Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
September 4, 2024

Administrator
Tuff Memorial Home
505 East 4th Street
Hills, MN 56138

RE: CCN: 245548
Cycle Start Date: July 30, 2024

Dear Administrator:

On August 26, 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.

Sincerely,

Kamala Fiske-Downing

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

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
August 13, 2024

Administrator
Tuff Memorial Home
505 East 4th Street
Hills, MN 56138

RE: CCN: 245548
Cycle Start Date: July 30, 2024

Dear Administrator:

On July 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 a pattern of deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level E), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

ELECTRONIC PLAN OF CORRECTION (ePoC)

Within **ten (10) calendar days** after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved.

To be acceptable, a provider's ePOC must include the following:

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.
- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

The state agency may, in lieu of an onsite revisit, determine correction and compliance by accepting the facility's ePoC if the ePoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

If an acceptable ePoC is not received within 10 calendar days from the receipt of this letter, we will recommend to the CMS Region V Office that one or more of the following remedies be imposed:

- Denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417);
- Civil money penalty (42 CFR 488.430 through 488.444).
- Termination of your facility's Medicare and/or Medicaid agreement (488.456(b)).

DEPARTMENT CONTACT

Questions regarding this letter and all documents submitted as a response to the resident care deficiencies (those preceded by an "F"and/or an "E" tag), i.e., the plan of correction should be directed to:

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

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

If substantial compliance with the regulations is not verified by October 30, 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 January 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) / 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
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,

Kamala Fiske-Downing
Federal Enforcement | Health Regulation Division
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
	245548	A. BUILDING _____ B. WING _____	C 07/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TUFF MEMORIAL HOME	505 EAST 4TH STREET HILLS, MN 56138

(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 7/28/24 through 7/30/24, 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 7/28/24 through 7/30/24, a standard recertification survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with requirements of 42 CFR Part 483, Subpart B, Requirements for Long Term Care Facilities. Your facility was NOT in compliance. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulations has been attained.	F 000		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments.	F 641		8/19/24

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

Electronically Signed | 08/17/2024

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 641	Continued From page 1 The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure resident status was accurately identified in the Minimum Data Set (MDS) assessment for 1 of 1 resident (R32) reviewed for prosthetics. Findings include: R32's, Face sheet identified he had a diagnoses of Transient Ischemic Attack (stroke), absence of left leg below knee amputation, anxiety and depression. R32's, 5/14/24 Significant change Minimum Data Set (MDS) identified R32 was cognitively intact, had used substantial/maximal assistance with activities of daily living and was dependent with mobility and transfers. R32's MDS, section GG, did not identify R32 had a left leg below the knee prosthetic. R32's, undated, current care plan identified he had a self-care performance deficit related to his left leg below knee amputation. The goal was for R32 to maintain current level of function. Interventions were for staff to apply the left leg stump shrinker sleeve and prosthetic to his left lower extremity for transfers, standing and/or pivoting with his hemi-walker, and to remove the left leg prosthetic when R32's request. Observation and interview on 7/28/24 at 6:56 p.m., identified R32 had a left leg prosthetic along with his left stump shrinker sleeve stored next to his recliner. He stated he had received his first	F 641	F641 It was identified that Resident R32 did not have limb prosthesis correctly coded in section GG0120 on his significant change MDS dated 5/14/2024. Modification MDS was created for significant change assessment 5/14/2024 for resident R32. Correction completed by checking limb prosthesis in Section GG0120. Modification MDS for 5/14/2024 submitted and accepted into iQIES on 7/30/2024. The MDS policy has been updated to state the process to modify or correct the resident’s assessment when an error or correction is needed to identify accurate coding of all MDS assessments. MDS coordinator uses a checklist for sections of the MDS on each assessment for every resident. On 7/30/2024, the MDS checklist was updated with listing of mobility devices asked in section GG0120: cane/crutch, walker, wheelchair, limb prosthesis, none of the above. MDS coordinator will complete the checklist with every resident’s assessment that is due per resident’s OBRA, PPS schedule, or change in status assessment. The MDS coordinator will use the checklist when completing Section GG on the MDS on each assessment for every resident to ensure accurate coding of mobility devices for all residents. MDS coordinator reviewed R25, R5, and	

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F 641	Continued From page 2 below the knee prosthetic approximately 2 years ago from Sioux Falls Orthopedic Institute and had recently received a newer left leg prosthetic that would assist him with ambulation and transfers. Interview on 7/30/24 at 10:58 a.m., with registered nurse (RN)-A stated she did not code R32's prosthetic accurately on his current MDS. She stated she would make a modification on R32's MDS. Interview on 07/30/24 03:53 p.m., with director of nursing (DON) would expect accurate coding on the MDS and plan to implement a verification process to prevent MDS errors from reoccurring. Review of 7/29/24, MDS policy identified MDS would be completed within the time frame guidelines and would refer to RAI (Resident assessment instrument) manual for updates. The policy lacked direction on how to correct and/or identify changes to the MDS when an error would occur.	F 641	R21 for accurate coding of mobility devices in section GG of their most recent MDS assessment. Accurate coding was noted. The MDS Coordinator and DON have reviewed section GG and the need to code mobility devices accurately. MDS coordinator was re-educated to code 8/13/2024 mobility devices in section GG accurately for every resident's assessment. The DON will monitor MDS coordinator for correct and accurate coding of mobility devices in Section GG 1x/week for 12 weeks.	
F 881 SS=D	Antibiotic Stewardship Program CFR(s): 483.80(a)(3) §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)(3) An antibiotic stewardship program that includes antibiotic use protocols and a system to monitor antibiotic use. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the	F 881	F881	8/19/24

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F 881	Continued From page 3 facility failed to develop an antibiotic stewardship program which included development of protocols and a system to monitor antibiotic use, to ensure appropriate antibiotics were utilized to prevent antibiotic resistance for 1 of 5 resident (R12) who had an order for an antibiotic with no end date. Findings include: R12's 6/4/24, Significant Change Minimum Data Set (MDS) assessment identified her cognition was intact, she used a walker for mobility, and was independent with activities of daily living (ADL's). Review of R12's current diagnosis list identified a diagnosis of chronic cystitis without hematuria (inflammation of the bladder that can predispose patient to bladder infections). R12's current medication administration record identified she has been taking cephalexin (antibiotic) 250 milligrams (mg) daily for a diagnosis of chronic cystitis starting upon admission in January of 2024. Review of R12's current care plan identified she was on antibiotic therapy related to chronic bladder infections. Staff were to monitor adverse reactions or signs and symptoms of secondary infections related to antibiotic therapy. The care plan made no mention that staff should monitor for effectiveness, or review to ensure the long-term antibiotic therapy remained appropriate. There was no documentation to support other methods of prevention, such as cranberry juice or diet changes had been attempted, nor that it was being overseen by a specialist or medical provider routinely.	F 881	It was identified that the facility failed to develop an antibiotic stewardship program which included the development of protocols and a system to monitor antibiotic use, to ensure appropriate antibiotics were utilized to prevent antibiotic resistance for R12 she had an order for an antibiotic with no end date. The Antibiotic Stewardship Program policy was reviewed and implemented on 8/13/2024. The Noting Orders checklist (that all nurses use) was updated for all antibiotics to have side effects checked for the duration of medication. All long-term antibiotics are placed in the doctor's rounds book for evaluation. Also, a 72-hour time-out check is done to ensure they are on the correct antibiotic. Antibiotics are documented daily for effectiveness and side effects of antibiotics. All antibiotics will have the dose, duration, and indication for use. At the end of antibiotic treatment, the nurse will assess that the goal was met. Corrected on 8/13/2024 The admission checklist was updated for all antibiotic orders to indicate the dose, duration, and reason for being on the medication at the time of admission. This will insure that all new residents coming in will be checked so this will not happene again. Corrected on 8/13/2024 All antibiotics will be tracked to resolution on all QAPI meetings and talked about	

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F 881	Continued From page 4 Review of the June 2024 Quality Assurance and Performance Improvement (QAPI) minutes identified that 2 residents R6 and R15 had received antibiotic therapy, the minutes included the type of antibiotic, duration, and the indication for use. The minutes made no mention of R12's use of chronic antibiotics. Review of the facilities infection surveillance monthly report identified they had been tracking infections and antibiotic use in the facility; however, the report did not include any tracking for R12's use of a prophylactic antibiotic cephalexin oral capsule 250 mg daily for a diagnosis of chronic cystitis without hematuria (bladder infection). Interview on 7/30/24, at 10:02 a.m., with the infection preventionist (IP) identified R12 had an order for antibiotics in place when she was admitted to the facility in January of 2024. The order did not include an end date, and she had not followed up to obtain one. She thought the order came from a previous doctor but was not certain and did not have a copy of the original order. They had no documentation that the antibiotic had been monitored for effectiveness, had not completed a time out, and had not followed up with the primary physician to see if the medication should be reviewed by a urologist to ensure it remained an appropriate treatment. She identified that they did not have an end date because it was used prophylactically to prevent infection. She had not included it in her monthly infection report or the QAPI facility antibiotic use report because although R12 is taking an antibiotic, she does not have an active infection. She identified that R12 has not had any	F 881	until they are off antibiotics. All Nurses were re-educated on what to put into the computer and how to track it. IP nurse was educated on keeping all antibiotics on QAPI until they were off. Antibiotics will be discussed with the doctor every 60 days, and Emma pharmacy consultant during her monthly med recs. Audits will be done monthly for 4 months started 8/8/2024 to ensure they are in the minutes of QAPI. The DON/IP will oversee this.	

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F 881	Continued From page 5 complaints of pain or discomfort and has had no recent infections. R12 is seen by her primary doctor every 60 days at the facility, however, she was unable to provide any documentation that the physician had reviewed the long term antibiotic or any documented rationale for the continued use of the antibiotic. R12's primary physician was not available for interview during the survey period. Review of the 11/14/23, Antibiotic Stewardship Program policy identified that all prescriptions for antibiotics shall specify the dose, duration, and indication for use. Staff will monitor the response to antibiotics, and laboratory results when available, and consult with the physician to determine if the antibiotic is still indicated or adjustments should be made. Antibiotics upon admission weather a new admission or a re-admission to the facility shall be reviewed for appropriateness. Antibiotic orders obtained from consulting, specialty, or emergency providers shall be reviewed for appropriateness.	F 881		

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	245548	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**07/29/2024**

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TUFF MEMORIAL HOME	**505 EAST 4TH STREET** **HILLS, MN 56138**

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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 07/29/2024. At the time of this survey, Tuff Memorial Home 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 | 08/19/2024

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	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.

Tuff Memorial Home was constructed as follows:
The original building was constructed in 1959, is one-story, has a partial basement, is fully fire sprinkler protected and is of Type II(111) construction;
The 1st Addition was constructed in 1962, is one-story, has no basement, is fully fire sprinkler protected and is of Type II(111) construction;
The 2nd Addition was constructed in 1975, is

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K 000	Continued From page 2 one-story, has no basement, is fully fire sprinkler protected and is of Type II(111) construction; The 3rd Addition was constructed in 1988, is one-story, has a full basement, is fully fire sprinkler protected and is of Type V(111) construction; The 4th Addition was constructed in 1998, is one-story, has no basement, is fully fire sprinkler protected and is of Type V(000) construction. The facility has a capacity of 48 beds and had a census of 36 at the time of the survey.	K 000		
K 291 SS=D	The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by: 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 observation or a review of available documentation and staff interview, the facility failed to maintain the emergency light above exit door 14 per NFPA 101 (2012 edition), Life Safety Code, sections 7.9 and 19.2.9.1. This deficient finding could have a isolated impact on the residents within the facility. Findings include: On 07/29/2024 at 11:15 AM, it was revealed by observation that the emergency light above the exit 14 door did not function when tested during the inspection.	K 291	K-291 Means of Egress Requirements 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 A facility wide inspection of all emergency exit lights is done every 30 days, including a 30 second monthly and 90 minutes yearly test. The deficient light above exit 14 door was found to have a weak battery	8/19/24

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	245548	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**07/29/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TUFF MEMORIAL HOME	**505 EAST 4TH STREET HILLS, MN 56138**

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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	and was immediately replaced. All other emergency exit lights were rechecked on 9/1/24 as per code with no additional issues, the maintenance department keeps stock of replacement batteries in case of failure on inspection, routinely completed on the first of the month.	
K 345 SS=E	Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to test the transmission of the fire alarm signal per NFPA 101 (2012 edition), Life Safety Code sections 9.6.1.3, 9.6.1.5, NFPA 70, and NFPA 72. This deficient finding could have a patterned impact on the residents within the facility. Findings include: On 07/29/2024 at 11:20 AM, it was revealed by a review of available documentation that the sucessful transmission of the fire alarm signal was not being documented during the 2nd and 3rd shift fire drills. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 345	K-345 Protection 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 Per NFPA code, Fire drills are done quarterly on each shift, including a full test and confirmation with the alarm monitoring	8/19/24

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K 345	Continued From page 4	K 345	company. This includes the person responsible for the drill calling to confirm with the alarm monitoring company the signal was received. When fire drills are being conducted in the late night or overnight hours, the maintenance department will test the alarm system earlier the day of drill or next morning. This will be reasonably coordinated as not to disturb the residents during overnight hours. The tests include audible alarms and ensuring transmission of signal to the alarm company by the Maintenance department. Fire drill logs are updated and kept in the life safety code binder. 8/19/24 Drill was completed and verified the signal is being received by monitoring company.	
K 923 SS=D	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	K 923		8/17/24

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K 923	Continued From page 5 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 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 store oxygen cylinders per NFPA 99 (2012 edition), Health Care Facilities Code, section 11.6.5.2 and 11.6.5.3. This deficient finding could have an isolated impact on the residents within the facility. Findings include: On 07/29/2024 at 11:30 AM, it was revealed by observation that the oxygen storage area had both full and empty oxygen cylinders being stored in the same location and was not segregated. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 923	K-923 Health Care Facilities Code Requirements Gas Equipment – Cylinder and Container Storage = 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	

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K 923	Continued From page 6	K 923	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. = 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of = 300 cubic feet are not required to be 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) Oxygen cylinder storage will be segregated, slide out cabinet in West hallway will be full oxygen storage, this is a lockable cabinet. Empty oxygen cylinders are to be stored in the locked West storage hopper room, next to the nurse's station. An empty cylinder storage rack has been ordered and is scheduled to	

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K 923	Continued From page 7	K 923	arrive on 8/20/24, bringing our oxygen storage into compliance. Doors and empty storage rack will be clearly marked. Staff trained and educated, notified by Secure Conversations.	