Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
February 6, 2024

Administrator
Regina Senior Living
1175 Nininger Road
Hastings, MN 55033

RE: CCN: 245254
Cycle Start Date: January 25, 2024

Dear Administrator:

On January 25, 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:

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

If substantial compliance has been achieved, certification of your facility in the Medicare and/or

Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

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

If substantial compliance with the regulations is not verified by April 25, 2024 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by July 25, 2024 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

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

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

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

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

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

Please note that the failure to complete the informal dispute resolution process will not delay the dates

specified for compliance or the imposition of remedies.

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

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

Feel free to contact me if you have questions.

Sincerely,

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245254	A. BUILDING ______ B. WING ______	C 01/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGINA SENIOR LIVING	**1175 NININGER ROAD** **HASTINGS, MN 55033**

(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 1/22/24 through 1/25/24, 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 1/22/24 through 1/25/24 , a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was not compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. In addition to the recertification survey, the following complaints were reviewed with no deficiencies issued: H52548931C (MN88334) H52548932C (MN93729) H52548937C (MN96333) HS0598936C (MN96347) H52548934C (MN96409) H52548935C (MN97611) 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	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — Electronically Signed
TITLE
(X6) DATE — 02/15/2024

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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F 000	Continued From page 1 be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.	F 000		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to monitor and maintain oxygen and nebulizer tubing and mask for 1 of 1 resident (R4) reviewed for respiratory care. Findings include: R4's annual Minimum Data Set (MDS), dated 11/7/23, indicated R4 was cognitively intact and required maximum assistance with toileting, personal hygiene, and lower body dressing and moderate assistance with bathing and upper body dressing. R4's Physician Orders indicated an order, dated 5/8/23, for oxygen at 2 liters per minute as needed to maintain oxygen saturation at or greater than 90%. The Physician Orders also	F 695	F695 This plan of correction constitutes the facility□s credible allegation of compliance. Preparation and/or execution of this plan does not constitute admission or agreement by the provider of the truths or facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed in accordance with federal and state law requirements. " Oxygen and Nebulizer Tubing for R4 was replaced and dated. Matrix order was reviewed and updated to reflect the dating and exchange of respiratory supplies. " All facility residents utilizing respiratory supplies had Matrix orders reviewed and updated to reflect the dating	3/1/24

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F 695	Continued From page 2 indicated an order, dated 1/6/24, for albuterol sulfate solution for nebulization, inhale twice a day. R4's electronic medical record (EMR), including Physician Orders, Medication Administration Record, Treatment Administration Record, and Care Plan, were reviewed and lacked interventions to change the oxygen tubing, nasal cannula, nebulizer tubing and nebulizer mask. During observation and interview on 1/22/24 at 6:34 p.m., R4's oxygen concentrator was on and the oxygen tubing and nasal cannula were laying on the floor near the oxygen concentrator. R4 stated he was recently on isolation for respiratory syncytial virus (RSV) and had been using oxygen throughout the day when he feels short of breath. R4's family member (FM)-A confirmed R4 had still been using his oxygen occasionally as needed. During observation and interview on 1/23/24 at 1:33 p.m., R4's oxygen tubing was on the floor and his nebulizer mask was attached to the nebulizer machine laying on a dresser. Both lacked a label or a date. R2 stated he has not used his oxygen today but did use it yesterday. During an interview on 1/24/24 at 1:10 p.m., licensed practical nurse (LPN)-A said the expectation was to change oxygen and nebulizer tubing weekly and that the task should show up in the treatment record. LPN-A stated R4 had been on isolation for RSV and was still using his oxygen occasionally. LPN-A confirmed documentation of changing R4's oxygen tubing and nebulizer mask and tubing was not in his treatment record.	F 695	and exchange of respiratory supplies. Undated supplies were exchanged. " Nursing staff received education regarding Cleaning of Oxygen Equipment and Cleaning of Nebulizer Equipment Policies; both of which include the dating and exchange of respiratory equipment. " Respiratory equipment audits will be completed 1 time per week for 4 weeks. Results of audits shall be reported at the facility Quality Council meeting with ongoing frequency and duration to be determined through analysis and review of results if substantial compliance is not met.	

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F 695	Continued From page 3 During an interview on 1/25/24 at 9:06 a.m., the director of nursing (DON) stated that the expectation would be for oxygen and nebulizer tubing to be changed weekly and for the task to be on the treatment record. A facility policy titled Cleaning of Oxygen Equipment, dated June 2017, indicated the oxygen nasal cannula and tubing should be replaced weekly and labeled with the date and clinician's initials. A facility policy titled Cleaning of Nebulizer Equipment, dated June 2017, indicated the nebulizer mask should be disconnected from the machine and rinsed out after each use and the tubing and mask should be replaced weekly.	F 695		
F 757 SS=D	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be	F 757		3/1/24

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F 757	Continued From page 4 reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to offer or attempt non-pharmacological interventions for pain prior to administering as needed (PRN) pain medications for 1 of 5 residents (R254) reviewed for unnecessary medications. Findings include: R254's Face Sheet, dated 1/25/24, indicated R254 was admitted to the facility on 1/8/24 with the following diagnoses; malignant neoplasm of pharynx and hypopharynx (throat cancer), secondary neoplasm of the right and left lung (lung cancer), throat pain and unspecified pain. R254's Physician Order Report, dated 1/25/24 indicated an order for hydromorphone (an opioid used to treat moderate to severe pain) 2 milligram (mg) tablet, give 1 tablet by mouth every 6 hours scheduled and every 4 hours PRN. R254's pain assessment, dated 1/13/23, listed not applicable ("NA") for non-pharmacololgical pain interventions under the symptom managment interventions section. R254's initial care plan was reviewed and lacked interventions to address R254's pain, including medication and non-pharmacological interventions.	F 757	F757 " Matrix orders and care plan for R254 updated to reflect nonpharmacological interventions of resident□s preference, to be offered prior to PRN pain medication administration. " All facility residents with orders for PRN pain medication reviewed to reflect nonpharmacological interventions of resident□s preference to be offered prior to pain medication administration. Care plans updated accordingly. " Nursing staff received education regarding Pain Management Policy; including the use of nonpharmacological interventions prior to PRN pain medication administration. " Nonpharmacological Intervention audits will be completed 1 time per week for 4 weeks. Results of audits shall be reported at the facility Quality Council meeting with ongoing frequency and duration to be determined through analysis and review of results if substantial compliance is not met.	

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F 757	Continued From page 5 R254's Medication and Treatment Record, dated 1/1/24 - 1/25/24, indicated R254 received PRN hydromorphone on 1/8/24, 1/9/24, 1/22/24 x 2, 1/24/24 x 2, and 1/25/24. The record lacked any indication non-pharmacological interventions were attempted prior, or in conjunction with, the hydromorphone use. R254's progress notes were reviewed and lacked any indication of non-pharmacological pain interventions being offered or used prior to, or in conjunction with, hydromorphone use. During an interview on 1/22/24 at 6:58 p.m., R254 stated he was often in pain but had not tried or been offered any pain interventions other than his hydromorphone. During an interview on 1/24/24 at 1:10 p.m., licensed practical nurse (LPN)-A stated staff were expected to offer interventions such as an ice pack or repositioning when a resident had pain and if a non-pharmacological pain intervention was offered or used it would be documented in a progress note. During an interview on 1/24/24 at 11:53 a.m., nurse manager, LPN-B, stated non-pharmacological pain interventions should be individualized to each resident and should be documented in the Medication and Treatment Record or a progress note. A facility policy titled Pain Management, reviewed 9/7/23, indicated the interdisciplinary team would implement individualized interventions to promote comfort.	F 757		
F 880 SS=D	Infection Prevention & Control	F 880		3/1/24

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F 880	Continued From page 6	F 880		

CFR(s): 483.80(a)(1)(2)(4)(e)(f)

§483.80 Infection Control
The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.

§483.80(a) Infection prevention and control program.
The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:

§483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;

§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:
(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;
(ii) When and to whom possible incidents of communicable disease or infections should be reported;
(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;
(iv)When and how isolation should be used for a

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F 880	Continued From page 7 resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to prevent the potential for and increased risk of a urinary tract infection by placing catheter bag on the floor for 1 of 1 residents (R3) reviewed for catheter care. Findings include: R3's Minimum Data Set (MDS) indicated R3 had moderate cognitive impairment and did not have	F 880	F880 " Catheter bag for R3 was removed from the floor at time of observation during the survey period. Dignity bag placed over catheter bag for additional barrier. Care plan updated. " All facility residents with indwelling catheters had dignity bags placed as an additional barrier. Care plans updated to include the use of dignity bags. " Nursing staff received education	

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F 880 Continued From page 8

behaviors. The MDS also indicated R3 needed partial assistance with oral hygiene and eating; substantial assistance with personal hygiene, bathing, upper body dressing and mobility and was dependent with toileting and lower body dressing.

R3's Face Sheet dated 1/25/24, indicated R3 had diagnoses of Parkinson's disease with dyskinesia, polyosteoarthritis(condition characterized by joint pain and stiffness) , flaccid neuropathic bladder (condition that leads to urinary retention or the inability to fully empty the bladder), urinary retention (difficulty urinating and completely emptying the bladder) , inflammatory polyarthropathy (pain and inflammation in more than 5 joints) and pulmonary hypertension (a type of blood pressure that affects arteries in the lungs and in the heart) due to left heart disease.

R3's undated orders form indicated R3 required a 16 french indwelling catheter with a 10 cubic centimeter (cc) balloon, monitor urine outputs, catheter cares every shift, change catheter bag every two weeks, and change the catheter every six weeks.

R3's urinary catheter care plan dated 11/8/23, indicated, R3 had a catheter to manage a flaccid neuropathic bladder, malignant neoplasm (cancer) of the posterior wall of the bladder with potential for infection related to inability to void, overflow incontinence and inability to void without urinary catheter.

During observation and interview on 1/23/24 at 1:52 p.m., R3's catheter bag was uncovered lying on the floor and the catheter's drainage tube was in contact with the floor. R3 stated sometimes the

F 880

regarding Standard Infection Control Practices and Policies.
" Infection Control audit in regards to catheter care will be completed 1 time per week for 4 weeks. Results of audits shall be reported at the facility Quality Council meeting with ongoing frequency and duration to be determined through analysis and review of results if substantial compliance is not met.

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F 880	Continued From page 9 staff hangs the bag on the recliner chair, and added "but mostly they [staff] leave the bag on the floor." During interview on 1/23/24 at 12:28 p.m., nursing assistant (NA)-A verified the catheter bag was on the floor, and stated the bag should not be left on the floor due to infection control issues. NA-A stated the drainage bag usually is inside the privacy bag and hung on the trash can, located next R3's recliner chair. During interview on 1/24/24 at 12:14 p.m., licensed practical nurse (LPN)-A stated the catheter bag should be on a privacy bag and should never touch the floor. LPN-A stated, "having it on the floor is not okay due to infection control issues." During interview on 1/25/24 at 9:59 a.m., the director of nursing (DON) stated the catheter should be kept high enough to drain per gravity and should be kept off the floor due to the potential risk for infections. Facility's policy titled Prevention of Catheter-Associated Urinary Tract Infections dated 2017 indicated, infections associated with catheters "can result in a decline in resident function and mobility, acute acre hospitalizations, and increased mortality. Prevention is key."	F 880		
F 883 SS=D	Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2) §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that-	F 883		3/1/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245254	A. BUILDING ______ B. WING ______	C **01/25/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGINA SENIOR LIVING	**1175 NININGER ROAD** **HASTINGS, MN 55033**

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F 883	Continued From page 10 (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. §483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes	F 883		

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F 883	Continued From page 11 documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure 2 of the 5 residents (R2 and R29) reviewed for immunizations were offered and/or provided the pneumococcal vaccination series as recommended by the Centers for Disease Control (CDC) to help reduce the risk of associated infection(s). Findings include: A CDC Pneumococcal Vaccine Timing for Adults feature, dated 3/15/2023, identified various tables when each (or all) of the pneumococcal vaccinations should be obtained. This identified when an adult over 65 years old had received the complete series (i.e., PPSV23 and PCV13; see below) then the patient and provider may choose to administer Pneumococcal 20-valent Conjugate Vaccine (PCV20) for patients who had received Pneumococcal 13-valent Conjugate Vaccine (PCV13) at any age and Pneumococcal Polysaccharide Vaccine 23 (PPSV23) at or after 65 years old. R2's facility immunization record, dated 01/24/24, indicated she was 86 years old. The record indicated she received a PCV13 on 6/15/2008	F 883	F883 " R2 and R29 were offered the pneumococcal vaccination series as recommended by the CDC. " All facility residents were reviewed for eligibility to receive the pneumococcal vaccination series. Qualifying residents were offered the pneumococcal vaccination series as recommended by the CDC. " Facility Infection Preventionist received education regarding Pneumococcal Policy and CDC Pneumococcal Vaccination Series Guidance. " Pneumococcal Vaccination audits will be completed 1 time per week for 4 weeks. Results of audits shall be reported at the facility Quality Council meeting with ongoing frequency and duration to be determined through analysis and review of results if substantial compliance is not met.	

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F 883	Continued From page 12	F 883		

followed by PPSV23 on 4/10/2017. The record lacked documentation of shared clinical decision making with the provider for PCV20 at least 5 years after the last pneumococcal dose. The record lacked documentation R2 was offered or received PCV20.

R29's facility immunization record, dated 01/24/24, indicated he was 79 years old. The record indicated he received a PPSV23 on 3/16/2009 followed by the PCV13 on 4/27/2015. The record lacked documentation of shared clinical decision making with the provider for PCV20 at least 5 years after the last pneumococcal dose. The record lacked documentation R29 was offered or received PCV20.

During an interview with infection preventionist (IP), on 1/25/24 at 8:14 a.m., IP stated she is using the current CDC recommendations from March 2023. IP verified R2 and R29's pneumococcal immunizations as listed above. IP verified they had not been offered PCV20 or PCV15.

During an interview with director of nursing (DON), on 1/25/24 at 10:05 a.m., DON indicated that it was a collaboration to ensure residents are up to date on immunizations. DON indicated that she verifies immunizations upon admission through MIIC (Minnesota Immunization Information Connection), their electronic health record system and will ask residents/families for history. DON stated, immunizations are given upon admission as needed. DON indicated she uses the current Centers for Disease Control and Prevention (CDC) recommendations for immunization guidelines.

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F 883	Continued From page 13 Copies of vaccination records for R2 and R29 were requested of the facility but never received. A facility policy titled "Pneumococcal Vaccines for Residents" with a review date of 9/23 was provided. Policy indicated: "it is the policy of BHS communities to provide education and administration of the PPSV23 and PCV13 to the residents of the facility according to CDC recommendations." CDC now recommends pneumococcal conjugate vaccine PCV15 or PVC20 for adults who have never received a prior pneumococcal conjugate vaccine PCV13 if they are 65 years or older and have certain chronic medical conditions or other risk factors. For adults who have only received PCV13 but not PPSV23, CDC recommends vaccine providers give PPSV23 as previously recommended. One reference indicated is CDC updated guidance - MMWR 1/28/22.	F 883		

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	245254	A. BUILDING **01 - NURSING HOME** B. WING ______	**01/23/2024**

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REGINA SENIOR LIVING	**1175 NININGER ROAD** **HASTINGS, MN 55033**

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K 000	INITIAL COMMENTS	K 000		

FIRE SAFETY

An annual Life Safety Code survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 01/23/2024. At the time of this survey, REGINA SENIOR LIVING 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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed | TITLE | (X6) DATE: 02/15/2024

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	K 000		

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.

REGINA SENIOR LIVING is a 1 story building with full basement.

The original building was constructed at 2 different times. The original building, 1 story with basement, was constructed in 1965 and was determined to be of Type II (111) construction. In 2012, a 1 story addition (TCU) was constructed

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K 000	Continued From page 2 and was determined to be of Type II (111) construction. Because the original building and addition are of the same type of construction allowed for existing buildings, the facility was surveyed as one building, Type III (111). The facility is fully protected throughout by an automatic sprinkler system and has a fire alarm system with smoke detection in corridors and spaces open to the corridors that is monitored for automatic fire department notification. The facility has a capacity of 57 beds and had a census of 56 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidence by:	K 000		
K 353 SS=F	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked ______ b) Who provided system test ______ c) Water system supply source ______	K 353		1/30/24

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K 353	Continued From page 3 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, and staff interview the facility failed to inspect and maintain the sprinkler system in accordance with NFPA 101 (2012 edition), Life Safety Code, sections 4.6.12, 9.7.5, 9.7.6, NFPA 25 (2011 edition) Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, section(s), 4.1.1, 4.4, 5.2, NFPA 13 (2010 edition), Standard for the Installation of Sprinkler Systems, section(s), 7.7.1.4, 8.5.6. These deficient findings could have a widespread impact on the residents within the facility. Findings include: 1. On 01/23/2024 between 10:30 AM and 4:30 PM, it was revealed by observation in the Basement Corridor between the I.T. Closet and the Mechanical Shop that I.T. cabling was positioned to obstruct the spray pattern of sprinkler head(s). 2. On 01/23/2024 between 10:30 AM and 4:30 PM, it was revealed by observation in the Basement - Mechanical Room that cabling was zip-tied to the sprinkler system. 3. On 01/23/2024 between 10:30 AM and 4:30 PM, it was revealed by observation on the Mian Floor - Supplies Storage Closet, across from RM 112, that vertical storage of items was closer than 18 inches to the sprinkler head(s).	K 353	K353: Sprinkler System Maintenance and Testing 1. Detailed description of the corrective action taken or planned to correct the deficiency. a. The IT cabling that was obstructing the spray pattern of the sprinkler heads has been re-secured to the hard deck. b. The cabling found to be zip-tied to the sprinkler line has been removed from the sprinkler line and re-attached to the appropriate location. c. The top shelf in the Main Floor Supplies Storage closet has been removed to prevent supplies from being placed within 18 inches of the ceiling. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. a. Sprinkler lines will be inspected monthly to ensure nothing is obstructing the spray patterns of any sprinkler heads. b. Sprinkler lines will be inspected monthly to ensure nothing is attached to the sprinkler lines. c. Storage rooms will be inspected monthly to ensure supplies are not being placed within 18 inches of the ceilings. 3. Indicate how the facility plans to monitor future performance to ensure	

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K 353	Continued From page 4 An interview with the Maintenance Director verified these deficient findings at the time of discovery.	K 353	solutions are sustained. a. Monthly inspections of sprinkler lines and storage rooms have been added to facility□s TELS system which is an automated work order/maintenance tracking system. 4. Identify who is responsible for the corrective actions and monitoring of compliance. Scott Peplinski, EVS Director 5. The actual or proposed dated for completion of the remedy. January 30th, 2024	
K 372 SS=F	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain and inspect smoke / fire dampers per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.7, 8.5.5, NFPA 105 (2010	K 372	K372: Subdivision of Building Spaces □ Smoke Barrier Construction 1. Detailed description of the corrective	2/28/24

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K 372	Continued From page 5 edition), Standard for Smoke Door Assemblies and Other Opening Protectives, section 6.5, 6.6. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 01/23/2024 between 10:30 AM and 4:30 PM, it was revealed by observation that in the Basement - "No Name Room" adjacent to the Elevator, that a fire / smoke damper close to the floor exhibited signs of fluid / water exposure from above. The assembly had either oxidation / corrosion, bring into question whether the damper was operational. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 372	action taken or planned to correct the deficiency. a. EVS Director has contacted an electrician to test the smoke damper identified and ensure it is fully functional and operating properly. Tech One is going to inspect and verify damper works with fire suppression system. Any necessary adjustments or repairs will be made. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. a. Semi-annual inspections of dampers to ensure functioning properly 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. a. Damper has been added to TELS for inspection every 6 months. 4. Identify who is responsible for the corrective actions and monitoring of compliance. Scott Peplinski, EVS Director 5. The actual or proposed dated for completion of the remedy. February 28, 2024	
K 374 SS=F	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Doors 2012 EXISTING	K 374		3/10/24

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K 374	Continued From page 6 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 the smoke 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: 1. On 01/23/2024 between 10:30 AM and 4:30 PM, it was revealed by observation in the Basement adjacent to the I.T. Closet that the fire / smoke barrier doors did not self-close and seal the opening upon test. 2. On 01/23/2024 between 10:30 AM and 4:30 PM, it was revealed by observation in the Basement - PT / OT area that the smoke barrier door exhibited a vertical door-to-door gap greater than 1/8 inch. An interview with the Maintenance Director verified these deficient findings at the time of discovery.	K 374	K374: Subdivision of Building Spaces Smoke Barrier Doors 1. Detailed description of the corrective action taken or planned to correct the deficiency. a. Smoke barrier doors by the basement IT closet are planned to be either repaired or replaced. Quotes have been requested and Fire Marshal will be notified once doors are fully operational. b. Smoke barrier doors by the Therapy Department have been repaired to correct the vertical gap and ensure it is no larger than 1/8 inch. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. a. Monthly inspections of smoke barrier doors in basement and quarterly inspections of all smoke barrier doors to ensure functioning properly and have the	

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K 374	Continued From page 7	K 374	appropriately sized vertical gap. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. a. Smoke barrier doors have been added to the TELS system for routine inspections. 4. Identify who is responsible for the corrective actions and monitoring of compliance. Scott Peplinski, EVS Director 5. The actual or proposed dated for completion of the remedy. March 10, 2024	
K 741 SS=C	Smoking Regulations CFR(s): NFPA 101 Smoking Regulations Smoking regulations shall be adopted and shall include not less than the following provisions: (1) Smoking shall be prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area shall be posted with signs that read NO SMOKING or shall be posted with the international symbol for no smoking. (2) In health care occupancies where smoking is prohibited and signs are prominently placed at all major entrances, secondary signs with language that prohibits smoking shall not be required. (3) Smoking by patients classified as not	K 741		2/12/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245254	A. BUILDING **01 - NURSING HOME** B. WING ____________	01/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGINA SENIOR LIVING	**1175 NININGER ROAD** **HASTINGS, MN 55033**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 741	Continued From page 8 responsible shall be prohibited. (4) The requirement of 18.7.4(3) shall not apply where the patient is under direct supervision. (5) Ashtrays of noncombustible material and safe design shall be provided in all areas where smoking is permitted. (6) Metal containers with self-closing cover devices into which ashtrays can be emptied shall be readily available to all areas where smoking is permitted. 18.7.4, 19.7.4 This REQUIREMENT is not met as evidenced by: Based on review of available documentation and staff interview, the facility failed to implement and maintain proper documentation associated to facility smoking regulations per NFPA 101 (2012 edition), Life Safety Code , section 19.7.4. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 01/23/2024 between 10:30 AM and 4:30 PM, it was revealed by review of available documentation that the facility smoking policy did not identify location(s) where staff and/or clients are allowed to smoke. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 741	K741: Smoking Regulations 1. Detailed description of the corrective action taken or planned to correct the deficiency. a. The facility smoking policy has been updated to clearly indicate the location of the designated smoking area on campus. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. a. Policy has been added to the list of policies to be reviewed annually at the facility level. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. a. Review the Smoking Policy annually and make any required updates.	

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	245254	A. BUILDING **01 - NURSING HOME** B. WING ______	**01/23/2024**

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K 741	Continued From page 9	K 741	4. Identify who is responsible for the corrective actions and monitoring of compliance. Scott Peplinski, EVS Director 5. The actual or proposed dated for completion of the remedy. February 12, 2024	
K 761 SS=F	Maintenance, Inspection & Testing - Doors CFR(s): NFPA 101 Maintenance, Inspection & Testing - Doors Fire doors assemblies are inspected and tested annually in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives. Non-rated doors, including corridor doors to patient rooms and smoke barrier doors, are routinely inspected as part of the facility maintenance program. Individuals performing the door inspections and testing possess knowledge, training or experience that demonstrates ability. Written records of inspection and testing are maintained and are available for review. 19.7.6, 8.3.3.1 (LSC) 5.2, 5.2.3 (2010 NFPA 80) This REQUIREMENT is not met as evidenced by: Based on document review and staff interview the facility failed accurately document the inspection and test doors per NFPA 101 (2012 edition), Life Safety Code, sections 7.2.1.15, and NFPA 80 (2010 edition), sections 5.2.1. This deficient condition could have a widespread impact on the residents within the facility.	K 761	K761: Maintenance, Inspection & Testing Doors 1. Detailed description of the corrective action taken or planned to correct the deficiency. a. Inspection of all doors will be	2/28/24

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K 761	Continued From page 10 Findings include: On 01/23/2024 between 10:30 AM and 4:30 PM, it was revealed by review of available documentation that door inspection forms were found to be missing content, findings, and identification of staff completing the inspection and testing of doors. An interview with Maintenance Director verified this deficient finding at the time of discovery.	K 761	completed and required documentation prepared. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. a. EVS Director will review completed annual inspection forms and ensure they have been done both accurately and completed in their entirety prior to filing in the Life Safety Binder. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. a. Task has been added to TELS system for reminders and tracking completion. 4. Identify who is responsible for the corrective actions and monitoring of compliance. Scott Peplinski, EVS Director 5. The actual or proposed dated for completion of the remedy. February 28, 2024	
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,	K 914		2/5/24

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	245254	A. BUILDING **01 - NURSING HOME** B. WING ______	01/23/2024

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K 914	Continued From page 11 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: Based on a review of available documentation and staff interview, the facility failed to accurately document electrical receptacle testing in resident rooms per NFPA 99 (2012 edition), Health Care Facilities Code, section(s) 6.3.3.2, 6.3.4, 6.3.4.1.3, 6.3.4.2. These deficient findings could have a widespread impact on the residents within the facility. Findings include: On 01/23/2024 between 10:30 AM and 4:30 PM, it was revealed by a review of available documentation that the documentation presented for review was incomplete in it capture of information related to who completed the outlet testing in resident / client rooms. An interview with the Maintenance Director verified	K 914	K914: Electrical Systems Maintenance and Testing 1. Detailed description of the corrective action taken or planned to correct the deficiency. a. Form used for documenting electrical receptacle testing in resident rooms has been revised and missing information completed in full. Items added are the individual who completed the testing. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. a. EVS Director will review completed receptable testing forms and ensure they	

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	245254	A. BUILDING **01 - NURSING HOME** B. WING	**01/23/2024**

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K 914	Continued From page 12 this deficient finding at the time of discovery.	K 914	have been done both accurately and completed in their entirety prior to filing in the Life Safety Binder. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. a. Electrical receptable testing is in TELS system to ensure tracking and monitoring for proper completion. 4. Identify who is responsible for the corrective actions and monitoring of compliance. Scott Peplinski, EVS Director 5. The actual or proposed dated for completion of the remedy. February 5, 2024	
K 920 SS=F	Electrical Equipment - Power Cords and Extens CFR(s): NFPA 101 Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL	K 920		2/9/24

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K 920	Continued From page 13 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to manage usage electrical devices in accordance with NFPA 99 (2012 edition), Health Care Facilities Code, section 10.2.3.6, 10.2.4, 10.5.2.3 and NFPA 70, (2011 edition), National Electrical Code, sections 110.3(B), 400.8 (1) and UL 1363. These deficient findings could have an isolated impact on the residents within the facility. Findings include: 1. On 01/23/2024 between 10:30 AM and 4:30 PM, it was revealed by observation in the following locations in the facility that appliances were found connected to relocatable power strips: Basement - PT / OT Office; Main Floor - D.O.N. Office; Clinical Manager Office. 2. On 01/23/2024 between 10:30 AM and 4:30 PM, it was revealed by observation that on the Main Floor - D.O.N. Office that relocatable power strips were daisy-chained An interview with the Maintenance Director verified these deficient findings at the time of discovery.	K 920	K920: Electrical Equipment Power Cords and Extension Cords 1. Detailed description of the corrective action taken or planned to correct the deficiency. a. All appliances noted to be plugged into removable power strips are now plugged into dedicated circuits. Power strips that were daisy chained have been disconnected and all non-compliant power strips have been removed. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. a. All non-direct care offices/areas will be inspected on a quarterly basis to ensure compliance. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained.	

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K 920	Continued From page 14	K 920	a. Quarterly inspections have been set up in TELS system for tracking and monitoring for completion. 4. Identify who is responsible for the corrective actions and monitoring of compliance. Scott Peplinski, EVS Director 5. The actual or proposed dated for completion of the remedy. February 9, 2024	
K 923 SS=F	Gas Equipment - Cylinder and Container Storag CFR(s): NFPA 101 Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited-combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be	K 923		2/28/24

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K 923	Continued From page 15 stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain proper medical gas storage and management per NFPA 99 (2012 edition), Health Care Facilities Code, sections 9.3.7, 9.3.7.5.3, 11.6.5, NFPA 55 (2010 edition), Compressed Gases and Cryogenic Fluid Code, section(s) 6.15. These deficient findings could have a widespread impact on the residents within the facility. Findings include: 1. On 01/23/2024 between 10:30 AM and 4:30 PM, it was revealed by observation in the Med Gas (O2) Storage Room that there was mixed storage of cylinders. 2. On 01/23/2024 between 10:30 AM and 4:30 PM, it was revealed by observation in the Med Gas (O2) Storage Room, used for transfill, that it	K 923	K923: Gas Equipment Cylinder and Container Storage 1. Detailed description of the corrective action taken or planned to correct the deficiency. a. Cylinders were separated and secured. Oxygen vendors were contacted to remove all empty cylinders same day this was identified as a problem. b. Rooftop exhaust inspected and motor to be replaced. Quarterly inspection completed. c. The mechanical lock on the door to the Med Gas Storage room has been adjusted so the locking bypass function is disabled and staff are no longer able to utilize the bypass option.	

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K 923	Continued From page 16 could not be confirmed that proper mechanical ventilation was operational. 3. On 01/23/2024 between 10:30 AM and 4:30 PM, it was revealed by observation that Med Gas (O2) Storage Room was found to be unsecured. An interview with the Maintenance Director verified these deficient findings at the time of discovery.	K 923	2. Address the measures that will be put in place to ensure the deficiency does not reoccur. a. Inspections of the Med Gas storage room have been implemented on a weekly basis to ensure proper storage of cylinders, the room is locked properly and the mechanical ventilation is functioning properly. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. a. Weekly inspections have been set up in TELS system for tracking and monitoring for completion. 4. Identify who is responsible for the corrective actions and monitoring of compliance. Scott Peplinski, EVS Director 5. The actual or proposed dated for completion of the remedy. February 28, 2024	

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
April 1, 2024

Administrator
Regina Senior Living
1175 Nininger Road
Hastings, MN 55033

RE: CCN: 245254
Cycle Start Date: January 25, 2024

Dear Administrator:

On March 6, 2024, the Minnesota Department(s) 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
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