Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

August 31, 2023

Administrator
Avera Granite Falls Care Ctr
250 Jordan Drive
Granite Falls, MN 56241

RE: CCN: 245243
Cycle Start Date: August 10, 2023

Dear Administrator:

On August 10, 2023, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be a pattern of deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level E), 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:

Nicole Osterloh, RN, Unit Supervisor
Marshall District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
1400 East Lyon Street, Suite 102
Marshall, Minnesota 56258-2504
Email: nicole.osterloh@state.mn.us
Office: 507-476-4230
Mobile: (507) 251-6264 Mobile: (605) 881-6192

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

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

If substantial compliance with the regulations is not verified by November 10, 2023, (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by February 10, 2024, (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

INFORMAL DISPUTE RESOLUTION (IDR) / INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

In accordance with 42 CFR 488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to:

Nursing Home Informal Dispute Process
Minnesota Department of Health
Health Regulation Division
P.O. Box 64900
St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: https://mdhprovidercontent.web.health.state.mn.us/ltc_idr.cfm

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

Questions regarding all documents submitted as a response to the Life Safety Code deficiencies (those preceded by a "K" tag), i.e., the plan of correction, request for waivers, should be directed to:

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

Please contact me with any questions regarding this letter.

Sincerely,

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245243	A. BUILDING _____ B. WING _____	C 08/10/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVERA GRANITE FALLS CARE CTR	250 JORDAN DRIVE GRANITE FALLS, MN 56241

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments On 8/7/23 through 8/10/23, a survey for compliance with Appendix Z, Emergency Preparedness Requirements, §483.73(b)(6) was conducted during a standard recertification survey. The facility was IN compliance. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	E 000		
F 000	INITIAL COMMENTS On 8/7/23 through 8/10/23, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were reviewed with NO deficiencies cited: H52434284C (MN94207), H52434285C(MN88976 and MN89042), H52434286C (MN89040), and H52434287C (MN94691). 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 substantial compliance with the	F 000		

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

Electronically Signed | 09/06/2023

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

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F 000	Continued From page 1 regulations has been attained.	F 000		
F 644 SS=D	Coordination of PASARR and Assessments CFR(s): 483.20(e)(1)(2) §483.20(e) Coordination. A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes: §483.20(e)(1)Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care. §483.20(e)(2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to notify the county (designated State Mental Health Authority) for 1 of 1 resident (R32) with new onset mental illness. Findings include: R32's 12/14/22, annual Minimum Data Set (MDS) assessment identified R32 had a delusional disorder, dementia, psychotic disorder, and obsessive compulsive disorder. R32's 7/11/23, physician progress notes identified	F 644	Citation F644 During a state survey it was identified resident (R32) the facility failed to notify the county of a new onset of mental illness. R32 initial PAS did not identify a diagnosis of mental illness. PASSR Level II is scheduled for September 8th,2023 for compliance on (R32). Action the facility will take to ensure this does not reoccur: Review of Diagnosis of new residents. Review on the PASSR along with	9/6/23

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F 644	Continued From page 2 a diagnosis of delusional disorder, paranoid ideation, and cognitive decline. R32's undated care plan printed on 8/9/23, identified problems with delirium and psychosocial well-being with behaviors of being withdrawn, having negative statements, repetitive physical movements, self-deprecation, expression of unrealistic fears, and recurrent statements that something bad was going to happen. R32's 1/4/21, Initial Pre-Admission Screening (PAS), did not identify a diagnosis of mental illness and did not indicate the need for a Level II PASARR to be completed. Interview on 8/9/23 at 8:00 a.m., with social service designee identified that upon receiving the pre-admission screen she reviews to ensure all diagnosis are listed. She was not aware she should notify the county authority when a new diagnosis has been identified. A policy related to Level II PASARR was requested, however none was provided.	F 644	diagnosis list included with referral for admission. Weekly behavioral meeting began on August 23rd, 2023. During this meeting the team will evaluate which residents are in their MDS window along with any residents needing reviewed. Team will review any current behaviors along with current diagnosis. If the resident has recently had a new diagnostic assessment which indicated a new diagnosis the team will review, and the county authority will be notified a PASSAR Level II is needed. The social worker/social worker designee will complete the DHS form 3457 and submit to the county. After a PASSAR Level II is completed the residents care plan will reflect any necessary accommodations stated on the PASSAR Level II. Audits: Weekly MDS audits to monitor for any new diagnosis in the past three months to ensure compliance with PASSAR Level II Review in QAPI monthly, for compliance and any concerns.	
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when	F 761		9/6/23

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F 761	Continued From page 3 applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to accurately reconcile 1 of 1 resident's (R12) lorazepam (narcotic anti-anxiety medication) upon receipt from the pharmacy and ensure 2 of 2 resident's (R99 and R33) medications were immediately removed from the medication cart and not co-mingled and stored with in-use medication for other residents. Findings include: Observation on 8/8/23 at 2:26 p.m., with registered nurse (RN)-A and trained medication aide (TMA)-A during a controlled narcotic medication count identified R12 had one unopened blister pack containing lorazepam. Review of the pharmacy label on the medication card listed 28 tablets, however only 27 were filled.	F 761	F761-SSD Label /Store Drugs and Biologicals 1. On 8/08/2023 it was identified during the narcotic count that R12 had one unopened blister pack containing Lorazepam. Pharmacy label indicated there were 28 pills delivered, however there were only 27 filled. 2. Surveyor also noted that there were discontinued medications from a resident R99 that were in the Narcotic box who had expired on 7/24/2023 and discontinued medication from R33. Corrective Action Education provided to Licensed Staff on August 16th, 2023.	

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F 761	Continued From page 4 Review of the Controlled Drug Receipt/Record/Disposition form for R12's lorazepam noted it had been received on 7/25/23 and the count was to be 30 tablets. There was no indication staff identified the errors in amounts between the blister pack that was filled, the pharmacy label on the pack or the amount staff recorded on the form. Observation on 8/8/23 at 2:45 p.m., of the medication cart on B-Wing identified several medications for R99 (who died on 7/24/23) and R33 were not removed upon their death and/or after medications were discontinued and remained in the cart co-mingled with in-use medications for other residents. The medications for R99 were: 1.) 2 Ativan (anti-anxiety medication) 0.25 milligram. (mg) blister packs. One had tablet remaining and another contained 20 tablets. 2.) 4 Ativan 0.325 mg blister packs. 5 tablets remained in 1 blister pack, and the remaining 3 had 4 tablets each remaining. 3.) 2 Oxycodone liquid (narcotic pain medication) bottles, 1 with 4 milliliters (ml) remaining and the other full bottle with 5 ml remaining. 4.) 1 box of Fentanyl patches (narcotic pain medication) 37.5 mg/hr. with 4 patches remaining. The medications for R33 were: 1.) Tramadol (medication for pain) 325 mg blister pack with 1 tablet remaining and a 2 tramadol 25 mg blister packs each containing 30 tablets. Interview on 8/8/23 at 2:57 p.m., with RN-A and TMA-A identified the charge nurse on duty was responsible for receiving and verifying medications delivered from the pharmacy. Both RN-A and TMA-A voiced surprise the inaccurate	F 761	Topics included 1. Education on Frameworks presented by Megan Arend RN (LTC Pharmacy) 2. Discussion on State Survey, review of processes related to Narcotic Destruction and 3. Enhanced Barriers by Patty Massmann RN IC/IP Nurse Policy Reviewed: 1. Licensed Staff will sign in Narcotics into the Ledger, they are to ensure that the correct amount is put in accordance with what was delivered by pharmacy. 2. If there is a discrepancy, licensed staff is to notify Pharmacy immediately. 3. Two staff are to complete the Narcotic count and sign off that it was completed and accurate. 4. Discontinued medication will be destroyed within 24 hours or the next business day with two Registered Nurses. Education on Frameworks Vision completed on 8/16/2023 on how to efficiently document and destroy narcotics within a timely manner. Measures of Success (How will we know if this action is successful) 1. Narcotic Audits done weekly by DON or Support Nurse 2. Monthly Controlled Medication Audits on both Neighborhoods 3. Audits will be reviewed in Monthly QAPI Meetings to ensure compliance.	

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F 761	Continued From page 5 count of medication in R12's blister pack "had not been caught" either at the time of receipt or during shift change narcotic counts that had taken place, since receipt of the medication on 7/25/23 and 8/8/23. RN-A reported controlled medications were left in the narcotic box of the medication cart until 2 RN's "had time" to remove them for destruction as they had to be witnessed. Staff kept narcotic medications for residents who either died or medications were discontinued in the lock box in the medication cart co-mingled with in-use medications for other residents. Interview on 8/08/23 at 4:33 p.m., with the director of nursing (DON) identified her expectation was medications were to be checked for accuracy upon receipt from pharmacy. If there was an inaccuracy in the amount or dosage received, staff were to immediately contact the pharmacy to report the issue and acquire the correct medication and/or label. She voiced concern that multiple narcotic counts had taken place since R12's medication was received, and the discrepancy had not been caught. The DON was unaware discontinued narcotics had been stored with in-use medications until staff had time to destroy them. Interview on 8/10/23 at 12:09 p.m., with the consultant pharmacist reported his expectation for discontinued narcotic medications was not to store those medications co-mingled with in-use medications due to the potential for medication errors and/or the potential for diversion. R12's medication discrepancy with the number of tablets of lorazepam indicated the error began at the pharmacy with only 27 pills packaged instead of the 28 listed on the label. Staff should be verifying accurate medication counts upon receipt	F 761		

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F 761	Continued From page 6 and during daily counts. Review of the September 2022 policy LTC Controlled Substance Distribution, Storage, Administration, and Destruction identified there was no reference to accurate reconciliation when medication was received from pharmacy, nor was there any mention of the need to immediately remove medications not in use from medications in-use or appropriate destruction of those medications.	F 761		
F 883 SS=E	Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2) §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza	F 883		9/6/23

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F 883	Continued From page 7 immunization due to medical contraindications or refusal. §483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure 4 of 5 residents (R13, R32, R34, and R37) were appropriately vaccinated against pneumococcal disease upon admission and/or offer updated vaccination per Centers for Disease Control (CDC) vaccination recommendations. This had the ability to affect all 30 residents.	F 883	Avera Granite Falls Care Center POC CMS Recertification Survey Tag: F883 SS=E Influenza and Pneumococcal Immunizations LTC Resident Immunization Program (Influenza, Pneumococcal, COVID-19) Avera Marshall Region Specific	

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F 883	Continued From page 8 Findings include: Review of the current CDC pneumococcal vaccine guidelines located at https://www.cdc.gov/vaccines/vpd/pneumo/hcp/pneumo-vaccine-timing.html, identified for: Adults 65 years of age or older, staff were to offer and/or provide based off previous vaccination status as shown below: a) If NO history of vaccination, offer and/or provide: aa) the PCV-20 OR bb) PCV-15 followed by PPSV-23 at least 1 year later. b) For PPSV-23 vaccine ONLY (at any age): aa) PCV-20 at least 1 year after prior PPSV-23 OR bb) PCV-15 at least 1 year after prior PPSV-23 c) For PCV-13 vaccine ONLY (at any age): aa) PCV-20 at least 1 year after prior PCV13 OR bb) PPSV-23 at least 1 year after prior PCV13 d) For PCV-13 vaccine (at any age) AND PPSV-23 BEFORE 65 years: aa) PCV-20 at least 5 years after last pneumococcal vaccine dose OR bb) PPSV-23 at least 5 years after last pneumococcal vaccine dose Review of the 5 sampled residents for vaccinations identified: 1.) R13 was admitted on 12/4/18. R13 received her PCV-23 on 10/18/11 and her PCV-13 on 10/17/19. There was no documentation to support R13 had been offered the PCV-15 or PCV-20 to ensure she was updated with current CDC guidance for vaccines.	F 883	Information policy reviewed and updated with regional Infection Preventionist. This policy along with the updated CDC guidelines regarding the PCV20 were reviewed with DON, Infection Preventionist & presented for review at the August 21, 2023 LTC QAPI Committee meeting, attended by the DON, IP, Quality Coordinator, Medical Director, RN Support Staff, Social Worker, Activities Director, and LTC Consulting Pharmacist. The following email notification was sent to residents families on 8/11/2023, informing all of the CDC pneumococcal vaccination guidelines and the availability of the PCV20 if desired. Dear Residents and Families, CDC has updated requirements that residents be informed of the most recent update to the pneumococcal vaccinations series, PCV20. Attached is the Vaccination Information Sheet regarding the PCV20. Your provider will address this updated vaccination and eligibility to receive it at your resident s next scheduled rounds, or at your next care conference. Let me know if you have questions or would like to be evaluated for your eligibility to receive this vaccination prior to your next rounds or care conference. PCV 20 vaccination guidelines along with the VIS presented at Family Council @ Avera Granite Falls 8/16/2023. Pneumococcal vaccination guidelines	

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	245243	A. BUILDING _____ B. WING _____	C 08/10/2023

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F 883	Continued From page 9 2.) R32 was admitted on 1/5/21. R32 received his PCV-13 on 4/5/21 and his PCV-23 on 4/11/22. There was no documentation to support R13 had been offered the PCV-15 or PCV-20 to ensure he was updated with current CDC guidance for vaccines. 3.) R34 was admitted on 6/9/23. R34 received her PCV-13 on 5/19/16 and her PCV-23 on 10/22/19. There was no documentation to support R13 had been offered the PCV-15 or PCV-20 to ensure she was updated with current CDC guidance for vaccines. 4.) R37 was admitted on 11/4/21. R37 received her PCV-13 on 9/14/15 and PCV-23 on 9/14/15. There was no documentation to support R13 had been offered the PCV-15 or PCV-20 to ensure she was updated with current CDC guidance for vaccines. Clarification on administration dates had been requested but nothing was provided. Interview on 8/8/23, at 11:40 a.m., with infection control preventionist (IC) identified her expectation was the RN completing the admission would review vaccination status upon admission and contact the primary doctor to obtain an order for the expropriate vaccinations per CDC vaccination guidance. Review of the current, undated immunization policy identified the facility was to follow CDC recommendations for the pneumococcal vaccinations and included a link to assist staff to the most updated CDC vaccination recommendations.	F 883	presented to the Avera Granite Falls Medical Staff on 9/7/23, addressing the need for shared decision making when prescribing the PCV20 to be addressed during routine nursing home rounds or sooner if requested by the resident. Residents immunization status will be reviewed upon admission and annually thereafter to insure pneumococcal vaccinations are up to date. Upon admission, the Infection Preventionist will access MIIC to review the resident s current vaccination status. The CDC PneumoRecs VaxAdvisor tool will be used to determine which pneumococcal vaccines are recommended for the resident. The recommendation will be communicated to the RN admitting the resident, who will address the recommendation with the resident, resident s family as applicable, and resident s provider. PCV 20 will be offered and if residents or POA declines, declination will be documented in the EMAR. The Infection Preventionist will complete a monthly audit, ensuring the vaccination recommendations have been addressed and present the audited information at the monthly QAPI/Infection Prevention meetings.	

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	245243	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**08/07/2023**

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AVERA GRANITE FALLS CARE CTR	**250 JORDAN DRIVE** **GRANITE FALLS, MN 56241**

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K 000	INITIAL COMMENTS Fire Safety An annual Life Safety Code survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 08/07/2023. At the time of this survey, Avera Granite Falls Care Center was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: IF PARTICIPATING IN THE E-POC PROCESS, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED.	K 000		

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

Electronically Signed | 09/06/2023

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

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K 000	Continued From page 1 Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR By email to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A detailed description of the corrective action taken or planned to correct the deficiency. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. 4. Identify who is responsible for the corrective actions and monitoring of compliance. 5. The actual or proposed date for completion of the remedy. Avera Granite Falls Care Center was built in 2015, and is one-story in height, has no basement, is fully fire sprinkler protected and was determined to be of Type V(111) construction. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors which is monitored for automatic fire department notification. The facility has a capacity of 48 beds and had a	K 000		

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K 000	Continued From page 2 census of 47 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 345 SS=D	Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This REQUIREMENT is not met as evidenced by: Based on documentation review and staff interview, the facility failed to inspect and maintain initiating devices of fire alarm system in accordance with NFPA 101 (2012 edition), Life Safety Code, sections 19.3.4 and 9.6.2, and NFPA 72 (2010 edition) National Fire Alarm and Signal Code, sections 14.1.1 and 14.2.2 This deficient finding could have an isolated impact on the residents within the facility. Findings include: On 08/07/2023 between 11:00 AM to 2:00 PM, it was revealed during documentation review that the fire alarm system servicing vendor had noted 2 duct detectors that could not be inspected due to weather. No supporting documentation was provided or available for review to confirm the noted devices had been inspected when weather permitted.	K 345	Citation 0345 On 8/07/2023 it was identified that facility failed to inspect and maintain devices due to weather during last annual inspection to ensure devices were working appropriately. 1) Summit Fire Protection Came on site to the care center on 8-21-23. To complete the Annual inspection. Inspection was done by Paul Ward of Summit Fire Protections. 2) To address that the duct detectors are not missed again Annually. Due to weather conditions. Our annual inspection will now be done in October. Years before this have been getting completed in December. 3) To monitor performance the duct detectors will be set off with smoke	9/6/23

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K 345	Continued From page 3 An interview with the Environmental Services Manager verified this deficient finding at the time of discovery.	K 345	quarterly to make sure they are functioning properly. Also, they will be checked for function during our monthly fire drills. 4) Steven Schwartz Environmental Services Manager is responsible for corrective actions to be taken on all line safety at the Avera Granite Falls Care Center. Corey Moe is responsible for the monitoring of compliance with all line safety at the Granite Falls Care Center. 5) The completed date of remedy is 8-21-23. By Summit Fire Protections. Plan of correction to be reviewed in monthly QAPI Meeting	

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

September 22, 2023

Administrator
Avera Granite Falls Care Center
250 Jordan Drive
Granite Falls, MN 56241

RE: CCN: 245243
Cycle Start Date: August 10, 2023

Dear Administrator:

On September 17, 2023, the Minnesota Departments of Health and Public Safety, completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Please contact me with any questions regarding this letter.

Sincerely,

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