Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
June 17, 2025

Administrator
Good Samaritan Society - Woodland
100 Buffalo Hills Lane
Brainerd, MN 56401

RE: CCN: 245488
Cycle Start Date: June 4, 2025

Dear Administrator:

On June 4, 2025, 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 isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G), The Statement of Deficiencies (CMS-2567) is being electronically delivered. Because corrective action was taken prior to the survey, past non-compliance does not require a plan of correction (POC).

This survey also found other 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),whereby corrections are required.

REMEDIES

As a result of the survey findings and in accordance with survey and certification memo 16-31-NH, this Department recommended the enforcement remedy(ies) listed below to the CMS location for imposition. The CMS location concurs and is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Mandatory Denial of Payment for new Mediare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective September 4, 2025.

The CMS location will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective September 4, 2025. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective September 4, 2025.

You should notify all Medicare/Medicaid residents admitted on, or after, this date of the restriction. The remedy must remain in effect until your facility has been determined to be in substantial compliance or your provider agreement is terminated. Please note that the denial of payment for new admissions includes Medicare/Medicaid beneficiaries enrolled in managed care plans. It is your obligation to inform managed care plans contracting with your facility of this denial of payment for new admissions.

The CMS location may determine to impose other remedies such as a Civil Money Penalty.

- Civil money penalty. (42 CFR 488.430 through 488.444)

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; *has been assessed a total civil money penalty of not less than $13,343*; *has been subject to a denial of payment*, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

If you have not achieved substantial compliance by September 4, 2025, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, Good Samaritan Society - Woodland will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from September 4, 2025. You will receive further information regarding this from the State agency. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions.

Under Public Law 105-15 (H.R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

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

DEPARTMENT CONTACT

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
State Fire Safety Supervisor
Health Care & Correctional Facilities
MN Department of Public Safety-Fire Marshal Division

445 Minnesota St., Suite 145
St. Paul, MN 55101
Email: travis.ahrens@state.mn.us
Web: www.sfm.dps.mn.gov
Cell: 1-507-308-4189

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.

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 - Health Regulation Division staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for their 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 SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by December 4, 2025 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. 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.

APPEAL RIGHTS

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40, et seq. You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at https://dab.efile.hhs.gov no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

tamika.brown@cms.hhs.gov

Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted as of October 1, 2014, unless you do not have access to a computer or internet service. In those circumstances you may call the Civil Remedies Division to request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a written request for a waiver along with your written request for a hearing. A written request for a hearing must be filed no later than sixty (60) days after receiving this letter, by mailing to the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
202-795-7490

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Tamika Brown at (312) 353-1502. Information may also be emailed to tamika.brown@cms.hhs.gov.

INFORMAL DISPUTE RESOLUTION (IDR)

In accordance with 42 CFR 488.331 **and Minnesota Statute 144A.10 subd 15**, 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: https://forms.web.health.state.mn.us/form/NHDisputeResolution

This request must be sent within the same ten calendar days you have for submitting an ePoC for the cited deficiencies. 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.

A copy of the Department's informal dispute resolution policies is posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

In accordance with 42 CFR § 488.431 and Minnesota Statute 144A.10 subd 16, when a CMP subject to being collected and placed in an escrow account is imposed, you have one opportunity to question cited deficiencies through an Independent IDR process. You may also contest scope and severity assessments for deficiencies which resulted in a finding of SQC or immediate jeopardy. 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: https://forms.web.health.state.mn.us/form/NHDisputeResolution

A facility may not use both IDR and independent IDR for the same deficiency citation(s) arising from the same survey unless the IDR process was completed prior to the imposition of the CMP. This request must be sent within ten calendar days of receipt of this offer. An incomplete Independent IDR process will not delay the effective date of any enforcement action.

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.

Feel free to contact me if you have questions.

Sincerely,

Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
PO Box 64975 | 625 Robert Street North
St. Paul, MN 55164-0975
Office: 651-201-4384
Email: holly.zahler@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245488	A. BUILDING _____ B. WING _____	C 06/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - WOODLAND	100 BUFFALO HILLS LANE BRAINERD, MN 56401

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments On 6/1/25 through 6/4/25, a survey for compliance with §483.73, Appendix Z, Emergency Preparedness Requirements for Long Term Care Facilities 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 6/1/25 through 6/4/25, a standard recertification survey was conducted at your facility. Complaint investigations were 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: H54885768C (MN00112136) and H54885948C (MN00110032) with no deficiencies cited. 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 regulations has been attained.	F 000	Past noncompliance: no plan of correction required.	
F 689	Free of Accident Hazards/Supervision/Devices	F 689		

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

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 689 SS=G	Continued From page 1 CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure staff responded to resident request for toileting assistance in a timely manner for 1 of 4 residents (R23) reviewed for falls. This resulted in actual harm for R23 who fell while attempting to transfer independently, resulting in a head laceration which required emergency medical care. The facility implemented corrective action prior to the survey, therefore, the deficient practice was issued at past non-compliance. Findings include: R23's admission Minimum Data Set (MDS) dated 4/7/25, identified R23 had intact cognition. R23 was occasionally incontinent of bladder, continent of bowel and required maximum assistance to transfer and toilet. R23 was unable to ambulate. R23's care plan dated 4/1/25, identified R23 was at risk for falls related to activity intolerance. A goal was listed for R23 to be free of injury. Intervention included to allow R23 to make position changes slowly due to orthostatic blood pressure changes. A second intervention was	F 689	Past noncompliance: no plan of correction required.	

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F 689	Continued From page 2 added on 6/2/25, which directed staff to ensure R23 was wearing appropriate footwear. The care plan identified R23 had a self care deficit and required assistance of one to transfer and toilet. Interventions included to transfer R23 with assist of one and a mechanical stand aid and to toilet every three hours. A progress note on 5/29/25, identified R23 was found lying on the floor of her room next to her recliner. R23 had a large laceration to her forehead and R23 was sent to the emergency room to be evaluated. R23 stated she was going to go to the bathroom when she fell. R23 did not have shoes or gripper socks on at the time. Her call light was utilized prior to her fall and staff reported R23 was told she was next in line for assistance. R23 returned from the emergency room at 11:28 p.m. with eleven sutures to the laceration at the center of her forehead and purple bruising started to appear. R23's Fall Scene Huddle Worksheet dated 5/29/25, identified R23 was found on the floor in her room at 7:55 p.m., after having tried to self transfer. R23's recliner was all the way up in the elevated position and R23 was wearing socks on her feet. R23 was incontinent of urine and stated she had to go to the bathroom. Staff had offered to assist R23 to use the bathroom prior to supper and had declined the need. R23 was last toileted at 2:23 p.m. Nursing assistant (NA)-C last checked with R23 at 6:37 p.m. and notified R23 she would be the next resident to be assisted. The Summary Call Data by Room dated 5/26/25, identified identified R23 had put on her call light at 7:18 p.m. and the call light was turned off 38 minutes later when she was found on the floor.	F 689		

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F 689	Continued From page 3 R23's Resident Event Abstract dated 5/29/25, identified an unobserved fall had occurred. R23 had stated she was going to go to the bathroom. R23's call light had been used prior to the fall and staff reported they had told R23 she would be next to be assisted to the bathroom and get ready for bed. On 6/1/25, at 5:10 p.m. R23 was seated in a wheelchair in her room, waiting for supper service. R23 had a laceration on the center of her forehead from her hairline to above her eyebrows that had sutures holding the edges together. Bruising was also noted surrounding the laceration. R23 stated she had fallen a few days before and hit her head on the bedside table. During interview on 6/2/25, at 3:29 p.m. NA-A stated she worked the evening of 5/29/25. She remembered it had gotten really busy with all the resident call lights. R23 had put her call light on but it had just been so busy that evening. During interview on 6/2/25, at 3:30 p.m. NA-B stated R23 would always ring her call light to go to the bathroom and at times staff would tell her they would be back in just a minute and R23 would wait. NA-B had never seen R23 attempt to take herself to the bathroom. When interviewed on 6/2/25, at 3:37 p.m. trained medication assistant (TMA)-A stated R23 would put on her call light when needed to use the bathroom and at times staff would tell her they would be back in a minute and R23 would always wait for staff to return. TMA-A had never known R23 to make self transfer attempts.	F 689		

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F 689	Continued From page 4 During interview on 6/2/25, at 4:30 p.m. NA-D stated R23 needed assistance to go to the bathroom and was always continent of urine. R23 would ring her call light when needed to go to the bathroom and sometimes, would wheel to the doorway to look for help to the bathroom, if she was in her wheelchair. NA-D heard R23 had to wait a long time for assistance to the bathroom that evening and finally just tried to go on her own. When interviewed on 6/2/25, at 4:57 p.m. registered nurse (RN)-A stated she was working on the evening R23 had fallen. R23 had put on her call light and the NA went in and told her she would be the next to be assisted to bed and then they found her on the floor. R23's recliner was fully upright and RN-A thought she had been trying to stand and fell. Staff asked her before and after supper if she had wanted to use the bathroom and she had declined. R23 was not able to bear weight and had regular socks on, not gripper socks. RN-A assessed R23's injury and had sent her to the emergency room to be evaluated. During interview on 6/3/25, at 12:00 p.m. the director of nursing (DON) stated she had reviewed the facility video the night of R23's fall and spoken with staff who worked that evening. Staff entered R23's room and told her she was next to be assisted to bathroom and bed; however, staff assisted two other residents to bed first. The DON checked to see who the two residents were that were assisted before R23 and both residents had behaviors of anxiety, hollering out and were a high fall risk, so the staff put them to bed first. In the meantime, R23 had decided she could not wait and attempted to go herself.	F 689		

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F 689	Continued From page 5 The DON reviewed the incident with all the NA's involved and provided education that call lights were a priority over putting residents to bed and the importance of toileting residents when they requested it. The DON stated she had also educated staff at shift change to approach R23 more directly when attempting to assist her to the bathroom instead of just asking. When a staff member saw a resident call light on, they were to check in frequently with the resident and/or get on their walkie's when a call light was on and needed to be addressed and request help. The staff on other wings needed to answer call lights and help out. During the fall investigation it was determined the the cause of R23's fall was because the call light was not addressed timely. Staff had checked in with her and told her they would be back to assist but did not get back to her timely. The staff were educated on answering call lights promptly and responding immediately to resident's request to be assisted to the bathroom. The facility' corrective actions were confirmed through a sample of other residents reviewed for falls, including R23, and verbal interviews with staff and management to affirm education was completed. R23's medical record was reviewed and verified R23 had been comprehensively assessed for fall risk, and the IDT review process was being completed since R23's fall. There were no other concerns identified regarding falls during the onsite survey. The facility policy Fall Prevention and Management dated 4/8/25, directed staff to care plan appropriate interventions to prevent falls and communicate fall risks and interventions to prevent a fall before it occurred.	F 689		

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F 689	Continued From page 6 The facility policy Call Light dated 7/29/24, identified a purpose to ensure residents always had a method for calling for assistance and to promptly answer resident's call lights. When a resident's call light was observed, staff were to go to the resident's room promptly and respond to the resident's request as soon as possible.	F 689		

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	245488	A. BUILDING **01** B. WING _____	**06/02/2025**

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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 06/02/2025. At the time of this survey, Good Samaritan Society-Woodland 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) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. 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 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. IF OPTING TO USE AN EPOC, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K TAGS) TO: HEALTH CARE FIRE INSPECTIONS	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		06/23/2025

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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GOOD SAMARITAN SOCIETY - WOODLAND	**100 BUFFALO HILLS LANE** **BRAINERD, MN 56401**

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K 000	Continued From page 1 STATE FIRE MARSHAL DIVISION 445 MINNESOTA STREET, SUITE 145 ST. PAUL, MN 55101-5145, or By e-mail 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. Good Samaritan Society, Woodland is a 1-story building without a basement. The building was constructed in 1982 and was determined to be of Type V(111) construction. The building is separated from the apartment building with a 2-hour fire barrier and is divided into 3 smoke zones with 1-hour fire barriers. The building is fully sprinkler protected and has a fire alarm system with smoke detection in the corridors and spaces open to the corridors that is monitored for automatic fire department notification.	K 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245488	A. BUILDING **01** B. WING _____	**06/02/2025**

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K 000	Continued From page 2 The facility has a capacity of 42 beds and had a census of 35 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced 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 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	K 324	Disclaimer: Preparation and execution of	7/31/25

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K 324	Continued From page 3 facility failed to maintain their kitchen hood discharge nozzles per NFPA 101 (2012 edition), Life Safety Code, section 9.7.3.1, NFPA 96 (2011 edition), Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, section 10.2.6 and NFPA 17A (2009 edition), Standard for Wet Chemical Extinguishing Systems section 7.2.2. This deficient finding could have an widespread impact on the residents within the facility. Findings include: On 06/02/2025 at 10:20 AM, it was revealed by observation that at the time of the survey, the facility failed to maintain the discharge nozzles. During the survey of the commercial kitchen it was discovered that the discharge nozzles were incorrectly positioned over the 6-burner stove. An interview with the Administrator, Administrator in Training and Maintenance Supervisor verified this deficient finding at the time of discovery.	K 324	this response and plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. For the purposes of any allegation that the center is not in substantial compliance with federal requirements of participation, this response and plan of correction constitutes the center's allegation of compliance in accordance with section 7305 of the State Operations Manual. 1. On 6/2/2025 the discharge nozzles were placed in the correct position over the 6-burner stove. The nozzles were also tightened to ensure they cannot be moved to a different position. 2. All residents have the potential to be affected by this deficient practice. On 6/2/2025 the discharge nozzles were placed in the correct position over the 6-burner stove. 3. Maintenance and dietary staff members were educated on the correct positions of the discharge nozzles, and to notify maintenance if they were positioned incorrectly. In addition to the monthly ansul hood inspection, maintenance will inspect nozzles after each hood cleaning to ensure that the deficient practice does not recur. 4. Maintenance supervisor or designee	

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K 324	Continued From page 4	K 324	will inspect the discharge nozzles weekly x4, and then bi-weekly x2, and monthly x1. The results of these audits will be reviewed and reported at the monthly Quality Committee meeting.	