Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
November 9, 2023

Administrator
Zumbrota Care Center
433 Mill Street
Zumbrota, MN 55992

RE: CCN: 245376
Cycle Start Date: August 10, 2023

Dear Administrator:

On October 18, 2023, we notified you a remedy was imposed. On November 3, 2023, the Minnesota Departments 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 October 20, 2023.

As authorized by CMS the remedy of:

- Mandatory denial of payment for new Medicare and Medicaid admissions effective November 10, 2023 did not go into effect. (42 CFR 488.417 (b))

In our letter of October 18, 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 November 10, 2023, due to denial of payment for new admissions. Since your facility attained substantial compliance on October 20, 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 Therefore, the NATCEP prohibition is rescinded.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.

Please contact me with any questions regarding this letter.

Sincerely,

Lori Hagen

Lori Hagen, Compliance Analyst
Federal Enforcement
Health Regulation Division
Minnesota Department of Health
Telephone: 651-201-4306
E-Mail: Lori.Hagen@state.mn.us

Protecting, Maintaining and Improving the Health of All Minnesotans

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August 28, 2023

Administrator
Zumbrota Care Center
433 Mill Street
Zumbrota, MN 55992

RE: CCN: 245376
Cycle Start Date: August 10, 2023

Dear Administrator:

On August 10, 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:

Renee McClellan, Unit Supervisor
Metro A District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
85 East Seventh Place, Suite 220
P.O. Box 64900
Saint Paul, Minnesota 55164-0900
Email: renee.mcclellan@state.mn.us
Office: 651-201-4391 Mobile: 651-328-9282

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a Post Certification Revisit (PCR), of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

FAILURE TO ACHIEVE SUBSTANTIAL COMPLIANCE BY THE THIRD OR SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

If substantial compliance with the regulations is not verified by November 10, 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 February 10, 2024, (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

Please contact me with any questions regarding this letter.

Sincerely,

Lori Hagen, Compliance Analyst
Federal Enforcement
Health Regulation Division
Minnesota Department of Health
Telephone: 651-201-4306
E-Mail: Lori.Hagen@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245376	A. BUILDING _____ B. WING _____	C 08/10/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ZUMBROTA CARE CENTER	433 MILL STREET ZUMBROTA, MN 55992

(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 8/7/23-8/10/23, a survey for compliance with Appendix Z, Emergency Preparedness Requirements, §483.73(b)(6) was conducted during a standard recertification survey. The facility was in compliance. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	E 000		
F 000	INITIAL COMMENTS On 8/7/23-8/10/23, 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. The following complaints were reviewed with no deficiencies cited: H53764256C (MN00083825), H53764254C (MN00085848), H53764253C (MN00086448), H53764257C (MN00090755). AND The following complaints were reviewed H53764255C (MN00086583), with a deficiency cited at 812. 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.	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		09/07/2023

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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F 000	Continued From page 1 Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulations has been attained.	F 000		
F 803 SS=E	Menus Meet Resident Nds/Prep in Adv/Followed CFR(s): 483.60(c)(1)-(7) §483.60(c) Menus and nutritional adequacy. Menus must- §483.60(c)(1) Meet the nutritional needs of residents in accordance with established national guidelines.; §483.60(c)(2) Be prepared in advance; §483.60(c)(3) Be followed; §483.60(c)(4) Reflect, based on a facility's reasonable efforts, the religious, cultural and ethnic needs of the resident population, as well as input received from residents and resident groups; §483.60(c)(5) Be updated periodically; §483.60(c)(6) Be reviewed by the facility's dietitian or other clinically qualified nutrition professional for nutritional adequacy; and §483.60(c)(7) Nothing in this paragraph should be construed to limit the resident's right to make personal dietary choices. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, and document review, the facility failed to ensure	F 803	How corrective action will be accomplished for those residents found to	10/20/23

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F 803	Continued From page 2 menus were followed, met the nutritional needs of the residents, and were reviewed by the facility Registered Dietitian (RD). This has the potential to affect all 33 residents. Findings include: Review of the facility menus for the week of 08/05/23 to 08/11/23, provided by the dietary manager (DM) revealed the facility menu lacked a low sodium diet, diabetic diet, and finger food or bite size diets. Review of the physician order sheets in the electronic medical record (EMR) and the diet list provided by the DM from physician orders, the facility currently had physician orders for four residents on diabetic diets, seven on finger or bite size foods, and two residents on low sodium diets for which there were no menus. Observation of the meal service on 08/07/23 at 5:00 p.m., revealed the presence of menu items of turkey ala king, a mixed vegetable diced and minced, and mashed potatoes. None of the items provided were prepared for finger foods, low sodium, or diabetic diets. The four residents served two diabetic and two low sodium diets were served the menu items of turkey ala king, mashed potatoes, and mixed vegetables without modifications for their particular needs. In addition, no finger food or bite size foods were prepared. One finger food or bite size diet was served puffed popcorn (amount unknown), one protein bar-cut up and one half of a bologna sandwich. These items were not on the menu. The one pureed diet was not prepared and brought up to the first floor serving area until prompted by the surveyor. The cook had finished	F 803	have been affected by the deficient practice: 1. Resident Diet Orders were reviewed from the EHR and cross referenced to Dietary Software to ensure correct diets are printing on tray tickets. 2. Resident that was receiving pureed diet was on Hospice at time of survey has passed away. 3. Dietary Manager has trained cooks on how to utilize the dietary spreadsheets prior to meal service to ensure proper meal components, textures, and therapeutic diets, including finger foods are served to residents. 4. RD reviewed and modified therapeutic diets for the current menu cycle to ensure all menu items meet professional dietary standards for each therapeutic diet How the facility will identify other residents having the potential to be affected by the same deficient practice: Dietary Manager and/or Registered Dietitian will review diet orders in the EHR and ensure all residents with modified therapeutic diets are properly entered into the Dietary software/tray ticket program. What measure will be put into place, or systemic changes made to ensure that the deficient practice will not recur: The Registered Dietitian will sign and date all RD created menus and RD created spreadsheets and same them in PDF format available to Dietary Manager.	

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F 803	Continued From page 3 serving all the residents when asked about the pureed food. She went downstairs, heated up the food and brought it upstairs to serve. Further, the menu served did not list portion sizes. The portion sizes were listed on the recipe sheet not the menu. Further observation of the evening meal on 08/07/23 at 5:00 p.m., revealed three residents on minced or soft diets were served two ounces of mashed potatoes and two ounces of vegetables. The recipe sheet called for four ounces mashed potatoes and four ounces of mixed vegetables. Interview with the cook (C)-Aserving the meals noted above on 08/07/23 at 5:45 p.m., indicated she served those diets in that manner because she was told to do that. C-A had no recollection of who told her to serve the three minced diets with low portion sizes. Interview with the DM on 08/07/23 at 5:45 p.m., verified the menus had no accompanying spreadsheet or portion sizes. Interview with the RD on 08/09/23 at 12:00 p.m., revealed she had menus from 2021 but verified the current menu did not have low sodium, bite size, finger foods or diabetic diets. She also could not verify she had reviewed and approved the current menus being used at the facility. Review of the facility policy and procedures on 8/07/23 through 8/9/23, revealed there is no policy for following the menus or menu substitution. This was verified by the Administrator and DM on 08/09/23 at 3:30 p.m.	F 803	ZHS utilitizes a general display menu for all residents. Diet extension spreadsheets are a resource for the specific diet textures and therapeutic diets. The spreadsheet headings will be updated to refelct he current year and the Dietary Manager will ensure daily spreadsheets are available to dietary staff. Registered Dietitian will review and update menus & spreadsheets throughout each menu cycle to ensure therapeutic diets meet professional dietary standards for each therapeutic diet. Registered Dietitian utilizes the Academy of Nutrition & Dietitics as references for therapeutic diets. The residents tray ticket provides specific menu items to serve each individual resident as well as portion size. The Registered Dietitian will create a Menu Substitution Policy for ZHS Dietary Staff Education will include the following: 1. Cooks will be educated on how to utilize the menu spreadsheets prior to meal service to ensure that the proper meal components, textures and therapeutic diets are served to all residents. 2. Cook staff will be trained on portion sizes 3. Cook staff will be trained on how to read tray tickets 4. Cook staff will be educated on the Menu Substitution Policy	

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F 803	Continued From page 4	F 803	How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur: The Dietary Manager, Administrator, Corporate Dietitian and/or Delegate will audit all components of the plan of correction 3 times per week for 2 weeks and if 100% compliant, move to auditing 2 times per week for 2 weeks and if 100% compliant, then conduct random audits no less than 3 meals per month for three (3) months. All findings will be reported to the quarterly QAPI Committee for recommendations on additional monitoring.	
F 812 SS=F	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		10/20/23

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F 812	Continued From page 5 §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 observations, interviews, and document review, the facility failed to ensure it stored, prepared, and served food in accordance with professional standards for food safety. This could affect all 31 residents at the facility. Findings include: Observation and interview on 08/07/23 at 12:10 p.m., during the initial kitchen tour, revealed the handwashing sink in the large main kitchen closest to the kitchen area was lacking soap and paper towels. The dietary manager (DM) indicated maintenance or housekeeping took care of changing soap and paper towels, not the kitchen staff. Observation of the ice machine on 08/07/23 at 12:10 p.m., in the main kitchen near the sink, revealed no record or log of cleaning the ice machine. During interview at the time of the observation, the DM stated she would get the records from maintenance. Interview with the maintenance director (MD) on 08/08/23 at 10:50 a.m., MD stated he had no records or logs of cleaning the ice machine as a service company had been cleaning the ice machine. He did not think it had been serviced since it was installed. Review of the specifications obtained from the administrator file cabinet of the ice machine on page 13 indicated the ice machine "shall be	F 812	How corrective action will be accomplished for those residents to have been affected by the deficient practice: No specific residents were identified to be affected by the deficient practice. Soap & hand towels were immediately installed in the kitchen. Staff were trained on where to find supplies & how to replace. The chicken in the refrigerator was immediately thrown away. The microwave was cleaned immediately. Refrigerator in serving kitchen was cleaned and all undated food items were thrown away. The floor was cleaned in the main kitchen refrigerator. Paper products were implemented due to the dishwasher not properly sanitizing. How the facility will identify other residents having the potential to be affected by the same deficient practice: All residents that would be admitted to the facility would have the potential to be affected by this deficient practice.	

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F 812	Continued From page 6 cleaned two times per year or every six months to ensure safe use". The front page of specifications had a handwritten note revealing "installed 6/22". Observation on 08/07/23 at 12:10 p.m., of the main kitchen walk-in refrigerator, revealed a large amount of chicken breasts in an open garbage bag resting in a plastic container unlabeled without a date. During interview at the time of the observation, the DM indicated she did not know how long the chicken had been in the refrigerator thawing. She indicated the policy stated three days for thawing, however, she could not produce this policy during the survey and was unable to verify the date the chicken was placed in the walk-in refrigerator. Observation on 08/07/23 at 12:15 p.m., of the microwave in the main kitchen near the appliances and kitchen sink, revealed large food particles too numerous to count of various colors including red and yellow stuck to the top of the microwave inside. Interview with the DM at the time of the observation verified the condition of the microwave and indicated housekeeping was in charge of cleaning. Observations on 08/07/23 at 12:25 p.m., revealed the refrigerator on the first floor serving area was large amount of yellow, red, brown, and white crumbs too numerous to count and spills throughout the refrigerator and freezer section of the refrigerator. Further revealed, the refrigerator contained five small cheesecakes in serving dishes on a tray, with cellophane covering half of the cheesecakes, lacking a date. Interview with the DM at the time of the observation verified the condition of the refrigerator and indicated it was housekeeping responsibilities to clean the device.	F 812	What measures will be put into place, or systemic changes made to ensure that the deficient practice will not recur: Staff were re-educated on 8/8/2023 on where to find soap and hand towel supply as well as how to change and refill when empty. DM will continue to monitor hand washing supplies on an ongoing basis. The ice machine was cleaned on 9/12/2023. The Maintenance Director has added the ice making to the preventative maintenance scheduled with our contracted company. The next scheduled cleaiming will be March 2024 under the PM contract. DM reviewed thawing procedures with cooking staff on 8/8/2023. DM will create a Food Thawing policy by 9/15/2023. DM will review policy with all staff. DM will implement a cleaning schedule for cooking staff that will include the microwave and serving kitchen refrigerators. DM will train all PM cooks to monitor daily all food dates in supplement refrigerator in the kitchenette serving area. DM implemented dating of Mighty Shake supplements on 8/9/2023. Per the product spec sheet, the supplement should be allowed 3 days for thawing and then discarded 14 days after thawing. Staff will	

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F 812	Continued From page 7 DM stated she did not know how long the cheesecake had been in the refrigerator and stated they were going in the garbage. Observation 08/07/23 at 5:45 p.m., of the refrigerator near the serving area on the first floor revealed 11 thawed "mighty shakes" on a tray without dates of thawing. The side panel of the mighty shake container indicated use within 14 days of thawing. Interview with dietary aide (DA)-1 at the time of the observation indicated the shakes were generally used within the day they are brought up. DA-1 indicated he brought the shakes up this afternoon from the kitchen but could not state which shakes he brought up from the kitchen. DA-1 also indicated he did not know how long each shake had been thawing. Observation 08/07/23 at 5:50 p.m., of the floor of the walk-in refrigerator, revealed the floor had standing water near the thawing chicken bin, along with paper, tape from boxes, and a large amount of brown and white food debris. Interview with the DM at the time of the observation stated "we do not have a cleaning process in place or working order" at this time and verified the walk-in refrigerator needed cleaning. On 08/08/23 at 10:30 a.m., five additional thawed shakes were in the walk-in refrigerator in the main kitchen. Interview with the DM at the time of the observation verified she did not know how long the shakes had been thawing in the main kitchen or in the service area. She also clarified the facility has no system to determine the length of time thawing for each shake before serving. Review of the contents of the shakes revealed each shake contains skim milk as it's main ingredient.	F 812	be trained in thawing and discarding procedures for supplements. DM will schedule regular cleaning of the walk-in cooler. DM will educate staff on ongoing cleaning and removal of any debris on the floor. The new dishwasher is being installed on 9/12/2023. The dishwasher will have a booster heater that will hold temps high enough to meet sanitation requirements without additional chemicals. Once installed, the DM will educate staff on proper operation of DW along with temperature recording requirements and the procedure if the DW is not working properly. DM will review and train all staff on Care Center-Dietary Department Policy for Sanitation and Safety Cleaning Dishes/Dish machine. Regional Director reviewed job description with Registered Dietitian to ensure understanding of position expectations. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur: The Administrator, Dietary Manager and Registered Dietitan will audit 3 times per week for 3 weeks, then 2 times per week for 4 weeks, and then report results to QAPI Committee for ongoing monitoring recommendations.	

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F 812	Continued From page 8 Observation on 08/08/23 at 12:55 p.m., of the dish machine running, revealed as dishes were running through the machine, the gauges to the dish machine were not moving despite the dishwasher going through the cycles. Three more attempts were made without the gauges moving. The washed items were faintly warm after leaving the dishwasher. Interview with the DM at the time of the observation indicated she has only been here six weeks and has not noticed the dishwasher temperature gauges not working. Review of the temperature gauge log filled out by staff indicated the gauges were working and recorded 120 degrees washing cycle for low temperature dishwashing for the first seven days of the month. A placard on the side of the dishwasher indicated the washing and rinsing cycle shall be 120 degrees for low temperature dishwashers. When strips were used at this time to read the amount of sanitizer present after the wash, the strip read zero parts per million (PPM) or no sanitizing agent present. Further interview on 08/08/23 at 1:30 p.m., the DM and maintenance director on 08/08/23 at 1:30 PM indicated "we had it serviced," the technician told us we did not need the booster to work or heat the water, only the sanitizer. Further interview revealed that both the DM and maintenance director had no idea of the temperature of the water during the washing and rinsing cycle. Interview on 08/09/23 at 3:15 p.m., the administrator indicated she did not have a procedure when the dishwasher was not working correctly. She went onto indicate the dishwasher was to be replaced in January 2023 and June	F 812	RD will be conducting weekly visits for 3 weeks to assist with staff education and auditing. Once education is complete and if audits are 100%, RD will reduce visits to every 2 weeks for one month and then a monthly visits for 6 months. RD will review all items in POC at site visits, document findings and submit to QAPI for ongoing monitoring recommendations.	

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F 812	Continued From page 9 2023 as shown in leasing contracts signed by the facility. She stated she did not know why the dishwasher had not arrived or been replaced. She stated, "we have not fixed the dishwasher because we planned on replacing it." Interview on 08/09/23 at 12:00 p.m., the Registered Dietitian (RD) indicated she had not been in the kitchen for six weeks and was not aware of the above noted sanitation issues. Review of the facility policy on use of the dishwasher machine provided by the DM from the computer titled "Care Center-Dietary Department, Policy for Sanitation and Safety, Cleaning Dishes/Dish machine," dated 04/20/22, indicated on page one, halfway down that Low Temperature Dishwashing (chemical sanitizer) shall have a final rinse of 50 PPM. Review of the document titled "Job Description-Dietician," dated 10/14/22 and provided by the Administrator from her computer, revealed on page four, sixth bullet from the top "monitors all components of dietary services for regulatory compliance."	F 812		
F 835 SS=F	Administration CFR(s): 483.70 §483.70 Administration. A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the	F 835	What corrective actions will be	10/20/23

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F 835	Continued From page 10 facility's administrator failed to provide adequate oversite and resources to meet the needs of the residents by failing to ensure kitchen equipment was maintained and functioning, nutritive therapeutic diets were provided, and an effective quality assurance process improvement (QAPI) plan was implemented to identify quality concerns, implement quality improvements measures, and monitor for improvement of identified concerns were maintained. This had the potential to affect all 33 residents who reside in the facility. F803: Based on observations, interviews, and document review, the facility failed to ensure menus were followed, met the nutritional needs of the residents, and were reviewed by the facility Registered Dietitian (RD). This has the potential to affect all 33 residents. F812: F687: Based on interview and document review, the facility failed to maintain a quality assessment and assurance (QAA)/quality assurance process improvement (QAPI) committee that was effective in identifying, implementing actions, and continued monitoring to ensure residents received nutritive therapeutic diets and the facility kitchen had sanitary and functioning equipment. This deficient practice had the potential to affect all 33 residents currently residing in the facility. F865: Based on interview and document review, the facility failed to implement a comprehensive Quality Assurance and Performance Improvement (QAPI) program that identified concerns with care in the facility were identified reviewed to maintain acceptable levels of	F 835	accomplished for those residents found to have been affected by the deficient practice: No specific residents were identified to be affected by the alleged deficient practice. All kitchen equipment needing repairs have been identified and vendors contacted for inspection/repairs. All residents with therapeutic diets have been identified and tray cards updated. The facility did have QAPI meetings in which deficient areas are identified. How other residents having the potential to be affected by the same deficient practice will be identified: All future residents have 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: The facility did have QAPI on Q1 on January 24, 2023, Q2 on June 27, 2023, and Q3 on July 31, 2023. Deficient practices in the kitchen had been identified at reflected in the June and July minutes through both a mock survey conducted by Corporate Quality RN as well as Corporate RD Dietary Reviews. Administrator will been re-educated on roles & responsibilities of Administrator per the job description, including daily oversight of each department and the	

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F 835	Continued From page 11 performance and continually improved. This had the potential to affect 33 residents residing in the facility. When interviewed on 8/10/23 at 11:19 a.m., the administrator stated she was unable to provide any quality improvement documentation or meeting minutes. There was "a lot going on" since the previous director of nursing left and the facility "just hasn't been able to work on things". The administrator acknowledged the QAPI should have a performance improvement plan (PIP), but the facility quality measures were 4 and 5 stars and there wasn't much identified to work on. The administrator stated the dishwasher problem had been worked on for a long time and she had been unaware of it not working until survey started on 8/7/23. The kitchen staff had been educated about monitoring the sanitizer and water temperatures, but she was not aware that had not been done and it was unknown how long the dishwasher was not working. Furthermore, the administrator did not know what the delay in installation was and acknowledged had been months since the contract was signed. The administrator stated the dishwasher problem was fixed yesterday and had not been notified by kitchen staff the dishwasher was still not functioning properly. The administrator was sure she had sent an email inquiring about the delay in instillation but was not able to provide one. The administrator was aware of one oven not functioning properly but was not aware of the others not working. The administrator had not been aware of any concerns with the ability to provide therapeutic diets. The administrator stated there had been continued education to the cook (C)-A and thought the education had been sufficient and stated there was no education	F 835	overall Quality Program of the facility. Administrator will be re-educated on QAPI policies & procedures. F803 - Corporate RD and DM have developed a plan of correction to address all concerns cited, developed policies related to menu substitution, will implement staff training, and complete audits as described in POC. F865 & F867 - The facility did identify deficient practices in the kitchen from a Mock Survey dated 7/10/23 as well as through a quarterly review from the Corporate RD and this was noted in the QAPI minutes. Minutes will be made available to surveyors during re-survey. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur: Regional Director or their Corporate Designee will be onsite in facility 2 or more days per week to monitor the implementation of the POC, ensure building/equipment repairs are addressed timely, coordinate/implement monthly Quality Improvement Workgroup, attend quarterly QAPI Committee per POC and provide additional training, support and oversight of the Administrator. The Regional Director and/or Designee will provide this onsite support for two months and then review progress with QAPI Committee for additional support & recommendations.	

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F 835	Continued From page 12 documentation or monitoring in place. The Administrator acknowledged "there was a lot of work to be done". A facility policy titled Quality Assurance Process Improvement Plan revised 10/8/18, directed the administrator had the responsibility for ensuring that QAPI was implemented throughout the care center. A facility document titled Job Description Nursing Home Administrator no date, directed the administrator was responsible for assuming administrative authority, responsibility and accountability of all activities and programs of the care center including: -making routine inspections of the care center to assure that established policies and procedures are being implemented and followed. -conduct departmental performance evaluations in accordance with policy and procedures. -ensure the care center is maintained in a safe manner by assuring necessary equipment was maintained to perform services. -assist the quality improvement committee in developing and implementing plans to correct identified quality deficiencies. -ensure all individuals receiving services receive care in a manner that maintains or enhances their quality of life without impeding on the rights and safety of others.	F 835		
F 865 SS=F	QAPI Prgm/Plan, Disclosure/Good Faith Attmpt CFR(s): 483.75(a)(1)-(4)(b)(1)-(4)(f)(1)-(6)(h)(i) §483.75(a) Quality assurance and performance improvement (QAPI) program. Each LTC facility, including a facility that is part of a multiunit chain, must develop, implement, and	F 865		10/20/23

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F 865	Continued From page 13 maintain an effective, comprehensive, data-driven QAPI program that focuses on indicators of the outcomes of care and quality of life. The facility must: §483.75(a)(1) Maintain documentation and demonstrate evidence of its ongoing QAPI program that meets the requirements of this section. This may include but is not limited to systems and reports demonstrating systematic identification, reporting, investigation, analysis, and prevention of adverse events; and documentation demonstrating the development, implementation, and evaluation of corrective actions or performance improvement activities; §483.75(a)(2) Present its QAPI plan to the State Survey Agency no later than 1 year after the promulgation of this regulation; §483.75(a)(3) Present its QAPI plan to a State Survey Agency or Federal surveyor at each annual recertification survey and upon request during any other survey and to CMS upon request; and §483.75(a)(4) Present documentation and evidence of its ongoing QAPI program's implementation and the facility's compliance with requirements to a State Survey Agency, Federal surveyor or CMS upon request. §483.75(b) Program design and scope. A facility must design its QAPI program to be ongoing, comprehensive, and to address the full range of care and services provided by the facility. It must:	F 865		

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F 865	Continued From page 14 §483.75(b)(1) Address all systems of care and management practices; §483.75(b)(2) Include clinical care, quality of life, and resident choice; §483.75(b)(3) Utilize the best available evidence to define and measure indicators of quality and facility goals that reflect processes of care and facility operations that have been shown to be predictive of desired outcomes for residents of a SNF or NF. §483.75(b) (4) Reflect the complexities, unique care, and services that the facility provides. §483.75(f) Governance and leadership. The governing body and/or executive leadership (or organized group or individual who assumes full legal authority and responsibility for operation of the facility) is responsible and accountable for ensuring that: §483.75(f)(1) An ongoing QAPI program is defined, implemented, and maintained and addresses identified priorities. §483.75(f)(2) The QAPI program is sustained during transitions in leadership and staffing; §483.75(f)(3) The QAPI program is adequately resourced, including ensuring staff time, equipment, and technical training as needed; §483.75(f)(4) The QAPI program identifies and prioritizes problems and opportunities that reflect organizational process, functions, and services provided to residents based on performance indicator data, and resident and staff input, and	F 865		

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F 865	Continued From page 15 other information. §483.75(f)(5) Corrective actions address gaps in systems, and are evaluated for effectiveness; and §483.75(f)(6) Clear expectations are set around safety, quality, rights, choice, and respect. §483.75(h) Disclosure of information. A State or the Secretary may not require disclosure of the records of such committee except in so far as such disclosure is related to the compliance of such committee with the requirements of this section. §483.75(i) Sanctions. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to implement a comprehensive Quality Assurance and Performance Improvement (QAPI) program that identified concerns with care in the facility were identified reviewed to maintain acceptable levels of performance and continually improved. This had the potential to affect 33 residents residing in the facility. Findings include: The facility's QAPI meeting minutes for the past three meetings was requested, however was not provided. Documentation and evidence of the facility's ongoing performance improvement activities was	F 865	What corrective action will be accomplished for those residents found to have been affected by the deficient practice: No specific residents were identified to be affectd by the alleged deficient practice. Administrator received immediate re-education regarding QAPI activities, policies, and meeting requirements. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken: QAPI minutes were reviewed for the prior three quarters and verified that they were	

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F 865	Continued From page 16 requested, however was not provided. Documentation and evidence of a recent performance improvement plan (PIP) was requested, however was not provided. When interviewed on 8/10/23 at 11:19 a.m., the administrator was unable to provide QAPI meeting minutes or documentation ongoing quality improvement activities. The administrator acknowledged the QAPI team was not able to get started on any work as there had been some changes in nursing and kitchen leadership. The administrator stated there had been some education for nursing assistants and documentation of the different resident assistance levels, however there was no documented follow-up to ensure the education was effective. The QAPI team reviewed the facility quality measures and stated overall, they receive 4 or 5 stars so there was not many concerns to work on. The administrator stated she was aware the QAPI team was "supposed to have a PIP and there was always room to improve on something" but acknowledged there had not been any work on one. A facility policy titled Quality Assurance Process Improvement Plan revised 10/8/18, directed the QAPI committee will review data from relevant sources to monitor and assure systems are being maintained to achieve the highest level of quality care for the care center. Furthermore, the policy directed staff will identify areas for improvement and determine PIPs.	F 865	complete. What measures will be put into place, or systemic changes made to ensure that the deficient practice will not recur: QAPI Meetings were held for Q1 on 1/24/2023, Q2 on 6/27/2023, and Q3 on 7/31/2023. The next quarterly meeting is scheduled for 10/11/2023. The facility does have an active QAPI program in which quality improvement efforts are identified based on resident satisfaction surveys, quality measures, complaints/grievances, survey results, PIIP/QIIP and other factors. These quality improvement measures are continually being reassessed, modified and enhanced for improvement. Administrator will be re-educated on QAPI Policy, Program Documentation, Administrator roles & responsibilities in job description. How will facility monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur: Regional Director of Operations, Corporate Director of Quality or their designee will attend next two quarterly meetings to ensure compliance with regulations. If compliant, attendance at meetings will be discontinued.	
F 867 SS=F	QAPI/QAA Improvement Activities CFR(s): 483.75(c)(d)(e)(g)(2)(i)(ii)	F 867		10/20/23

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F 867	Continued From page 17 §483.75(c) Program feedback, data systems and monitoring. A facility must establish and implement written policies and procedures for feedback, data collections systems, and monitoring, including adverse event monitoring. The policies and procedures must include, at a minimum, the following: §483.75(c)(1) Facility maintenance of effective systems to obtain and use of feedback and input from direct care staff, other staff, residents, and resident representatives, including how such information will be used to identify problems that are high risk, high volume, or problem-prone, and opportunities for improvement. §483.75(c)(2) Facility maintenance of effective systems to identify, collect, and use data and information from all departments, including but not limited to the facility assessment required at §483.70(e) and including how such information will be used to develop and monitor performance indicators. §483.75(c)(3) Facility development, monitoring, and evaluation of performance indicators, including the methodology and frequency for such development, monitoring, and evaluation. §483.75(c)(4) Facility adverse event monitoring, including the methods by which the facility will systematically identify, report, track, investigate, analyze and use data and information relating to adverse events in the facility, including how the facility will use the data to develop activities to prevent adverse events.	F 867		

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F 867	Continued From page 18 §483.75(d) Program systematic analysis and systemic action. §483.75(d)(1) The facility must take actions aimed at performance improvement and, after implementing those actions, measure its success, and track performance to ensure that improvements are realized and sustained. §483.75(d)(2) The facility will develop and implement policies addressing: (i) How they will use a systematic approach to determine underlying causes of problems impacting larger systems; (ii) How they will develop corrective actions that will be designed to effect change at the systems level to prevent quality of care, quality of life, or safety problems; and (iii) How the facility will monitor the effectiveness of its performance improvement activities to ensure that improvements are sustained. §483.75(e) Program activities. §483.75(e)(1) The facility must set priorities for its performance improvement activities that focus on high-risk, high-volume, or problem-prone areas; consider the incidence, prevalence, and severity of problems in those areas; and affect health outcomes, resident safety, resident autonomy, resident choice, and quality of care. §483.75(e)(2) Performance improvement activities must track medical errors and adverse resident events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the	F 867		

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F 867	Continued From page 19 facility. §483.75(e)(3) As part of their performance improvement activities, the facility must conduct distinct performance improvement projects. The number and frequency of improvement projects conducted by the facility must reflect the scope and complexity of the facility's services and available resources, as reflected in the facility assessment required at §483.70(e). Improvement projects must include at least annually a project that focuses on high risk or problem-prone areas identified through the data collection and analysis described in paragraphs (c) and (d) of this section. §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; (iii) Regularly review and analyze data, including data collected under the QAPI program and data resulting from drug regimen reviews, and act on available data to make improvements. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to maintain a quality assessment and assurance (QAA)/quality assurance process improvement (QAPI) committee that was effective in identifying, implementing actions, and	F 867	What corrective action will be accomplished for those residents found to have been affected by the deficient practice:	

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F 867	Continued From page 20 continued monitoring to ensure residents received nutritive therapeutic diets and the facility kitchen had sanitary and functioning equipment. This deficient practice had the potential to affect all 33 residents currently residing in the facility. Findings include: The Certification and Survey Provider Enhanced Reports (CASPER)-3 (assessment data was converted to quality measures (QM) to evaluate nursing home's performance) dated 8/3/23, identified the following prior deficiency by month and year: -F812-Food Procurement, Store/Prepare/Serve Sanitary conditions were cited on prior survey 3/23/22, and was cited at a scope and severity (S&S) of an E. The facility's QAPI meeting minutes for the past three meetings was requested however was not provided. Records of communication or email regarding maintenance on the facility dishwasher and ovens was requested however was not provided. A facility dishwasher quote dated 1/26/23, indicated a new dishwasher with instillation was received from Upper Lake Foods Incorporated. However, there was no signature of acceptance and lacked evidence the facility was agreeable to the quoted price, or the dishwasher was ordered. A facility lease agreement from LRS Leasing dated 5/9/23, indicated a high heat dishwasher was leased starting on 3/1/23. Records of communication or email regarding	F 867	No specific residents were identified to be affected by the alleged deficient practice. How other residents having the potential to be affected by the same deficient practice will be identified: The deficient practice has the potential to impact all newly admitted residents. What measures will be put into place, or systemic changes made to ensure that the deficient practice will not recur: The facility did conduct QAPI Meetings for Q1 on 1/24/23, Q2 on 6/27/2023, and Q3 on 7/31/2023. Sanitary Conditions of the Kitchen were noted in the minutes for both the June and July meeting minutes and will be provided to the surveyors during re-survey. Administrator has been re-educated on Administrator Roles & Responsibilities per the job description, QAPI policy, and QAPI Plan. The facility will be implementing a Quality Improvement Workgroup that will meet monthly in between the QAPI Committee. This group will assist in monitoring the POC, develop/review resident satisfaction action plans, review findings from corporate quality/operations/dietary/environmental audits/mock surveys, assist in identifying additional deficient practices & initiating performance improvement plans to present to QAPI Committee. The first	

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F 867	Continued From page 21 delay of dishwasher instillation was requested however was not provided. Staff education on therapeutic diets, maintaining appropriate levels of sanitizer and appropriate temperature for the dishwasher and any evidence of monitoring of compliance was requested however was not provided. F803: Based on observations, interviews, and document review, the facility failed to ensure menus were followed, met the nutritional needs of the residents, and were reviewed by the facility Registered Dietitian (RD). This has the potential to affect all 33 residents. See F812 When interviewed on 8/10/23 at 11:19 a.m., the administrator was unable to provide QAPI meeting minutes or documentation ongoing quality improvement activities. The administrator acknowledged the QAPI team was not able to get started on any work as there had been some changes in nursing and kitchen leadership. The administrator stated there has been ongoing work to replace the dishwasher and the latest contract for pricing was signed in January. The administrator was not sure what was taking so long for the dishwasher to arrive and further stated the kitchen staff have had numerous reminders and education about the need to ensure the dishwasher temps and sanitation was working properly. The administrator was unaware the dishwasher was not working properly or for how long. The administrator acknowledged there was no documentation of the education or monitoring to ensure staff were following the correct process to ensure	F 867	meeting will be in September with the full QAPI Committee in October. The new dishwasher is being installed on 9/12/2023. The facility will document all individual and group education specific to the POC for therapeutic diets, DW operation and ongoing monitoring. The facility will also implement this practice of formally documenting any education when deficient practices are specific to an individual or if all staff need to be educated. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur: Regional Director, Director of Quality and/or their designee will be present at the monthly and quarterly meetings for 6 months to ensure proper QAPI policies & processes are followed. If in compliance, Regional Director and Director of Quality discontinue attendance based on QAPI Committee direction and monitor progress through site visits and review of meeting minutes.	

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F 867	Continued From page 22 dishwasher temperatures and sanitation was working. The administrator was waiting on a quote for the combi-oven but wasn't sure when the quote was requested. The oven with the broken door latch was approved to be replaced but waiting until October and the new fiscal year to order. The administrator was not aware of the other ovens not working and it had not been brought to her attention by the kitchen manager. The administrator stated staff were expected to place any repair requests in the maintenance book and verified this was not completed. Furthermore, the administrator was not aware of any recent concerns or a lack of therapeutic menus. There had been some concerns and kitchen staff had training recently from a dietary manager from another facility. The training was on therapeutic diets and included portion sizes. The administrator further stated the cook had been educated many times about finger food options and the cook "knew better." The administrator verified she had not been able to find documentation of the education and there was not a system in place for monitoring to ensure residents had received appropriate diets. The administrator expected dietary staff to be aware and report equipment concerns and understand what was needed to serve residents appropriate therapeutic diets A facility policy/procedure titled Quality Assurance Process Improvement Plan revised10/8/18, directed the QAPI committee minutes will reflect ongoing performance improvement plans, team members who are responsible for the plans and results of the projects. Furthermore, the policy/procedure directed the QAPI committee to monitor progress to ensure interventions or actions are implemented and effective in making	F 867		

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F 867	Continued From page 23 sustaining improvements.	F 867		
F 880 SS=F	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 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	F 880		10/20/23

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F 880	Continued From page 24 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 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 and interview, the facility failed to ensure staff were following standard precaution guidelines to prevent the spread of infection by wearing personal protective equipment (PPE), while processing contaminated linens. This had the potential to affect all 33 residents who resided within facility.	F 880	All nursing staff were educated on what PPE is to be worn when using the hopper to rinse out contaminated linen. DON put gowns in the soiled utility rooms and ensured that protective eyewear and gloves were also available. Signs were posted in the soiled utility rooms that state to wear gowns, gloves, masks and	

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F 880	Continued From page 25 Findings include: On 8/9/23 at 2:19 p.m., nursing assistant (NA)-A provided a tour of a soiled utility room and described the process for gathering, sorting, and bagging of clothes and linens, NA-A stated soiled clothing and linens had to be rinsed out in the hopper sink located in the soiled utility room. NA-A stated protective eyewear and latex gloves needed to be worn when operating the hopper. NA-A further stated gowns were not donned when the hopper was used, and gowns were not available in the soiled utility room. On 8/09/23 at 2:42 p.m., NA-B provided a tour of a second soiled utility room and described the process for gathering, sorting, and bagging of clothes and linens, NA-B stated soiled clothing and linens had to be rinsed out in the hopper sink located in the main soiled utility room. NA-B stated protective eyewear and latex gloves needed to be worn when operating the hopper. NA-B further stated gowns were not donned when the hopper was used, and gowns were not available in the soiled utility room. During interview on 8/10/23 at 9:08 a.m. ,the director of nursing/Infection Preventionist (DON), stated she expected staff to wear a gown, gloves, mask, and eye protection when they use the hopper. DON also stated education is provided to teach proper handling procedures of the linens. further, the DON stated it was important for staff to wear the proper PPE to prevent the spread of infection. Facility policy titled, Linen Handling, last revised 3/20/17, consisted of all soiled linen or clothing would be rinsed out in a hopper in the soiled utility	F 880	protective eyewear when using the hopper. The Linen Handling policy was reviewed, and no revisions were made. DON or designee will audit to see if proper PPE was worn and or randomly interview staff to see if they know the correct procedure. This will be done 3x/week for 4 weeks, 2x/week for 3 weeks, 1x/week for 2weeks. Housekeeping will audit supplies weekly. Audit results will be brought to QAPI for further recommendations and ongoing monitoring.	

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F 880	Continued From page 26 room; workers to re-bag pre-rinsed linens and clothing before placing in a laundry cart or depositing in laundry chute; and that gloves, gowns, and face masks would be used by staff.	F 880		
F 883 SS=D	Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2) §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. §483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal	F 883		10/20/23

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F 883	Continued From page 27 immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure 1 of 1 resident (R12), admitted during the 2022/2023 influenza season (October 1 through March 31) was offered the influenza vaccine in accordance with the Center of Disease Control (CDC) recommendation. Findings include: R12's admission Minimum Data Set (MDS) dated 01/12/23, indicated R12 was cognitively intact and was admitted to the facility on 1/12/2023. R12's face sheet dated 01/12/23, indicated diagnoses included, ataxia (loss of control of body movements) hypertension, bifascicular	F 883	R12 was offered the Influenza vaccine. Reports he is a non-vaccer related to diagnosis and personal preference. VIS offered declined, VAR reviewed signature obtained Care plan updated. Resident does not want to be offered vaccines. This could potentially happen to all residents that are newly admitted. DON and or designee went through all new admits since 10/21/2022 last flu-vaccination day, ensuring that the resident had the influenza vaccine and if not, they were offered the vaccine. If any had not received it and were not offered, they will be offered the influenza vaccine.	

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F 883	Continued From page 28 block (abnormal heart beat), and polyneuropathy (peripheral nerve damage). R12's Immunization Report dated 8/10/23, indicated R12 did not receive the influenza vaccine while at the facility, and his medical record lacked evidence the influenza vaccine was offered or contraindicated. During interview on 8/10/23, at approximately 1:00 p.m., the DON acknowledged R12's record lacked evidence the influenza vaccine was offered or declined. The facility's Influenza Vaccination Policy, last revised 7/18/23, indicated all residents will be offered the influenza vaccine annually between October 1st and March 31st. In addition, the policy also indicated documentation of evidence the resident or resident's representative was provided education regarding the benefits and side effects of influenza and pneumococcal immunizations will be put on file and the resident's immunization history will be documented and maintained on the immunization record for each resident's medical record.	F 883	The Resident Immunizations policy was reviewed with no revisions made. A consent form was made for nursing staff to use for each admission and added to the admission packet. Nursing staff were educated on the policy/procedure of receiving a signature for either consent or declination. DON or designee will do audits on new admissions to ensure that they were offered vaccinations if needed. Audits will occur with each new admission for 3 months. Results of the audits will be brought to QAPI for further recommendations and monitoring.	
F 908 SS=F	Essential Equipment, Safe Operating Condition CFR(s): 483.90(d)(2) §483.90(d)(2) Maintain all mechanical, electrical, and patient care equipment in safe operating condition. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure essential kitchen equipment was maintained in operating condition. This could affect all 31 residents.	F 908	What corrective action will be accomlished for those residents found to have been affected by the deficient practice:	10/20/23

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F 908	Continued From page 29 Findings include: Observation of the kitchen equipment during the initial tour on 08/07/23 at 11:50 a.m., revealed the convection oven located in the main kitchen had a sign on the front door indicating the device was "out of order." A second oven in the main kitchen with six burners next to the convection oven had the oven door propped open with tape. The oven door would not close and could not be used . Observation on 08/07/23 at 11:55 a.m., revealed a third oven in the main kitchen, one with two ovens, a griddle on top on one side and six burners on top on the other side, revealed the oven to the right side burned too hot for all food placed onto it and the oven on the left cooked too slow requiring over twice the amount of time to cook one item. Observation of one sink near the walk-in refrigerator/freezer on 08/07/23 at 12:00 p.m., revealed one of two sinks connected had a large hole where a commercial garbage disposal once was used. Interview on 08/07/23 at 12:15 p.m., the dietary manager (DM) stated the convection oven was waiting for approval for repairs. According to the DM at this time, a man just looked at the convection oven and "we are waiting to see what needs to be done and the charges." She indicated she told maintenance about the other stoves, and nothing had happened. The DM had no invoice or documentation anyone had looked at the convection oven in order to assess and make repairs.	F 908	It is the practice of ZHS to ensure kitchen equipment is maintained properly. No specific residents were identified to be affected by the alleged deficient practice. A Maintenance Book was implemented in the Kitchen and staff educated to enter any maintenance/equipment issues identified. How the facility will identify other residents having the potential to be affected by the same deficient practice: All necessary equipment that needs repair work have been idenfitied and service has been scheduled. The Maintenance Book has been implemented in the kitchen to record any new issues. What measures will be put into place, or systemic changes made to ensure that the deficient practice will not recur: As soon as issues were discovered with the convection oven located in the main kitchen the DM contacted Legend Companies and requested a service person to come to ZHS and look at the oven. The service person stated that he would get a quote to the DM. At the time of the survey the facility was waiting for the quote. After continuous follow up with Legend Companies to send over the quote ZHS received it on 8/24/2023. The quote was approved to move forward with the repair and the DM notified Legends Companies.	

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F 908	Continued From page 30 Interview on 08/08/23 at 8:30 a.m., the maintenance director (MD) stated he was not told these kitchen devices did not work (ovens and garbage disposal). He had no work order or maintenance request to look at the ovens and garbage disposal. He also stated someone looked at the convection oven. The MD was unable to provide documents of any item in the kitchen in disrepair had been assessed for necessary repairs and costs. Review of the maintenance logbook at the nursing station on 08/10/23 at 8:45 a.m., revealed no entries from the kitchen staff or anyone regarding the essential equipment such as ovens and garbage disposals that were in disrepair. Interview on 08/09/23 at 3:30 p.m., the administrator stated, "we do not have a policy or procedure for maintenance repairs, we put the request in the maintenance logbook and take it from there."	F 908	ZHS has contacted a service technician to inspect the second oven in the main kitchen with six burners next to the convection oven with the door. Any service needs on that oven will be implemented based on the Service Tech's recommendations. One of the two sinks that had a hole for a commercial garbage disposal had a new disposal was installed on 9/5/23. The facility had another commercial garbage disposal in the kitchen that was in working condition. The Administrator created a maintenance book for the dietary department. This book is located in the dietary department. All staff are being trained regarding the of documenting equipment issues immediately. If the issue is emergent staff need to contact maintenance and/or the Administrator right away and document the issue in the book. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur: Administrator or designee will audit 3 times per week for 2 weeks, then 2 times per week for 1 week, then on a random basis. The auditing results will be reported at quarterly QAPI meetings for recommendations and ongoing monitoring.	
F 924 SS=F	Corridors have Firmly Secured Handrails	F 924		10/20/23

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F 924	Continued From page 31 CFR(s): 483.90(i)(3) §483.90(i)(3) Equip corridors with firmly secured handrails on each side. This REQUIREMENT is not met as evidenced by: Based on observations and interview, the facility failed to ensure handrails were equipped on both sides of the corridor for two corridors. This has the potential to affect 15 residents. Findings include: Observation on 08/08/23 at 10:25 a.m., revealed the lower-level therapy area corridor was not equipped with handrails on either side of the corridor. The corridor was 102 feet from the elevator past the therapy area to the exit door and eight feet wide. Observation on 08/10/23 at 12:15 p.m., revealed a small 10 foot long by eight feet wide corridor leading from the main dining room on the upper level and the first floor to the main corridor was not equipped with handrails on either side of this corridor. Residents in the dining room use the corridor to access their bedrooms. Interview on 08/09/23 at 7:50 a.m., the occupational therapy aide (OTA), indicated therapy walked residents in the lower-level corridor without handrails. OTA stated, "it would be nice if we had handrails downstairs." Interview on 08/10/23 at 12:20 p.m., the administrator stated she did not notice the lack of handrails in the lower level and/or dining room corridor.	F 924	Corrective action will be accomplished for those residents found to have been affected by thedeficient practice: It is the practice of ZHS to ensure the safety of all residents. No residents were specifically identified to be affected by this deficient practice. All current residents will not be walked in the lower level hallway or the corridor connecting to the dining room until handrails are installed. Residents will be walked by therapy on the main level of the facility where handrails are present. A sign has been posted at the corridor notifying staff and directing residents to use the main corridor for entrance/exiting of the dining room. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken: Therapy Director was notified to not have any residents walking in the lower level therapy hallways until handrails are installed. Therapy will only walk residents on the main level of the nursing home where handrails are installed. A sign is posted in the short corridor notifying staff and directing residents to use the main corridor for entrance/exiting of the dining	

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	245376	A. BUILDING _____ B. WING _____	C 08/10/2023

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F 924	Continued From page 32	F 924	room. What measures will be put into place, or systemic changes made to ensure that the deficient practice will not reoccur: Handrails have been ordered for the lower level therapy hallway and the service corridor by the resident dining room. Handrails will be installed as soon as they are delivered. A full audit of the facility resident areas has been conducted to ensure that handrails are present in all corridors. How the facility will montior its corrective actions to ensure that the deficient practice is being corrected and will not reoccur: The Administrator will monitor the installation of handrails in the corridors and report to QAPI Committee when completed. The Safety/AWAIR committee will monitor that facility handrails are in all resident use corridors and that they are secure and findings will be reported to QAPI.	

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K 000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety Code survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 08/09/2023. At the time of this survey, ZUMBROTA CARE CENTER 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 | 09/07/2023

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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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. ZUMBROTA CARE CENTER is a 1-story building, with a partial basement The building was constructed at (3) different times. The original building was constructed in 1964 and was determined to be of Type II (000) construction, with a partial basement. In 1968, an addition was constructed and was determined to be of Type II (000) construction, with no basement. Finally, in 2014 a 2-story addition was	K 000		

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K 000	Continued From page 2 constructed and was determined to be of Type II (000) construction, with no basement. Because the original building and the (2) additions meet the construction types allowed for existing buildings, those portions of the facility were surveyed as one building. Because the original building and additions are compatible construction types allowed for existing buildings of this height, the facility was surveyed as one building as allowed in the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care Occupancies. The facility is fully protected throughout by an automatic sprinkler system and has a fire alarm system with smoke detection in corridors and spaces open to the corridors which is monitored for automatic fire department notification. The facility has a capacity of 40 beds and had a census of 31 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 345 SS=D	Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72	K 345		10/20/23

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K 345	Continued From page 3 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to maintain and test the fire alarm system per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.4.1, 9.6.1.3, and NFPA 72 (2010 edition), National Fire Alarm and Signaling Code, section 17.145.5. This deficient finding could have a isolated impact on the residents within the facility. Findings include: On 08/09/2023 between 9:00 AM and 12:30 PM, it was revealed by observation that the manual fire alarm pull-station located in the Day Room was fully access obstructed. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 345	The item obstructing the manual fire alarm pull-station in the Day Room was moved. Signage will be posted on 9/7/23 stating “please not obstruct the fire alarm pull-station. Maintenance Director (MD) will audit pull stations throughout the facility weekly for one month.	
K 353 SS=F	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source	K 353		10/20/23

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K 353	Continued From page 4 _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview the facility failed to maintain the sprinkler system in accordance with NFPA 101 (2012 edition), Life Safety Code, sections 4.6.12, 9.7.5, 9.7.6 and NFPA 25 (2011 edition) Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, section(s), 5.2.2.2 , NFPA 13 (2010 edition), Standard for the Installation of Sprinkler System, sections 7.7.1.4, 8.5.6. These deficient findings could have a widespread impact on the residents within the facility. Findings include: 1. On 08/09/2023 between 9:00 AM and 12:30 PM, it was revealed by observation that in the Basement Boiler Room Corridor that cabling was attached to a hanger of the sprinkler system piping. 2. On 08/09/2023 between 9:00 AM and 12:30 PM, it was revealed by observation that in the Basement Storage Room that cable bundles were resting upon and presenting weight loading to the sprinkler system piping. 3. On 08/09/2023 between 9:00 AM and 12:30 PM, it was revealed by observation that in the Basement Boiler Room that piping was resting upon and presenting weight loading to the sprinkler system piping.	K 353	Findings 1 through 4 regarding cable bundles being attached to the sprinkler system piping system have all been attached to the ceiling. Administrator to verify completion. Finding 5 regarding a sprinkler head in the basement storage room was found to be obstructed by storage. The boxes have been removed. Administrator to verify completion.	

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K 353	Continued From page 5 4. On 08/09/2023 between 9:00 AM and 12:30 PM, it was revealed by observation that in the Basement Boiler Storage Room that cable bundles were resting upon and presenting weight loading to the sprinkler system piping. 5. On 08/09/2023 between 9:00 AM and 12:30 PM, it was revealed by observation that in the Basement Boiler Storage Room that a sprinkler head was found obstructed by storage. An interview with the Maintenance Director verified these deficient findings at the time of discovery.	K 353		
K 920 SS=D	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 immediately upon completion of the purpose for	K 920		10/20/23

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K 920	Continued From page 6 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 manage usage of relocatable power taps in accordance with NFPA 99 (2012 edition), Health Care Facilities Code, section 10.2.3.6, and NFPA 70, (2011 edition), National Electrical Code, sections 110.3(B), 400.8 (1) and UL 1363. This deficient finding could have an isolated impact on the residents within the facility. Findings include: On 08/09/2023 between 9:00 AM and 12:30 PM, it was revealed by observation, that in RM 108, an appliance (refrigerator) was connected to a relocatable power tap. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 920	Appliance in room 108 is now directly plugged into a wall outlet. Education was provided to the staff member on the health care facilities code. MD will audit appliances throughout the facility weekly for one month.	
K 923 SS=F	Gas Equipment - Cylinder and Container Storag CFR(s): NFPA 101 Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited- combustible construction, with door (or gates outdoors) that can be secured. Oxidizing	K 923		10/20/23

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K 923	Continued From page 7 gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain proper medical gas storage and management per NFPA 99 (2012 edition), Health Care Facilities Code, sections 11.3.2. These deficient findings could have a widespread impact on the residents within the facility. Findings include: 1. On 08/09/2023 between 9:00 AM and 12:30	K 923	The mixed storage of empty and full O2 cylinders were correctly placed on 8/9/23. The med gas storage room where O2 tanks are stored contain less than or equal to 300 cubic feet in a single smoke compartment. Staff have been trained that if there is no white tab on an O2 tank they are not to use that tank. The west corridor room where O2 tanks	

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K 923	Continued From page 8 PM, it was revealed by observation that in the Med Gas Storage Room there was mixed storage of empty / full cylinders. 2. On 08/09/2023 between 9:00 AM and 12:30 PM, it was revealed by observation that in the Med Gas Storage Room was found unsecured - leaving the cylinders exposed to tamper and unauthorized access. 3. On 08/09/2023 between 9:00 AM and 12:30 PM, it was revealed by observation that in the West Corridor of the facility adjacent to the Bathing Room, there was unsecured storage of Med Gas cylinders in the open corridor. At time of discovery cylinders were fully exposed to tamper and unauthorized access. 4. On 08/09/2023 between 9:00 AM and 12:30 PM, it was revealed by observation that in the Basement Housekeeping Office, there was unsecured storage of Med Gas cylinders and exposure to combustible materials that were locate within 5 feet of the cylinders. At time of discovery cylinders were fully exposed to tamper and unauthorized access. An interview with the Maintenance Director verified these deficient findings at the time of discovery.	K 923	are stored contain less than or equal to 300 cubic feet in a single smoke compartment. Staff have been trained that if there is no white tab on an O2 tank they are not to use that tank. The tank in the basement housekeeping office has been removed. The DM or designee will audit 2 times a week for 1 month and 1 time per week for 1 month. The auditing results will be reported at quarterly QAPI meetings for recommendations and ongoing monitoring. As well as the monthly safety AWAIR meeting.	
K 926 SS=C	Gas Equipment - Qualifications and Training CFR(s): NFPA 101 Gas Equipment - Qualifications and Training of Personnel Personnel concerned with the application, maintenance and handling of medical gases and cylinders are trained on the risk. Facilities	K 926		10/20/23

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K 926	Continued From page 9 provide continuing education, including safety guidelines and usage requirements. Equipment is serviced only by personnel trained in the maintenance and operation of equipment. 11.5.2.1 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on a review of available documentation the facility failed to confirm that a medical gas training program is in use per NFPA 99 (2012 edition), Health Care Facilities Code, section 11.5.2.1. This deficient finding widespread impact on the residents within the facility. Findings include: On 08/09/2023 between 9:00 AM and 12:30 PM, it was revealed by a review of available documentation that documentation presented for review did not confirm initial medical gas training and/or refresher programs training for staff that interface or administer medical gases (O2) in use at the facility. An interview with Administrator verified this deficient finding at the time of discovery.	K 926	The DM is currently providing the required medical gas training for all staff that interface or administer medical gases (O2) in use at the facility. DM will include this training in the new hire onboarding process. Training will be completed annually.	