DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
December 7, 2023

Administrator
Good Samaritan Society - International Falls
2201 Keenan Drive
International Falls, MN 56649

RE: CCN: 245318
Cycle Start Date: October 19, 2023

Dear Administrator:

On November 28, 2023, the Minnesota Departments of Health and Public Safety, completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

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

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
October 31, 2023

Administrator
Good Samaritan Society - International Falls
2201 Keenan Drive
International Falls, MN 56649

RE: CCN: 245318
Cycle Start Date: October 19, 2023

Dear Administrator:

On October 19, 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:

Jen Bahr, RN, Unit Supervisor
Bemidji District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
705 5th Street NW, Suite A
Bemidji, Minnesota 56601-2933
Email: Jennifer.bahr@state.mn.us
Office: (218) 308-2104 Mobile: (218) 368-3683

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of

the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

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

If substantial compliance with the regulations is not verified by January 19, 2024 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by April 19, 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
travis.ahrens@state.mn.us
Cell: 1-507-308-4189

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245318	A. BUILDING _____ B. WING _____	C 10/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - INTERNATIONAL FALLS	2201 KEENAN DRIVE INTERNATIONAL FALLS, MN 56649

(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 10/16/23 - 10/19/23, a survey for compliance with Appendix Z, Emergency Preparedness Requirements, §483.73(b)(6) was conducted during a standard recertification survey. The facility was NOT in compliance. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulation has been attained.	E 000		
E 041 SS=F	Hospital CAH and LTC Emergency Power CFR(s): 483.73(e) §482.15(e) Condition for Participation: (e) Emergency and standby power systems. The hospital must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section and in the policies and procedures plan set forth in paragraphs (b)(1)(i) and (ii) of this section. §483.73(e), §485.625(e), §485.542(e) (e) Emergency and standby power systems. The [LTC facility CAH and REH] must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section. §482.15(e)(1), §483.73(e)(1), §485.542(e)(1), §485.625(e)(1)	E 041		11/29/23

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

Electronically Signed | 11/10/2023

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

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

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

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E 041	Continued From page 3 Based on a review of available documentation and staff interview, the facility failed to test and inspect the generator per NFPA 99 (2012 edition), Health Care Facilities Code, section 6.4.4.1.1.4, and NFPA 110 (2010 edition), Standard for Emergency and Standby Power Systems, section 8.4.1 and 8.4.2. These deficient findings could have a widespread impact on the residents within the facility. Findings include: On 10/17/23 between 9:00 a.m. and 1:00 p.m., available documentation of the emergency generator was reviewed with the environmental services director, maintenance and testing weekly generator inspections were not performed from 10/16/2022 to 10/17/2023. In addition, the 36 month - 4 hour load band test could not be provided. An interview was conducted at the time of the documentation review with the environmental services director and they verified these deficient findings at the time of discovery.	E 041	Preparation and execution of this response and plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. For the purposes of any allegation that the center is not in substantial compliance with federal requirements of participation, this response and plan of correction constitutes the center's allegation of compliance in accordance with section 7305 of the State Operations Manual. E041 LTC Emergency Power It is the policy of this facility to test and maintain essential electrical system equipment (generator) in accordance with Regulation Z and NFPA requirements. Corrective action will include: 1. The maintenance director and/or designee contacted the emergency generator vendor to complete the 36 month 4 hour load bank testing. Load Bank test is scheduled for 11/15/2023 2. The maintenance director and/or designee were trained in the requirement of weekly visual inspections, monthly 30 minute 30% load bank test, annual 4 hour load bank test if monthly testing cannot be completed and 36 month 4 hour load bank test.	

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E 041	Continued From page 4	E 041	Assurance of On-Going compliance: 1. The location□s computerized preventative maintenance program for generators was updated to include weekly visual inspections, monthly 30 minute 30% load bank test, annual 4 hour 30% load bank testing as necessary, and the 36 month 4 hour load bank test. 2. The maintenance director and/or designee will complete weekly visual inspections weekly x4 and weekly thereafter, monthly 30 minute 30% load bank test and monthly thereafter. Completion reports will be provided to the QAPI committee and administrator.	
F 000	INITIAL COMMENTS On10/16/23 - 10/19/23, 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 deficiency issued. H53186406C (MN93970), H53186407C (MN92081), and H53186408 (MN95126). 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		

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F 000	Continued From page 5 Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.	F 000		
F 572 SS=F	Notice of Rights and Rules CFR(s): 483.10(g)(1)(16) §483.10(g) Information and Communication. §483.10(g)(1) The resident has the right to be informed of his or her rights and of all rules and regulations governing resident conduct and responsibilities during his or her stay in the facility. §483.10(g)(16) The facility must provide a notice of rights and services to the resident prior to or upon admission and during the resident's stay. (i) The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. (ii) The facility must also provide the resident with the State-developed notice of Medicaid rights and obligations, if any. (iii) Receipt of such information, and any amendments to it, must be acknowledged in writing; This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure the resident Bill of Rights were provided verbally and ongoing for residents of the facility for 2 of 2 residents (R22, R43) interviewed during resident meeting. This deficient practice had the potential to affect all 48 residents residing in the facility.	F 572	How corrective action will be accomplished for those residents found to have been affected by the deficient practice. It was identified during resident interviews that R22 and R43 didn□t know what the Residents□ Bill of Rights was. R43 was given a copy, R22 declined a copy, stating she already had a copy.	11/28/23

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F 572	Continued From page 6 Findings include: R22's quarterly Minimum Data Set (MDS) dated 9/8/23, identified R22 had no cognitive impairment. R43's quarterly MDS dated 9/12/23, identified R43 had no cognitive impairment. During an interview on 10/17/23 at 1:03 p.m., R22 and R43 stated they did not know what the Residents' Bill of Rights was. R22 thought she received a paper when she was admitted to the facility, and possibly had it in a drawer in her room. R43 did not recall ever receiving anything about it. Neither recalled a resident council meeting where the Bill of Rights was discussed either. During an interview on 10/18/23 at 8:08 a.m., social services designee (SSD) stated she conducted the resident council meetings with residents and had been doing that for approximately a year. The Residents' Bill of Rights was provided to the residents during admission and the booklets were always available at the suggestion box for residents. SSD did not review the rights with residents during resident council because she thought it just needed to be available to residents. During an interview on 10/18/23 at 3:21 p.m., the director of nursing (DON) stated residents and families were given a handbook during the admission process, but it was not verbally discussed with them. It was something that could be done during resident council. The facility Resident's Right for Skilled Nursing	F 572	How the facility will identify other residents having the potential to be affected by the same deficient practice. The facility recognizes that all residents could be affected by this practice. A copy of resident□s rights will be placed at resident bedside and a booklet will continue to be provided upon admission. What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur. An update was made to the resident council agenda; each month a right will be shared and discussed during the meeting. All resident rights will be discussed within each 12 months. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur. Social service designee or delegate will audit resident council meetings monthly for 3 months. Audit will be brought to QAPI for further review by the IDT to discuss any recommendations and/or revisions to process.	

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F 572	Continued From page 7 facilities revised 10/4/16, identified the resident has the right to be informed of his or her rights and of all rules and regulations governing the resident conduct and responsibilities during his or her stay in the facility. The facility policy Notification of Changes in Resident Rights revised 1/18/23, identified the facility would promptly notify the resident and, if known, the resident's legal representative or interested family member when there was a change in resident rights under federal or state law. The policy failed to identify if the facility staff provided ongoing communication to residents about their rights.	F 572		
F 623 SS=D	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or	F 623		11/28/23

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F 623	Continued From page 8	F 623		

discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged.
(ii) Notice must be made as soon as practicable before transfer or discharge when-
(A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section;
(B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section;
(C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section;
(D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or
(E) A resident has not resided in the facility for 30 days.

§483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following:
(i) The reason for transfer or discharge;
(ii) The effective date of transfer or discharge;
(iii) The location to which the resident is transferred or discharged;
(iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request;
(v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman;
(vi) For nursing facility residents with intellectual

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F 623	Continued From page 9 and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure the long term care ombudsman was notified of facility initiated transfers for 1 of 2 residents (R7) reviewed for	F 623	How corrective action will be accomplished for those residents found to have been affected by the deficient practice. It was identified that the facility	

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F 623	Continued From page 10 hospitalization. Findings include: R7's significant change Minimum Data Set (MDS) dated 9/27/23, identified no cognitive impairment. R7's progress notes identified the following: - 9/10/23, R7 was transferred and admitted to the hospital for illness. - 9/12/23, R7 was readmitted following transfer on 9/10/23. - 9/22/23, R7 was transferred to the hospital for illness on 9/18/23 and returned on 9/22/23. R7's medical record lacked evidence notification was sent to the state ombudsman's office regarding the transfers to the hospital. During an interview on 10/18/23 at 2:08 p.m., the director of nursing (DON) stated the process for notifying the state ombudsman was the responsibility of the social services designee (SS)-A and would expect the notification to be done in the required time frame. During an interview on 10/19/23 at 10:45 a.m., the social services designee (SSD) stated the process for notifying the state ombudsman happens every day she works. SSD reviewed the previous evenings progress notes for resident and also pull up a report which identified any residents who were transferred. Once a transfer was identified, a notice would be sent to the state ombudsman and a copy of the notice would be scanned into the resident's chart. SSD stated R7 did not have a notification the ombudsman regarding the transfers on 9/10/23 and 9/18/23. SSD stated did not know what happened but the	F 623	failed to ensure that the Long-Term Care Ombudsman was notified when R7 was transferred and admitted to the hospital on two different occasions. R7 has since returned to the facility. How the facility will identify other residents having the potential to be affected by the same deficient practice. The DNS or designee will complete an audit of residents transferred in the past 30 days to ensure Notice of Transfer/Discharge and Bed hold were issued and Ombudsman notified. What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur. Clinical staff,Household leaders and Social Services will be re-educated regarding completing Notice of Transfer/Discharge policy upon transfer/discharge of a resident. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur. The Social Services Designee or delegate will audit transfers/discharges weekly for 8 weeks then monthly x2 months to ensure resident and/or resident representative and Ombudsman are notified. Audit will be brought to QAPI for further review by the IDT to discuss any recommendations and/or revisions to process	

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F 623	Continued From page 11 notifications were not done. If they were done, there would of been a progress note and the notification scanned in. The facility's Discharge and Transfer Policy dated 12/27/22, identified when a resident was transfer, the facility was required to send a notice to a representative of the Office of the State Long-Term Care Ombudsman.	F 623		
F 625 SS=D	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which	F 625		11/28/23

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F 625	Continued From page 12 specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to provide the resident/responsible party a written bed hold policy at the time of hospital transfer for 1 of 1 residents (R7) who was reviewed for hospitalization. Findings include: R7's significant change Minimum Data Set (MDS) dated 9/27/23, identified no cognitive impairment. R7's progress notes identified the following: - 9/10/23, R7 was transferred and admitted to the hospital for illness. - 9/12/23, R7 was readmitted following transfer on 9/10/23. - 9/22/23, R7 was transferred to the hospital for illness on 9/18/23 and returned on 9/22/23. R7's medical record lacked evidence a bed hold was provided at the time of transfer for either hospitalization. During an interview on 10/16/23 at 2:35 p.m., R7 stated she was hospitalized twice in September 2023, and did not recall receiving a notification of bed hold when she was transferred. During an interview on 10/18/23 at 1:57 p.m., the household coordinator (HC) for Voyageur's Haven unit stated she was working on the unit since the beginning of September 2023, and was not trained on doing bed holds nor had she worked on any for R7. It was the social service designee (SS)-A who would have done that.	F 625	How corrective action will be accomplished for those residents found to have been affected by the deficient practice. It was identified that the facility failed to provide resident a written bed hold policy at time of hospital transfer. How the facility will identify other residents having the potential to be affected by the same deficient practice. The DNS or designee will complete an audit of residents transferred in the past 30 days to ensure resident/responsible party were informed on bed hold policy. What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur. Household leaders, nursing staff and Social Services will be re-educated on Bed Hold Policy procedure. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur. Social Service designee and/or delegate will audit bed hold process 3x/wk for 4 weeks, 1x/wk for 4 weeks then 1x month x 3 months until compliance is sustained. The results will be brought to the monthly QAPI meeting for review and/or further recommendations.	

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F 625	Continued From page 13 During an interview on 10/18/23 at 2:08 p.m., the director of nursing (DON) stated whenever a resident was transferred out of the facility a bed hold should be completed. The staff would either have the resident or resident representative sign it or get verbal consent and document in the chart it was provided. The DON would then expect a copy of the bed hold to be scanned into the resident's chart. It is the responsibility of SS-A to ensure beholds were done. During an interview on 10/19/23 at 10:45 a.m., the SS-A stated she would check if bed holds were done for any resident who was transferred out. If the bed hold was completed, she would expect it to be documented in the chart and a copy of the bed hold scanned to the resident's chart. For R7's transferees in September 2023, the procedure was starting to be delegated to the households to ensure bed holds were done timely. SS-A stated she had not trained the other household leads the process for bed holds and there were no bed bed holds completed for R7's transfer to the hospital on 9/10/23 or 9/18/23. The facility Bed-Hold Policy dated 12/18/22, identified the social worker or designated individual ill provide the notice of bed-hold policy to the resident and/or resident representative.	F 625		
F 641 SS=B	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by:	F 641		11/28/23

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F 641	Continued From page 14 Based on interview and document review the facility failed to ensure accurate coding of the Minimum Data Set (MDS) for 5 of 5 residents (R3, R40, R4, R25, R1) reviewed for restraints; and 1 of 5 residents (R26) reviewed for unnecessary medications. Findings include: R3's quarterly Minimum Data Set (MDS) dated 9/6/23, identified R3 had a severe cognitive impairment and included a diagnosis of multiple sclerosis. A bedrail as used as a restraint daily. R3's care plan revised 9/8/23, identified R3 had an activities of daily living (ADL) self-care performance deficit related to muscle wasting and atrophy and MS. R3 used bilateral bed rails to assist with bed mobility. R3's Physical Devise and/or Restraint Evaluation and Review dated 10/18/23, identified R3's bedrails would not be a restraint for R3. R3's Medication Review Report dated 10/19/23, identified grab bars were used for assisting in bed mobility. During an observation on 10/16/23 at 2:50 p.m., R3 was lying in bed with a grab bar on each side of the bed. During an interview on 10/18/23 at 10:03 a.m., nursing assistant (NA)-A stated R3 used his grab bars to assist with repositioning while in bed. R40's quarterly Minimum Data Set (MDS) dated 9/9/23, identified R40 had severe cognitive impairment and included a diagnosis of cancer	F 641	How corrective action will be accomplished for those residents found to have been affected by the deficient practice. Modifications made to R3, R40, R25, R4 and R1 MDS□s P0100A to reflect that bed rails are not used as a restraint. R26 MDS updated section N0410E to reflect 0 anticoagulants used in the last 7 days. How the facility will identify other residents having the potential to be affected by the same deficient practice. MDS Coordinator will audit all residents with bed rails recent MDS to determine if question P0100A is correct and modify if applicable. In addition reviewing question P0100A, MDS will audit questions N0410 A thru H to ensure accuracy and modify if needed. What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur. The MDS coordinator was re-educated on accurately coding section P0100A on 10/18/23 by state surveyor and review of the RAI manual. The MDS Coordinator was re-educated on question N0410E difference between anticoagulant and antiplatelet on 10/17/23. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur. MDS audits will be completed by the DNS or designee, 2 records will be audited per week for 2 weeks then 1 record weekly for 2 weeks, then 2 records per month ongoing for coding accuracy.	

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F 641	Continued From page 15 with metastasis to the brain. A bedrail was used as a restraint daily. R40's care plan revised 9/6/23, identified R40 had an ADL self-care performance deficit related to weakness. R40 required moderate assist of two for bed mobility with the use of bilateral assist bars. R40s Physical Device and/or Restraint Evaluation and Review dated 9/9/23, identified R40's bedrails would not be a restraint for R40. During an observation on 10/16/23 at 2:00 p.m., R40 was lying in bed with a grab bar on each side of the bed. During an interview on 10/17/23 at 4:14 p.m., nursing assistant (NA)-A and NA-B stated R40 used the grab bars to assist with turning. During an interview on 10/18/23 at 12:08 p.m., registered nurse (RN)-B stated restraints were assessed by visualizing the resident during use, and the only restraints the facility used were bedrails and Wander Guards (devices to alert staff to potentially unsafe wandering). Bedrails were mainly used to promote the resident's independence as much as possible. RN-B stated R3's and R40's bedrails were not restraints because of this and were coded on R3's and R40s' MDS because they used the bedrails daily. R4's quarterly MDS dated 9/24/23, identified sleeve cognitive impairment and included a diagnosis of Alzheimer's disease. R7 was an extensive assist with bed mobility and transfers. A bed rail was used daily as a restraint.	F 641	The auditing results will be reported at the quarterly QAPI meetings for recommendations and ongoing monitoring	

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F 641	Continued From page 16 R4's Physical Device and/or Restraint Evaluation and Review dated 9/24/23, identified R4's bed rails would not be a restraint. During observation on 10/16/23 at 2:53 p.m., R3 was in bed and had bed rails on on the upper portion of both sides of the bed. During an interview on 10/18/23 at 1:40 p.m., NA-C stated R4 uses the bed rails on the bed to help with R3 with bed mobility, and didn't restrict R4's movements. R25's quarterly MDS dated 9/14/23, identified no cognitive impairment and included a diagnosis of paraplegia (paralysis of the legs). R25 was an extensive assist with bed mobility and transfers.A bed rail was used daily as a restraint. R25's Physical Device and/or Restraint Evaluation and Review dated 9/13/23, identified R25 bed rails would not be a restraint. On 10/16/23 at 3:00 p.m., bed rails on upper portion on both sides of R25's bed were observed. R25 stated the bed rails on the bed to helped R25 move from side to side and did not restrict his movement. R1's quarterly MDS dated 9/18/23, identified moderately impaired cognition with a diagnosis of Alzheimer's dementia. R1 was independent with bed mobility. A bed rail was used as a restraint daily. R1's undated care plan identified R1 had an ADL self-care deficit related to dementia, weakness, and unsteady gait. R1 independently used	F 641		

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F 641	Continued From page 17 bilateral grab bars for turning side to side. R1's Physical Device and/or Restraint Evaluation and Review dated 9/15/23, identified R1's bed rails would not be a restraint. During an interview on 10/18/23 at 3:14 p.m., NA-E stated R1 used the grab bar to transfer herself. During an interview on 10/19/23 at 9:02 a.m., NA-D stated R1 used the rails independently for pivot transfers and readjusting in bed. During an interview on 10/18/23 at 3:25 p.m., the director of nursing (DON) stated restraint assessments and MDS were expected to be coded accurately to promote care of the residents. R26's quarterly MDS dated 8/24/23 identified severe cognitive impairment and diagnoses of atrial fibrillation and long-term use of antiplatelet medication. R26 used anticoagulant medication daily. R26's undated provider orders lacked an order for anticoagulant medication. During an interview on 10/17/23 at 3:25 p.m., RN-B confirmed R26 was on Plavix (an antiplatelet medication) at the time of the 8/24/23, MDS and section N of the MDS was looking for anticoagulant (a medication that prevents blood clots from forming, a "blood thinner") use. RN-B recognized now that she had made an error when coding that MDS.	F 641		

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F 641	Continued From page 18 Sanford Policy Rehab/Skilled and Long-Term Care MDS 3.0 dated 6/13/23, identified the purpose was to complete the Resident Assessment Instrument (RAI) within the federally mandated timeline. During the observation period each team member will review the electronic medical record (EMR) to determine if there was accurate documentation to support coding for the MDS. The MDS coordinator would complete a validation verification of the entire MDS. A "significant error" was defined as an error in an assessment where the resident's overall clinical status was not accurately represented (i.e., miscoded) and a significant correction would be completed.	F 641		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure an environment free from accident hazards for 1 of 2 residents (R31) reviewed for accident hazards. Findings include: R31's quarterly Minimum Data Set (MDS) dated 8/22/23, identified R31 had moderately intact cognition and a diagnosis of Parkinson's disease.	F 689	How corrective action will be accomplished for those residents found to have been affected by the deficient practice. R31 distance between mattress and bed rail was identified as being a risk for possible accident due to the space between being greater than 4.75 inches per the FDA. R31 personal mattress was removed immediately and replaced with a standard facility mattress.	11/28/23

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F 689	Continued From page 19 R31 needed limited assistance with bed mobility and transfers. R31's undated, care plan identified R31 was independent with a grab bar on one side of the bed. On 10/16/23 at 2:27 p.m., R31's bed and grab bar were observed. There was a space of about four to five inches between the mattress and the grab bar of R31's bed. On 10/18/23 at 9:58 a.m., the maintenance director (MD) measured five inches in the space between the mattress and grab bar. The MD stated he didn't do any kind of measuring with the bed rails and either the director of nurses (DON) or a nurse manager would know about bed rail safety, he didn't know what the measurements should be. During an interview on 10/18/23 at 10:10 a.m., the DON stated environmental services installed the bed rails, but the DON was not sure if anyone was measuring the entrapment zones of the bed rails. DON recalled R31 brought her own mattress to the facility and that was probably why there was a gap. During an interview on 10/19/23 at 10:14 a.m., the interim-administrator stated he was not sure what the process for inspection and maintenance of beds, mattresses and bed rails was here but that he would check in their maintenance computer system for routine inspection and maintenance. The risks to the resident could be entrapment which could lead to negative outcomes.	F 689	How the facility will identify other residents having the potential to be affected by the same deficient practice. On 10/19/2023 the Maintenance team completed bed and side rail inspections on all facility beds. All other beds were in compliance with the FDA recommendations. What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur. Facility will not allow any outside mattresses unless purchased by Society-approved vendors and measurements. All staff educated on FDA recommendations and the potential harm if recommendations aren't followed, Bed Safety Including Bed Rails, Side Rails, Assist Bars policy. Included in the admission packet for all new resident, a brochure titled "A Guide to Bed Safety." Bed and Side rail inspections will be completed quarterly. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur. All facility beds including the mattresses and bed rails will be inspected quarterly by the maintenance team to ensure bed/mattresses meet FDA recommendations. DNS will audit quarterly X2. Audit will be brought to QAPI for further review by the IDT to discuss any recommendations and/or revisions to process.	

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F 689	Continued From page 20 During an interview on 10/19/23 at 10:33 a.m., the DON stated the risks of bed rails that didn't fit the bed would be entrapment, strangulation and up to death. A facility policy, Bed Safety Including Bed Rails, Side Rails and Assist bars dated 9/28/23, identified bed rail/side rail/assist bar usage would only occur when the total bed environment (bed frame, mattress, rails, and overlays) had been inspected and verified to be free of entrapment risk. The policy further indicated new bed equipment, or any component of bed equipment must be purchased from Society-approved vendors and with approved configurations. The Food and Drug Administration (FDA) identifies seven zones in a hospital-type bed system where there is potential for entrapment. Zone 3 is the area between the rail and the mattress and has a recommended dimension of less than 4.75 inches because this space is made larger by compression of the mattress from the patient's head.	F 689		
F 692 SS=D	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte	F 692		11/28/23

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	245318	A. BUILDING _____ B. WING _____	C 10/19/2023

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F 692	Continued From page 21 balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure ongoing monitoring of weight for nutrition status was implemented as directed for 2 of 2 residents (R2, R21) reviewed fro nutrition. Findings include: R2's quarterly Minimum Data Set (MDS) dated 8/11/23, identified R2 had a severe cognitive impairment and diagnoses included stage 3 pressure ulcer, muscle weakness, and hemiplegia and hemiparesis following a nontraumatic intracerebral hemorrhage. R2 was dependent upon staff for all care areas and had no known weight loss. R2's care plan undated, identified R2 had a potential for alternation in nutrition related to diagnosis and history of losing weight. R2 had a healing pressure ulcer. The care plan lacked to identify R2's weight data collection R2's Medication Review Report dated 1/24/23, identified R2 received a high-calorie shake three times a day wiht meals and as needed if unable to eat/refusal to eat meal. The report lacked to	F 692	How corrective action will be accomplished for those residents found to have been affected by the deficient practice. Facility failed to ensure ongoing monitoring of weight for nutrition status for R2 and R21. R2 and R21 care plans reviewed and updated. How the facility will identify other residents having the potential to be affected by the same deficient practice. All current and future residents have the potential to be affected by the deficient practice. DNS and/or designee will review all residents who are experiencing significant weight loss and ensure they are reviewed during risk committee and have appropriate interventions, assessments and goals completed. What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur. Risk committee will continue meeting on a regular basis to review weights and address any current residents with weight loss to ensure appropriate follow up or	

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F 692	Continued From page 22 identify staff were directed to obtain R2's weight. Dietitican Assessment V2 dated 5/10/23, identified intake adequate to meeting calculated nutrtional requirements exhibited by stable weight. Registered dietitian to monitor weight and intake ongoing, assess annually and as needed. R2's Nutritional Status note dated 10/16/23 at 6:51 p.m., identified R2 was monitored by the interdisciplinary risk team for skin integrity, weight loss concerns. R2's weight was 146 lbs, body mass index (BMI) was in a healthy range at 22.6. R2's weight was stable for one month, but significant decline in the past 6 months. R2 received high calorie shakes, increased kcal/protein, fluid at meals to promote skin integrity. Intake decline noted past week with comfort care consideration by family. Registered dietitian to monitor weight and intake ongoing, assess quarterly and as needed. The care plan failed to to identify the timing of R2's weight data collection. R2's Weights and Vitals Summary identified the following: 1/3/23 168 pounds (lbs) 2/8/23 166.9 lbs 3/9/23 167 lbs 3/15/23 162.2 lbs 3/22/23 162.6 lbs 4/11/23 163 lbs 5/3/23 162.8 lbs 5/31/23 163.2 lbs 6/7/23 163.5 lbs 6/8/23 163.2 lbs 6/14/23 160 lbs 9/15/23 143.6 lbs 10/6/23 145.4 lbs	F 692	interventions. Education provided to clinical staff on weight and height and Nutrional Risk policies and importance of getting weights per the care plans. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur. The DNS and/or desginee will monitor and audit residents who are experiencing significant weight loss to ensure weight monitoring is being completed per the plan of care. Audits scheduled for 3x/wk for 2 weeks, 1x/wk for 4 weeks then 1x month x 3 months until compliance is sustained. The results will be brought to the monthly QAPI meeting for review and/or further recommendations.	

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F 692	Continued From page 23 10/7/23 146 lbs 10/18/23 151 lbs During an interview on 10/18/23 at 1:37 p.m., nursing assistant (NA)-B stated there were four residents that needed to be weighed daily because nursing was watching for fluid retention or because the resident was losing weight. R2 was weighed once a week. During an interview on 10/18/23 at 2:09 p.m., registered dietitian (RD) stated staff believed R2 was not going to have a good outcome because R2 ultimately controlled what she would do. The RD was aware staff were not collecting R2's weights weekly and stated it was discussed in the weekly interdisciplinary team (IDT) meeting weekly. The RD stated she was told R2 refused to be weighed, but RD did not know. The IDT talked about R2's weight collection at least weekly. During an interview on 10/18/23 at 4:58 p.m., registered nurse (RN)-A stated the staff did talk about R2 during the IDT meeting because R2 had struggled with her weight for a while. R2 should be weighed more frequently and R2 had been declining even though there were interventions in place. Staff had not weighed R2 weekly, but had been listed on R2's kardex to be collected weekly since 9/12/20. RN-A stated she was unaware staff were not collecting R2's weight weekly and, especially, that staff were documenting the weight as "not applicable". During an interview on 10/18/23 at 5:34 p.m. the director of nursing (DON) stated were expected to collect resident weights as directed to allow nurses to ensure the resident was safe, healthy	F 692		

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F 692	Continued From page 24 and staff were doing their job. The facility policy Weight and Height revised 9/18/23, identified residents at nutritional risk would be weighed weekly. R21's quarterly MDS dated 9/2/23, R21 did not have short- or long-term memory issues. R21 required set up for meals R21's weight was 142 pounds (lbs). R21's Dietician Assessment dated 6/10/23, identified on 3/1/23, R21 weighed 167.2 lbs and on 6/6/23, R21 weighed 148.2 lbs, a 7.5% weight loss in three months. A nutritional problem was added to R21's care plan but failed to identify staff interventions to prevent further weight loss. R21's undated care plan identified R21 was able to eat independently after set-up and directed staff to weigh R21 per protocol. The care plan failed to to identify the timing of R21's weight data collection. R21's undated, Medication Review Report, identified R21 had a regular diet. The report lacked orders for if/when staff were to obtain weights. R21's Mini-Nutritional Assessment dated 9/1/23, identified R21 had a moderate decrease in food intake, had a weight loss of greater than 6.6 lbs, and was at risk for malnutrition. R21's Dietician Assessment dated 9/26/23, identified R21's appetite had not changed, and did not have an order for medical nutritional supplements. On 3/1/23, R21 weighted 167.2 lbs.	F 692		

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F 692	Continued From page 25 and on 8/9/23, R21 weighed 141.8 lbs identifying a 15.2% weight loss. The assessment failed to identify staff interventions to prevent further weight loss. R21's progress noted dated 9/12/23 through 10/16/23, the following: - 10/3/23, the provider was notified of R21's decreased intake. The provider ordered labwork and recommended follow up once labs were completed. - 10/16/23, the RD was waiting for R21's weekly weight to assess for a trend. On 10/11/23, R21 weighed 125.8 lbs which was a significant weight loss over the past six months, intake was variable, and R21 generally ate less than 50%. R21's case was discussed with the interdisciplinary (IDT) risk team. The dietary manager (DM) recommended staff to continue to encourage and monitor, offer three times per day snacks after meals, provide increased kcal at meals per diet list, and recommended initiation of high cal supplement per MD prescription if undesirable weight loss continued. The note failed to identify a timeframe for follow up. R21's undated, Weights and Vitals report, identified the following weights: - 6/14/23 147.8 lbs - 6/28/23 145.9 lbs - 7/26/23 141.6 lbs - 8/9/23 141.8 lbs - 10/3/23 128.4 lbs - 10/7/23 125.6 lbs - 10/11/23 125.8 lbs - 10/18/23 128.4 lbs During interview on 10/18/23 at 2:17 p.m., NA-B stated R21 did not eat very much and didn't eat at	F 692		

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F 692	Continued From page 26 all if she was in pain. R21 would usually eat snacks between meals. During interview on 10/19/23 at 9:46 a.m., R21 stated she was not hungry and didn't want to eat anything that morning. During interview on 10/18/23 at 3:44 p.m., RD stated the DM attended the daily morning stand up meeting. The DM reminds staff about getting weekly weights. Diet/nutrition information was also discussed at the weekly IDT meeting. They discussed R21 quite often at these meetings because of R21's weight loss. If residents at risk for weight loss eat less than 25% of a meal or wasn't weighed weekly an alert would populate for RD to review and would bring the information to the IDT meeting for discussion. R21 did not have any weights documented from 8/9/23 through 10/3/23, and was uncertain why. The facility had really good communication but just not enough follow through. During interview on 10/19/23 at 9:23 a.m., RN-A stated R21 had been slowly losing weight since admission and was supposed to be weighed monthly. During 8/23 through 10/23, RN-A hadn't monitored if R21's weights were being completed. RN-A stated R21 should have been weighed monthly and had not been. During joint interview on 10/19/23 at 9:47 a.m., NA-D and NA-A stated R21 was a weekly weight because of a significant weight loss. Staff know when to weigh a resident because it is in the computer and will automatically pop up as a task to complete. The nurses also let staff know if there is a missed weigh from the previous week.	F 692		

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F 692	Continued From page 27 During interview on 10/19/23 at 10:03 a.m., DON stated since admission R21 was weighed consistently. They discussed R21's weight loss every week at the morning stand up meeting and at the weekly IDT meeting. They are trying to get staff onboard with weighing R21 every week and are following her in the weekly high risk meeting. Residents are supposed to be weighed monthly although that does not always happen. The facility needs to come up with a better plan for following through with weights. The facilities Weight and Height policy dated 9/18/23, directed staff to ensure the resident maintained an acceptable parameter of nutritional status regarding weight, to accurately measure, monitor for weight loss/gain and to report changes immediately to the physician and family and/or resident. Residents who were at nutritional risk would be weighed weekly.	F 692		
F 699 SS=D	Trauma Informed Care CFR(s): 483.25(m) §483.25(m) Trauma-informed care The facility must ensure that residents who are trauma survivors receive culturally competent, trauma-informed care in accordance with professional standards of practice and accounting for residents' experiences and preferences in order to eliminate or mitigate triggers that may cause re-traumatization of the resident. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to comprehensively assess for trauma informed care to identify potential triggers and avoid potential re-traumatization for 1 of 1 resident (R5) reviewed who had a history of	F 699	How corrective action will be accomplished for those residents found to have been affected by the deficient practice. Facility failed to comprehensively assess for trauma informed care and	11/28/23

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F 699	Continued From page 28 trauma. Findings include: R5's quarterly Minimum Data Set (MDS) dated 9/9/23, identified R5 had severe cognitive impairment and diagnoses included post-traumatic stress disorder (PTSD) cerebral palsy, anxiety and depression. R5 exhibited rejection of care, verbal behavioral symptoms directed towards other such as threatening others, screaming at others and/or cursing at others, and behavioral symptoms not directed toward others such as hitting or scratching self, pacing, and/or verbal/vocal symptoms such as screaming or disruptive sounds. R5's Trauma Assessment dated 6/9/23, identified R5 never experienced some form of trauma or a stressful event. The assessment failed to identify R5 had a diagnosis of PTSD. R5's care plan revised 9/8/23, identified R5 had a behavior symptom related to anxiety, PTSD, bipolar disorder, mood (affective) disorder exhibited by refusal of cares, screaming out at staff during cares, and berating comments towards staff members. The care plan lacked individualized trauma-informed approaches or interventions and identification of triggers to avoid potential re-traumatization. On 10/17/23 at 3:21 p.m., R5 was awake and lying on her back in bed. R5 stated she was "fine" and "ok" but was unwilling to talk about her trauma history. During an interview on 10/18/23 at 1:40 p.m., nursing assistant (NA)-B was unaware R5 had a	F 699	identify potential triggers to avoid re-traumatization for R5. R5 care plan reviewed, and triggers for resident were updated. How the facility will identify other residents having the potential to be affected by the same deficient practice. All residents with PTSD have the potential to be affected by the deficient practice and their plan of care will be reviewed and updated as needed. What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur. Education will be provided to clinical staff related to Trauma informed Care policy and IDT will get additional training on completion of trauma assessment on admission. All residents with diagnosis of PTSD or similar care plans will be audited to ensure resident specific interventions are placed to avoid re-traumatization. All new admissions with PTSD will be followed in risk committee X4 weeks to ensure triggers are identified/ and resident specific interventions are placed. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur. DNS and/ or designee will audit trauma assessments and care plan interventions for completion for current and new admits with PTSD diagnosis weekly for 4 weeks and then twice a month for 1 month and then 1x for 1 month. Audit will be brought to QAPI for	

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F 699	Continued From page 29 diagnosis of PTSD but "she's got a lot more than that going on if you ask me." R5 only wanted to be called by her name, no hon, no sweetie. R5 did not like to be rushed or placated and refused to be changed or turned. NA-B knew R5 had cerebral palsy but could not understand why R5 did not want to be changed on time for two minutes than have to change her entire bed linens for 20 minutes. R5 did not like to be told what staff were doing as R5 already knew what staff were doing. For example, if you had R5 turned and she said "ouch," don't say you're almost done. R5 would yell that she knows. R5 just wanted it over with. R5 had a good sense of humor and liked to joke around and liked to talk about religion. During an interview on 10/18/23 at 1:48 p.m., licensed practical nurse (LPN)-A stated R5 did not like to get out of bed and did not like to be touched. LPN-A stated R5 had a history of sexual assault and that's where the not liking to be touched came from. R5 did not like anything to do with touching, such as showers, turning/repositioning and/or changing of her incontinent brief. During an interview on 10/18/23 at 1:52 p.m., NA-A stated R5 had a lot of behaviors. R5 refused cares, yelled at staff and many others. R5 did not liked to be called anything but her name and did not like to be exposed. R5 told NA-A she had a history of sexual assault when she was younger. R5 would not take a shower, she just would not. Staff were trying to figure something out for R5 like a bathing suit during showers, but it was not working. During an interview on 10/18/23 at 4:41 p.m.,	F 699	further review by the IDT to discuss any recommendations and/or revisions to process.	

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F 699	Continued From page 30 registered nurse (RN)-A stated R5 was unlike anyone she had ever met before. R5 shared her history of sexual assault with RN-A, but RN-A was unsure she documented the history. Staff had to be slow and patient with R5 during cares. Staff could not provide too much information either because R5 thought staff were lecturing her. R5's triggers were important to care plan to promote R5's care and well being. During an interview on 10/18/23 at 5:27 p.m., the director of nursing (DON) stated assessment and care planned interventions for trauma informed care were important to allow staff to care for the resident in the best way possible. The facility policy Trauma Informed Care revised 10/26/22, identified the facility would provide trauma-informed care and avoid re-traumatizing residents. The policy directed the trauma assessment was required within five days of admission for all new residents and as needed. While the interview was conducted, staff were to focus on understanding the resident's experience (what happened to the resident) rather than trying to correct their behavior. Document how trauma was currently affecting the resident. Individualize care plan interventions to avoid re-traumatization; use the trauma assessment to the psychosocial well-being deficit for actual or potential to relive trauma. When indicated, refer to a clinical/mental health professional.	F 699		
F 700 SS=D	Bedrails CFR(s): 483.25(n)(1)-(4) §483.25(n) Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If	F 700		11/28/23

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F 700	Continued From page 31 a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. §483.25(n)(1) Assess the resident for risk of entrapment from bed rails prior to installation. §483.25(n)(2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. §483.25(n)(3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. §483.25(n)(4) Follow the manufacturers' recommendations and specifications for installing and maintaining bed rails. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to comprehensively assess and obtain informed consent, prior to resident use of bed rails for 1 of 2 residents (R31) reviewed for bed rail use. Findings include: R31's quarterly Minimum Data Set (MDS) dated 8/22/23, identified R31 had moderately intact cognition and a diagnosis of Parkinson's disease. R31 needed limited assistance with bed mobility and transfers. R31's undated care plan identified R31 was independent with a grab bar on one side of the bed.	F 700	How corrective action will be accomplished for those residents found to have been affected by the deficient practice. Facility failed to complete a comprehensive assessment and obtain a consent for bed rails on R31. R31□s daughter (responsible party) was contacted on 10/19/2023 and informed of risks and benefits with the use of bed rails. Daughter did give consent. On 10/18/23 the Physical Device and/or Restraint Evaluation and Review was completed and bed rails were listed as a non-restraint. How the facility will identify other residents having the potential to be affected by the same deficient practice. DNS audited	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 700	Continued From page 32 R31's medical record lacked an assessment for bed rail alternatives, entrapment risk, or informed consent for bed rail use. On 10/16/23 at 2:27 p.m., R31's bed was observed and there was a grab bar attached to the bed. During an interview on 10/18/23 at 10:10 a.m., the director of nurses (DON) stated the usual process on admission was that an assessment was done, and physical therapy was involved, to see if they can or should use a bed rail. The DON confirmed there was not informed consent for bed rail use in R31's medical record. The DON stated she would look for the bed rail assessment for R31. During an interview on 10/18/23 at 12:08 p.m., the DON confirmed she could not find any bed rail assessments for R31. During an interview on 10/19/23 at 10:33 a.m., the DON stated knowing the risk for entrapment would come from the assessment, which wasn't done in this case. The risks would be for entrapment, strangulation and up to death. During an interview on 10/19/23 at 10:14 a.m., the interim-administrator stated the expectation was that nurses would do an assessment for safety and appropriateness of the rail or assist bar and then care plan appropriately. The family and resident needed to be informed of risks and benefits. The risks to the resident would be entrapment which could lead to negative outcomes. A facility policy, Bed Safety Including Bed Rails,	F 700	charts of residents with bed rails for Physical Device and/or Restraint Evaluation and Review completion as well as bed rails being care planned. This was completed on 10/18/23. What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur. Education will be provided to clinical staff on alternatives to bed rails and proper procedure for implementation including completing the appropriate assessment and obtaining consent. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur. DNS and/or designee will audit all current residents with bed rails to verify verbal consent and/or signed consent has been obtained. All future admits and family will be educated on bed rail safety. DNS and/or designee will audit new residents with bed rails for assessment completion and consent X6 months. Audit will be brought to QAPI for further review by the IDT to discuss any recommendations and/or revisions to process.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245318	A. BUILDING _____ B. WING _____	C 10/19/2023

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F 700	Continued From page 33 Side Rails and Assist bars dated 9/28/23, identified the purpose of the policy was to reduce entrapment risk by providing appropriate resident assessment and use of less restrictive alternatives to side rails and to promote bed safety. Prior to use of bed rails, side rails, safety rails, grab bars and assist bars a Physical Device and Restraint Assessment would be completed.	F 700		
F 812 SS=D	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. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure food was stored in accordance with professional standards for food service safety in 3 of 3 unit kitchenettes. This practice had the potential to affect all residents consuming food at the facility.	F 812	It is the policy of this facility to procure food from approved sources and to store, prepare, distribute and serve food in accordance with professional standards for food service safety.	11/28/23

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F 812	Continued From page 34 Findings include: During an observation on 10/19/23 at 9:11 a.m., the resident refrigerator on the Kempton unit had dried streaks of a white substance and fingerprints covering both fridge doors and freezer drawer. The freezer had an open container of Lactaid ice cream, and a container of Rebel ice cream without names or opened-on dates. The fridge contained a plastic container covered with plastic wrap, labeled "goulash" with no resident name or opened-on date. During an interview on 10/19/23 at 9:17 a.m., dietary aid (DA)-C on the Kempton unit confirmed the outside of fridge had dried streaks of a white substance and fingerprints covering both fridge doors and freezer drawer. DA-C stated they were supposed to clean the unit kitchens on Sundays, but with how it looked she would say it probably didn't get done last week, and the expectation was all resident personal food is labeled with their name and all food is dated when opened or received. During an observation on 10/19/23 at 9:25 a.m., the resident refrigerator on the Voyager unit contained Sysco frozen, sliced strawberries in a container in the fridge, dated 9/23/23. The fridge and freezer in the back of the kitchenette contained an open container of liquid eggs with no open date. The outside of both refrigerators were smeared with fingerprints, and dried streaks of a clear to white-colored substance. During an interview on 10/19/23 at 9:29 a.m., DA-B stated their policy was to throw out food three days after it was opened and dated. DA-B	F 812	Corrective Action: 1. The Dietary staff disposed of all non-dated or outdated food and beverage items from each of the household refrigerators. All improperly sealed containers were emptied and cleaned. All surfaces of refrigerators on all households were cleaned. All remaining food and beverages items in refrigerators are labeled and dated appropriately. 2. All residents had the potential to be affected by the deficient practice. Assurance of On-Going Compliance: 1. All dietary staff to be educated on safe food storage, preparation, distribution, cleaning schedule and service by dietary manager or designee. 2. cleaning schedule created and in place in each household kitchen area with tasks, frequency and documentation noted. 3. Dietary manager or designee will conduct audits of household kitchen areas including cleaning compliance and food storage, labeling and dating compliance. Audits will be completed weekly x4, then monthly x3. 4. Findings of audits will be presented to administrator and monthly QAPI committee for recommendations.	

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F 812	Continued From page 35 was not sure why the strawberries were still in that fridge and did not know the open date for the liquid eggs, so she would throw both out. DA-B stated she wiped out the fridge daily and would wipe up spills as they happen. During an observation on 10/19/23 at 9:38 a.m., the resident refrigerator on the Dove Island unit had dried drips of brown liquid on the freezer drawer, the doors were spotted with a dried white substance and contained the following: -an open container of half-and-half with no opened-on date -sweet and sour pork in plastic container covered with plastic wrap, dated 10/14. -a drawer with whip cream in a clear, plastic tube, a head of lettuce wrapped in plastic with part of it sticking out and brown in color, dated 10/13. The drawer itself had whip cream smeared on inside of drawer and on the head of lettuce. -pale-colored lunch meat wrapped loosely in plastic wrap, dated 9/26. -boxes of juice with dried drips of brown liquid on the outside of them. During an interview on 10/19/23 at 9:45 a.m., DA-A stated she tried to wipe the fridge as much as she could, but she didn't work over there all the time. DA-A stated they threw things out after three days. During an interview on 10/19/23 at 9:55 a.m., the dietary manager (DM) stated the expectation was that all food was to be labeled and dated, and left-over food would be tossed three days after it was received. The DM removed the whip cream and lettuce from the refrigerator drawer and stated, "this needs to be done better". The risks would be food safety, quality, and chance of cross	F 812		

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F 812	Continued From page 36 contamination with things like whipping cream all over inside a drawer with lettuce that wasn't wrapped up all the way. During an interview on 10/19/23 at 10:10 a.m., the interim-administrator stated he would expect resident food to be labeled, dated appropriately, and discarded according to their guidelines. The risks would be food-borne illness. A facility policy, Date Marking - Food and Nutrition dated 4/12/23, identified the purpose was to provide guidelines for proper date-marking to ensure that food was handled and stored safely. Time/temperature Control for Safety (TCS) food was defined as a food which required time/temperature control to limit pathogenic microorganism growth or toxin formation. Ready-to-eat items, such as lunchmeat, were recommended to be stored at or below 41 degrees and discarded after seven days. A policy regarding dating and storage of left-over food was not received. A facility policy, Cleaning Schedule - Food and Nutrition Services dated 1/12/23, identified the purpose was to provide guidelines for proper cleaning of kitchen immobile equipment, such as refrigerators/freezers. Refrigerated units were to be put on a schedule to ensure regular cleaning and food spills would be cleaned immediately. A facility schedule of cleaning was not received.	F 812		
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program	F 880		11/28/23

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F 880	Continued From page 37 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 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	F 880		

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F 880	Continued From page 38 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, interview and document review, the facility failed to ensure laundry services were conducted in a manner to promote sanitary conditions. This had the potential to affect all residents who ultilized bedspreads. Findings include: On 10/17/23 at 8:55 a.m., a jumbled pile of bedspreads was piled onto a rolling office chair with the edges of the bedding touching the floor. Housekeeping (HSKG)-A stated the bedspreades were left that way the evening prior and would need to be re-washed. HSKG-A was not the normal laundry staff member and was covering	F 880	F880 Infection Prevention & Control It is the policy of this facility to 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. Corrective Action to include: 1. staff education on the basics of infection control including the handling of linens.	

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F 880	Continued From page 39 for the day. On 10/17/23 at 5:27 p.m., The jumbled pile of bedspreads remained on the rolling office chair, and several had fallen onto the floor. HSKG-A stated the last load of linens for the day were being folded and would be delivered to the units for use. HSKG-A stated "I'll just be honest. If you hadn't walked in, I would have just folded them [the bedspreads] and put them in the cupboard, but I'll rewash them now." During an interview on 10/18/23 at 3:17 p.m., the director of nursing (DON) stated she expected environmental services to launder linens and put them back into supply for use the same day. If something touched the floor, it needed to be rewashed and treated appropriately. During an interview on 10/18/23 at 4:19 p.m., registered nurse (RN)-A stated she was responsible for the facility's infection prevention (IP) program. RN-A had not conducted any audits of the laundry. When items touched the floor, it would need to be rewashed. A facility laundry policy was requested but not received.	F 880	Assurance of On-Going compliance: 1. Maintenance director or designee will complete an audit of laundry handling by staff weekly x4, then monthly x2. 2. Results of audits to be presented to administrator and QAPI committee.	
F 883 SS=E	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	F 883		11/28/23

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F 883	Continued From page 40 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 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	F 883		

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F 883	Continued From page 41 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 provide the most recent Centers for Disease Control (CDC) education regarding the potential risks and benefits of the pneumococcal vaccine for 4 of 5 residents (R4, R5, R21, R29) reviewed for immunizations. Findings include: R4's quarterly Minimum Data Set (MDS) dated 9/24/23, identified R4 was admitted to the facility on 12/16/22, was 93 years old and had a diagnosis of Alzheimer's disease. R4's Immunization Report dated 10/19/23, identified R4 received a pneumococcal polysaccharide vaccine (PPSV23) on 11/27/13. R4's medical record did not include evidence R4 or R4's representative received education regarding pneumococcal vaccine booster and there was no indication R4 was offered the pneumococcal vaccine per CDC guidance. R5's quarterly MDS dated 9/9/23, identified R5 was admitted to the facility on 6/5/23, was 68 years old and had a diagnosis of diabetes. R5's Immunization reported dated 10/19/23, identified R5 received a PPSV23 on 3/5/18, and a pneumococcal conjugate vaccine (PCV13) on	F 883	How corrective action will be accomplished for those residents found to have been affected by the deficient practice. Facility failed to provide R4, R5, R21, R29 the most recent CDC education regarding potential risks and benefits for the pneumococcal vaccine. These residents were assessed and offered the pneumococcal vaccine. Risk and benefits were explained to residents/responsible party and consent was given for administration. How the facility will identify other residents having the potential to be affected by the same deficient practice. An audit will be completed on all current residents to determine vaccination compliance. All residents will be offered and documented their vaccination options to maintain compliance. Residents without up-to-date immunizations will be offered, educated and given vaccines as needed and as resident/representative allows. What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur. Education will be provided to RNs/ LPNs Pneumococcal vaccine policy by the DNS	

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F 883	Continued From page 42 5/25/13. R5's medical record did not include evidence R5 or R5's representative received education regarding pneumococcal vaccine booster and there was no indication R5 was offered the pneumococcal vaccine per CDC guidance. R21's quarterly MDS dated 9/2/23, identified R21 was admitted to the facility on 1/10/23, was 76 years old and had a diagnosis of chronic obstructive pulmonary disease (COPD). R21's Immunization Report dated 10/19/23, identified R21 received a PPSV23 on 10/28/03, and 11/5/08; and received a PCV13 on 9/25/15. R21's medical record did not include evidence R21 or R21's representative received education regarding pneumococcal vaccine booster and there was no indication R21 was offered the pneumococcal vaccine per CDC guidance. R29's quarterly MDS dated 7/15/23, identified R29 was admitted to the facility on 8/12/21, was 91 years old and had a diagnosis of diabetes. R29's Immunization Report dated 10/19/23, identified R29 received a PPSV 23 on 10/8/96, 12/13/01, and 10/25/02. R29's medical record did not include evidence R29 or R29's representative received education regarding pneumococcal vaccine booster and there was no indication R29 was offered the pneumococcal vaccine per CDC guidance. The facility provided Vaccine Information Statement (VIS) Pneumococcal Conjugate Vaccine dated 5/12/23, identified education regarding the need for PCV13, PCV15 and PCV20.	F 883	with emphasis on ensuring that the vaccine is offered, consent/declination obtained, administered and documentation is present within the medical record. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur. DNS and/or designee will complete audits on all new admits for X 3 months to ensure that vaccination was offered, education provided and administered if consented for and documentation is present in the medical record. Audit will be brought to QAPI for further review by the IDT to discuss any recommendations and/or revisions to process.	

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F 883	Continued From page 43 The facility's Immunizations/Vaccinations for Residents policy dated 9/21/23, identified residents would be reviewed for immunizations upon admit and annually. Resident's would be reviewed the immunization recommendations change and education will be provided. The policy included up to date pneumococcal vaccination recommendations.	F 883		
F 909 SS=D	Resident Bed CFR(s): 483.90(d)(3) §483.90(d)(3) Conduct Regular inspection of all bed frames, mattresses, and bed rails, if any, as part of a regular maintenance program to identify areas of possible entrapment. When bed rails and mattresses are used and purchased separately from the bed frame, the facility must ensure that the bed rails, mattress, and bed frame are compatible. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to conduct regular inspection of all bed frames, mattresses, and bed rails as part of a regular maintenance program 1 of 2 residents (R31) reviewed for bed rail safety. Findings include: On 10/16/23 at 2:27 p.m., R31's bed was observed and there was a grab bar attached to the bed. There was a space of about four to five inches between the mattress and the grab bar of R31's bed. During an interview on 10/18/23 at 9:58 a.m., the maintenance director (MD) stated he didn't do	F 909	It is the policy of the facility to ensure the resident environment remains as free of accidents hazards as is possible and each resident receives adequate supervision and assistance devices to prevent accidents. Corrective Action: 1. R31 personal mattress was removed immediately and replaced with a standard, FDA compliant, facility mattress. 2. The maintenance team completed bed and side rail inspections on all facility beds. All other beds were in compliance with FDA recommendations.	11/28/23

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GOOD SAMARITAN SOCIETY - INTERNATIONAL FALLS	2201 KEENAN DRIVE INTERNATIONAL FALLS, MN 56649

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 909	Continued From page 44 any kind of inspecting or measuring of beds or bed rails and didn't know what the measurements for bed safety should be. There wasn't a schedule for regularly inspecting beds, mattresses, or bed rails. During an interview on 10/18/23 at 10:10 a.m., the director of nursing (DON) stated environmental services installed the bed rails, but she was not sure if anyone was taking measurements for bed safety. During an interview on 10/19/23 at 10:14 a.m., the interim-administrator stated he was not sure what the process for inspection and maintenance of beds, mattresses and bed rails was here but that he would check in their maintenance computer system for routine inspection and maintenance. The risks to the resident could be entrapment which could lead to negative outcomes. Maintenance records for regular bed inspection and maintenance was requested but not received. A facility policy Bed Safety Including Bed Rails, Side Rails and Assist bars dated 9/28/23 identified annual inspections of all bedframes, mattresses and bed rails were required to identify and eliminate any potential entrapment issues and to ensure that these devices were compatible with the bed frame and mattress. An inspection was required upon application of a different assistive device or purchase of a new bed frame or changing out a mattress. These inspections must be documented.	F 909	Assurance on On-Going compliance: 3. Facility will prohibit outside mattresses to be used unless purchased by Society-approved vendors and are of FDA compliant measurements. All staff educated on FDA recommendations and the potential harm if recommendations aren't followed, Bed Safety Including Bed Rails, Side Rails, Assist Bars policy. Included in the admission packet for all new resident, a brochure titled "A Guide to Bed Safety." Bed and Side rail inspections will be completed quarterly. 4. the maintenance director/or designee will complete a 100% bed audit/inspection. to be done quarterly x4. All findings will be brought to administrator and QAPI committee for recommendations.	

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GOOD SAMARITAN SOCIETY - INTERNATIONAL FALLS	**2201 KEENAN DRIVE** **INTERNATIONAL FALLS, MN 56649**

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K 000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety recertification survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 10/17/2023. At the time of this survey, Good Samaritan Society-International Falls was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: IF PARTICIPATING IN THE E-POC PROCESS, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED.	K 000		

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

Electronically Signed | 11/10/2023

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. The Good Samaritan Society International Falls is a new 1-story building, no basement, and was determined to be Type V (111) construction. The building is separated from the new assisted living building with a 2-hour fire barrier. The building is fully fire sprinkler protected in accordance with NFPA 13 Standard for the Installation of Sprinkler Systems (2010 edition) with quick response sprinkler heads. The facility is also protected by a complete automatic fire	K 000		

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GOOD SAMARITAN SOCIETY - INTERNATIONAL FALLS	**2201 KEENAN DRIVE INTERNATIONAL FALLS, MN 56649**

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K 000	Continued From page 2 alarm system with smoke detectors throughout the corridors and areas open to the corridor and in all sleeping rooms that is monitored that is installed in accordance with NFPA 72 "The National Fire Alarm Code" (2010 edition). The building is divided into 3 smoke compartments by 1-hour smoke barriers and 2-hour fire barriers. The facility has a capacity of 54 beds and had a census of 50 at the time of the survey.	K 000		
K 291 SS=E	The requirements at 42 CFR, Subpart 483.70(a), are NOT MET as evidenced by: Emergency Lighting CFR(s): NFPA 101 Emergency Lighting Emergency lighting of at least 1-1/2-hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1 This REQUIREMENT is not met as evidenced by: Based on observation the facility failed to maintain emergency lighting system per NFPA 101 (2012 edition), Life Safety Code sections 19.2.9.1 and 7.9.1.3. This deficient practice could have a patterned impact on the residents within the facility. Findings include: On 10/17/2023 between 9:00am and 1:00pm,it was revealed by observation that the facility failed to conduct the annual 90 minute required Emergency Lighting test.	K 291	Preparation and execution of this response and plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. For the purposes of any allegation that the center is not in substantial compliance with federal requirements of participation, this response and plan of correction	11/28/23

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K 291	Continued From page 3 An interview with the Director of Maintenance verified these deficient findings at the time of discovery.	K 291	constitutes the center's allegation of compliance in accordance with section 7305 of the State Operations Manual. K291 NFPA 101 Emergency Lighting It is the policy of the facility to inspect, test and maintain all Emergency lighting systems per NFPA standards and regulations. Corrective Action will include: 1. The maintenance director and/or designee will conduct functional testing for a minimum of 1.5 hours for the emergency lighting system to meet requirements. Completed 11/27/2023 2. The facilities preventative maintenance program will be updated to include annual 1.5 hours testing of the emergency lighting system. Completed 11/1/23 3. The Maintenance Director and or designee will maintain documentation of the emergency lighting testing in accordance with NFPA requirements. Beginning 11/27/23 Assurance of On-Going Compliance. 1. The maintenance director and/or designee will verify the location's computerized preventive maintenance program is updated to include emergency	

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K 291	Continued From page 4	K 291	lighting testing annual requirement. 2. Results of the testing will be reported to the location's administrator and QAPI committee.	
K 346 SS=F	Fire Alarm System - Out of Service CFR(s): NFPA 101 Fire Alarm - Out of Service Where required fire alarm system is out of services for more than 4 hours in a 24-hour period, the authority having jurisdiction shall be notified, and the building shall be evacuated or an approved fire watch shall be provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service. 9.6.1.6 This REQUIREMENT is not met as evidenced by: Based on document review and staff interview, the facility did not properly implement a fire watch protocol for when the fire alarm system is out of service for more than 4 hours in a 24-hour period, according to NFPA 101 2012 edition, Life Safety Code, section 9.6.1.6. This deficient finding could have a widespread impact on the residents within the facility. Findings include: 1.) On 10/17/2023 between 9:00am and 1:00pm, it was revealed that the facility's fire watch policy did not identify the fire alarm system outage period within a 24-hour period. 2.) On 10/17/2023 between 9:00am and 1:00pm, during documentation review it was revealed that the facility's fire watch policy did not state that the person performing fire watch is the sole duty of	K 346	K346 Fire Alarm System □ Out of Service It is the policy of the facility to follow fire watch procedures per NFPA standards and regulations. Corrective Action will include: 1. The facility Fire Watch Plan, Policy and procedures will be updated to comply with NFPA requirements to include the following but not limited to: a. Identifying the fire alarm system outage period within a 24 hour period. b. Fire watch policy to state the person performing the fire watch is the sole duty of that employee. Completed 11/7/23	11/28/23

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K 346	Continued From page 5 that employee. An interview with the Director of Maintenance verified these deficient findings at the time of discovery.	K 346	Assurance of On-Going Compliance: 1. The maintenance director and/or designee will verify the location□s computerized preventive maintenance program is updated to include an annual review of the fire watch plan. 2. Results of the review will be reported to the location□s administrator and QAPI committee.	
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 _____ 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 a review of available documentation and staff interview, the facility failed to maintain the automatic sprinkler system per NFPA 101	K 353	It is the policy of the facility to perform and ensure sprinkler systems are tested in accordance with NFPA standards and	11/28/23

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K 353	Continued From page 6 (2012 edition), Life Safety Code Section 19.7.6, and 4.6.12, NFPA 25 (2011 edition), Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, section 5.1.1.2. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 10/17/2023 between 9:00am and 1:00pm, it was revealed by a review of available documentation the facility failed to perform the quarter sprinkler system testing. An interview with the Director of Maintenance verified these deficient findings at the time of discovery.	K 353	regulations. Corrective Action to include: 1. The maintenance director and/or designee will contact the fire sprinkler vendor to schedule quarterly fire sprinkler inspection, testing and maintenance. Completed by 11/28/2023 2. Quarterly fire sprinkler inspection testing and maintenance will be completed by 11/28/2023. 3. The location's computerized preventative maintenance program will be updated to include quarterly fire sprinkler inspections, testing and maintenance. Completed 11/1/2023 Assurance of On-Going Compliance: 1. The maintenance director and/or designee will conduct quarterly fire sprinkler inspection, testing and maintenance as identified in our preventative maintenance program. 2. Results of the review will be reported to the location's administrator and QAPI committee.	
K 355 SS=D	Portable Fire Extinguishers CFR(s): NFPA 101 Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the	K 355	K355 Portable Fire Extinguishers	11/28/23

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K 355	Continued From page 7 facility failed to maintain access to portable fire extinguishers per NFPA 101 (2012 edition), Life Safety Code, section 9.7.4.1, and NFPA 10 (2010 edition), Standard for Portable Fire Extinguishers, section 7.3.1.1.1. This deficient finding could have an isolated impact on the residents within the facility. Findings include: On 10/17/2023 between 9:00am and 1:00pm, it was revealed by documentation review that the fire extinguishers annual inspection documentation could not be provided. An interview with the Director of Maintenance verified these deficient findings at the time of discovery.	K 355	It is the policy of the facility to maintain portable fire extinguishers in accordance with NFPA standards and regulations. Corrective Action will include: 1. The maintenance director did secure the documentation of the annual fire extinguisher inspection August 2023. 2. The location□s computerized preventative maintenance program will be updated to reflect completed testing and frequency requirements. Completed 11/1/2023 Assurance of On-Going compliance: 1. The location□s computerized preventative maintenance program has been updated to reflect timing of the completed inspection and to be conducted annually thereafter. 2. Results of the annual inspection will be reported to the location□s administrator and QAPI committee.	
K 372 SS=F	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct	K 372		11/28/23

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GOOD SAMARITAN SOCIETY - INTERNATIONAL FALLS	**2201 KEENAN DRIVE** **INTERNATIONAL FALLS, MN 56649**

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K 372	Continued From page 8 penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain their smoke barrier per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.7.1, 19.3.7.3, 8.5.2.2, and 8.5.6.5. These deficient findings could have a widespread impact on the residents within the facility. Findings include: On 10/17/2023 between 9:00am and 1:00pm, it was revealed by observation that there was a penetration running from one smoke compartment to another above the following doors; 1) Doors leading to Dove Island 2) Doors leading to Voyager Haven 3) Doors leading to Compton Cottage. An interview with the Director of Maintenance verified these deficient findings at the time of discovery.	K 372	K372 NFPA 101 Subdivision of Building Spaces □ Smoke Barrier It is the policy of the facility to maintain smoke barriers within subdivision of building spaces in accordance with NFPA standards and regulations. Corrective Action will include: 1. The maintenance director and/or designee sealed the wall penetration above the doors leading to Dove Island, Voyager Haven and Kempton Cottage with an UL1479 approved fire resistant caulking. Completed on 11/3/2023 2. The Maintenance director and/or designee will conduct routine inspections to meet this requirement. Any hazardous area wall or ceiling open penetration identified as not meeting this requirement will be repaired immediately. Beginning on 11/3/2023 Assurance of On-Going Compliance 1. The maintenance director and/or designee will conduct ongoing monthly	

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K 372	Continued From page 9	K 372	inspections to ensure smoke barriers meet this requirement for a period of 3 months and annually thereafter. 2. The location□s computerized preventative maintenance program will be updated to reflect the timing of the smoke barrier penetration inspections. 3. Results of the inspections will be reported to the location administrator and QAPI committee.	
K 521 SS=F	HVAC CFR(s): NFPA 101 HVAC Heating, ventilation, and air conditioning shall comply with 9.2 and shall be installed in accordance with the manufacturer's specifications. 18.5.2.1, 19.5.2.1, 9.2 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to inspect fire dampers per NFPA 101 (2012 edition), Life Safety Code, section 8.5.5.4.2, and NFPA 105 (2010 edition), Standard for Smoke Door Assemblies and Other Opening Protectives, section 6.5.2, 6.5.11, and 6.5.12. This deficient finding could have a widespread impact on the residents within the facility. Findings include:	K 521	It is the policy of this facility to maintain smoke dampers in accordance with NFPA standards and regulations. Corrective Action to include: 1. The maintenance director and/or designee will contact fire alarm vendor to schedule a fire damper inspection. Completed by 11/27/2023 2. Fire Damper inspection will be	11/28/23

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K 521	Continued From page 10 On 10/17/2023 between 9:00am and 1:00pm, it was revealed by a review of available documentation that the facility could not provide a fire damper inspection report. An interview with the Director of Maintenance verified these deficient findings at the time of discovery.	K 521	completed by 11/27/2023 Assurance of ongoing compliance: 1. The location's computerized preventative maintenance program will be updated to ensure annual inspections are included in accordance with NFPA requirements. 2. Results of the inspections will be reported to the QAPI committee and administrator.	
K 711 SS=F	Evacuation and Relocation Plan CFR(s): NFPA 101 Evacuation and Relocation Plan There is a written plan for the protection of all patients and for their evacuation in the event of an emergency. Employees are periodically instructed and kept informed with their duties under the plan, and a copy of the plan is readily available with telephone operator or with security. The plan addresses the basic response required of staff per 18/19.7.2.1.2 and provides for all of the fire safety plan components per 18/19.2.2. 18.7.1.1 through 18.7.1.3, 18.7.2.1.2, 18.7.2.2, 18.7.2.3, 19.7.1.1 through 19.7.1.3, 19.7.2.1.2, 19.7.2.2, 19.7.2.3 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to implement a fire safety plan per NFPA 101 (2012 edition), Life Safety Code, section 19.7.2.2. These deficient findings could have a widespread impact on the residents within the facility.	K 711	K711 Evacuation and Relocation Plan It is the policy of this facility to have a written plan for the protection of all patients and for their evacuation in the event of an emergency.	11/28/23

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	245318	A. BUILDING **03 - 2013 BUILDING** B. WING _____	**10/17/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - INTERNATIONAL FALLS	**2201 KEENAN DRIVE** **INTERNATIONAL FALLS, MN 56649**

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K 711	Continued From page 11 Findings include: 1. On 10/17/2023 between 9:00am and 1:00pm, it was revealed in a review of available documentation that the facility's fire s safety plan did not include an emergency phone call to the fire department. 2. On 10/17/2023 between 9:00am and 1:00pm, it was revealed in a review of available documentation that the facility's fire safety plan did not include the transmission of alarms to the fire department. An interview with the Director of Maintenance verified these deficient findings at the time of discovery.	K 711	Corrective Action will include: 1. The facility□s fire safety plan now includes an emergency phone call and number to the fire department. 2. The fire safety plan includes a step to verify the transmission of alarms to the fire department. Assurance of On-Going Compliance: 1. The location□s computerized preventative maintenance program has been updated to include the step of ensuring the facility□s fire alarm transmits to the fire department. 2. The maintenance director or designee will conduct audits to ensure the alarm connection has been verified. Results of the audits to will be presented to the administrator and QAPI committee.	
K 712 SS=F	Fire Drills CFR(s): NFPA 101 Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7	K 712		11/28/23

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K 712	Continued From page 12 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to conduct fire drills under varied times and conditions per NFPA 101 (2012 edition), Life Safety Code, sections 19.7.1.6, 4.7.4, and 4.6.1.1. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 10/17/2023 between 9:00am and 1:00pm, it was revealed by a review of available documentation that the facility was unable to show completed fire drills in the first quarter (January - March), second quarter (April - June), third quarter (July - September) fourth quarter (October - December). An interview with the Director of Maintenance verified these deficient findings at the time of discovery.	K 712	K712 NFP 101 Fire Drills It is the policy of the facility to perform and assure Monthly/Quarterly Fire Drills conducted in accordance with NFPA standards and requirements. Corrective Action will include: 1. Preventative maintenance program and instructions will be updated to include the following: a. Maintenance director and/or designee will be trained to follow NFPA fire drill testing requirements. Completed 11/6/2023 b. Quarterly fire drills will be conducted one per shift per quarter. Drills will be no closer than 2 hours apart from the last recorded drill for the shift and quarter. Drills will also be conducted on different dates, times and locations. 2. Make up drills will be performed to bring the existing drill schedule into compliance. Completed 11/9/2023 Assurance of On-Going Compliance: 1. The Maintenance director and/or designee will conduct and ensure fire drills are performed to meet NFPA standards and requirements and as identified in our preventative maintenance program.	

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K 712	Continued From page 13	K 712	2. Results of the fire drills including make up drills will be reported to the location administrator and QAPI committee.	
K 918 SS=F	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power	K 918		11/28/23

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K 918	Continued From page 14 source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to test and inspect the generator per NFPA 99 (2012 edition), Health Care Facilities Code, section 6.4.4.1.1.4, and NFPA 110 (2010 edition), Standard for Emergency and Standby Power Systems, section 8.4.1 and 8.4.2. These deficient findings could have a widespread impact on the residents within the facility. Findings include: 1) On 10/17/2023 between 9:00am and 1:00pm, it was revealed by a review of available documentation of the emergency generator maintenance and testing weekly generator inspections were not performed from 10/16/2022 to 10/17/2023. 2) On 10/17/2023 between 9:00am and 1:00pm, it was revealed by a review of available documentation of the emergency generator maintenance and testing that the 36 month - 4 hour load band test could not be provided. An interview with Environmental Services Director verified these deficient findings at the time of discovery.	K 918	K918 Electrical Systems Essential Electrical Systems It is the policy of this facility to test and maintain essential electrical system equipment (generator) in accordance with NFPA standards and regulations. Corrective action will include: 1. The maintenance director and/or designee contacted the emergency generator vendor to complete the 36 month 4 hour load bank testing. Load bank testing scheduled for 11/15/2023. 2. The maintenance director and/or designee to be trained in the requirement of weekly visual inspections, monthly 30 minute 30% load bank test, annual 4 hour load bank test if monthly testing cannot be completed and 36 month 4 hour load bank test. Completed on 11/7/2023 Assurance of On-Going compliance: 1. The location s computerized preventative maintenance program for generators was updated to include weekly visual inspections, monthly 30 minute 30% load bank test, annual 4 hour 30% load bank testing as necessary, and the	

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K 918	Continued From page 15	K 918	36 month 4 hour load bank test. 2. The maintenance director and/or designee will complete weekly visual inspections weekly x4 and weekly thereafter, monthly 30 minute 30% load bank test and monthly thereafter. Completion reports will be provided to the QAPI committee and administrator.	