Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
January 15, 2025

Administrator
Galeon
410 West Main Street
Osakis, MN 56360

RE: CCN: 245465
Cycle Start Date: October 30, 2024

Dear Administrator:

On December 2, 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.

Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
Orville L. Freeman Building | HRD 3A 3rd Floor
PO Box 64900
625 Robert Street North
St. Paul, MN 55155
Office: 651-201-4384
Email: holly.zahler@state.mn.us

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
January 15, 2025

Administrator
Galeon
410 West Main Street
Osakis, MN 56360

Re: Reinspection Results
Event ID: KUXT12

Dear Administrator:

On December 2, 2024, survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on October 30, 2024. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
Orville L. Freeman Building | HRD 3A 3rd Floor
PO Box 64900
625 Robert Street North
St. Paul, MN 55155
Office: 651-201-4384
Email: holly.zahler@state.mn.us

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
November 13, 2024

Administrator
Galeon
410 West Main Street
Osakis, MN 56360

RE: CCN: 245465
Cycle Start Date: October 30, 2024

Dear Administrator:

On October 30, 2024, 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:

Judy Loecken, Regional Operations Supervisor
St. Cloud B District Office
Health Regulation Division
Minnesota Department of Health
4140 Thielman Lane
Saint Cloud, Minnesota 56301-4557
Email: judy.loecken@state.mn.us
Office: (320) 223-7300 Mobile: (320) 241-7797

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

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

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

If substantial compliance with the regulations is not verified by January 30, 2025 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by April 30, 2025 (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)

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.

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

Feel free to contact me if you have questions.

Sincerely,

Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
Orville L. Freeman Building | HRD 3A 3rd Floor
PO Box 64900
625 Robert Street North
St. Paul, MN 55155
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
	245465	A. BUILDING _____ B. WING _____	C 10/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GALEON	410 WEST MAIN STREET OSAKIS, MN 56360

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments On 10/28/24 through 10/30/24, a survey for compliance with Appendix Z, Emergency Preparedness Requirements, §483.73 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 10/28/24 to 10/30/24 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: H54659767C (MN00106831) H54651008C (MN00107805). The following complaints were reviewed H54659968C (MN00107790) Deficient practice was identified related to incidental finding The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance.	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		11/19/2024

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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F 000	Continued From page 1 Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulations has been attained.	F 000		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by:	F 609		11/22/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 609	Continued From page 2 Based on interview and document review, the facility failed to report an allegation of abuse as required for 1 of 2 residents (R82) reviewed for abuse. Findings Include: R82's entry Minimum Data Set (MDS) included an entry date of 10/18/24. R82's Order Summary Report dated 10/30/24, included an order for Hospice. On 10/25/24, a report was filed with the State Agency which reported abuse was witnessed during a hospice aide visit on 10/25/24. The report indicated nursing assistant (NA)-B, a hospice nursing assistant, reported the abuse to registered nurse (RN)-A. During interview on 10/29/24 at 5:29 p.m., RN-A confirmed NA-B reported witnessing rough cares provided to R82. RN-A confirmed she had not completed a body assessment after receiving the report. RN-A stated she had spoken with someone at the facility about the alleged abuse, but did not remember who. RN-A stated she would typically report concerns about abuse to either the director of nursing (DON), administrator, or social worker. RN-A stated she could not remember reporting the concerns to any of the mentioned staff. During interview on 10/29/24 at 5:48 p.m., RN-B confirmed RN-A had not reported abuse to her. RN-B was informed of the concern of abuse during the team meeting the following morning. RN-B stated it was passed on during report that NA-B felt NA-A was rough with R82. RN-B was	F 609	R82 was affected by the deficient practice due to the facility failing to report an allegation of abuse. All residents could have been affected by the deficient practice as all living at Community Memorial Home are considered vulnerable adults. All resident were interviewed by the ADON and Care Coordinator. Residents were asked if they felt safe, if any harm or acts of abuse had been received. All stated no. Education on the vulnerable adult policy and procedure were discussed at the all staff meeting held on November 13th. All staff who did not attend will review the policy and procedure with the administrator or her delegate. Again at the nursing meeting and nurse aide information on Vulnerable Adult will be reviewed. Nurses meeting to be held on November 19th. Nurse Aide Meeting will be held on November 20th. The facility will interview residents one time weekly for a month, then 2 times monthly for 2 months, then will have on the care conference agenda to be asked quarterly. The date the deficiency will be corrected is: December 31st, 2024.	

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F 609	Continued From page 3 unsure if any additional follow up was completed. During interview on 10/29/24 at 6:18 p.m., DON stated she received a call from RN-C who reported an aide witnessed rough cares from a facility employee. DON was unable to recall what time she received the call. DON confirmed she did not file a report with the state agency about the alleged abuse. DON confirmed abuse should be reported within two hours of receiving the report. During interview on 10/30/24 at 2:30 p.m., administrator stated a thorough investigation should have been completed with any concerns of abuse. Administrator stated a thorough investigation would take two to three days to complete and the report of abuse should have been file prior to investigation. Facility abuse policy included all alleged violations involving abuse should be reported immediately, but no later than two hours after the allegation was made.	F 609		
F 610 SS=D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress.	F 610		11/22/24

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F 610	Continued From page 4 §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to investigate an allegation of abuse as required for 1 of 2 residents (R82) reviewed for abuse. Findings Include: R82's entry Minimum Data Set (MDS) included an entry date of 10/18/24. R82's Order Summary Report dated 10/30/24, included an order for Hospice. On 10/25/24, a report was filed with the State Agency which reported abuse was witnessed during a hospice aide visit on 10/25/24. The report indicated nursing assistant (NA)-B reported abuse to registered nurse (RN)-A. During interview on 10/29/24 at 5:29 p.m., RN-A confirmed NA-B reported witnessing rough cares provided to R82. RN-A confirmed she had not completed a body assessment after receiving the report. RN-A stated she would typically report concerns about abuse to either the director of nursing (DON), administrator, or social worker. RN-A confirmed she had not spoken with the alleged perpetrator after the report of abuse. During interview on 10/29/24 at 5:48 p.m., RN-B	F 610	R82 was affected by the deficient practice due to the facility failing to investigate an allegation of abuse. All residents could have been affected by the deficient practice as all living at Community Memorial Home are considered vulnerable adults. All resident were interviewed by the ADON and Care Coordinator. Residents were asked if they felt safe, if any harm or acts of abuse had been received. All stated no. Education on the vulnerable adult policy and procedure were discussed at the all staff meeting held on November 13th. All staff who did not attend will review the policy and procedure with the administrator or her delegate. Again at the nursing meeting and nurse aide information on Vulnerable Adult will be reviewed. Nurses meeting to be held on November 19th. Nurse Aide Meeting will be held on November 20th. The facility will interview residents one time weekly for a month, then 2 times monthly for 2 months, then will have on the care conference agenda to be asked quarterly. Any information obtained from residents, family or any individual regarding potential abuse will be reported to MAARC immediately and investigation will be completed. The date the	

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F 610	Continued From page 5 confirmed RN-A had not reported abuse to her. RN-B stated she was informed of the concern of abuse during a team meeting the following morning. RN-B stated it was passed on during report that NA-B felt NA-A was rough with R82. RN-B was unsure if any additional follow up was completed. RN-B stated it was standard procedure to take a staff member off the schedule after a report of alleged abuse. During interview on 10/29/24 at 6:18 p.m., director of nursing (DON) stated she received a call from RN-C who reported an aide witnessed rough cares from a facility employee. DON was unable to recall what day or time she received the call. DON stated she had spoken with the alleged perpetrator "within the hour" of receiving the phone call. DON stated she did not speak with any additional staff members or residents to complete a thorough investigation. DON confirmed she had not attempted to speak with the aide who reported the alleged abuse. DON stated she had completed a skin assessment of R82's but had not documented the assessment. DON stated she should have documented the assessment because "if it wasn't documented, it did not happen." DON stated she had handwritten notes regarding the incident, but was not able to produce them at the time of the interview. DON confirmed the alleged perpetrator continued to work after the report of alleged abuse. DON produced an undated, handwritten one page sheet of paper on 10/30/24. During interview on 10/30/24 at 2:30 p.m., administrator stated a thorough investigation should have been completed with any concerns of abuse. Administrator stated a thorough investigation would take two to three days to	F 610	deficiency will be corrected is: December 31st, 2024.	

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F 610	Continued From page 6 complete and would include interviews with other residents, mood/behavior monitoring and removing the alleged staff member from the schedule. Facility schedules indicated NA-A worked 10/25/24, 10/26/24, 10/29/24, and 10/30/24. Facility abuse policy included all alleged violations involving abuse should be investigated immediately. The investigation should have included resident's statements, involved staff and witness statements of events, a description of the resident's behavior and environment at the time of the incident, injuries present, and observation of resident and staff behaviors during the investigation. The alleged individual would be immediately removed.	F 610		

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
November 13, 2024

Administrator
Galeon
410 West Main Street
Osakis, MN 56360

Re: State Nursing Home Licensing Orders
Event ID: KUXT11

Dear Administrator:

The above facility was surveyed on October 28, 2024, through October 30, 2024, for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

To assist in complying with the correction order(s), a "suggested method of correction" has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the order within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html. The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute or rule after the statement, "This MN Requirement is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.

THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact:

Judy Loecken, Regional Operations Supervisor
St. Cloud B District Office
Health Regulation Division
Minnesota Department of Health
4140 Thielman Lane
Saint Cloud, Minnesota 56301-4557
Email: judy.loecken@state.mn.us
Office: (320) 223-7300 Mobile: (320) 241-7797

You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.

Please feel free to call me with any questions.

Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
Orville L. Freeman Building | HRD 3A 3rd Floor
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
	00109	A. BUILDING: _____ B. WING _____	C 10/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GALEON	410 WEST MAIN STREET OSAKIS, MN 56360

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 10/28/24 through 10/30/24, a licensing survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was NOT in compliance with the MN State Licensure and the following correction orders are issued. Please indicate in your electronic plan of correction you have reviewed these orders and	2 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00109	A. BUILDING: _____ B. WING _____	C 10/30/2024

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2 000	Continued From page 1 identify the date when they will be completed. The following complaints were reviewed during the survey: H54659767C (MN00106831) H54651008C (MN00107805), H54659968C (MN00107790). NO licensing orders were issued. Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled " ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health.	2 000		

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2 000	Continued From page 2 PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000		
21426	MN St. Statute 144A.04 Subd. 3 Tuberculosis Prevention And Control (a) A nursing home provider must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in CDC's Morbidity and Mortality Weekly Report (MMWR). This program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, residents, and volunteers. The Department of Health shall provide technical assistance regarding implementation of the guidelines. (b) Written compliance with this subdivision must be maintained by the nursing home. This MN Requirement is not met as evidenced by: Based on record review and interview the facility failed to ensure tuberculosis (TB) testing was	21426	Corrected	12/31/24

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21426	Continued From page 3 completed in the required time frame for 1 of 5 residents (R12) and 1 of 5 employees (O-A) reviewed for TB screening and testing. Findings include: The CDC guidelines for preventing the transmission of mycobacterium tuberculosis (TB) in Health Care Settings, 2005, directed that all residents and staff must receive a baseline TB screening, consist of an assessment for TB risk factors and history, assessment for current symptoms of active TB, and testing for the presence of infection with mycobacterium tuberculosis. According to the CDC and MDH Regulations for Tuberculosis Control in Minnesota Health Care Settings, 2013, there were multiple options for testing. This facility used the two-step skin test for TB. For residents, the testing needed to be completed within 72 hours of admission or within 3 months prior to admission, and for employees the first and seconds steps of the skin test needed to be completed within 1-3 weeks of the other. R12's quarterly Minimum Data Set (MDS) dated 10/2/24, indicated R12 was admitted on 3/9/2022. The Community Memorial Home Immunization Report dated 10/29/24, indicated R12 received a TB skin test on 3/22/22, and 4/5/22, outside of the required 72 hours from admission. The undated staff list, indicated employment start dates for the following employees: Office employee (O)-A's start date was 6/24/2024.	21426		

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21426	Continued From page 4 The Baseline TB Screening Tool for Health Care Workers form dated 6/24/2014, indicated O-A completed the first step of the TB skin test on 6/24/2024 and the second step of the TB skin test on 7/22/2024, outside of the required 1-3 weeks between testing. On 10/30/24 at 2:29 p.m., the infection preventionist registered nurse (RN)-B, confirmed the skin test completed for R12, and O-A were outside of the required testing time frames according to the CDC and MDH. RN-B stated it was the facility's policy complete resident testing upon admission, but was unaware of the requirement to test within 72 hours of admission. RN-B stated employees were screened prior to working with residents and then tested within two weeks. On 10/30/24 at 3:28 p.m., the director of nursing (DON) expected the residents to be screened and tested upon admission and then the second step within 2 week, and had the same expectation for employees upon their starting date of employment. The DON confirmed R12 and O-A's testing dates were all outside of the time requirements listed above. The Resident Screening for TB policy last reviewed 6/5/24, indicated prior to or at the time of admission, all new residents will receive TB screening and testing and/or chest radiograph in accordance with state requirements. The Employee TB Testing policy last reviewed 5/2024, indicated all new staff shall receive two Mantoux TB skin test given two weeks apart.	21426		

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K 000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety recertification survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 10/29/2024. At the time of this survey, Galeon was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: IF PARTICIPATING IN THE E-POC PROCESS, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED.	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		11/19/2024

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. This facility was surveyed as one building. Galeon is a two-story building with no basement. The building was constructed at three different times. The original building was constructed in 1963, is one story, and was determined to be of Type II(000) construction. In 1977, a one-story, Type II(000) expansion to the dining room was added. In 2008 a two-story Wellness Center was added. As of Nov 1, 2016, all sections are considered existing and were surveyed as one building. The building is fully fire sprinklered throughout. The	K 000		

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K 000	Continued From page 2 facility has a fire alarm system that includes smoke detection in the corridors and spaces open to the corridors that is monitored for automatic fire department notification. The resident rooms have battery-operated smoke detectors. The facility has a capacity of 40 beds and had a census of 38 at the time of the survey. The requirements at 42 CFR, Subpart 483.70(a), are NOT MET as evidenced by:	K 000		
K 291 SS=E	Emergency Lighting CFR(s): NFPA 101 Emergency Lighting Emergency lighting of at least 1-1/2-hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to test and maintain emergency lighting per NFPA 101 (2012 edition), Life Safety Code, sections 19.2.9.1 and 7.9.3.1.1. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 10/29/2024 between 8:45 AM and 12:00 PM, it was revealed by a review of available documentation that at the time of the survey the facility could not provide documentation showing that they have been conducting the annual 90-minute functional test of emergency lighting in the facility.	K 291	On 11/18/2024 Maintenance Director and staff completed Nursing Home inspection of all battery-operated emergency lighting to ensure a 90-minute test was run and all were in working condition. Annually each November a 90-minute test will be completed and noted on monthly emergency lighting form that this was completed. The Administrator will ensure completion by signing off annually each November that the 90-minute emergency test was completed.	12/31/24

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K 291	Continued From page 3 An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 291		
K 321 SS=E	Hazardous Areas - Enclosure CFR(s): NFPA 101 Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) This REQUIREMENT is not met as evidenced by:	K 321		12/31/24

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K 321	Continued From page 4 Based on observation and staff interview, the facility failed to maintain hazardous area enclosures per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.2.1, 19.3.2.1.3, and 19.3.6.3.5. These deficient findings could have a patterned impact on the residents within the facility. Findings include: On 10/29/2024 between 8:45 AM and 12:00 PM, it was revealed by observation that the following doors leading to hazardous areas did not latch when they were closed using the self-closing device: Laundry Room, East Wing Soiled Utility Room, and West Wing Soiled Utility Room. An interview with the Maintenance Director verified these deficient findings at the time of discovery.	K 321	On 11/1/2024 replaced the door closure and now the door closes correctly. All doors leading to hazardous materials rooms will be inspected monthly along with fire drills. Will be documented at time of fire drill and audit form/calendar. Administrator will review and sign off monthly that those are being completed. Date of Completion December 31st, 2024.	
K 324 SS=D	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	K 324		12/31/24

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K 324	Continued From page 5 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 a review of available documentation and staff interview, the facility failed to inspect their kitchen hood per NFPA 101 (2012 edition), Life Safety Code, section 19.3.2.5.1 and 9.2.3, and NFPA 96 (2011 edition), Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, section 11.2.1. This deficient finding could have an isolated impact on the residents within the facility. Findings include: On 10/29/2024 between 8:45 AM and 12:00 PM, it was revealed by a review of available documentation that at the time of the survey the facility could not provide documentation showing that their kitchen hood had been inspected twice within the last 12 months. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 324	On 11/1/2024 Director of Environmental Services contacted Summit and received copy of completed inspection of hood on 6/7/2024. Call placed to Summit to schedule for the next semi annual inspection which will be held in December 2024. Director of Environmental Services and the Administrator will sign off on inspection audit form/calendar 2 times yearly when completed.	
K 345 SS=F	Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101	K 345		12/31/24

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K 345	Continued From page 6 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 review of available documentation and staff interview, the facility failed to maintain the fire alarm system per NFPA 101 (2012 edition), Life Safety Code, section 9.6.1.3, and NFPA 72 (2010 edition), National Fire Alarm and Signaling Code, sections 14.2.1.2.2, and 14.6.2. These deficient findings could have a widespread impact on residents within the facility. Findings include: On 10/29/2024 between 8:45 AM and 12:00 PM, it was revealed by review of available documentation that seven devices and one pull station failed during the annual fire alarm inspection that took place on July 3, 2024 in the Wellness Center. At the time of the survey, there was no documentation showing that the devices and pull station were repaired. An interview with the Maintenance Director verified these deficient findings at the time of discovery.	K 345	On 11/15/2024 pull stations were replaced and tested. Testing failed. Summit came back on 11/18/2024 replaced a pull station, testing completed two times and passed. Hard drive also cleared. Will test pull stations monthly with fire drills to assure in working on condition.	
K 353 SS=F	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing	K 353		12/31/24

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K 353	Continued From page 7 Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on observation, review of available documentation, and staff interview, the facility failed to maintain the fire sprinkler system per NFPA 101 (2012 edition), Life Safety Code, section 9.7.5, and 9.7.8, and NFPA 25 (2011 edition), Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, sections 4.3, 5.2.1.1.2 (3) and (5). These deficient findings could have a widespread impact on residents within the facility. Findings include: 1. On 10/29/2024 between 8:45 AM and 12:00 PM, it was revealed by a review of available documentation that the facility did not have documentation for the quarterly inspections, the annual inspection, and the 5-year inspection.	K 353	After completion of Fire Marshal Survey, documents were located showing completion of the testing. Information was emailed to fire marshal. Going forward Director of Environmental Services will keep copy of completed documents in Fire Marshal Binder for inspection. Environmental Services Director will audit each quarter for one year to assure the system test was completed. Administrator will also sign off.	

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K 353	Continued From page 8 2. On 10/29/2024 between 8:45 AM and 12:00 PM, it was revealed by observation that the collar of the sidewall sprinkler in the Dietary Storage Closet was not properly installed and resting on the deflector plate of the sprinkler head. 3. On 10/29/2024 between 8:45 AM and 12:00 PM, it was revealed by observation that there were sprinklers heads in the laundry room that were covered in lint. An interview with the Maintenance Director verified these deficient findings at the time of discovery.	K 353		
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 a review of available documentation, the facility failed to maintain portable fire extinguishers per NFPA 101 (2012 edition), Life Safety Code, section 9.7.4.1, and NFPA 10 (2010 edition), Standard for Portable Fire Extinguishers, section 7.2.4.1. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 10/29/2024 between 8:45 AM and 12:00 PM, it was revealed by review of available	K 355	On 11/1/2024 Director of Environmental Services contacted Summit and received copy of the completed inspection of the fire extinguishers. Inspection was completed 12/11/23. Next inspection will be held in December of 2024. Information was emailed to fire marshal. Going forward Director of Environmental Services will keep copy of completed documents in Fire Marshal Binder for inspection. Annual sign off of inspection will be completed by the Director of Environmental Services and the	12/31/24

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	245465	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**10/29/2024**

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K 355	Continued From page 9 documentation that the facility did not have documentation showing that the annual fire extinguisher inspections took place in the facility. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 355	administrator.	
K 374 SS=E	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 facility failed to maintain smoke and fire barrier doors per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.7.8, and 8.5.4.1. These deficient findings could have a widespread impact on the residents within the facility. Findings include: On 10/29/2024 between 8:45 AM and 12:00 PM it was revealed by observation that the following	K 374	On 10/31/2024 Director of Environmental Services and assistance replaced smoker barrier and adjusted door closure timing. Director of Environmental Services will audit doors each month during fire drill and will sign off on inspection audit form/calendar each month. Administrator will review and sign off.	12/31/24

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K 374	Continued From page 10 smoke barrier doors did not close completely leaving a gap between the door leaves: 1. Smoke Barrier doors leading to the West Wing 2. Smoke Barrier doors leading to the South Wing 3. Smoke Barrier doors leading to the pool Outlook area An interview with the Maintenance Director verified these deficient findings at the time of discovery.	K 374		
K 700 SS=E	Operating Features - Other CFR(s): NFPA 101 Operating Features - Other List in the REMARKS section any LSC Section 18.7 and 19.7 Operating Features requirements that are not addressed by the provided K-tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included in Form CMS-2567. This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to maintain smoke and fire dampers per NFPA 101 (2012 edition), Life Safety Code, sections 19.7.6, and 4.6.12, and NFPA 105 (2010 edition), Standard for Smoke Door Assemblies and Other Opening Protectives, sections 6.5.11, and 6.5.12. This deficient finding could have a widespread impact on residents within the facility. Findings include: On 10/29/2024 between 8:45 AM and 12:00 PM, it was revealed by review of available documentation that there was not documentation	K 700	Documentation was found after Fire Marshal Survey completed. Information was forwarded to the fire marshal. Testing was completed on 7/17/2022. Next testing will need to be completed by July of 2026. The Director of Environmental Services and the Administrator will sign off on upon completion.	12/31/24

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K 700	Continued From page 11 available showing that the fire and smoke dampers had been tested within the last 4 years. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 700		
K 712 SS=F	Fire Drills CFR(s): NFPA 101 Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to conduct fire drills per NFPA 101 (2012 edition), Life Safety Code sections 19.7.1.6. These deficient findings could have a widespread impact on the residents within the facility. Findings include: On 10/29/2024 between 8:45 AM and 12:00 PM, it was revealed by a review of available documentation that at the time of the survey the facility could not provide documentation showing that a fire drill was conducted during the first shift and second shift of the 4th quarter of 2023, and	K 712	All monthly fire drills will be prescheduled each year to ensure all shifts and months are accounted for. The administrator will sign off on each month□s fire drill to ensure completion. Fire Drill policy was reviewed and updated to indicate that all drills will be varied throughout the quarter with a minimum of 90 minutes difference in times of drill. Maintenance Director will record all times of drills and review the administrator for one year. The administrator will sign off on audits being completed.	12/31/24

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K 712	Continued From page 12 the 3rd shift of the 1st quarter of 2024. An interview with the Maintenance Director verified these deficient findings at the time of discovery.	K 712		
K 761 SS=E	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: Based on observation and staff interview, the facility failed to maintain service counter fire doors per NFPA 101 (2012 edition), Life Safety Code, sections 19.7.6, 8.3.3.1, and 4.6.12, and NFPA 80 (2010 edition), Standard for Fire Doors and Other Opening Protectives, sections 5.2.14.1, and 5.2.14.3. These deficeint findings could have a patterned impact on residents within the facility. Findings include: On 10/29/2024 between 8:45 AM and 12:00 PM,	K 761	Viking Garage Door Company was here on 11/14/2024 to inspect door and will give quote for replacing and repairing non function door. In the mean the door will be locked shut and not used until working properly with completion of new device. Administrator and Director of Environmental Services will review quote and schedule for installation to happen at earliest appointment opening. Company feels it would be 4 to 6 weeks minimum.	12/31/24

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K 761	Continued From page 13 it was revealed by observation that the overhead rolling service counter fire door from the kitchen to the dining room, and the overhead rolling service counter fire door leading from the dish room to the dining room were not in proper working order and unable to close completely if activated. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 761		
K 914 SS=F	Electrical Systems - Maintenance and Testing CFR(s): NFPA 101 Electrical Systems - Maintenance and Testing Hospital-grade receptacles at patient bed locations and where deep sedation or general anesthesia is administered, are tested after initial installation, replacement or servicing. Additional testing is performed at intervals defined by documented performance data. Receptacles not listed as hospital-grade at these locations are tested at intervals not exceeding 12 months. Line isolation monitors (LIM), if installed, are tested at intervals of less than or equal to 1 month by actuating the LIM test switch per 6.3.2.6.3.6, which activates both visual and audible alarm. For LIM circuits with automated self-testing, this manual test is performed at intervals less than or equal to 12 months. LIM circuits are tested per 6.3.3.3.2 after any repair or renovation to the electric distribution system. Records are maintained of required tests and associated repairs or modifications, containing date, room or area tested, and results. 6.3.4 (NFPA 99) This REQUIREMENT is not met as evidenced by:	K 914		12/31/24

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K 914	Continued From page 14 Based on a review of available documentation and staff interview, the facility failed to conduct the electrical testing and maintenance per NFPA 99 Standards for Health Care Facilities 2012 edition, section 6.3.3.2 , 6.3.4.1.3, and 6.3.4.2.1.2. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 10/29/2024 between 8:45 AM and 12:00 PM, it was revealed by a review of available documentation that at the time of the survey the facility did not have documentation showing that electrical receptacle testing had taken place within the last 12 months. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 914	Inspection form was created to complete annual audit for electrical receptacles. Audit was completed on 11/13/2024 by the Environmental Services Director Assistance. The Environmenatl Services Director and the administrator will ensure completion by signing off on annual audit of electrical receptacles	