the position of the washcloth with each cleansing stroke. With a clean washcloth, rinse with warm water using the above technique. Return foreskin to normal position. Use a clean washcloth with warm water and soap to cleanse and rinse the catheter from insertion site to approximately four inches outward.	F 690		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who	F 695		8/18/23

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F 695	Continued From page 23 needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure oxygen use parameters were followed and oxygen tubing was changed in a timely manner for 2 of 2 residents (R12, R39) reviewed for respiratory care. Findings include: R12's quarterly Minimum Data Set (MDS) assessment dated 3/15/23, indicated R12 was cognitively intact, required oxygen therapy. R12's Diagnosis Report, included chronic obstructive pulmonary (COPD) disease (a group of lung disease that block airflow and make it difficult to breathe), idiopathic sleep related nonobstructive alveolar hypoventilation (clinical pattern in which the ventilatory insufficiency occurs primarily during sleep putting the individual at risk for hypoxemia), obstructive sleep apnea (intermittent airflow blockage during sleep). R12's care plan dated 11/8/22, indicated R12 had congestive heart failure, goals were to have clear lung sounds, heart rate and rhythm within normal limits. Interventions included oxygen at two liters per minute per nasal cannula. In addition, R12's care plan dated 11/4/22, indicated R12 had COPD related to smoking, immobility, and excessive weight. Interventions included oxygen via nasal cannula at two to four liters per minute to keep oxygen saturations equal to or greater	F 695	F 695 R 12 oxygen tubing was changed on 8/8/23. R 39 oxygen tubing was changed on 8/8/23. Both R 12 and R 39 oxygen orders were reviewed and updated to indicate amount of oxygen to be used. R 12 MD was updated that oxygen administration during survey review was not administered at the ordered liter flow. The MDs response will be recorded in the resident electronic medical record. There were no ill effects experienced from this deficient practice. All existing residents who utilize oxygen, their tubing was changed, and oxygen orders were reviewed and updated as needed. Future residents who utilize oxygen will have the tubing changed weekly and accurate oxygen orders initiated and implemented per facility policy. Licensed nurses and TMAs were in-serviced on the Department of Respiratory policy with emphasis on section labeled steps in procedure item #7 that oxygen tubing is changed every 7 days and as needed and the Oxygen Administration Policy that oxygen orders must be verified and reviewed prior to administration of oxygen. Assistant Director of Nursing and/or designee is responsible for compliance.	

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F 695	Continued From page 24 than 90%. R12's Order Summary Report initiated date 3/1/23, indicated R12 had an order to change oxygen tubing and clean filters on Saturday nights. In addition, R12 had an order for oxygen at four liters via nasal cannula to keep oxygen saturation greater than 88% and to record liters per minute. R12's treatment record for May and June indicated oxygen tubing was not changed on 5/20/23 and 6/17/23 and lacked documentation of how much oxygen was in use. During an observation on 6/20/23 at 12:37 p.m., R12 was wearing oxygen, the tubing was not dated. During an observation on 6/22/23 at 7:01 a.m., R12 was wearing oxygen, the tubing was not dated and was at five liters per minute via nasal cannula. R12's nurse's notes were reviewed from 6/22/23-5/1/23, lacked documentation to use five liters of oxygen. During an interview on 6/22/23 at 8:24 a.m., registered nurse (RN)-A verified R12's oxygen was at five liters per minute. RN-A stated there was no way to know how long the oxygen had been at five liters. RN-A verified the oxygen was out of the ordered parameters and if R12 needed an oxygen rate higher than four liters the provider should have been notified. During an interview on 6/22/23 at 12:46 p.m., the assistant director of nursing (ADON) verified he	F 695	Audits on oxygen orders and oxygen therapy accuracy and tubing changes will begin 2x week for 2 weeks, weekly x 2 weeks, then monthly to ensure sustained compliance. Audits will be reviewed by the Administrator and the Administrator will take the audit results to QAPI for review and recommendation. Compliance: 08/18/2023	

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F 695	Continued From page 25 would expect staff to document a progress note anytime they made a change in a resident's oxygen delivery rate. The ADON stated if a resident required oxygen outside of the ordered parameters they would need to contact the provider for orders. R39 R39's significant change Minimum Data Set (MDS) assessment, dated 4/26/23, indicated R39 was cognitively intact and had diagnoses of chronic obstructive pulmonary disease (COPD), acute and chronic respiratory failure. R39's care plan, dated 9/4/20, indicated a problem statement for altered respiratory status related to COPD. However, the care plan did not address oxygen therapy or care and maintenance of oxygen equipment. R39's provider order summary, indicated oxygen tubing was to be changed weekly on Saturday nights. During an observation and interview on 6/20/23 at 1:26 p.m., R39 stated he wears oxygen when he lays down and at night. The oxygen tubing was dated 5/28/23. During an observation and interview on 6/23/23 at 8:38 a.m., licensed practical nurse (LPN)-A stated oxygen tubing was changed twice a week. LPN-A confirmed the date on R39's oxygen tubing was written on a piece of tape attached to the tubing and read 5/28/23. LPN-A stated that it should be	F 695		

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F 695	Continued From page 26 changed. During an interview on 6/22/23 at 12:35 p.m., trained medication aid (TMA)-C stated oxygen tubing was changed every week. During an interview on 6/23/23 at 8:51 a.m., LPN-B stated oxygen tubing was changed once a week on night shift. During an interview on 6/23/23 at 8:57 a.m., registered nurse (RN)-C stated weekly oxygen tubing changes were important to help prevent excess humidity and potential infection. During an interview on 6/23/23 at 10:59 a.m., assistant director of nursing (ADON) stated oxygen tubing was to be changed every week. This was important to help prevent possible infections. A facility document titled, Oxygen Administration and dated 11/1/21, indicated its purpose was to provide guidelines for safe oxygen administration and did not address the care and maintenance of oxygen equipment, as was requested.	F 695		
F 698 SS=D	Dialysis CFR(s): 483.25(l) §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on interview and document review the	F 698	F 698	8/18/23

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F 698	Continued From page 27 facility failed to monitor a fluid restriction for 1 of 1 resident (R32) who received dialysis. Findings include: R32's significant change Minimum Data Set (MDS) assessment dated 5/17/23, indicated R32 was cognitively intact. Diagnoses included heart failure and end stage renal disease. The Care Assessment Area (CAA) summary indicated nutritional status was a specialized area of concern but did not address fluid maintenance as a area of concern. R32's care plan dated 3/1/23, indicated had a risk for fluid volume overload with interventions that included monitor and document intake as per facility protocol. The care plan lacked information related to a fluid restriction of 1200 milliliters (ml) every 24 hours. R32's care sheet undated lacked, information related to a fluid restriction or the need to document fluid intakes. R32's Order Summary Report (OSR) dated 3/24/23, indicated a provider order for 1200 ml per 24 hours was entered. Review of R32's Treatment Assessment Report (TAR) from 4/1/23 to 6/23/23 indicated there was a fluid restriction of 1200 ml every 24 hours that needed documented on every shift. The TAR also indicated the following: On 4/4/23 there was no intake documented on the evening shift On 4/9/23 there was no intake documented on the night shift	F 698	R 32 fluid restriction order was updated on 8/6/2023 to include fluid breakdown for nursing. R 32□s weights from survey exit to present were reviewed and the fluid restriction omissions were reported to the MD for further orders/recommendations. R 32 care plan was reviewed and updated to include current fluid restrictions. All existing residents who are on fluid restrictions will be reviewed and orders updated as needed. Future residents who are on fluid restrictions will have physician orders with amounts entered and recorded by the licensed nurse. Licensed nurses, nurse aides and trained medication aides will be in-serviced on the Encouraging/Restricting Fluid policy with focus on accurately recording nursing and dietary intake and recording the total amount of fluids consumed during the shift. Director of Nursing and/or designee is responsible for compliance. Audits on fluid restriction order accuracy, total amount of fluids consumed during the shift and resident care plan will begin 2x week for 2 weeks, weekly x 2 weeks, then monthly to ensure sustained compliance. Audits will be reviewed by the Administrator and the Administrator will take the audit results to QAPI for review and recommendation. Compliance: 08/18/2023	

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F 698	Continued From page 28 On 4/21/23 and 4/22/23 there was no intake documented on either evening shift. On 4/30/23 there was no intake documented on the evening shift. On 5/2/23 there was no intake documented on the evening shift. On 5/18/23 there was no intake documented for both evening and night shift. On 6/1/23 there was no intake documented for evening shift On 6/15/23 there was no intake documented for evening shift. The TAR from 4/1/23 to 6/23/23 also indicated the following: On 4/18/23 R32's intake totaled 1560 ml for 24 hrs. On 4/19/23 R32's intake totaled 1370 ml for 24 hrs. On 4/25/23 R32's intake totaled 1560 ml for 24 hrs. On 5/12/23 R32's intake totaled 1460 ml for 24 hrs. On 5/27/23 R32's intake totaled 1360 ml for 24 hrs. Review of R32's dialysis communication sheets from 6/14/ to 6/21/23 indicated the following: On 6/14/23 R32 had a pre-dialysis weight of 395.3 lbs and a post weight of 392.3 lbs. On 6/19/23 R32 had a pre-dialysis weight of 413.8 lbs and a post weight of 387.8 lbs. The estimated dry weight (when all excess fluid is removed from the body) should have been 385lbs On 6/21/23 R32 had a pre-dialysis weight of	F 698		

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F 698	Continued From page 29 402.6 pounds (lbs) and a post weight of 392.3. The estimated dry weight (when all excess fluid is removed from the body) should have been 385lbs R32 weight gain was 12 pounds from the end of treatment on 6/19/23 to the beginning of treatment on 6/21/23. During an interview on 6/22/23 at 8:49 a.m., nurse assistant (NA)-E stated anybody on a fluid restriction had to be monitored and the intake had to be reported to the nurse so it could be documented in the chart each shift. R 32 was a dialysis resident who was on a fluid restriction. NE-E was unaware of how much of a fluid restriction R32 was on. NA-E stated there was no assigned amount for each shift or meals but staff needed to keep a running track all day to make sure R32 did not go over her allowed amount of fluid. During an interview on 6/22/23 at 9:04 a.m., nurse assistant (NA)-D stated they found out in morning report with the nurses who was a fluid restriction and who needed intakes reported. NA-D stated they did not have any residents on fluid restrictions or needed intakes recorded. During an interview on 6/22/23 at 12:32 p.m., licensed practical nurse (LPN)-B stated staff would find out in morning report who was on a fluid restriction. The NAs would report the shift intake to the nurse at the end of the shift so it could be recorded in the medical record. LPN-B stated there was no set amount R32 was allowed to have each shift so the documentation had to be reviewed on a continuous bases so staff were aware if R32 went over her allowed amount.	F 698		

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F 698	Continued From page 30 During an interview on 6/22/23 at 12:54 p.m., registered nurse (RN)-C stated R32 was on a 1200 ml fluid restriction every 24 hrs. RN-C stated the NA's were responsible to get report from the nurses regarding residents who were on a fluid restriction. It was then up to the NA's to report the intake to the nurse every shift for documentation. We do not have an assigned amount that kitchen brings up on the trays or that nursing is allowed to give the resident. RN-C stated at the end if staff did not follow the fluid restriction of a dialysis resident it could place the resident in fluid overload, putting extra pressure on the heart and lungs. During an interview on 6/22/23 at 1:33 p.m., the dietary director stated any resident that had a fluid restriction would be placed on the care plan and would be restricted to 120 ml of fluid for each tray to allow more fluid intake throughout the day. During an interview on 6/23/23 at 12:45 p.m., the dialysis center registered nurse (RN)-E stated most dialysis residents fluid restriction have been 1500 ml per 24 hours. R32 was on a 1200 ml per 24 hour fluid restriction due to her increase risk for fluid overload and stress on her heart related to her diagnosis of heart failure. RN-E stated the last several dialysis sessions for R32 had been difficult due to significant weight gains, making it more difficult, and sometimes impossible, to reach her dry weight. The RN-E indicated they are only able to remove so much fluid at one time due to the risk on the heart if to much fluid was removed in a short time. RN-E stated when excess fluid is seen it is because of either excess fluid intake or diet concerns. If dialysis staff are not able to remove enough fluid with each dialysis treatment then the resident would return to the	F 698		

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F 698	Continued From page 31 facility still having excess fluid in the body and pressure on the heart and lungs. During an interview on 6/23/23 at 1:14 p.m., the assistant director of nursing (ADON) stated an expectation that fluid restrictions were placed on the care plan so staff would be able to keep the residents safe. All fluid restrictions would be documented accurately every shift so all residents on a fluid restriction were safe from fluid overload which could cause complications with the heart and lungs. Facility policy Encouraging and Restricting Fluids last reviewed 12/29/21, indicated accurate recording of fluid intake would be performed and an intake record would be maintained in the resident room.	F 698		
F 761 SS=E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately	F 761		8/18/23

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F 761	Continued From page 32 locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to label medications with open dates for 2 of 12 residents (R21, R50), ensure facility stock medications were dated after opening for 3 of 3 medication carts reviewed and to ensure self-administration of medication (SAM) orders were in place for powders and inhalers stored in a resident room for 1 of 1 resident (R5) reviewed for medication administration, storage and labeling. Findings include: Observation and review of the Park Breeze medication cart on 6/22/23 at 2:15 p.m. with registered nurse (RN)-B revealed the following resident and facility medications which were opened and in use, but not dated after opening: -R21 latanoprost (used to treat high pressure in the eye) eye drops -R50 fluticasone (used to treat seasonal allergies) nasal spray -Facility stock vitamin D3 tablets -Facility stock polyethylene glycol 3350 (generic Miralax) powder Observation and review of the first-floor medication cart on 6/22/23 at 9:18 a.m. with	F 761	F 761 R 50 Fluconazole was removed and replaced on 8/8/23. R 21 Latanoprost was removed and replaced on 08/08/2023. A new self-administration of medication assessment was performed on both R 5 and R 21 and their orders and care plans were updated as needed. House stock medications located on Park Breeze and on 1st floor medication cart were removed and replaced on 8/8/23. All other existing residents who self-administer medication, their medications were checked for expiration dates and self-administration of medication assessments and care plans were updated as needed. All other existing medication carts were audited and expired medications were removed as needed. Future admissions, residents who desire to self-administer medications will have an assessment completed, IDT team review for appropriateness, MD order obtained and monitoring of medication administration and expiration dates. House stock medications will be dated by nursing staff when opened and removed when expired. Licensed nurses and trained medication	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245227	A. BUILDING _____ B. WING _____	C 06/23/2023

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F 761	Continued From page 33 trained medication aid (TMA)-A revealed the following facility stock medications which were opened and in use, but not dated after opening: -Facility stock magnesium oxide tablets -Facility stock multi vitamins tablets -Facility stock vitamin C tablets During an interview on 6/22/23 at 9:18 a.m., TMA-A stated she was not sure what the process was for dating facility stock medications. TMA-A confirmed other facility stock medications in this cart are labeled with an opened-on date. During an interview on 6/22/23 at 2:15 p.m., RN-B confirmed the process was to date medications upon opening. During an interview on 6/23/23 at 2:35 p.m., the assistant director of nursing (ADON) confirmed medications needed to be dated when opened. According to the "PharMerica's (American Pharmacy Company) abridged list of medications with shortened expiration dates" published on 3/6/23, indicated "once certain products are opened and in use, they must be used within a specific timeframe to avoid reduced stability and sterility and potentially reduced efficacy ..." A drug product's Beyond Use Date (BUD) is the manufacturers supplied expiration date OR the shortened date after opening .... whichever comes first" R5's significant Change Minimum Data Set (MDS) assessment dated 6/8/23 indicated R5 was cognitively intact with diagnoses of rheumatoid arthritis unspecified, anxiety, major	F 761	aides will be in-serviced on the self-administration of medication policy with focus on item #11 that resident medications will remove expired, discontinued or re-called medications and will also be in-serviced on the Storage of Medication Policy that nursing is responsible for maintaining medication storage and preparation areas in a clean, safe, and sanitary manner. Director of Nursing and/or designee is responsible for compliance. Audits on expired medications on the medication cart, residents who self-administer medications and self-administration assessments will begin weekly x 3 weeks then monthly to ensure compliance. Audits will be reviewed by the Administrator and the Administrator will take the audit results to QAPI for review and recommendation. Compliance: 08/18/2023	

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F 761	Continued From page 34 depressive disorder, diabetes type 2, and fibromyalgia. R5's care plan lacked information regarding self-administration of medications. R5's Self Administration of Medications assessment dated 6/4/23 indicated the assessor was unable to determine if resident wanted to self admin medications and did not indicate R5 was safe to self-administer medications. R5's Self administration of Medications assessment dated 11/19/20 indicated R5 wanted to self-administer eye drops, inhaler, and nebulizer after set-up. Resident was approved to store mediations in room and self-administer and directed nurses to remind R5 when it was time for medications. When interviewed on 6/20/23 at 3:03 p.m., R5 pointed to inhalers on her bedside table and stated she had two inhalers in her room. R5 indicated the red and gray inhaler was preventative and the yellow inhaler was for an emergency when she could not breath. On 6/23/23 at 9:24 a.m. R5 had two inhalers on her bedside table. When interviewed on 6/23/23 at 10:46 a.m., registered nurse (RN)-G stated medication self-administration assessments should be done each quarter to determine if a resident was safe to self-administer medications to themselves. RN-G stated she had done an assessment on 6/4/23 for R5 but was not able to determine R5 could safely self-administer medications because R5 had experienced recent mental and physical	F 761		

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F 761	Continued From page 35 health decline. RN-G stated R5 should not have inhalers at her bedside. RN-G walked down to R5's room and confirmed R5 had a Symbicort and an Albuterol inhaler on her nightstand. RN-G confirmed R5 also had Nystatin power, nystatin external cream, triamcinolone cream, and triple antibiotic ointment, in her room on the ledge in front of her tv. RN-G stated the topical creams, ointments, and powders could be in the room of a resident who was not approved for self-administration of medications because the items were administered by the nurses. RN-G exited the room without removing any medications from R5's room. When interviewed on 6/23/23 at 12:13 p.m., the assistant director of nursing (ADON) stated Medication Self-administration assessments should be done every quarter and/or as needed. The ADON stated for a resident to be able to self-administer medications, the resident must have an order in place and a current assessment that indicated the resident was safe to self-administer. The ADON stated if the resident did not have both, all medications would have to be removed from the resident's room for all around safety and to ensure the resident was not taking the medications incorrectly. The ADON stated things like nystatin powders and creams should not be left in patient rooms because the items were wound care items and the nurses needed to make skin observations when those items were being used. In addition, the ADON stated it was not safe to have unsecured medications in resident rooms. Facility policy Self-Administration of Medications dated 12/3/21, included: -As part of the comprehensive assessment the	F 761		

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F 761	Continued From page 36 inter-disciplinary team assesses each resident to determine if they can cognitive and physically self-administer medications safely. -Self-administered medications are stored in a safe secured place, which is not accessible by other residents. If this is not possible in the resident room, the medications will be stored in the medication cart or medication room. -Any medications found at bedside that are not authorized for self-administration are turned over to the nurse in charge for return to the family or responsible party. Facility policy Storage of Medications dated 12/3/21, included: drugs and biologicals used in the facility are stored in locked compartments. Compartments include rooms. Nursing staff is responsible for maintaining medication storage and preparation areas in a clean, safe, and sanitary manner.	F 761		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility.	F 812		8/18/23

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F 812	Continued From page 37 §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure food was stored under safe and sanitary conditions with-in the individual unit fridges. This had the potential to impact all residents who received facility nourishment items or stored food from the unit fridges. Findings include: During an observation and interview on 6/22/23 at 12:27 p.m., the Dietary Manger (DM) opened the unit patient fridge on the Memory Care unit. The fridge's top shelf had a salad in a plastic container. The DM picked up the container, verified it was not labeled or dated and stated it was likely a staff member's lunch. The fridge also contained a unlabeled, undated zip lock baggie of salami and a opened, unlabeled bottle of Gatorade. The DM stated the items were likely staff items. The DM verified the freezer had food debris and brown spots and streaks on the bottom of the main compartment and door of the freezer. The DM stated for proper food storage, the freezer should be clean and not have food debris. During an observation and interview on 6/22/23 at 12:32 p.m., with the DM of the Morning Light West unit fridge. There was labeled and dated facility food and resident food. The fridge also contained a cloth lunch box, a brown paper sack and a plastic bag. The DM verified the bags	F 812	F 812 The memory care, morning light west and park breeze refrigerated items were all removed, and refrigerators were thoroughly cleaned on 8/9/23. There were no ill effects experienced by residents during this deficient practice. All other common area refrigerators were assessed and cleaned as needed. Future food storage for residents, the items will be dated and discarded if not consumed in 7 days and the refrigerators will be cleaned monthly and as needed per facility policy. Licensed nurses, nurse aides and dietary employees will in-serviced on the food storage policy that all resident food items must be dated and discarded if not consumed within 7 days. In addition, the dietary department will be in-serviced on the refrigerator cleaning policy that refrigerators will be thoroughly cleaned from inside and out. Spills and leaks will be cleaned as they occur. Lastly, the residents will be educated at the next resident council tentatively scheduled for 08/10/2023 on the food storage policy that items that are left beyond 7 days will be discarded. Director of Dietary and/or designee is responsible for compliance. Audits on refrigerator cleaning, dating of items and refrigerator temperatures will	

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F 812	Continued From page 38 contained food, were not labeled, or dated, and indicated it was likely the items belonged to staff. The freezer contained approximately 20 Ice packs. A registered nurse (RN)-D at the desk stated they didn't really use the ice packs for anything, staff just threw them in the freezer. RN-D indicated the ice packs were from drug transportation boxes. The DM got a garbage can and threw away the ice packs. The DM verified the inside of the freezer had food debris and liquid streaks on the bottom of the freezer and on the inside door. During an observation and interview on 6/22/23 at 12:39 p.m., the Park Breeze unit fridge contained food that was dated and labeled. The freezer was full of drug delivery icepacks. The freezer also contained an unlabeled handled roller device in a zip lock baggie and a bagless gel ice pack approximately four by eight inches in size with a resident name on it. The DM stated he did not know what the handled object was and removed it and the personal ice pack from the freezer. The DM threw away the drug transport ice packs and a container of orange juice from the fridge. The DM verified the bottom of the freezer had food debris and a brown substance. The DM stated the unit fridges were for resident food only, so there should not be ice packs or personal care items in any of the unit fridges. The unit staff should be keeping the fridges clean and managing the food to ensure it is labeled, dated, and thrown when past acceptable dates. The DM stated the food debris found in the freezers on the Memory Care, Park breeze, and the Morning Light West units was not acceptable for safe sanitary food storage standards. When interviewed on 6/22/23 at 12:44 p.m.,	F 812	begin weekly x 3 weeks then monthly to ensure compliance. Audits will be reviewed by the Administrator and the Administrator will take the audit results to QAPI for review and recommendation. Compliance: 08/18/2023	

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F 812	Continued From page 39 RN-B stated she tried very hard to keep the fridge cleaned and to throw away outdated food, but that it was difficult to keep up due to the number of patients that stored food in the fridge. When interviewed on 6/22/23 at 12:46 p.m., nursing assistant (NA)-D looked at the ice pack and the handled device and stated she didn't think those items should be stored in the patient fridge because of infection control issues. NA-D stated the handled item was an ice roller like a face wrinkle roller, only large so it could be used to roll over muscle and body pain. Policies addressing unit food storage and fridge cleaning were requested and not received.	F 812		
F 880 SS=E	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: §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	F 880		8/18/23

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F 880	Continued From page 40 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 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	F 880		

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F 880	Continued From page 41 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 hand hygiene and glove use practices were maintained for 2 of 2 residents (R45, R50) observed during cares. Findings include: During an observation on 6/22/23 at 7:40 a.m., nursing assistant (NA)-A was observed walking down a hallway wearing gloves. NA-A entered R45's room wearing a pair of gloves, NA-A was in the room briefly, exited the room still wearing gloves and walked down the hallway to another nursing unit. On the way NA-A stopped and touched a mechanical lift parked in the hallway, touched a second mechanical lift in the hallway still wearing the gloves. NA-A then pushed R50 in her wheelchair to her room. NA-A then proceeded to look through a bin in R50's room for a comb and hair ties. NA-A placed a hair tie on her wrist and combed R50's hair parted her hair and put R50's hair into two pony tails while wearing the same gloves. NA-A still wearing the same gloves exited R50's room, she pushed R50's wheelchair to a common area. On 6/22/23 at 7:46 a.m., NA-A stopped at the desk briefly still wearing the same gloves. NA-A then stopped and pushed a mechanical lift wearing the same gloves and entered R45's room	F 880	F 880 NA-A will receive hand hygiene education on 8/10/23. There were no ill effects experienced by any resident during this deficient practice. The mechanical lifts were cleaned on 8/10/23. All existing and future residents will have hand hygiene performed by facility staff before and after care is rendered. All facility staff will be in-serviced on the Hand Hygiene Policy with emphasis on item #7 that hand hygiene must be performed, before coming on duty, before and after performing resident care and when handling equipment. Assistant Director of Nursing and/or designee is responsible for compliance. Visual Audits on hand hygiene and glove usage will begin 2x week x 2 weeks, weekly x 2 weeks then monthly to ensure compliance. Audits will be reviewed by the Administrator and the Administrator will take the audit results to QAPI for review and recommendation. Compliance: 08/18/2023	

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	245227	A. BUILDING _____ B. WING _____	C 06/23/2023

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F 880	Continued From page 42 with the mechanical lift and wearing the same gloves. During an interview on 6/22/23 at 7:47 a.m., NA-A stated she wore gloves at all times, stating it was cleaner. NA-A verified she did not change her gloves at anytime during the observation and touched a few pieces of equipment and fixed a residents hair. NA-A verified she had been educated on hand hygiene and glove use. During an interview on 6/22/23 at 8:24 a.m., registered nurse (RN)-A stated staff had been trained on hand hygiene and glove use. RN-A stated she would expect staff to change gloves between taking care of residents, after leaving a residents room, between "certain" cares, and between all glove changes. During an interview on 6/22/23 at 9:16 a.m., NA-B stated the facility had provided infection prevention training including hand hygiene and glove use. NA-B stated she would not expect to see staff wearing gloves in the hallways. The facility policy Handwashing/Hand Hygiene dated 1/18/22, directed staff to do the following: - Wash hands with soap (antimicrobial or non-antimicrobial) and water for the following situations: When hands are visibly soiled; and After contact with a resident with infectious diarrhea including, but not limited to infections caused by norovirus, salmonella, shigella and C. difficile. - Use an alcohol-based hand rub containing at least 62% alcohol; or, alternatively, soap (antimicrobial or non-antimicrobial) and water for the following situations: Before and after coming	F 880		

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F 880	Continued From page 43 on duty; Before and after direct contact with residents; Before preparing or handling medications; Before performing any non-surgical invasive procedures; Before and after handling an invasive device (e.g., urinary catheters, IV access sites); Before donning sterile gloves; Before handling clean or soiled dressings, gauze pads, etc.; Before moving from a contaminated body site to a clean body site during resident care; After contact with a resident ' s intact skin; After contact with blood or bodily fluids; After handling used dressings, contaminated equipment, etc.; After contact with objects (e.g., medical equipment) in the immediate vicinity of the resident; After removing gloves; Before and after entering isolation precaution settings; Before and after eating or handling food; Before and after assisting a resident with meals; and After personal use of the toilet or conducting your personal hygiene. -In addition the policy instructed staff on the following; "The use of gloves does not replace hand washing/hand hygiene. Integration of glove use along with routine hand hygiene is recognized as the best practice for preventing healthcare-associated infections."	F 880		

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	245227	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**06/22/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety recertification survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 06/22/2023. At the time of this survey, Bayshore Residence & Rehab Ctr 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 | 08/09/2023

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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	245227	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**06/22/2023**

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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. Bayshore Health Center is a 2-story building with no basement. The original building was constructed in 1969, with an addition in 1978. The original building buildings and additions are all Type II (111) construction; therefore, the facility was inspected as one building. The building is fully fire sprinkler protected. The facility has a complete fire alarm system with smoke detection in spaces open to the corridor that is monitored for automatic fire department	K 000		

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K 000	Continued From page 2 notification. The facility has a capacity of 139 beds and had a census of 95 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 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)	K 321		8/18/23

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K 321	Continued From page 3 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 hazardous storage rooms per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.2.1.3 and 7.2.1.8.1. These deficient finding could have a widespeed impact on the residents within the facility. Findings include: On 06/22/2023, between 9:30am and 12:30pm, it was revealed by observation that storage rooms on Birch Walk Wing did not have a self-closing device. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 321	K321 On 8/10/23 the rooms on Beachwalk were organized. Storage items were removed or discarded. A closing device was added to room 120. All other resident rooms, closets, and non-storage areas were observed to assure no hazardous storage areas. No further issues were found. Compliance will be documented quarterly in TELS Maintenance. Maintenance and/or designee is responsible for compliance.	
K 324 SS=D	Cooking Facilities CFR(s): NFPA 101 Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with	K 324		8/18/23

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K 324	Continued From page 4 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2 This REQUIREMENT is not met as evidenced by: Based on documentation review and staff interview, the facility failed to test and inspect the kitchen hood ventilation and fire suppression system per NFPA 101 (2012 edition), Life Safety Code, section 9.2.3 and NFPA 96 (2011 edition), Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, section 11.2.1. This deficient finding could have an isolated impact on the residents within the facility. Findings Include: On 06/22/2023, between 9:30am and 12:30pm, it was revealed by a review of available documentation that inspection documentation for the kitchen hood ventilation and fire suppression system was not available. The facility could not provide completed test/inspection documentation for the semi-annual kitchen hood suppression system inspections for the last 6 months. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 324	K324 The facility uses Northland Fire and Safety for the kitchen hood and Ansul system inspection, testing, and maintenance. The kitchen hood inspection and cleaning was completed on 1/8/23. The kitchen hood ventilation and fire suppression inspection was completed on 4/4/23. Kitchen hood cleaning, ventilation and fire suppression inspection reports were placed in the fire safety book which is kept in the Maintenance Director’s office. The facility requested the Maintenance Director be added to the email list of the reports that are sent with each service or inspection. Future reports will be maintained in the fire safety book and stored in the Maintenance Director’s Office. Maintenance and/or designee is responsible for compliance.	

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K 351 SS=D	Sprinkler System - Installation CFR(s): NFPA 101 Spinkler System - Installation 2012 EXISTING Nursing homes, and hospitals where required by construction type, are protected throughout by an approved automatic sprinkler system in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. In Type I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where state or local regulations prohibit sprinklers. In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area of the closet does not exceed 6 square feet and sprinkler coverage covers the closet footprint as required by NFPA 13, Standard for Installation of Sprinkler Systems. 19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1) This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain spacing between storage and the sprinkler system per NFPA 101 (2012 edition), Life Safety Code, Section 9.7.5, NFPA 25 (2011 edition), Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, Section 5.2.1.2, and NFPA 13 (2010 edition), Standard for the Installation of Sprinkler Systems, Sections 8.6.5.3.2 and 8.15.9. These deficient findings could an isolated impact on the residents within the facility. Findings include: On 06/22/2023, between 9:30am and 12:30pm, it was revealed by observation that storage	K 351	K351 On 8/4/23 the top storage shelves in the brief storage room were removed to assure 18” clearance compliance. The employees that stock central supply will be educated on the 18” clearance regulation. All areas of the facility were observed 8/4/23 to assure 18” clearance to fire sprinklers. A log will be created and maintained in the TELS maintenance system to be completed every four months.	8/18/23

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K 351	Continued From page 6 materials had been placed on a storage rack, bringing the storage materials within the required 18 inch clearance area under the sprinkler heads. These obstructions were found in the second floor Briefs Storage Room. An interview with the Director of Maintenance verified these deficient findings at the time of discovery.	K 351	Maintenance and/or designee is responsible for compliance.	
K 355 SS=F	Portable Fire Extinguishers CFR(s): NFPA 101 Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain access to portable fire extinguishers per NFPA 101 (2012 edition), Life Safety Code, section 9.7.4.1, and NFPA 10 (2010 edition), Standard for Portable Fire Extinguishers, section 7.3.1.1.1. This deficient finding could have a widespreed impact on the residents within the facility. Findings include: On 06/22/2023, between 9:30am and 12:30pm, it was revealed by documentation review that the fire extinguishers annual inspection documentation could not be provided. An interview with the Maintenance Director verified this deficient finding at the time of	K 355	The annual fire extinguisher inspection was completed 4/6/23. The annual fire extinguisher inspection was placed in the fire safety book which is kept in the Maintenance Director's office. Future reports will be maintained in the fire safety book and stored in the Maintenance Director's Office. Maintenance and/or designee is responsible for compliance.	8/18/23

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K 355	Continued From page 7 discovery.	K 355		
K 363 SS=F	Corridor - Doors CFR(s): NFPA 101 Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485	K 363		8/18/23

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K 363	Continued From page 8 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain corridor doors per NFPA 101 (2012 edition), Life Safety Code, section 19.3.6.3.5. This deficient finding could have a widespreed impact on the residents within the facility. Findings include: On 06/22/2023, between 9:30am and 12:30pm, it was revealed by observation that the resident room door D105 does not latch. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 363	The door to room 105 was adjusted 8/8/23 and closes properly. All corridor doors were tested 8/8/23 to assure proper function. A quarterly log will be created and maintained in the TELS maintenance system. Maintenance and/or designee is responsible for compliance.	
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.	K 372		8/18/23

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K 372	Continued From page 9 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain their smoke barrier per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.7.1, 19.3.7.3, 8.5.2.2, and 8.5.6.5. These deficient findings could have a widespread impact on the residents within the facility. Findings include: On 06/22/2023, between 9:30am and 12:30pm, it was revealed by observation that there was a penetration running from one smoke compartment to another in the following locations: 1) Entrance to the East Wing - Park Breeze 2) Above Fire Door by room 237 3) Above Fire Door by room 112 4) Above Fire Door by room 121 An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 372	Wall penetrations were sealed using red-colored fire caulk at the entrance to the East Wing Park Breeze, above Fire Door by room 237, above Fire Door by room 112, and above Fire Door by room 121. Maintenance will inspect future contractor work to assure all penetrations are sealed properly by contractors. Maintenance and/or designee is responsible for compliance.	
K 712 SS=F	Fire Drills CFR(s): NFPA 101 Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms.	K 712		8/18/23

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K 712	Continued From page 10 19.7.1.4 through 19.7.1.7 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to conduct fire drills under varied times and conditions per NFPA 101 (2012 edition), Life Safety Code, sections 19.7.1.6, 4.7.4, and 4.6.1.1. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 06/22/2023, between 9:30am and 12:30pm, it was revealed by a review of available documentation that fire drills were not completed: 1) first shift, missing fourth quarter (October - December) fire drill. 2) second shift, missing first quarter (January - March) and third quarter (July - September) fire drills 3) third shift missing second quarter (April - June) fire drill. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 712	The missing fire drills were placed in the fire safety book which is kept in the Maintenance Director's office. Future fire drills shall be conducted under varied times and conditions. The drill reports will be maintained in the fire safety book and stored in the Maintenance Director's Office. Maintenance and/or designee is responsible for compliance.	
K 761 SS=F	Maintenance, Inspection & Testing - Doors CFR(s): NFPA 101 Maintenance, Inspection & Testing - Doors Fire doors assemblies are inspected and tested annually in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives. Non-rated doors, including corridor doors to	K 761		8/18/23

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K 761	Continued From page 11 patient rooms and smoke barrier doors, are routinely inspected as part of the facility maintenance program. Individuals performing the door inspections and testing possess knowledge, training or experience that demonstrates ability. Written records of inspection and testing are maintained and are available for review. 19.7.6, 8.3.3.1 (LSC) 5.2, 5.2.3 (2010 NFPA 80) This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to inspect fire doors per NFPA 101 (2012 edition), Life Safety Code section 8.3.3.1, and NFPA 80 (2010 edition), Standard for Fire Doors and Other Opening Protectives, section 5.2.1. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 06/22/2023, between 9:30am and 12:30pm, it was revealed by review of available documentation the required annual door inspection documentation was not available at the time of the survey. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 761	The annual door inspection will be completed 8/10/23. A log to assure compliance with the annual door inspection will be documented in TELs Maintenance. Maintenance and/or designee is responsible for compliance.	
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	K 918		8/18/23

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K 918	Continued From page 12 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 a review of available documentation and staff interview, the facility failed to install and maintain generators per NFPA 99 (2012 edition), Health Care Facilities Code, section 6.4.4.1.1.3, 6.4.1.1.16.2 and 6.4.1.1.17, and NFPA 110 (2010 edition), Standard for Emergency and Standby	K 918	Total Energy Systems completed the annual load bank test for the generator on 6/27/23. A log to assure compliance with the annual load bank generator test will be	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245227	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**06/22/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 918	Continued From page 13 Power Systems, sections 5.6.5.2, 5.6.5, 5.6.5.6, 5.6.5.6.1, 5.6.6, 8.3.8,8.4.1, 8.4.2.1, 8.4.2.3,8.4.9, 8.4.9.1, 8.4.9.2 and 8.4.9.5.1. These deficient findings could have a widespread impact on the residents within the facility. Findings include: On 06/22/2023, between 9:30am and 12:30pm, it was revealed by a review of available documentation that the four (4) Hour load bank test was not completed. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 918	documented in TELs Maintenance. Maintenance and/or designee is responsible for compliance.	
K 920 SS=E	Electrical Equipment - Power Cords and Extens CFR(s): NFPA 101 Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed	K 920		8/18/23

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	245227	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**06/22/2023**

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K 920	Continued From page 14 immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain the usage of electrical adaptive devices per NFPA 99 (2012 edition), Health Care Facilities Code, sections 10.5.2.3.1 and 10.2.4.2.1, NFPA 70, (2011 edition), National Electrical Code, sections 400-8, and UL 1363. This deficient finding could have a patterned impact on the residents within the facility. Findings include: On 06/22/2023, between 9:30am and 12:30pm, it was revealed by observation that there were several electrical appliances plugged into a power strip in resident ' s rooms list as follows. 1) Room 263 - 6-plex outlet device with multi-plug extension cord 2) Room 260 - 6-plex out device with extension cord 3) Room 248 - 6-plex out device with extension cord An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 920	The extension cords were removed from power strips in rooms 248, 260, and 263. A room-to-room search was conducted 8/9/23 to assure all power strips are compliant with the usage of adaptive electrical devices. A log to assure compliance with the usage of adaptive electrical devices will be documented quarterly in TELs Maintenance. Maintenance and/or designee is responsible for compliance.	