Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
January 30, 2024

Administrator
St Crispin Living Community
213 Pioneer Road
Red Wing, MN 55066

RE: CCN: 245449
Cycle Start Date: December 7, 2023

Dear Administrator:

On January 25, 2024, the Minnesota Departments of Health and Public Safety completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Feel free to contact me if you have questions.

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
December 27, 2023

Administrator
St. Crispin Living Community
213 Pioneer Road
Red Wing, MN 55066

RE: CCN: 245449
Cycle Start Date: December 7, 2023

Dear Administrator:

On December 7, 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:

Pete Cole, RN Unit Supervisor
Metro Team C District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
85 East Seventh Place, Suite 220
P.O. Box 64900
Saint Paul, Minnesota 55164-0900
Email: peter.cole@state.mn.us
Office/Mobile: (651) 249-1724

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 March 7, 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 June 7, 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
	245449	A. BUILDING _____ B. WING _____	C 12/07/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST CRISPIN LIVING COMMUNITY	213 PIONEER ROAD RED WING, MN 55066

(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 12/4/23 to 12/7/23, a survey for compliance with Appendix Z, Emergency Preparedness Requirements, §483.73 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 015 SS=C	Subsistence Needs for Staff and Patients CFR(s): 483.73(b)(1) §403.748(b)(1), §418.113(b)(6)(iii), §441.184(b)(1), §460.84(b)(1), §482.15(b)(1), §483.73(b)(1), §483.475(b)(1), §485.542(b)(1), §485.625(b)(1) [(b) Policies and procedures. [Facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated every 2 years [annually for LTC facilities]. At a minimum, the policies and procedures must address the following: (1) The provision of subsistence needs for staff and patients whether they evacuate or shelter in	E 015		1/23/24

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

Electronically Signed | 01/04/2024

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

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E 015	Continued From page 1 place, include, but are not limited to the following: (i) Food, water, medical and pharmaceutical supplies (ii) Alternate sources of energy to maintain the following: (A) Temperatures to protect patient health and safety and for the safe and sanitary storage of provisions. (B) Emergency lighting. (C) Fire detection, extinguishing, and alarm systems. (D) Sewage and waste disposal. *[For Inpatient Hospice at §418.113(b)(6)(iii):] Policies and procedures. (6) The following are additional requirements for hospice-operated inpatient care facilities only. The policies and procedures must address the following: (iii) The provision of subsistence needs for hospice employees and patients, whether they evacuate or shelter in place, include, but are not limited to the following: (A) Food, water, medical, and pharmaceutical supplies. (B) Alternate sources of energy to maintain the following: (1) Temperatures to protect patient health and safety and for the safe and sanitary storage of provisions. (2) Emergency lighting. (3) Fire detection, extinguishing, and alarm systems. (C) Sewage and waste disposal. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to include in their policies and procedures how to handle sewage and waste	E 015	This Plan of Correction constitutes the facilities credible allegation of compliance preparation and/or execution of this plan	

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E 015	Continued From page 2 disposal for clients and staff whether they evacuate or shelter in place during an emergency. This had the potential to affect all 50 residents and staff of the facility. Findings include: On 12/7/23 at 8:00 a.m., during a review of the facility's Emergency Preparedness Program (EPP), the files lacked detail on how to ensure for the adequate disposal of sewage and waste in the event of the disruption of the facility's water source. During an interview on 12/7/23 at 10:00 a.m. the environmental service director (ESD) verified the EPP lacked this information. The ESD stated the EPP will be updated as soon as possible.	E 015	does not constitute admission or agreement by the provider of the truths or facts alleged or conclusions set forth in the statements of deficiencies. The plan of correction is prepared and/or executed in accordance with federal and state law requirements. EVS Director will add supplemental information to the current Utility Emergency Policy including waste and sewage disposal as per current City Emergency Management Plan: “We do have an emergency contact list for critical facilities in case of a water emergency and Benedictine is listed on that. We do have emergency response plans for both water and wastewater as well. We do have emergency generators at all critical facilities as well as portable generators to ensure as much critical infrastructure can remain operational as possible.” jerry.plein@ci.red-wing.mn.us Deputy Director of Utilities EVS will report to Safety Team and Quality Council on January 16, 2024 updated Policy including sewage and waste disposal, and then annually. All staff will be educated regarding sewage and waste disposal on 1/4/2024. EVS Director/staff are responsible for corrective actions and monitoring of compliance.	

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E 041	Continued From page 3	E 041		
E 041 SS=C	Hospital CAH and LTC Emergency Power CFR(s): 483.73(e) §482.15(e) Condition for Participation: (e) Emergency and standby power systems. The hospital must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section and in the policies and procedures plan set forth in paragraphs (b)(1)(i) and (ii) of this section. §483.73(e), §485.625(e), §485.542(e) (e) Emergency and standby power systems. The [LTC facility CAH and REH] must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section. §482.15(e)(1), §483.73(e)(1), §485.542(e)(1), §485.625(e)(1) 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	E 041		1/23/24

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E 041	Continued From page 4 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 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.	E 041		

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E 041	Continued From page 5 (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: Based on a review of available documentation and staff interview, the facility failed to test and inspect their emergency generator per NFPA 99 (2012 edition), Health Care Facilities Code, section 6.4.4.1.1.3, and NFPA 110 (2010 edition), Standard for Emergency and Standby Power Systems, section 8.4.1, 8.4.2, and 8.4.6. This deficient finding could have a widespread impact on all the residents within the facility. Findings include: On 12/06/2023 between 9:30 a.m. and 1:30 p.m., it was revealed during documentation review that monthly inspection and testing reports were incomplete in data capture - identifying or confirming that the Auto Transfer Switch is being tested.	E 041	This Plan of Correction constitutes the facilities credible allegation of compliance preparation and/or execution of this plan does not constitute admission or agreement by the provider of the truths or facts alleged or conclusions set forth in the statements of deficiencies. The plan of correction is prepared and/or executed in accordance with federal and state law requirements. EVS Director/staff will maintain inspection and testing as required weekly, exercised under load 30 minutes monthly, and exercised once every 36 months for 4 continuous hours. Results will be documented and kept in Life Safety Book.	

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E 041	Continued From page 6 During interview with the maintenance director this was dificient finding was verified at the time of discovery.	E 041	EVS Director will report results of generator tests and inspections to Safety Team monthly for 3 months, 2024. All staff will be educated regarding generator testing and inspections on 1/4/2024. Staff will be instructed to use the red outlets (indicating generator power) in resident rooms for medical equipment.	
F 000	INITIAL COMMENTS On 12/4/23 to 12/7/23, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was not in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. In addition to the recertification survey, the following complaint was reviewed The following complaint was reviewed with no deficiency issued. H54497708C (MN99018) The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the	F 000		

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F 000	Continued From page 7 regulations has been attained.	F 000		
F 554 SS=D	Resident Self-Admin Meds-Clinically Approp CFR(s): 483.10(c)(7) §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure 1 of 1 residents (R101) was comprehensively assessed and deemed safe to self-administer medications, including a narcotic that was found at his bedside. Findings include: R101's Resident Face Sheet indicated R101 was admitted to the facility on 11/29/23. Therefore, R101 did not have a reported Minimum Data Set (MDS) or Care Area Assessment (CAA) completed. R101's care plan dated 12/5/23, indicated R101 had a risk for impaired psychosocial wellbeing related to a dementia. Interventions included encouraging relaxation techniques, activities, and one to one visits. R101 also had an alteration in communication related to cognitive impairment. The care plan also indicated R101 took psychotropic drugs for insomnia, and bipolar disorder (a mental health disorder causing extreme moods from mania to depression). Interventions included administering medication per order, monitoring for target behaviors, and reporting efficacy of medication use. R101's care plan also indicated R101 had an activities of daily	F 554	This plan of correction constitutes the facility's credible allegation of compliance. Preparation and/or execution of this plan does not constitute admission or agreement by the provider of the truths or facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed in accordance with federal and state law requirements. R101 is no longer a resident of the facility. All residents without self-administration orders in place had their rooms checked to ensure no other residents without a self-administration order had medications at bedside. All nursing staff were re-educated on Benedictine's policy on medications being brought to the community by the resident/family, and instructed to notify a member of the licensed nursing team right away if any medications are noted to be within a resident room.	1/23/24

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F 554	Continued From page 8 living (ADL) deficit and required assistance with transfers, bathing, grooming, oral cares, ambulation, and mobility. R101's diagnoses included acute respiratory failure with hypoxia (low oxygen levels), dementia with Lewy bodies, other specified crystal arthropathies (pseudo-gout, a formation of calcium pyrophosphate crystals in the joints resulting in pain and inflammation), obstructive sleep apnea, bipolar disorder, and a kidney transplant. R101's orders dated 11/29/23, indicated R101 took amitryptyline 2% (an antidepressant) gabapentin 5% (an anticonvulsant), Ketamine 5% (an anesthetic controlled substance) in a compounded lipoderm cream twice a day topically, as needed, for pain. R101's Medication Administration Record (MAR) lacked indication R101 had used the cream since his admission to the facility. R101's Self-Administration of Medication Assessment (SAM) dated 11/29/23, indicated R101 did not want to self-administer medication including creams/ointments. No further assessment was completed. During an observation and interview on 12/4/23 at 5:45 p.m., R101 was lying in bed and his family member (FM)-A was visiting. Two medication bottles were on R101's bedside table. The bottles labels were worn and no information including resident name or medication name was visible. R101 stated he rubbed the medication onto his shoulders and neck, almost daily, for gout pain. R101 further stated the medication was from his home and contained amitriptyline, ketamine and a third medication he could not recall.	F 554	Policy: Medications brought to the community by the resident/family added to all admission packets and discussed upon facility admission with the admitting resident and present family members. Room audits looking for any medications brought in from a family member will be conducted per MDS schedule 3x weekly x2 weeks, then 2x weekly x2 weeks, then as needed to validate ongoing compliance. The results of the audits will be reported through the facility QA committee with ongoing frequency and duration to be determined through analysis and review of results.	

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F 554	Continued From page 9 During an observation on 12/5/23 at 10:58 a.m., nursing assistant (NA)-B exited R101's room with a portable vitals machine. The two unmarked medication bottles remained on R101's bedside table. During an observation on 12/6/23 at 8:10 a.m., R101 was asleep in bed and the two medication bottles remained on his bedside table. During an observation and interview on 12/6/23 at 11:41 a.m., the assistant director of nursing (ADON) verified the two medication bottles remained in R101's room. The ADON stated because the bottles were unlabeled and had been opened prior to R101 being admitted to the facility, staff were unable to verify the contents of the bottles. The ADON also stated controlled substance medications were to be double locked in a medication cart or medication room to ensure proper usage. The ADON further stated R101 had a history of not taking his medications appropriately and the provider did not want him self administering medications. During an interview on 12/7/23 at 1:56 p.m., the director of nursing (DON) stated all medications brought into the facility from a resident's home needed to be labeled and unopened. The DON also stated residents wanting to self-administer medications were to be assessed to determine their ability to self-administer medications safely and appropriately. The DON further stated all controlled substance medications were to be double locked in a medication cart or room for safe storage. The facility Self-Administration of Medications	F 554		

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F 554	Continued From page 10 policy dated 2020, indicated each resident's mental and physical ability was to be assessed for the appropriateness of self-administering medications. If it was determined a resident was unable to self-administer medications safely, nursing staff was to administer the medications to the resident and document when the medications were taken. A facility Medication Storage policy was not received.	F 554		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary	F 657		1/23/24

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F 657	Continued From page 11 team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to ensure timeliness of person-centered care conferences for 2 of 2 residents (R19, R35) to include review and revision of the care plan by an interdisciplinary team and the resident. Findings include: R19's quarterly Minimum Data Set (MDS), dated 10/2/23, indicated R19 was admitted to the facility on 3/8/22, was cognitively intact, was independent with bed mobility, needed supervision with transfers, required set up to eat, oral hygiene, and needed moderate assistance with personal hygiene and bathing. Diagnoses included chronic kidney disease, diabetes mellitus, hyperlipidemia (high blood cholesterol), depression, and hypertension (high blood pressure). R19's care plan revised on 10/3/23, indicated the last conference was on 4/12/23 and documented the next care conference was on 7/12/23. R19's Care Conference Report dated 12/6/23, had documentation of care conferences held on 7/13/22, 10/5/22, 1/11/23 and 4/23/23. During an interview on 12/4/23 on 1:34 p.m., R19 stated she had not attended a care conference for at least 6 to 8 months. R19 stated, usually her brother, herself (R19) and a staff member attended her care conference. R19 stated,	F 657	This plan of correction constitutes the facility's credible allegation of compliance. Preparation and/or execution of this plan does not constitute admission or agreement by the provider of the truths or facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed in accordance with federal and state law requirements. R19 has a care conference scheduled for 1/5/24 current care plan and preferences will be reviewed. R35 has a care conference scheduled for 1/5/24 current care plan and preferences will be reviewed. All residents reviewed to ensure care conferences are scheduled for the 1st Quarter. Care conference reminders given to residents with tentative care conference dates and times. Interdisciplinary Team re-educated on resident/family participation in care planning policy and expectation for care conferences to include a social worker, nurse, nurse aide, member of food and nutrition services staff, and therapy associate.	

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F 657	Continued From page 12 "usually a nurse comes to my room and asks me if a have any concerns and how am I doing?" During an interview on 12/6/23 at 1:18 p.m., social worker (SW)-A stated R19's care conference was due in January 2024. SW-A stated the care conferences were scheduled based on the MDS assessments' schedule. SW-A stated for long term residents the care conferences are scheduled every three months and as needed. SW-A verified R19's electronic record lacked documentation of a care conference since 4/12/23. During an interview on 12/7/23 at 10:46 a.m., the nurse manager/register nurse (RN)-D stated care conferences were done quarterly. RN-D stated on 10/5/23 she met with R19 in her room, no other staff member participated, and verified there was no documentation of this meeting on R19's electronic medical record. During an interview on 12/7/23 at 11:28 a.m., the director of nursing stated the long-term care resident had care conferences quarterly and as needed for significant changes or per resident request. The DON stated, care conferences needed to be attended by all disciplines and if any discipline was unable to attend, the discipline needed to send their information to the social worker to discuss it with the resident or their family. R35's quarterly MDS dated 10/23/23, indicated R23 was admitted on 10/10/22, and had no cognitive deficits. A review of R35's progress notes indicated that R35's last care conference was on 7/14/23.	F 657	Care conference documentation and attendance to be reviewed weekly x12 weeks by the IDT. The results of the audits will be reported through the facility QA committee with ongoing frequency and duration to be determined through analysis and review of results.	

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F 657	Continued From page 13 A review of R35's medical record did not demonstrate a care conference had occurred after 7/14/23 or a reason this would not have been practicable for R35. During an interview on 12/4/23 at 2:04 p.m., R35 stated he didn't remember the last time he had a care conference with his providers and wished he had been more updated and involved with his care. During an interview on 12/5/23 at 1:10 p.m., SW-A stated R35 was supposed to have his care conference on 10/22/23 for this quarter but it was missed. SW-A stated that R35 would not have his next care conference until the following quarter. During an interview on 12/7/23 at 2:46 p.m., the DON stated that SW-A scheduled the quarterly care conferences. The DON stated these conferences were important to ensure residents were informed about their care and were able to personalize the plan as needed. The facility's Comprehensive Assessments and Care Planning policy dated 7/2/18, indicated the care planning process should include direct observation and communication with the resident. The resident or resident representative should have been involved in creating a person-centered care plan and if it was not practicable for them to have been involved, it must be documented in the resident's medical record. Policy titled Resident/Family Participation in Care Planning dated 2017, indicated the purpose was to ensure residents were informed of their rights and actively participated in person centered care	F 657		

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F 657	Continued From page 14 planning per their discretion. The policy also indicated the resident and invitees participated in the care planning process with the interdisciplinary team.	F 657		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure provider orders were followed for 1 of 1 residents (R45) who had developed edema in his right arm after a stroke. Findings include: R45's admission Minimum Data Set (MDS) dated 10/16/23, indicated R45 had severe cognitive deficits and was dependent for all activities of daily living (ADLs). R45's diagnoses included hemiplegia/hemiparalysis (partial one-sided paralyis) to right dominant side secondary to a stroke and hypertensive (high-pressure) kidney disease. R45's Care Area Assessment (CAA) dated 10/16/23, indicated R45 triggered for communication, pressure ulcers, and pain.	F 684	This plan of correction constitutes the facility's credible allegation of compliance. Preparation and/or execution of this plan does not constitute admission or agreement by the provider of the truths or facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed in accordance with federal and state law requirements. R45□s tubi-grip order changed to include visual checks with meals to ensure it is applied and at HS to ensure it is removed. All residents with edema treatment orders in place were reviewed for order accuracy and care plans updated with treatment preferences.	1/23/24

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F 684	Continued From page 15 R45's progress noted dated 10/9/23, indicated R45 had no edema. R45's order dated 10/30/23, indicated to elevate R45's right upper extremity (RUE) as much as possible to decrease edema. R45's order dated 11/10/23, indicated to apply a tubi-grip wrap (compression wrap) to R45's RUE during the day and to remove it at night. During an observation on 12/4/23 at 3:52 p.m., R45 was semi-reclined in bed with his right arm on one pillow raising it to the level of the top of his right thigh. R45's right arm lacked a tubi-grip wrap and was bluish-purple and swollen to his elbow. During an observation on 12/5/23 at 11:00 a.m., R45 was in bed. His right arm was on one pillow at the level of his right thigh with a tubi-grip wrap on it. R45's hand was bluish-purple, and his hand and arm were swollen to his elbow. During an observation on 12/6/23 at 8:05 a.m., R45 was sitting up in bed, feeding himself breakfast with his right arm between a pillow and his right thigh. R45's right arm lacked a tubi-grip wrap and appeared bluish-purple and was swollen. During an observation on 12/6/23 at 11:06 a.m., R45 was reclined in his bed with his right arm resting on one pillow and no tubi-grip wrap applied. R45's right arm was bluish-purple and swollen. During an observation on 12/7/23 at 8:09 a.m., R45 was lying in bed, semi-reclined and awake. R45's right arm was on a single pillow with no	F 684	All nursing staff are being provided with re-educated on following treatments as ordered and need to document all refusals. Audits of residents with treatments in place to reduce edema will be conducted three times a week for two weeks, then two times a week for two weeks, then once a week. Audits will be reviewed by IDT. The results of the audits will be reported through the facility QA committee on 01/16/24 with ongoing frequency and duration to be determined through analysis and review of results.	

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F 684	Continued From page 16 tubi-grip wrap applied. During an observation and interview on 12/7/23 at 9:20 a.m., R45 was sitting up in bed, his right arm was elevated on two pillows and appeared pink in color with swelling noted only to his hand and no tubi-grip wrap applied. R45 asked if this surveyor could help him put on his tubi-grip wrap because it "works really good" and he liked to have it on every day. During an interview on 12/4/23 at 5:25 p.m., licensed practical nurse (LPN)-A stated staff were supposed to elevate R45's right arm, however, it was a "never-ending battle." During an interview on 12/7/23 at 9:24 a.m., registered nurse (RN)-B stated R45 should have two pillows under his right arm to ensure it is elevated high enough to decrease his swelling. RN-B further stated R45 was to have a tubi-grip wrap on his right arm all day to help decrease the swelling also. During an interview on 12/6/23 at 11:45 a.m., the assistant director of nursing (ADON) stated R45's tubi-grip arm wrap should have been applied every day, all day, and removed at night according to his orders to control edema unless R45 had refused. The ADON further verified although R45 did not have a tubi-grip wrap on his arm, his electronic medical record (EMR) had been charted to indicate he did. During an interview on 12/7/23 at 2:07 p.m., the director of nursing (DON) stated R45's right arm should be on two pillows to ensure it was elevated at or above his heart to decrease swelling and improve circulation and his tubi-grip	F 684		

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F 684	Continued From page 17 wraps should have been applied during waking hours as ordered. A facility policy related to treatment of edema was requested but not received.	F 684		
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 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 comprehensively assess, develop, and implement interventions for ongoing and unplanned weight loss for 1 of 1 residents (R30) who had significant weight loss. Findings include:	F 692	This plan of correction constitutes the facility's credible allegation of compliance. Preparation and/or execution of this plan does not constitute admission or agreement by the provider of the truths or facts alleged or conclusions set forth in the statement of deficiencies.	1/23/24

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F 692	Continued From page 18 R30's significant change in status Minimum Data Set (MDS) dated 11/19/23, indicated R30 had impaired cognition, needed set up assistance with eating and required extensive assistance for all other activities of daily living (ADLs). R30's diagnoses included dementia, malnutrition, depression, chronic obstructive pulmonary disease (COPD), low back pain, high blood pressure, and osteoporosis (weak and brittle bones). R30's Care Area Assessment (CAA) sated 10/27/23, indicated R30 triggered for visual function, ADL function, urinary incontinence, falls, nutritional status, pressure ulcer and psychotropic drug use. R30's care plan dated 11/03/22, indicated R30 had potential for altered nutrition/hydration status related to dysphagia (difficulty swallowing), dementia, anemia, history of aspiration pneumonia (occurs when food or fluid is breathed into the airway or lungs instead of being swallowed), history of unstageable pressure injury, fracture at admission, malnutrition, low BMI (low body weight), osteoporosis (weak and brittle bones). Care plan indicated R30 prefers to remain in bed, supplements in place to help meet nutritional needs. Interventions included diet per MD, honor likes/dislikes and offer preferred fluids with and between meals, water at bedside. Interventions also included nutritional related meds and supplements per MD, provide meal set-up and/or assistance with eating per SLP, snacks per patient request and/or policy, monitor weight, intake labs, texture tolerance, skin and/or additional nutrition/hydration parameters as appropriate and no eggs.	F 692	The plan of correction is prepared and/or executed in accordance with federal and state law requirements. R30□s weight loss and coinciding supplements were reassessed by dietician on 12/18/23. Ongoing, R30 will be assessed monthly and as needed. R30□s weights have increased with resolution of acute illness and additional supplements. All resident weights are reviewed monthly by the RD, when significant weight changes are noted, weight monitoring will be increased from once a week to twice a week weights until weights have stabilized. All nursing staff are being re-educated on following the ordered level of supervision needed for residents during meals. Audits at meal times will be conducted of residents who require supervision with meals twice a week for four weeks. The results of the audits will be reported through the facility QA committee with ongoing frequency and duration to be determined through analysis and review of results.	

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F 692	Continued From page 19 R30's nutrition progress note dated 11/22/23, indicated that weight loss is not planned or prescribed. R30's nutrition progress note dated 11/19/23, indicated the registered dietician (RD) indicated R30 requires supervision with meals. "Meal intakes: many poor with two being good during ARD [time period for significant change assessment after hospitalization]. Supplement three times daily is variable." R30's nutrition progress note dated 10/27/23, indicated supplement provided with meals is mostly good but variable. R30's weights (in pounds) were as follows: -6/2/23 at 1:54 p.m., 107.3 "Fairly stable weights" -9/15/23 at 1:27 p.m., 104 -10/13/23 at 10:35 a.m., 100.4 -11/15/23 at 1:44 p.m., 94.6 11/23/23 at 1.53 p.m., 92 On 06/02/2023, the resident weighed 107.3 pounds. On 11/23/2023, the resident weighed 92 pounds which is a negative 14.26 % weight loss. R30's diet orders included: 3/14/23: Chocolate ensure with meals 11/28/23: 8 oz ensure clear between meals R30's meal intake summary dated 11/7/23 - 12/7/23 -over the last 30 days, overall poor intake R30's physician note dated 11/10/23, indicated R30 had no appetite, weight noted on 11/9/23 of 47.7 kg [99.8 lbs.] and to continue with speech	F 692		

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F 692	Continued From page 20 therapy, modified diet, nutritional supplement, and monitoring. During observation on 12/4/23 at 2:52 p.m., R30 had two ensures and a water on her bedside table. One of the ensures was full and the other ensure was two-thirds full. During interview and observation with R30 on 12/5/23 at 11:53 a.m., R30 stated that she does not eat in the dining room because staff would have to help get her up. Upon entry to R30's room, the door was closed tight. R30 had her lunch tray which had mashed potatoes, meatloaf, whole cooked carrots, and a brownie. R30 had eaten some of the mashed potatoes. R30 had three bottles of ensure on her bed side table next to her lunch tray. During interview and observation on 12/6/23 at 8:19 a.m., R30 stated that no staff are with her when she eats meals. R30 was observed to be slouched down in bed, the head of the bed was elevated and R30 stated she was done eating breakfast. R30's door was shut upon entrance. During an interview on 12/6/23 at 8:25 a.m., nursing assistant (NA)-B stated R30 always ate breakfast in her room as that was her preference, liked her door shut and did not need assistance with meals. NA-B stated that R30 does not need supervision with meals, was recently in the hospital due to complications from COVID and is back to her baseline. During an interview on 12/6/23 at 3:57 p.m., assistant director of nursing (ADON) stated R30's intake can be poor, recently had COVID and pneumonia, likes her supplements and needs	F 692		

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F 692	Continued From page 21 supervision with her meals. ADON stated R30 need for supervision was on her care plan to help ensure she is sitting up right as she has a hernia and had aspiration pneumonia. ADON stated supervision during a meal means that staff needs to be able to see the resident while they are eating. During interview on 12/7/23 at 8:04 a.m., nursing assistant (NA)-C stated that she is not aware of R30 needed supervision or assistance with meals. During interview on 12/7/23 at 8:05 a.m., nursing assistant (NA)-D stated that R30 always had the door to her room closed. NA-D stated that R30 is not supervised during meals and R30 is a set up for meals. NA-D stated that if R30 needs anything R30 would put her call light on. On 12/7/23 at 8:25 a.m., it was observed that R30's breakfast tray was delivered to R30's room. At 8:27a.m., staff delivering tray exited R30's room. During an interview on 12/7/23 at 8:29 a.m., nursing assistant (NA)-E verified that they had just delivered R30's breakfast tray to R30. NA-E verified the door was shut and there is no staff in R30's room. NA-E stated that R30 does not need supervision with meals, she just needs set up, and she is not checked on during meals. During an interview on 12/7/23 at 9:23 a.m., registered dietician (RD) stated she would run a report to look for significant weight changes, and if a significant weight change was noted, RD would request the resident to be reweighed to ensure accuracy, then address the concern if the	F 692		

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F 692	Continued From page 22 weight was not expected or desired. RD stated she has not met with R30 to discuss weight loss. RD stated that her communication has been with the staff. RD stated that she indicated that R30 needed supervision with meals. RD indicated the expectation with the supervision would be staff would provide encouragement to eat to help her increase her food intake. RD stated she does this for residents who have had weight loss and suffer from dementia as it has been beneficial as residents with dementia need encouragement and supervision with meals. During an interview on 12/7/23 at 10:04 a.m., R30 stated that no staff had talked to her about any weight loss. R30 stated she does not want to lose any weight. R30 is unsure what she weighs now but majority of her life she has weight between 107-110 lbs which is what she thinks she is at. The facility Weight Protocol policy dated 8/1, residents were to be weighed upon admission and at least monthly thereafter. Each resident's weight is monitored and fluctuations of greater than or equal to 5% in one month, or 7.5% in three months, or 10% in six months will be assessed and appropriate individualized dietary interventions and documentation will be implemented. A resident's physician and responsible party were to be notified of any significant weight change.	F 692		
F 740 SS=D	Behavioral Health Services CFR(s): 483.40 §483.40 Behavioral health services. Each resident must receive and the facility must provide the necessary behavioral health care and services to attain or maintain the highest	F 740		1/23/24

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F 740	Continued From page 23 practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Behavioral health encompasses a resident's whole emotional and mental well-being, which includes, but is not limited to, the prevention and treatment of mental and substance use disorders. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to comprehensively assess suicidal ideation and develop safety interventions for 1 of 1 residents (R23) who had made suicidal statements and was assessed for behavioral-emotional health. Findings include: R23's quarterly Minimum Data Set (MDS) dated 7/17/23, indicated R23 had intact cognition with no behaviors noted. R23's mood was not assessed. The MDS indicated that R23 required partial assistance for toileting and dressing. R23's significant change MDS dated 8/15/23, indicated R23 had moderately impaired cognition with disorganized thinking and an altered level of consciousness. The MDS indicated that R23's mood assessment was not completed. The MDS indicated R23 had delusions present with symptoms such as hitting, scratching, pacing, or disruptive sounds. R23's Care Area Assessment (CAA) dated 8/15/23, indicated R23 triggered for delirium, cognitive loss/dementia, communication, psychosocial well-being, mood state, and behavioral symptoms.	F 740	This plan of correction constitutes the facility's credible allegation of compliance. Preparation and/or execution of this plan does not constitute admission or agreement by the provider of the truths or facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed in accordance with federal and state law requirements. Interventions for identified resident: On 12/06/2023, resident #23 had a hospitalization stay for Mental Health Crisis from 08/29/2023 □ 09/12/2023, resident returned to facility in stable condition. Medical Record was reviewed and sent to the Quality Assurance committee for process improvement opportunities. On 12/06/2023, PHQ2-9 was completed on Resident #23 to assess for suicidal ideation, ongoing safety, and mental well-being. PHQ2-9 resulted in a score of zero; indicating no signs or symptoms of depression at this time. On 12/06/2023, resident #23□s room was assessed for safety utilizing the Suicide Policy Attachment: Environmental	

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F 740	Continued From page 24 R23's significant change MDS dated 11/2/23, indicated R23 had intact cognition and required set-up help with eating and dependent assistance with toileting. The MDS indicated that R23 was diagnosed with depression, anxiety, and a psychotic disorder. R23's CAA dated 11/2/23, indicated R23 triggered for cognitive loss/dementia and behavioral symptoms. R23's order summary dated 2/7/23, indicated an order to monitor for antidepressant target behaviors such as wanting to/talking about dying, yelling, frowning, lack of interest in activities, social isolation, negative statements, crying, and sad facial expressions. The order also indicated nursing staff should monitor for antidepressant side effects. R23's emergency department provider note dated 2/8/23 at 3:26 p.m., indicated R23 was at the emergency department related to altered mental status and auditory and visual hallucinations. The note indicated the voices had told her "that she should die." The note indicated that she had no suicidal plans. The note indicated the provider thought the confusion could have been related to oxycodone (opioid pain medication) use with the addition of Zoloft (an antidepressant) and recommended holding the oxycodone. R23's care plan dated 4/12/23, indicated R23 preferred staff to check on her hourly during the waking hours. R23's order summary dated 4/14/23, indicated an order to check in with R23 hourly during waking hours. R23's medical/treatment record dated 7/1/23-	F 740	Checklist. Interventions included shortening of the call light in both the resident bathroom and the resident room and removal of plastic garbage bags. On 12/06/2023, room interventions were added to the resident□s care plan for ongoing safety and well-being. Caregivers updated and educated on newly implemented interventions. Current facility nursing staff, including agency/contract associates received education on the importance of reporting any indications or potential threats of self-harm by resident #23 immediately; beginning on 12/06/2023. This education will continue until completed by all facility associates and agency/contract associates. Staff will be educated prior to working the next scheduled shift. Interventions for other residents at risk: On 12/06/2023, all facility residents had a review completed of nursing progress notes dating back to August 1, 2023 to identify potential risk for self-harm. No documentation of self-harm was noted. On 12/06/2023, all facility residents reviewed to ensure PHQ9 and/or PHQ2-9 completed within current quarter. On 12/06/2023, residents identified as high risk on previous PHQ9 and/or PHQ2-9 had updated PHQ2-9 completed to assess for suicidal ideation, ongoing safety, and mental well-being. On 12/06/2023, residents identified as high risk on previous PHQ9 and/or PHQ2-9 had a review of Provider Dictations dating back to August 1, 2023	

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F 740	Continued From page 25 7/31/23, indicated R23 had made comments about "wanting to/talking about dying" on 7/29/23. R23's medical/treatment record dated 8/1/23-8/31/23, indicated R23 had made comments about "wanting to/talking about dying" on 8/1/23, 8/2/23, 8/17/23, 8/20/23, 8/26/23, 8/27/23, and 8/28/23. R23's Resident Mood Interview form dated 7/17/23, indicated R23 had no thoughts such as being "better off dead" or about hurting herself in some way, or other symptoms of depression at the time of the interview. R23's progress note dated 7/26/23 at 4:06 p.m., indicated family had requested that staff speak to R23 related to her "strange comments and ['things not adding up']" R23 indicated there was too much going on in her life right now and hoped everything would be better when a new month came. The note indicated that R23 appeared to have been unable to process her life events, including the death of a family member. R23's progress note dated 7/28/23 at 1:06 p.m., indicated family had asked staff again to talk with R23 related to concern that R23 was "more ['mixed up.']" R23's progress note dated 7/28/23 at 4:00 p.m. identified the provider was notified of family request to increase Zoloft. The provider increased the Zoloft on 7/29/23. R23's progress note dated 7/29/23 at 8:50 p.m., indicated R23 was crying and yelling frantically at family members and made comments about dying. The note indicated R23 had deescalated, taken her medications, and then again became	F 740	to identify potential risk for self-harm. On 12/06/2023, residents identified as high risk had care plan interventions reviewed and updated as necessary. Providers notified of current status, medications, and interventions. Systemic Changes: On 12/06/2023, Suicide Threats by the Resident Policy reviewed for accuracy, no revisions needed. Current facility nursing staff, including agency/contract associates received education beginning on 12/06/2023. This education will continue until completed by all facility associates and agency/contract associates. Staff will be educated prior to working the next scheduled shift. Education includes: Suicide Threats by the Resident Policy Attachment A: PHQ Addendum Attachment B: Suicidal Risk Factors and Warning Signs Attachment C: Suicide Algorithm Attachment D: Environmental Safety Checklist Attachment E: Suicide Crisis Plan Reporting of indications or potential threats of self-harm immediately. On 12/07/2023, Facility implemented process to review facility resident progress notes in daily IDT meetings Monday - Friday. On 12/07/2023, Facility implemented process to review provider dictations as soon as they become available following scheduled appointments and/or visits.	

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F 740	Continued From page 26 very agitated with a depressed mood and made a statement about wanting to die. R23's progress note dated 7/31/23 at 10:35 a.m., indicated social services and the DON had assessed R23 related to staff and family requests. The note indicated R23 was abnormally slow to respond when asked how she was doing. The note indicated R23 eventually said "great" but was unable to expand further. The note indicated social services emailed the family and the county care coordinator to follow up on a mental health appointment. The facility also submitted a referral to a local clinic but an appointment was not scheduled. R23's progress note dated 7/31/23, at 11:30 a.m. identified the provider was notified of behaviors and provider stated, "There really isn't much we can do, she is not physically hurting herself or others, so there is no hard [sp] being done." R23's progress note dated 8/2/23 at 12:01 p.m., indicated R23 had been filling the trash cans in her room with her personal items so staff were checking the trash cans for these items. The note indicated nursing staff would continue to monitor R23's safety but did not indicate suicidal ideation had been assessed. R23's care plan dated 8/2/23, indicated R23 had a history of behavioral symptoms related to incorrect perceptions of reality and listed triggers to her symptoms such as the anniversary of her sister's death and exacerbating behaviors with one-to-one time with staff. The care plan listed interventions such as allowing the resident to have control over the situation when possible, attempting one-to-one conversations, establishing	F 740	Facility will review provider dictations and assessments as soon as they become available for Resident #23 for new treatments or interventions specifically related to behavioral health. Facility will implement any treatments or interventions identified by providers immediately. Facility will send residents to appointments with folders to transport facility/provider communication. Facility will confirm that collaborating hospitals and clinics have facility fax number on file. Facility will ensure that Nursing Management Team has access to hospital and clinic eMAR system to independently review available dictations. Ongoing audits of both facility progress notes and provider dictations will be completed twice weekly for 4 weeks to ensure that high risk residents and those with suicidal ideations have interventions in place to prevent mental health crisis. Results of audits shall be reported at the facility Quality Council meeting with ongoing frequency and duration to be determined through analysis and review of results if substantial compliance is not met.	

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F 740	Continued From page 27 trust, identifying relationships the resident could draw from, and psychiatric referrals as needed. R23's progress note dated 8/3/23 at 9:16 a.m., indicated R23 refused all morning medications, threw her breakfast tray "all over the room," and the one-to-one time spent with R23 was not effective. R23's progress note dated 8/3/23 at 5:17 p.m. identified an order was obtained with ok to send to ED for evaluation and treatment of psychosis if refuses lab/x-rays. R23's progress note dated 8/4/23 at 1:03 p.m., indicated family had significant concerns for resident safety due to behaviors. The note indicated the facility informed the family "that the family can pursue the ED or look into inpatient mental health to address these concerns." R23's progress note dated 8/4/23 at 1:14 p.m., indicated that R23 was sent to the emergency department (ED) per the family's request. R23's provider note with an addendum dated 8/4/23, indicated R23 had increased confusion and statements such as saying "'She wanted to die.'" The note indicated that R23 had been refusing medication routinely and was not eating her meals. The note indicated that R23 had been attempting to pack up her room and throw away her belongings. R23's hospital psychotherapy note dated 8/6/23 at 3:24 p.m., indicated R23 had acute suicidal thoughts that put her at risk for self-harm, harm to others, or harm to property. The note indicated R23 "had more days than not that she would	F 740		

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F 740	Continued From page 28 rather be dead." The note indicated that R23 had vivid memories in her mind that she could not get out. The writer attempted to assess R23's suicide risk but when asked, R23 was unable to elaborate on suicidal comments. The note indicated due to R23's limited conversation and confusion she was unable to obtain enough information to make an official mental health diagnosis. The writer recommended a formal self-harm evaluation. R23's hospital nursing progress note dated 8/6/23 at 6:02 p.m., indicated R23's family member visited and R23 informed her, she wanted to "kill herself by wrapping a cord around her neck." The note indicated R23 stated "'I would like to die and would use a rope around my neck but I don[']t have a rope.'" R23 also stated, "'I can't handle it anymore, these thoughts are terrible. I can't take it.'" The note indicated cords were removed from R23's room while in the hospital and R23 was continuously monitoring for her safety. R23's hospital psychiatry consult note dated 8/7/23 at 10:39 a.m., indicated R23 continued to demonstrate disorganized thinking, confusion, psychosis, impulsivity, agitation, and intermittently threw things across the room. The note indicated R23 was extensively assessed for a potential medical diagnosis that may have contributed to her mental health symptoms with no clear cause identified. R23 denied any active or passive suicidal ideation but endorsed voices telling her to do things and a desire to quiet those voices. The provider recommended administering risperidone (an antipsychotic medication) for R23's mental health symptoms and monitoring for its potential side effects. The note also recommended inpatient psychiatry placement for R23. The note indicated that R23 could return to the facility	F 740		

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F 740	Continued From page 29 depending on behaviors and recurring suicidal thoughts. R23's Level II Preadmission Screening dated 8/11/23, indicated R23 reported suicidal intent in the last two months. R23's hospital discharge note dated 8/11/23, indicated R23 had presented to the ED on 8/4/23, for worsening mental status over the previous two weeks. During this stay, she was evaluated by the psychology team and they felt R23 was experiencing delirium rather than acute psychosis or worsening dementia. The note indicated that behavioral health was consulted but it was difficult to obtain an accurate self-harm risk assessment due to R23's impaired cognitive status. The patient was maintained on one-to-one suicide precautions pending a behavioral health evaluation and determined R23 was not at risk for self-harm. The note indicated family continued to have concerns related to R23 failing to return to her mental health baseline. The note indicated that R23 would have benefitted from ongoing care with a geriatric psychiatrist or a psychologist. The note indicated that R23 was stable at discharge. R23's progress note dated 8/11/23 at 2:18 p.m., indicated R23 had returned to the facility from the hospital. The note did not indicate facility knowledge of R23's previously stated suicide plan or assessment of the possible need for environmental safety modifications. R23's progress note dated 8/11/23 at 2:33 p.m., indicated R23's family requested "checks" on R23. The note did not indicate facility knowledge of R23's previously stated suicide plan or assessment of the possible need for	F 740		

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F 740	Continued From page 30 environmental safety modifications. R23's progress note dated 8/12/23 at 2:22 a.m., indicated R23 would not respond verbally to questions and was found banging the table with her call light but would not say what she needed. R23's progress note dated 8/12/23 at 8:16 p.m., indicated R23 refused her meal and personal care that evening and told staff, "'I'm dead, I'm dead.'" The note indicated time was spent with the resident and safety was ensured. The note did not indicate suicidal ideation had been assessed. R23's progress note dated 8/13/23 at 9:46 a.m., indicated R23 continued to refuse care and her medications. The note indicated that the nursing assistant stayed in the room with R23 related to assistance needed for activity. R23's care plan dated 8/14/23, indicated R23 had behavioral symptoms such as not responding to staff, stating she was dead, throwing meal trays, and refusing medications. The care plan goal was to ensure that the resident would not harm herself or others during her delusional periods. The approach was assigning consistent staff members as able, not arguing against the residents' belief system, encouraging ventilation of feelings, providing a safe quiet environment during delusional periods, reinforcing and focusing on reality, and using clear concise terms. R23's progress note dated 8/14/23 at 11:39 a.m., indicated R23 was at risk for falls related to a recent psychiatric decline, and the call light and frequently used items were to remain in reach of	F 740		

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F 740	Continued From page 31 the resident. The note did not address alterations to this call light or continuous supervision. R23's progress note dated 8/14/23 at 10:25 p.m., indicated R23 had spit out most of her medications, did not allow cares, and showed little emotion. The note indicated R23 was "very depressed and confused." The note indicated R23 was checked on frequently to ensure safety. R23's progress note dated 8/14/23 at 1:52 p.m. the provider was notified of R23's distressing behaviors and ordered 1. Risperidone 0.5 mg in morning and keep bedtime dose. 2. Occupational Therapy to evaluate and treat. R23's Resident Mood Interview form dated 8/15/23 at 12:48 p.m., indicated R23 had thoughts such as being "better off dead" or about hurting herself in some way, half or more days in the past two weeks. Where the form asked if the responsible staff or provider had been informed of the results, the box was left blank. R23's progress note dated 8/15/23 at 1:27 p.m., indicated R23 required "some" one-to-one time with staff related to R23 removing her clothing, banging the tray table against the wall, and yelling out. R23's psychiatry progress note dated 8/16/23 at 8:45 a.m., indicated R23 denied suicidal ideation at this time. The note indicated that R23's family member informed the writer that "'she does talk about suicidal thoughts sometimes.'" The note indicated how important a daily routine was to R23 for her anxiety and how when the routine was changed, it had a negative effect on her.	F 740		

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	245449	A. BUILDING _____ B. WING _____	C 12/07/2023

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F 740	Continued From page 32 R23's progress note dated 8/17/23 at 2:37 p.m., indicated R23 continued to display "distressing behaviors" and the provider was notified who increased her risperidone dose. R23's care plan dated 8/17/23 indicated R23 had the potential for discomfort and side effects related to the use of antidepressant and antipsychotic medications. The care plan indicated nursing staff was ordered to observe the following anti-depressant target behaviors every shift: wanting to/talking about dying, yelling, frowning, lack of interest in activities, social isolation, negative statements, crying, and sad facial expressions. R23's care plan dated 9/8/22, indicated R23 was at an increased risk for altered mood related to her placement at the facility and need for assistance with daily tasks. The care plan indicated as an intervention, staff was to assess if R23 wanted alone time or encouragement to participate with others. R23's progress note dated 8/19/23 at 1:20 p.m., indicated facility staff replaced R23's call light with a soft touch call light because R23 had been hitting herself with the previous call light. R23's progress note dated 8/21/23 at 5:46 a.m., indicated R23 had told nursing staff, "'I will be dead in the morning.'" The note indicated nursing staff "regularly checked and changed" R23 but did not indicate suicidal ideation or the need for safety modifications had been assessed. R23's facility provider note dated 8/22/23 and signed on 8/24/23, indicated R23 was admitted to the local hospital from 8/4/23 to 8/11/23 for	F 740		

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F 740	Continued From page 33 psychosis and suicidal ideation. During her hospital stay, R23 informed her family that she "wanted to kill herself by wrapping a cord around her neck." The note indicated family was concerned that R23 had not returned to baseline but R23 had no acute medical needs and was discharged back to the facility. R23's progress note dated 8/26/23 at 12:55 p.m., indicated R23 was found in her room by staff trying to put a plastic bag over her head. The provider was contacted and medications were increased. The note indicated that R23 continued to groan, yell, and attempt to get up independently from her wheelchair. The note indicated staff were unable to leave R23 alone at this time but did not indicate plastic bags had been removed from her room. R23's progress note dated 8/26/23 at 8:51 p.m., indicated R23 remained on one-to-one observation the entire shift but when staff would walk away R23 would start calling out for help but was unsure what she needed. The note indicated R23 had stated, "'My mind is playing tricks on me. There are so many things going on in my mind.'" R23's progress note dated 8/27/23 at 11:35 a.m., indicated R23 would scream for help when no one was around and would throw items when left alone. The note also indicated that R23 required supervision to ensure safety. R23's progress note dated 8/28/23 at 10:40 a.m., indicated provider updated on continual distressing behaviors, risperidone dose subsequently increased to a total of 2.5 mg per day.	F 740		

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F 740	Continued From page 34 R23's progress note dated 8/28/23 at 5:57 a.m., indicated R23 would yell out when left alone in her room. R23's progress note dated 8/29/23 at 10:27 a.m., indicated R23 was found in her room with the "call light cord wrapped one time loosely around her neck." The note indicated R23 was then brought out to activities. The note indicated R23 continued to call out for help repeatedly but did not know what she wanted when she was questioned. R23 was placed on 1:1 supervision. R23's progress note dated 8/29/23 at 10:48 a.m., indicated nursing staff updated the provider and received an order to send R23 to the emergency department. R23's progress note dated 8/29/23 at 12:47 p.m., indicated R23 left the facility with a family member to receive treatment at an inpatient psychiatric facility. R23's hospital psychiatry provider note dated 8/31/23, indicated that per R23's family, she had attempted to either strangle or suffocate herself four times in the last six weeks via cords and plastic bags. R23 indicated she was unsure why she was in the emergency department and did not remember her self-harm behaviors. The note indicated that R23 believed she had perfect memory. R23's family indicated that R23 had been hearing the voice of her mother telling her "that it is 'okay to go' and has been observed talking to herself." The note indicated R23 had self-injurious behavior by beating items with her fists causing significant bruising. The note indicated R23 had a gradual onset of confusion, behavioral changes, and worsening mood with	F 740		

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F 740	Continued From page 35 impulsive self-harm behaviors that were "highly suggestive" of an onset of a "major neurocognitive disorder." The note indicated that R23 was admitted to an inpatient psychiatric hospital unit for care. R23's progress note dated 9/12/23 at 1:18 p.m., indicated R23 returned to the facility at 11:50 a.m. The note did not indicate what assessments and safety measures were to prevent death by suicide. R23's provider note dated 9/16/23 at 8:10 p.m., indicated R23 was admitted to an inpatient psychiatric unit on 8/30/23 for a history of four suicide attempts. The note indicated that on the day of discharge from the psychiatric hospital, R23 was not an acute safety risk but "there remains a considerable moderate chronic risk for suicide and violence given the overall history." The note indicated that "psychiatry can make a judgment regarding the level of risk for suicide and violence, we cannot predict if or when a patient may attempt suicide or become violent." The note indicated that such an evaluation was limited to a resident's willingness to divulge information. R23's progress note dated 10/7/23 at 1:42 p.m., indicated R23 called out for help the "entire shift." The note did not indicate mental health status was assessed for R23. The psychiatry progress note dated 11/6/23 at 2:35 p.m., indicated R23 and her daughter reported mental health symptoms had been improving. The note indicated R23's protective factors against dying by suicide include living in a staffed facility. The note indicated R23 remained	F 740		

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F 740	Continued From page 36 a low to moderate suicide risk. The psychiatry progress note dated 12/7/23 at 3:00 p.m., indicated R23 had a diagnosis of prolonged grief disorder and adjustment disorder with depressed mood. The note indicated R23's mood was anxious and depressed. During an observation on 12/4/23 at 4:01 p.m., R23 was sitting in her recliner with the call light in the left cup holder of the recliner's arm. The call light cord was more than six feet long and the cord was coiled once on the floor and the controller was in the left cup holder of the recliner's armrest. During an observation on 12/6/23 at 7:55 a.m., R23 was observed sitting in her recliner with her call light in the cup holder on the left armrest next to her with the call light cord hanging down the left side of the chair, pooling on the ground and wrapped behind the chair slightly above the top of the recliner where it was plugged into the wall. During an interview on 12/6/23 at 8:38 a.m., nursing assistant (NA)-A indicated she was not aware R23 had attempted suicide twice or if there were any interventions in place to ensure R23's safety. NA-A verified R23's call light cord had been accessible to R23 and was long enough to be wrapped around her neck while she was sitting in the recliner. During an interview on 12/6/23 at 9:16 a.m., registered nurse (RN)-A, the floor nurse in charge of R23's care, thought R23 had a "nervous breakdown" and was sent to an inpatient psychiatric facility but was unaware of her suicidal ideation history. RN-A verified that R23's care	F 740		

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F 740	Continued From page 37 plan lacked indication of R23's suicide attempts or interventions related to them. During an interview on 12/6/23 at 12:58 p.m., R23 stated she remembered not thinking straight but could not recall her past suicide attempts. R23 stated she felt she had been sleeping more lately than she wanted but did not currently have suicidal ideations. During an interview on 12/6/23 at 8:47 a.m., the assistant director of nursing (ADON) stated R23 had experienced depression and confusion leading to R23's inpatient psychiatric hospital stay, but was unsure about any further details or interventions to prevent further attempts. During an interview on 12/6/23 at 10:36 a.m., the director of nursing (DON) stated that R23 was solely being seen for her mental health needs virtually by a psychiatric therapist her family had set up for her. The DON stated they did not have access to R23's therapist's notes nor did they receive any form of updates related to R23's suicidal ideations or other mental health concerns, behaviors, or recommended interventions. The DON stated she was unaware of R23's statement indicating she wanted to kill herself by wrapping a cord around her neck or of any interventions in place to prevent future suicide attempts. The DON further stated that R23's care plan should have been updated to include interventions to ensure R23's continued safety and mental well-being. During an interview on 12/6/23 at 3:37 p.m., the physician assistant (PA) stated R23 had a history of depressive episodes with a change of mental status including in February and August of 2023.	F 740		

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F 740	Continued From page 38 The PA stated that R23's episodes would come on quickly and were not always predictable. The PA stated she expected staff to review hospital discharge notes and provider notes to assess for resident changes and possible interventions such as R23's threat to strangulate herself with her call light cord. The PA stated she expected staff to remove items from R23's room that R23 could have or had used to harm herself, including the call light cord and plastic bags. The PA stated R23's family conflict was a known trigger for symptoms of depression. The PA further stated that R23's care plan also should have been updated with interventions to ensure her ongoing safety and well-being. During an interview on 12/7/23 at 10:11 a.m., nurse manager (RN)-D stated R23 had an episode during August of 2023, where she was very confused, refused her medications, threw items around her room, and would frequently say things like "I am dead" or "this is the day I am going to die." RN-D stated she thought family conflicts as well as the death of a loved one had caused R23 emotional distress and had been one of the triggers for this episode. RN-D stated as interventions for her behaviors, facility staff utilized family visits and spent individual time with R23. RN-D stated that nursing staff would complete and document hourly checks on R23 that were recorded in the treatment administration record (TAR). RN-D stated they did not remove the corded call lights from R23's room. RN-D stated the facility did not use the associated clinic of psychology (ACP) personnel so the family had found a therapist for R23 to see themselves. RN-D stated they did not have access to R23's psychotherapy visits or receive updates from this provider but acknowledged this would have	F 740		

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F 740	Continued From page 39 helped assess when revisions for R23's care plan were needed or what mental health interventions would have been helpful. RN-D stated nursing staff had not been aware that R23 had stated a desire to die by suicide using a call light cord and therefore had not removed it. RN-D stated because of this unawareness, she had thought the attempts to die by suicide were more likely "behavioral" than related to suicidal ideation. RN-D stated the nurse managers were supposed to read through the after-visit summaries (AVS) but indicated she had not after R23 was hospitalized from 8/4/23 to 8/11/23. RN-D stated this knowledge would have helped prevent R23's non-fatal attempt at suicide on 8/29/23. RN-D stated nursing staff did not read through the facility provider notes and this also would have helped prevent this attempt. During an interview on 12/7/23 at 10:34 a.m., Family member (FM)-A stated during February of this year, R23 had an episode where she wanted to die and was hallucinating about the devil. FM-A stated that R23's second mental health episode began in the middle of July of this year. FM-A stated that R23 was very confused and had behaviors such as crying out for help and discarding her personal items. FM-A stated there had been a family conflict that may have triggered some of these behaviors. FM-A stated that R23 was then admitted to the hospital for the first time during this second episode and attempts were made to alter her psychiatric medication regimen before readmitting R23 to the facility. FM-A stated she then received a call from the facility informing her that they had found R23 with a plastic bag over her head. FM-A stated the facility then informed her that she needed to help them find a way for R23 to receive psychiatric care. FM-A	F 740		

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F 740	Continued From page 40 stated a psychiatric facility was eventually found for R23 but the facility had not been able to find transportation for her. FM-A stated she was informed that she would have to bring R23 to a psychiatric facility and was not offered staff assistance. FM-A stated she was very concerned for R23's safety given her active plans to die by suicide and drove with the car child locks in place so R23 could not jump out. FM-A stated it was a "horrific" experience but she "had to do what she had to do to get her back." FM-A stated she had been informed by the facility that the county could assess R23 for psychotherapy but was unaware of further assistance the facility provided her regarding this. FM-A stated she initially set up R23's psychotherapy appointments and continued to do so. During an interview on 12/7/23 at 1:57 p.m., RN-D stated after R23's inpatient psychiatric stay and hospitalization they had updated her care plan and adjusted her medications but because her behaviors seemed stable, they had not done any further suicide prevention interventions for R23. . During an interview on 12/7/23 at 2:46 p.m., the DON stated she expected the nurse manager to review the hospital notes and AVS to ensure no changes were needed to the plan of care. The DON also stated she would expect the provider to update them on any significant changes in condition such as plans to die by suicide. If they had been aware of the plan to die by suicide, they would have removed the call light cord and added additional interventions into the care plan to prevent this from happening. The facility Suicide Threats by the Resident policy dated 2/19, indicated that residents who had an	F 740		

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F 740	Continued From page 41 active risk of dying by suicide should not have been cared for at the facility and should have been assessed by a medical professional as soon as possible. The policy indicated if a staff member observed potential suicidal statements and behaviors by a resident, those should have been reported to the supervisor immediately and measures should have been taken to promote safety. The policy indicated that residents should have been screened for mood indicators including suicidal ideation and if a resident's statements or actions reflect suicidal ideation at any time, immediate actions should have been taken to maintain safety. The policy indicated all staff members were obligated to report risk factors and warning signs of possible suicidal ideation to their supervisor. The undated facility Suicide Assessment, indicated if a resident showed warning signs or risk factors for suicide, staff were to express concern to the resident and ask them specific questions. Staff then should have assessed the resident's risk of suicide by determining if they had a clear intent to die by suicide, determined if they had a plan that was imminent and capable of resulting in self-harm or death could have been implemented by the means the resident had available. If these risk factors were present staff, should immediately implement a crisis plan, monitor the resident continuously at an "arm[']s length," and transport the resident via ambulance to an acute care setting. If the resident was ambivalent regarding their intent to die by suicide, expressed a vague plan, or described a plan the resident was clearly incapable of implementing, staff should implement individualized safety checks. If the resident made vague statements such as, "'sometimes I wish I wasn't here' or 'I	F 740		

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F 740	Continued From page 42 wish I just wouldn't wake up again,'" or had changes in behavior such as becoming more withdrawn, giving away items, recent changes in medical status, hopeless/helpless statements, staff should have completed frequent monitoring checks or increased supervision of the resident. The assessment indicated they should have an emergency interdisciplinary team meeting and notify the physician, or established psychologist of this event. The assessment also indicated if the resident displayed any of these risk levels, staff should assess the resident's environment and remove items or modify conditions to ensure safety, consult with supervisor, physician, and psychologist, document what was observed in the medical record, and update the care plan to include risk factors and interventions.	F 740		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §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	F 880		1/23/24

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F 880	Continued From page 43 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 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.	F 880		

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F 880	Continued From page 44 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 maintain infection control practices during wound care to minimize the risk of infection for 1 of 1 residents (R35) observed for wound care. Findings include: An Infection Control Assessment and Response Program (ICAR) article titled Wound Care Infection Prevention Recommendations for Long-Term Care Facilities dated 11/30/22, indicated during wound care, health care providers should doff their gloves after handling dirty surfaces and supplies and before handling clean surfaces of a wound. R35's quarterly Minimum Data Set (MDS) dated 10/23/23, indicated R23 had intact cognition and required maximal assistance for bathing and personal hygiene and R35 was dependent on staff for toileting needs. R35's physician progress note dated 11/13/23, indicated R23 was diagnosed with diabetes, peripheral arterial disease (PAD- a condition in which narrowed arteries reduce blood flow to extremities), diabetes, a left below-the-knee and a right above-the-knee amputation, kidney disease, and heart failure. The note indicated	F 880	This plan of correction constitutes the facility's credible allegation of compliance. Preparation and/or execution of this plan does not constitute admission or agreement by the provider of the truths or facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed in accordance with federal and state law requirements. R35 continues to be seen by the vascular department at the VA in Minneapolis for routine wound care consultation, and treatment. All residents currently with wound care orders have the potential to be affected, infection control events utilizing McGeer's criteria are being completed on all residents who currently have wounds. The nurse who provided wound care to R35 received disciplinary action from the director of nursing regarding the incident observed during the survey period. The nurse was re-educated on facility hand hygiene policy and ICAR'S wound care infection prevention recommendations for long-term care facilities. Wound care	

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	245449	A. BUILDING _____ B. WING _____	C 12/07/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST CRISPIN LIVING COMMUNITY	213 PIONEER ROAD RED WING, MN 55066

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F 880	Continued From page 45 R35 had a wound on his left knee with exposed bone and no signs of osteomyelitis (infection of the bone). This wound had been debrided from two smaller wounds and treated with intravenous antibiotics and R35 was discharged on oral antibiotics. R35's order dated 12/2/23, indicated R35's left knee wound care consisted of a daily cleansing with wound cleanser spray, applying a cream to the wound, and covering it with a foam pad. During an observation and interview on 12/4/23 at 1:54 p.m., R35 was observed lying on his back in bed when licensed practical nurse (LPN)-C entered the room. LPN-C was observed donning personal protective equipment (PPE) including a gown and gloves. LPN-C then removed the visibiley soiled left knee foam pad dressing, sprayed wound cleanser onto the wound bed, and blotted cleanser off the wound with gauze. LPN-C continued wound care with the same pair of gloves and applied the wound cream directly to her gloved finger and spread the cream over the wound and exposed bone. LPN-C then applied the new foam dressing and doffed PPE. R35 stated he had recently had his wound debrided and the doctor had expressed concern over the detrimental effects an infection would have, with his bone exposed. LPN-C stated she had not changed gloves between removing the soiled dressing and applying the cream and new dressing to the wound bed. During an interview on 12/7/23 at 2:41 p.m., the director of nursing (DON) stated she expected the nurse to change her gloves after removing the soiled dressing and before applying the new one. The DON stated was worried about R35's risk for	F 880	educational module assigned to nurse who provided the wound care to R35. All licensed staff are being re-educated on facility hand hygiene policy and ICAR'S wound care infection prevention recommendations for long-term care facilities beginning on 1/4/24 and ongoing until completed. Audits of wound care will be conducted twice a week for four weeks. Additionally, along with the wound care audits, hand hygiene audits will also be conducted twice a week for four weeks. The results of the audits will be reported through the facility QA committee with ongoing frequency and duration to be determined through analysis and review of results.	

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F 880	Continued From page 46 infection and the effects this might have, if this was not completed correctly. A policy outlining infection control practices during wound care was not provided.	F 880		

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	245449	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**12/06/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST CRISPIN LIVING COMMUNITY	**213 PIONEER ROAD** **RED WING, MN 55066**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS FIRE SAFETY - BLDG 01 An annual Life Safety Code survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 12/06/2023. At the time of this survey, ST CRISPIN LIVING COMMUNITY 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 | 01/04/2024

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

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K 000	Continued From page 1 Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR By email to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A detailed description of the corrective action taken or planned to correct the deficiency. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. 4. Identify who is responsible for the corrective actions and monitoring of compliance. 5. The actual or proposed date for completion of the remedy. ST CRISPIN LIVING COMMUNITY consists of two connected buildings: (BLDG 01) is a 1 story building with basement, and (BLDG 02) is a 2 story with no basement; (BLDG 02) is a 2 story building with partial basement that is attached to (BLDG 01), but separated by 2 hour fire wall construction.	K 000		

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K 000	Continued From page 2 The facility was constructed at 2 different times. The original building (BLDG 01) is a 1 story building with a partial basement that was constructed in 1977 and was determined to be of Type V (111) construction. (BLDG 01) underwent extensive remodeling in 2018. The addition (BLDG 02) is a 2 story building with partial basement that was constructed in 2018 and was determined to be of Type II (111) construction. The facility is fully protected throughout by an automatic sprinkler system and has a fire alarm system with smoke detection in corridors and spaces open to the corridors that is monitored for automatic fire department notification. The facility was surveyed as two separate buildings. The facility has a capacity of 111 beds and had a census of 53 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidence by:	K 000		
K 324 SS=F	Cooking Facilities CFR(s): NFPA 101 Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply	K 324		1/23/24

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K 324	Continued From page 3 with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain proper safety and security measures related to a cooking device in a resident accessible corridor in accordance with NFPA 101 (2012 edition), Life Safety Code section 19.3.2.5.3(9) This deficient condition could have an widespread impact on the residents within the facility. Findings Include: On 12/06/2023 between 9:30 AM and 1:30 PM, it was revealed by observation that on the 1st Floor - Occupational Therapy Area, the cooking range was found not having the full protective / safety measures -120 min timeout shutoff. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 324	This Plan of Correction constitutes the facilities credible allegation of compliance preparation and/or execution of this plan does not constitute admission or agreement by the provider of the truths or facts alleged or conclusions set forth in the statements of deficiencies. The plan of correction is prepared and/or executed in accordance with federal and state law requirements. EVS toured the facility to determine current cooking ranges without the proper protective/safety measures. None were found. Hart's Electric ordered recommended key switch on 12/23/2023. They will install when it arrives – expected by 1/14/2024 Stove Key Switch and 120 Minute Timer EVS staff/director will visually inspect all	

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K 324	Continued From page 4	K 324	cooking range for full protective/safety measures (120 min. shutoff) monthly for 3 months. Results will be documented and kept in Life Safety Book. EVS Director will report results of monthly inspections at Safety Team monthly meetings, 2024; and Quality Council January 2024 meeting. EVS Director/staff are responsible for corrective actions and monitoring of compliance.	
K 345 SS=E	Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain the fire alarm system per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.4.1, 9.6.1.3, and NFPA 72 (2010 edition), National Fire Alarm and Signaling Code, section 17.14.5. This deficient finding could have a patterned impact on the residents within the facility. Findings include:	K 345	This Plan of Correction constitutes the facilities credible allegation of compliance preparation and/or execution of this plan does not constitute admission or agreement by the provider of the truths or facts alleged or conclusions set forth in the statements of deficiencies. The plan of correction is prepared and/or executed in accordance with federal and state law requirements.	1/23/24

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K 345	Continued From page 5 On 12/06/2023 between 9:30 AM and 1:30 PM, it was revealed by observation in the Basement corridor that a fire alarm manual pull station was access obstructed. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 345	On 12/14/2023 EVS staff worked with vending company to make pull station accessible. Vending machines - Obstructions were moved by vending company. Signs have been posted at pull stations to keep area clean. EVS staff/director will visually inspect all pull stations throughout the building for clear, unobstructed accessibility, monthly for 3 months. Results will be documented and kept in Life Safety Book. EVS Director will report results of monthly inspections at Safety Team monthly meetings, 2024; and Quality Council January 2024 meeting. All staff will be educated regarding maintaining conspicuous, unobstructed, and accessible pull stations at all times throughout the facility on 1/4/2024. Staff will be instructed to remove any obstructions or inform EVS staff. EVS Director/staff are responsible for corrective actions and monitoring of compliance.	
K 346 SS=C	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	K 346		1/23/24

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K 346	Continued From page 6 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 available documentation and staff interview, the facility failed to implement a fire alarm out of service policy per NFPA 101 (2012 edition), Life Safety Code, section 9.6.1.6. This deficient finding a widespread impact on the residents within the facility. This deficient finding could have a isolated impact on the residents within the facility. Findings include: On 12/06/2023 between 9:30 AM and 1:30 PM, it was revealed by a review of available documentation that no fire alarm - out of service policy was presented for review An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 346	This Plan of Correction constitutes the facilities credible allegation of compliance preparation and/or execution of this plan does not constitute admission or agreement by the provider of the truths or facts alleged or conclusions set forth in the statements of deficiencies. The plan of correction is prepared and/or executed in accordance with federal and state law requirements. Policy updated and reviewed; placed in Life Safety Binder on 12/29/2023. EVS Director will present policy to Safety Team January meeting 2024 and reviewed annually; and Quality Council January 2024 meeting. All staff will be educated on 1/4/2024 regarding No Fire Alarm – Out of Service Policy.	
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	K 353		1/23/24

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K 353	Continued From page 7 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 observation, a review of available documentation and staff interview the facility failed to inspect and maintain the sprinkler system in accordance with NFPA 101 (2012 edition), Life Safety Code, sections 4.6.12, 9.7.5, 9.7.6, NFPA 25 (2011 edition) Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, section(s), 4.1.1, 4.3, 4.4, 5.1.1.1, 5.2.1.1.2, 5.2.2.2 These deficient findings could have a widespread impact on the residents within the facility. Findings include: 1. On 12/06/2023 between 9:30 AM and 1:30 PM, it was revealed by a review of available documentation that no documentation was presented to confirm that quarterly inspections of the fire sprinkler system are occurring. 2. On 12/06/2023 between 9:30 AM and 1:30 PM, it was revealed by a review of available documentation that thee most current 5-yr fire sprinkler system inspection was completed in Q1 - 2018.	K 353	This Plan of Correction constitutes the facilities credible allegation of compliance preparation and/or execution of this plan does not constitute admission or agreement by the provider of the truths or facts alleged or conclusions set forth in the statements of deficiencies. The plan of correction is prepared and/or executed in accordance with federal and state law requirements. EVS Director has scheduled Olympic Fire Protection to review quarterly inspection with maintenance staff and provide training on 1/9/2024. EVS staff will complete quarterly inspections thereafter. Reports will be kept in the Life Safety Binder. EVS Director will present inspection reports to Safety Team quarterly in 2024; and Quality Council quarterly 2024 meeting.	

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K 353	Continued From page 8 3. On 12/06/2023 between 9:30 AM and 1:30 PM, it was revealed by observation in the Basement Mechanical Room that cabling was attached too and supported by the fire sprinkler system piping. An interview with the Maintenance Director verified these deficient findings at the time of discovery.	K 353	All staff will be educated on 1/4/2024 regarding quarterly Fire Sprinkler Inspection process. _____ EVS Director will has scheduled Olympic Fire Protection Schedule 5-year inspection for 1/9/2024. EVS Director will present inspection report to Safety Team when available in 2024; and Quality Council meeting when available 2024. All staff will be educated on 1/4/2024 regarding 5-year Fire Sprinkler Inspection. _____ EVS Director and staff removed all Cabling in basement mechanical room. (See picture) EVS staff/director will visually inspect all fire sprinkler pipes and heads to be free of cables or other obstructions throughout the building for 3 months. Results will be documented and kept in Life Safety Book. EVS Director will present report to Safety Team in meetings for 3 months in 2024; and Quality Council meeting on 1/16/2024. All staff will be educated on 1/4/2024	

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K 353	Continued From page 9	K 353	regarding Fire Sprinkler obstruction process.	
K 354 SS=C	Sprinkler System - Out of Service CFR(s): NFPA 101 Sprinkler System - Out of Service Where the sprinkler system is impaired, the extent and duration of the impairment has been determined, areas or buildings involved are inspected and risks are determined, recommendations are submitted to management or designated representative, and the fire department and other authorities having jurisdiction have been notified. Where the sprinkler system is out of service for more than 10 hours in a 24-hour period, the building or portion of the building affected are evacuated or an approved fire watch is provided until the sprinkler system has been returned to service. 18.3.5.1, 19.3.5.1, 9.7.5, 15.5.2 (NFPA 25) This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to implement a sprinkler system out-of-service policy per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.5.1, and 9.7.5 and NFPA 25 (2011 edition) Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, section 15.5.2. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 12/06/2023 between 9:30 AM and 1:30 PM, it was revealed by a review of available documentation that no sprinkler system - out of	K 354	This Plan of Correction constitutes the facilities credible allegation of compliance preparation and/or execution of this plan does not constitute admission or agreement by the provider of the truths or facts alleged or conclusions set forth in the statements of deficiencies. The plan of correction is prepared and/or executed in accordance with federal and state law requirements. Policy updated and reviewed; placed in Life Safety Binder Same as Fire Alarm System on 12/16/2023 (updated)	1/23/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245449	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**12/06/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST CRISPIN LIVING COMMUNITY	**213 PIONEER ROAD** **RED WING, MN 55066**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 354	Continued From page 10 service policy was presented for review An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 354	EVS Director will present policy to Safety Team January meeting 2024 and reviewed annually; and Quality Council January 2024 meeting. All staff will be educated on 1/4/2024 regarding No Fire Alarm – Out of Service Policy.	
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 facility failed to properly inspect, and maintain documentation of portable fire extinguishers in accordance with NFPA 101 (2012 edition), Life Safety Code, sections 19.3.5.12, 9.7.4.1, and NFPA 10 (2010 edition), Standard for Portable Fire Extinguishers, section 6.1.3.8 This deficient finding could have a isolated impact on the residents within the facility. Findings include: On 12/06/2023 between 9:30 AM and 1:30 PM, it was revealed by observation that in the Basement in the Soiled Linen Room that a fire extinguisher was found free-standing on the floor. An interview with the Maintenance Director verified this deficient finding at the time of	K 355	This Plan of Correction constitutes the facilities credible allegation of compliance preparation and/or execution of this plan does not constitute admission or agreement by the provider of the truths or facts alleged or conclusions set forth in the statements of deficiencies. The plan of correction is prepared and/or executed in accordance with federal and state law requirements. Holder was installed; extinguisher is in the holder on 12/13/2023. (See picture) EVS staff/director will visually inspect all fire extinguishers throughout the building for containment in proper holders, monthly for 3 months. Results will be documented and kept in Life Safety Book.	1/23/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245449	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**12/06/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST CRISPIN LIVING COMMUNITY	**213 PIONEER ROAD** **RED WING, MN 55066**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 355	Continued From page 11 discovery.	K 355	EVS Director will report results of monthly inspections at Safety Team monthly meetings, 2024; and Quality Council January 2024 meeting. All staff will be educated regarding fire extinguishers throughout the building being contained in proper holders on 1/4/2024. Staff will be instructed to report any extinguishers found out of holders to EVS staff. EVS Director/staff are responsible for corrective actions and monitoring of compliance. Provider's Plan of Correction	
K 374 SS=F	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Doors 2012 EXISTING Doors in smoke barriers are 1-3/4-inch thick solid bonded wood-core doors or of construction that resists fire for 20 minutes. Nonrated protective plates of unlimited height are permitted. Doors are permitted to have fixed fire window assemblies per 8.5. Doors are self-closing or automatic-closing, do not require latching, and are not required to swing in the direction of egress travel. Door opening provides a minimum clear width of 32 inches for swinging or horizontal doors. 19.3.7.6, 19.3.7.8, 19.3.7.9 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the	K 374	This Plan of Correction constitutes the	1/23/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245449	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**12/06/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST CRISPIN LIVING COMMUNITY	**213 PIONEER ROAD** **RED WING, MN 55066**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 374	Continued From page 12 facility failed to maintain the smoke barrier doors per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.7.8 and 8.5.4.1 This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 12/06/2023 between 9:30 AM and 1:30 PM, it was revealed by observation that the Basement smoke barrier doors upon testing did not self-close and seal the opening, allowing for the movement and passage of smoke between smoke compartments. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 374	facilities credible allegation of compliance preparation and/or execution of this plan does not constitute admission or agreement by the provider of the truths or facts alleged or conclusions set forth in the statements of deficiencies. The plan of correction is prepared and/or executed in accordance with federal and state law requirements. EVS staff/director will continue to work on a permanent solution to smoke barrier doors to ensure proper self-closing and sealing. Vendors have been contacted for service. EVS Director/staff will inspect all facility smoke barrier doors for proper self-closing and sealing monthly for 3 months. Results will be documented and kept in Life Safety Book. EVS Director will report results of all smoke barrier doors at Safety Team monthly meetings for 3 months, 2024; and Quality Council January 2024 meeting. All staff will be educated regarding smoke barrier doors on 1/4/2024. Staff will be instructed to report any door inconsistencies found to EVS staff. EVS Director/staff are responsible for corrective actions and monitoring of compliance.	
K 531 SS=F	Elevators CFR(s): NFPA 101	K 531		1/23/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245449	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**12/06/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST CRISPIN LIVING COMMUNITY	**213 PIONEER ROAD** **RED WING, MN 55066**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 531	Continued From page 13 Elevators 2012 EXISTING Elevators comply with the provision of 9.4. Elevators are inspected and tested as specified in ASME A17.1, Safety Code for Elevators and Escalators. Firefighter's Service is operated monthly with a written record. Existing elevators conform to ASME/ANSI A17.3, Safety Code for Existing Elevators and Escalators. All existing elevators, having a travel distance of 25 feet or more above or below the level that best serves the needs of emergency personnel for firefighting purposes, conform with Firefighter's Service Requirements of ASME/ANSI A17.3. (Includes firefighter's service Phase I key recall and smoke detector automatic recall, firefighter's service Phase II emergency in-car key operation, machine room smoke detectors, and elevator lobby smoke detectors.) 19.5.3, 9.4.2, 9.4.3 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain access to the Elevator Equipment Room per NFPA 101 (2012 edition), Life Safety Code, sections 19.5.3, 7.2.13, 7.14.6, 9.4.5. This deficient finding could have an widespread impact on the residents within the facility. Findings include: On 12/06/2023 between 9:30 AM and 1:30 PM, it was revealed by observation that the facility was unable to provide access to the secure elevator machine room, such that visual assessment and inspection of the room could be completed.	K 531	This Plan of Correction constitutes the facilities credible allegation of compliance preparation and/or execution of this plan does not constitute admission or agreement by the provider of the truths or facts alleged or conclusions set forth in the statements of deficiencies. The plan of correction is prepared and/or executed in accordance with federal and state law requirements. On 12/7/2023, key was located to elevator equipment room. It is labeled and in the key box in EVS office.	

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	245449	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**12/06/2023**

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ST CRISPIN LIVING COMMUNITY	**213 PIONEER ROAD** **RED WING, MN 55066**

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K 531	Continued From page 14 An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 531	EVS Director/staff will check for key in key box monthly, so access to machine room is available for visual inspection to be completed. Results will be documented and kept in Life Safety Book. EVS Director will report results elevator machine room access to Safety Team monthly for 3 months, 2024. All staff will be educated regarding elevator machine room access on 1/4/2024. EVS Director/staff are responsible for corrective actions and monitoring of compliance.	
K 761 SS=F	Maintenance, Inspection & Testing - Doors CFR(s): NFPA 101 Maintenance, Inspection & Testing - Doors Fire doors assemblies are inspected and tested annually in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives. Non-rated doors, including corridor doors to patient rooms and smoke barrier doors, are routinely inspected as part of the facility maintenance program. Individuals performing the door inspections and testing possess knowledge, training or experience that demonstrates ability. Written records of inspection and testing are maintained and are available for review. 19.7.6, 8.3.3.1 (LSC) 5.2, 5.2.3 (2010 NFPA 80) This REQUIREMENT is not met as evidenced by:	K 761		1/23/24

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	245449	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**12/06/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST CRISPIN LIVING COMMUNITY	**213 PIONEER ROAD RED WING, MN 55066**

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K 761	Continued From page 15 Based on a review of available documentation and staff interview the facility failed to maintain, inspect, and test doors per NFPA 101 (2012 edition), Life Safety Code, sections 19.7.6, 4.6.12, 7.2.1.15.2, and NFPA 80 (2010 edition), sections 5.2.1, 5.2.3.1. This deficient findings could have a widespread impact on the residents within the facility. Findings include: On 12/06/2023 between 9:30 AM and 1:30 PM, it was revealed by a review of available documentation, that no dated documentation was presented to confirm that door inspections are being completed An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 761	This Plan of Correction constitutes the facilities credible allegation of compliance preparation and/or execution of this plan does not constitute admission or agreement by the provider of the truths or facts alleged or conclusions set forth in the statements of deficiencies. The plan of correction is prepared and/or executed in accordance with federal and state law requirements. Recommendation was to add date by initial on form rather than dated only at the end of the page Forms need to be signed and dated. Inspection form for fire door inspection is in development to include dates for each door inspection. All doors, smoke barrier doors, are routinely inspected by EVS staff. EVS Director/staff will perform inspection of each door at least annually. Results will be documented and kept in Life Safety Book. EVS Director will report results of door inspections to Safety Team monthly for 3 months, 2024. All staff will be educated regarding door inspections on 1/4/2024. Staff will be instructed to report any door inconsistencies found to EVS staff. EVS Director/staff are responsible for corrective actions and monitoring of	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245449	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**12/06/2023**

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ST CRISPIN LIVING COMMUNITY	**213 PIONEER ROAD** **RED WING, MN 55066**

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K 761	Continued From page 16	K 761	compliance.	
K 918 SS=F	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70)	K 918		1/23/24

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	245449	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**12/06/2023**

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ST CRISPIN LIVING COMMUNITY	**213 PIONEER ROAD RED WING, MN 55066**

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K 918	Continued From page 17 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to document the month findings of the on-site emergency generator system per NFPA 99 (2012 edition), Health Care Facilities Code, section 6.4.4.1.1.3, 6.4.4.2 and NFPA 110 (2010 edition), Standard for Emergency and Standby Power Systems, 8.3.4, 8.3.4.1. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 12/06/2023 between 9:30 AM and 1:30 PM, it was revealed during documentation review that monthly inspection and testing reports were incomplete in data capture - identifying or confirming that the Auto Transfer Switch is being tested. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 918	This Plan of Correction constitutes the facilities credible allegation of compliance preparation and/or execution of this plan does not constitute admission or agreement by the provider of the truths or facts alleged or conclusions set forth in the statements of deficiencies. The plan of correction is prepared and/or executed in accordance with federal and state law requirements. EVS Director/staff will maintain inspection and testing as required weekly, exercised under load 30 minutes monthly, and exercised once every 36 months for 4 continuous hours. Results will be documented and kept in Life Safety Book. EVS Director will report results of generator tests and inspections to Safety Team monthly for 3 months, 2024. All staff will be educated regarding generator testing and inspections on 1/4/2024. Staff will be instructed to use the red outlets (indicating generator power) in resident rooms for medical equipment.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245449	A. BUILDING **02 - ST CRISPIN LIVING COMMUNITY** B. WING _____	**12/06/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST CRISPIN LIVING COMMUNITY	**213 PIONEER ROAD RED WING, MN 55066**

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K 000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety Code survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 12/06/2023. At the time of this survey, ST CRISPIN LIVING COMMUNITY 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 | 01/04/2024

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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ST CRISPIN LIVING COMMUNITY	**213 PIONEER ROAD** **RED WING, MN 55066**

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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. ST CRISPIN LIVING COMMUNITY consists of two connected buildings: (BLDG 01) is a 1 story building with basement, and (BLDG 02) is a 2 story with no basement; (BLDG 02) is a 2 story building with partial basement that is attached to (BLDG 01), but separated by 2 hour fire wall construction.	K 000		

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K 000	Continued From page 2 The facility was constructed at 2 different times. The original building (BLDG 01) is a 1 story building with a partial basement that was constructed in 1977 and was determined to be of Type V (111) construction. (BLDG 01) underwent extensive remodeling in 2018. The addition (BLDG 02) is a 2 story building with partial basement that was constructed in 2018 and was determined to be of Type II (111) construction. The facility is fully protected throughout by an automatic sprinkler system and has a fire alarm system with smoke detection in corridors and spaces open to the corridors that is monitored for automatic fire department notification. The facility was surveyed as two separate buildings. The facility has a capacity of 111 beds and had a census of 53 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidence by:	K 000		
K 346 SS=C	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 four 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:	K 346		1/23/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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K 346	Continued From page 3 Based on available documentation and staff interview, the facility failed to implement a fire alarm out of service policy per NFPA 101 (2012 edition), Life Safety Code, section 9.6.1.6. This deficient finding a widespread impact on the residents within the facility. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 12/06/2023 between 9:30 AM and 1:30 PM, it was revealed by a review of available documentation that no fire alarm - out of service policy was presented for review An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 346	This Plan of Correction constitutes the facilities credible allegation of compliance preparation and/or execution of this plan does not constitute admission or agreement by the provider of the truths or facts alleged or conclusions set forth in the statements of deficiencies. The plan of correction is prepared and/or executed in accordance with federal and state law requirements. Policy updated and reviewed; placed in Life Safety Binder on 12/29/2023. EVS Director will present policy to Safety Team January meeting 2024 and reviewed annually; and Quality Council January 2024 meeting. All staff will be educated on 1/4/2024 regarding No Fire Alarm – Out of Service Policy.	
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 _____	K 353		1/23/24

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	245449	A. BUILDING **02 - ST CRISPIN LIVING COMMUNITY** B. WING _____	**12/06/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST CRISPIN LIVING COMMUNITY	**213 PIONEER ROAD RED WING, MN 55066**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 353	Continued From page 4 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 inspect and maintain the sprinkler system in accordance with NFPA 101 (2012 edition), Life Safety Code, sections 4.6.12, 9.7.5, 9.7.6, NFPA 25 (2011 edition) Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, section(s), 4.1.1, 4.3, 4.4. These deficient findings could have a widespread impact on the residents within the facility. Findings include: 1. On 12/06/2023 between 9:30 AM and 1:30 PM, it was revealed by a review of available documentation that no documentation was presented to confirm that quarterly inspections of the fire sprinkler system are occuring. 2. On 12/06/2023 between 9:30 AM and 1:30 PM, it was revealed by a review of available documentation that thee most current 5-yr fire sprinkler system inspection was completed in Q1 - 2018. An interview with the Maintenance Director verified these deficient findings at the time of discovery.	K 353	This Plan of Correction constitutes the facilities credible allegation of compliance preparation and/or execution of this plan does not constitute admission or agreement by the provider of the truths or facts alleged or conclusions set forth in the statements of deficiencies. The plan of correction is prepared and/or executed in accordance with federal and state law requirements. EVS Director has scheduled Olympic Fire Protection to review quarterly inspection with maintenance staff and provide training on 1/9/2024. EVS staff will complete quarterly inspections thereafter. Reports will be kept in the Life Safety Binder. EVS Director will present inspection reports to Safety Team quarterly in 2024; and Quality Council quarterly 2024 meeting. All staff will be educated on 1/4/2024 regarding quarterly Fire Sprinkler Inspection process. _____	

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K 353	Continued From page 5	K 353	EVS Director will has scheduled Olympic Fire Protection Schedule 5-year inspection for 1/9/2024. EVS Director will present inspection report to Safety Team when available in 2024; and Quality Council meeting when available 2024. All staff will be educated on 1/4/2024 regarding 5-year Fire Sprinkler Inspection. _____ EVS Director and staff removed all Cabling in basement mechanical room. (See picture) EVS staff/director will visually inspect all fire sprinkler pipes and heads to be free of cables or other obstructions throughout the building for 3 months. Results will be documented and kept in Life Safety Book. EVS Director will present report to Safety Team in meetings for 3 months in 2024; and Quality Council meeting on 1/16/2024. All staff will be educated on 1/4/2024 regarding Fire Sprinkler obstruction process.	
K 354 SS=C	Sprinkler System - Out of Service CFR(s): NFPA 101	K 354		1/23/24

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K 354	Continued From page 6 Sprinkler System - Out of Service Where the sprinkler system is impaired, the extent and duration of the impairment has been determined, areas or buildings involved are inspected and risks are determined, recommendations are submitted to management or designated representative, and the fire department and other authorities having jurisdiction have been notified. Where the sprinkler system is out of service for more than 10 hours in a 24 hour period, the building or portion of the building affected are evacuated or an approved fire watch is provided until the sprinkler system has been returned to service. 18.3.5.1, 19.3.5.1, 9.7.5, 15.5.2 (NFPA 25) This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to implement a sprinkler system out-of-service policy per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.5.1, and 9.7.5 and NFPA 25 (2011 edition) Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, section 15.5.2. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 12/06/2023 between 9:30 AM and 1:30 PM, it was revealed by a review of available documentation that no sprinkler system - out of service policy was presented for review An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 354	This Plan of Correction constitutes the facilities credible allegation of compliance preparation and/or execution of this plan does not constitute admission or agreement by the provider of the truths or facts alleged or conclusions set forth in the statements of deficiencies. The plan of correction is prepared and/or executed in accordance with federal and state law requirements. Policy updated and reviewed; placed in Life Safety Binder Same as Fire Alarm System on 12/16/2023 (updated) EVS Director will present policy to Safety Team January meeting 2024 and reviewed annually; and Quality Council January 2024 meeting. All staff will be educated on 1/4/2024	

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K 354	Continued From page 7	K 354	regarding No Fire Alarm – Out of Service Policy.	
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 facility failed to properly inspect, and maintain documentation of portable fire extinguishers in accordance with NFPA 101 (2012 edition), Life Safety Code, sections 19.3.5.12, 9.7.4.1, and NFPA 10 (2010 edition), Standard for Portable Fire Extinguishers, section 6.1.3.8. This deficient finding could have a isolated impact on the residents within the facility. Findings include: On 12/06/2023 between 9:30 AM and 1:30 PM, it was revealed by observation that on the 1st Floor - Beauty Salon that a fire extinguisher was found free-standing on the floor. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 355	This Plan of Correction constitutes the facilities credible allegation of compliance preparation and/or execution of this plan does not constitute admission or agreement by the provider of the truths or facts alleged or conclusions set forth in the statements of deficiencies. The plan of correction is prepared and/or executed in accordance with federal and state law requirements. Holder was installed; extinguisher is in the holder on 12/13/2023. (See picture) EVS staff/director will visually inspect all fire extinguishers throughout the building for containment in proper holders, monthly for 3 months. Results will be documented and kept in Life Safety Book. EVS Director will report results of monthly inspections at Safety Team monthly meetings, 2024; and Quality Council January 2024 meeting.	1/23/24

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K 355	Continued From page 8	K 355	All staff will be educated regarding fire extinguishers throughout the building being contained in proper holders on 1/4/2024. Staff will be instructed to report any extinguishers found out of holders to EVS staff. EVS Director/staff are responsible for corrective actions and monitoring of compliance.	
K 374 SS=F	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Doors 2012 NEW Doors in smoke barriers have at least a 20 minute fire protection rating or are at least 1-3/4 inch thick solid bonded core wood. Required clear widths are provided per 18.3.7.6(4) and (5). Nonrated protective plates that do not exceed 48 inches from the bottom of the door are permitted. Horizontal-sliding doors comply with 7.2.1.14. Swinging doors shall be arranged so that each door swings in an opposite direction. Doors shall be self-closing and rabbets, bevels, or astragals are required at the meeting edges. Positive latching is not required. 18.3.7.6, 18.3.7.7, 18.3.7.8 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain the smoke barrier doors per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.7.8 and 8.5.4.1 This deficient finding could have a widespread impact on the residents within the facility.	K 374	This Plan of Correction constitutes the facilities credible allegation of compliance preparation and/or execution of this plan does not constitute admission or agreement by the provider of the truths or facts alleged or conclusions set forth in	1/23/24

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K 374	Continued From page 9 Findings include: On 12/06/2023 between 9:30 AM and 1:30 PM, it was revealed by observation on the 1st Floor - Hearthstone Neighborhood that the smoke door assembly exhibited an air-gap greater than 1/8 inch, allowing the movement and passage of smoke between smoke compartments. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 374	the statements of deficiencies. The plan of correction is prepared and/or executed in accordance with federal and state law requirements. EVS staff/director will continue to work on a permanent solution to smoke barrier doors to ensure proper self-closing and sealing. Vendors have been contacted for service. EVS Director/staff will inspect all facility smoke barrier doors for proper self-closing and sealing monthly for 3 months. Results will be documented and kept in Life Safety Book. EVS Director will report results of all smoke barrier doors at Safety Team monthly meetings for 3 months, 2024; and Quality Council January 2024 meeting. All staff will be educated regarding smoke barrier doors on 1/4/2024. Staff will be instructed to report any door inconsistencies found to EVS staff. EVS Director/staff are responsible for corrective actions and monitoring of compliance.	
K 761 SS=F	Maintenance, Inspection & Testing - Doors CFR(s): NFPA 101 Maintenance, Inspection & Testing - Doors Fire doors assemblies are inspected and tested annually in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives.	K 761		1/23/24

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K 761	Continued From page 10 Non-rated doors, including corridor doors to patient rooms and smoke barrier doors, are routinely inspected as part of the facility maintenance program. Individuals performing the door inspections and testing possess knowledge, training or experience that demonstrates ability. Written records of inspection and testing are maintained and are available for review. 18.7.6, 8.3.3.1 (LSC) 5.2, 5.2.3 (NFPA 80) This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview the facility failed to maintain, inspect, and test doors per NFPA 101 (2012 edition), Life Safety Code, sections 19.7.6, 4.6.12, 7.2.1.15.2, and NFPA 80 (2010 edition), sections 5.2.1, 5.2.3.1. This deficient findings could have a widespread impact on the residents within the facility. Findings include: On 12/06/2023 between 9:30 AM and 1:30 PM, it was revealed by a review of available documentation, that no dated documentation was presented to confirm that door inspections are being completed An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 761	This Plan of Correction constitutes the facilities credible allegation of compliance preparation and/or execution of this plan does not constitute admission or agreement by the provider of the truths or facts alleged or conclusions set forth in the statements of deficiencies. The plan of correction is prepared and/or executed in accordance with federal and state law requirements. Recommendation was to add date by initial on form rather than dated only at the end of the page Forms need to be signed and dated. Inspection form for fire door inspection is in development to include dates for each door inspection. All doors, smoke barrier doors, are routinely inspected by EVS staff. EVS Director/staff will perform inspection of each door at least annually. Results will be documented and kept in Life Safety Book.	

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K 761	Continued From page 11	K 761	EVS Director will report results of door inspections to Safety Team monthly for 3 months, 2024. All staff will be educated regarding door inspections on 1/4/2024. Staff will be instructed to report any door inconsistencies found to EVS staff. EVS Director/staff are responsible for corrective actions and monitoring of compliance.	
K 918 SS=F	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source 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	K 918		1/23/24

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K 918	Continued From page 12 circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to document the month findings of the on-site emergency generator system per NFPA 99 (2012 edition), Health Care Facilities Code, section 6.4.4.1.1.3, 6.4.4.2 and NFPA 110 (2010 edition), Standard for Emergency and Standby Power Systems, 8.3.4, 8.3.4.1. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 12/06/2023 between 9:30 AM and 1:30 PM, it was revealed during documentation review that monthly inspection and testing reports were incomplete in data capture - identifying or confirming that the Auto Transfer Switch is being tested. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 918	This Plan of Correction constitutes the facilities credible allegation of compliance preparation and/or execution of this plan does not constitute admission or agreement by the provider of the truths or facts alleged or conclusions set forth in the statements of deficiencies. The plan of correction is prepared and/or executed in accordance with federal and state law requirements. EVS Director/staff will maintain inspection and testing as required weekly, exercised under load 30 minutes monthly, and exercised once every 36 months for 4 continuous hours. Results will be documented and kept in Life Safety Book. EVS Director will report results of generator tests and inspections to Safety Team monthly for 3 months, 2024. All staff will be educated regarding generator testing and inspections on	

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K 918	Continued From page 13	K 918	1/4/2024. Staff will be instructed to use the red outlets (indicating generator power) in resident rooms for medical equipment.	