Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

August 7, 2025

Administrator
Good Samaritan Society - Jackson
601 WEST JACKSON
JACKSON, MN 56143

RE: CCN: 245455
Cycle Start Date: June 18, 2025

Dear Administrator:

On July 3, 2025, we notified you a remedy was imposed. On July 29, 2025, the Minnesota Departments of Health and Public Safety completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of July 11, 2025.

As authorized by CMS the remedy of:

• Discretionary denial of payment for new Medicare and Medicaid admissions effective July 18, 2025 did not go into effect. (42 CFR 488.417 (b))

In our letter of July 3, 2025, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from July 18, 2025 due to denial of payment for new admissions. Since your facility attained substantial compliance on July 11, 2025, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded. However, this does not apply to or affect any previously imposed NATCEP loss.

The CMS Location may notify you of their determination regarding any imposed remedies.

Feel free to contact me if you have questions.

Sincerely,

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Submitted
July 3, 2025

Administrator
Good Samaritan Society - Jackson
601 West Jackson
Jackson, MN 56143

RE: CCN: 245455
Cycle Start Date: June 18, 2025

Dear Administrator:

On June 18, 2025, survey was completed at your facility by the Minnesota Department 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.

Your facility was not in substantial compliance with the participation requirements and the conditions in your facility constituted immediate jeopardy to resident health or safety. This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted immediate jeopardy (Level J) whereby corrections were required. The Statement of Deficiencies (CMS-2567) is being electronically delivered.

REMOVAL OF IMMEDIATE JEOPARDY

On June 18, 2025, the situation of immediate jeopardy to potential health and safety cited at F578 was removed. However, continued non-compliance remains at the lower scope and severity of D.

REMEDIES

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

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective July 18, 2025.

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

The CMS location will notify your Medicare Administrative Contractor (MAC) that the denial of

payment for new admissions is effective July 18, 2025, (42 CFR 488.417 (b)). They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective July 18, 2025, (42 CFR 488.417 (b)).

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

NURSE AIDE TRAINING PROHIBITION

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

If you have not achieved substantial compliance by July 18, 2025, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, Good Samaritan Society - Jackson will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from July 18, 2025. You will receive further information regarding this from the State agency. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions.

However, under Public Law 105-15, you may contact the State agency and request a waiver of this prohibition if certain criteria are met.

ELECTRONIC PLAN OF CORRECTION (ePOC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable plan of correction (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. The failure to submit an acceptable ePOC can lead to termination of your Medicare and Medicaid participation (42 CFR 488.456(b)).

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.

DEPARTMENT CONTACT

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

Elizabeth Silkey, Regional Operations Supervisor
Mankato District Office
Health Regulation Division
Minnesota Department of Health
12 Civic Center Plaza, Suite #2105
Mankato, Minnesota 56001
Email: elizabeth.silkey@state.mn.us
Office: (507) 344-2742 Mobile: (651) 368-3593

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 their respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

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

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by December 18, 2025 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

APPEAL RIGHTS DENIAL OF PAYMENT

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

tamika.brown@cms.hhs.gov

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

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

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

APPEAL RIGHTS NURSE AIDE TRAINING PROHIBITION

Pursuant to the Federal regulations at 42 CFR Sections 498.3(b)(13)(2) and 498.3(b)(15), a finding of substandard quality of care that leads to the loss of approval by a Skilled Nursing Facility (SNF) of its NATCEP is an initial determination. In accordance with 42 CFR part 489 a provider dissatisfied with an initial determination is entitled to an appeal. If you disagree with the findings of substandard quality of care which resulted in the conduct of an extended survey and the subsequent loss of approval to conduct or be a site for a NATCEP, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Department Appeals Board. Procedures governing this process are set out in Federal regulations at 42 CFR Section 498.40, et. Seq.

A written request for a hearing must be filed no later than 60 days from the date of receipt of this letter. Such a request may be made to the Centers for Medicare and Medicaid Services (formerly Health Care Financing Administration) at the following address:

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

A request for a hearing should identify the specific issues and the findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. You do not need to submit records or other documents with your hearing request. The Departmental Appeals Board (DAB) will issue instructions regarding the proper submittal of documents for the hearing. The DAB will also set the location for the hearing, which is likely to be in Minnesota or in Chicago, Illinois. You may be represented by counsel at a hearing at your own expense.

INFORMAL DISPUTE RESOLUTION (IDR)

In accordance with 42 CFR 488.331 **and Minnesota Statute 144A.10 subd 15**, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to: **https://forms.web.health.state.mn.us/form/NHDisputeResolution**

This request must be sent within the same ten calendar days you have for submitting an ePoC for the cited deficiencies. Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

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

INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

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

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

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

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

Feel free to contact me if you have questions.

Sincerely,

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245455	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 06/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Good Samaritan Society - Jackson	601 WEST JACKSON , JACKSON, Minnesota, 56143

(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
E0000	Initial Comments On 6/16/25-6/18/25, a survey for compliance with §483.73, Appendix Z, Emergency Preparedness Requirements for Long Term Care Facilities was conducted during a standard recertification survey. The facility was IN compliance. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	E0000		
F0000	INITIAL COMMENTS On 6/16/25-6/18/25, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The survey resulted in an immediate jeopardy (IJ) to resident health and safety. An IJ F578 began on 4/17/25, when when a care conference progress note identified R5 remained DNR per MN POLST. However R5 stated his wish was a full code (CPR) to be administered and thought staff would complete CPR. The facility was notified of the IJ on 6/17/25, at 4:23 p.m.. The IJ was removed on 6/18/25 at 10:50 a.m., but non-compliance remained at the lower scope and severity level of D, isolated with no actual harm but potential to cause more than minimal harm. The following complaints were reviewed with NO deficiencies cited. : H54557108C (MN00111032). 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	F0000		

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 reverse for further 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.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245455	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 06/18/2025

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F0000	Continued from page 1 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 that substantial compliance with the regulations has been attained.	F0000		
F0578 SS = J	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information	F0578	R5 was the only resident affected. Facility staff met with R5 on 6/17/2025 to confirm his desire to change his advance directive from the previous Do Not Resuscitate order, written 4/21/22 and last confirmed by physician on 4/17/2025, to Do Resuscitate. A Minnesota POLST was completed reflect current wishes, signature obtained from R5 and physician. The electronic medical record was updated to reflect R5s current wishes on 6/17/2025 at 0859. Facility staff interviewed all residents or their representative to ensure understanding and agreement with their current advance directive order. Any changes were made at the time as needed. Facility reviewed Advance Directive including Cardiopulmonary Resuscitation (CPR) and Automated External Defibrillator (AED) and no changes to the policy were made, as the policy was found to be appropriate. Reviewed advanced directives for all residents in the building to ensure they reflected the wishes of each resident. The medical record was updated to reflect the review. This was completed at 12:45pm on 6/17/2025. Facility Admission/Readmission Checklist was updated to include verification of advance directive and to ensure it aligns with resident wishes. On 6/17/25 Regional clinical services director provided education to director of nursing that during care conference, verify advance directive order(s) match the resident or resident representative's current wishes and document understanding of current code status. If resident or representative expresses desire to change or modify an advance directive, follow procedures to update MN POLST. All licensed nursing staff and social services were educated on Advance Directive including Cardiopulmonary Resuscitation (CPR) and Automated External Defibrillator (AED) policy. All licensed nursing staff and social services were educated on the facility's Admission/Readmission Checklist and During the Stay Advance Directives by DNS or designee.	07/11/2025

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F0578 SS = J	Continued from page 2 to the individual directly at the appropriate time. This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to ensure resident's preferences/wishes for advance directives were accurately documented on the resident's electronic medical record (EMR) banner and physician orders which affected 1 of 19 residents (R5) reviewed for advance directives. This resulted in an immediate jeopardy (IJ) for R5 who would have been denied cardiopulmonary resuscitation (CPR) contrary to their wishes, in the absence of a pulse or respirations. The IJ began on 4/17/25 at 10:45 a.m., when a care conference occurred per progress note written by SS-A, attended by RN-C, R5, CCW-C included remains DNR per MN POLST. However R5 stated his wish was a full code (CPR) administered and thought the staff would complete CPR. R5's Provider Orders for Life-Sustaining Treatment (POLST) dated 5/12/20, identified R5 wished to have CPR administered, however, the physician orders in the EMR and EMR banner indicated R5 was do-not-resuscitate (DNR). A POLST completed 6/17/25, indicated CPR and full treatment. The administrator was notified of the IJ on 6/17/25, at 4:23 p.m. The IJ was removed on 6/18/25 at 10:50 a.m., but non-compliance remained at the lower scope and severity level of D, isolated with no actual harm but potential to cause more than minimal harm. Findings include: R5's significant change Minimum Data Set (MDS) assessment dated 3/26/25, indicated a Brief Interview for Mental Status score of 15, indicating intact cognition, hearing and vision were adequate and R5 understands and is understood. R5 required assistance from staff with activities of daily living (ADL), and had diagnoses of diabetes with neuropathy (nerve involvement), neurogenic (arising from nerves) bladder, arthritis, and hypertension (high blood pressure). On 6/16/25 at 5:30 p.m., R5's face sheet/banner in point click care (PCC) (computer program) indicated R5's code status was DNR. R5's most current Physician's Orders For Life	F0578	Continued from page 2 In addition all licensed nursing staff and social services were educated on the importance of using language the resident understands to explain their choice, and ensuring the resident understands their choice of advance directive by DNS or designee. To monitor performance and ensure on going compliance the Administrator or designee, will audit facility care plan conference notes to ensure resident code status wishes were reviewed, and validated per resident wishes weekly x4 monthly x2. Administrator or designee, will perform random audits following care conferences validating resident understanding of current code status wishes and ensuring updated MN POLST as needed weekly x4, monthly x2.	

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F0578 SS = J	Continued from page 3 Sustaining Treatment (POLST) located in the scanned EMR, signed by R5 and doctor of osteopathic medicine (DO)-B on 5/12/2020, identified R5's wishes were full code status. R14's Order Summary report dated 4/17/25, indicated DNR status. The DNR order had a start date of 4/21/22. R5's EMR care plan did not address R5's advanced directive wishes. A hospital progress note dated 4/15/22 at 3:53 p.m., by certified nurse practitioner (CNP)-E, indicated R5 was admitted for septic shock (severe drop in blood pressure caused by infection) and was hospitalized 4/6/22 through 4/20/22. R5 desires to continue all current interventions as he is making meaningful strides toward recovering from this crisis, however he is clear in not wanting permanent forms of life support specifically enteral nutrition (nutrition via stomach through a tube). Code status is DNR. A care conference progress note dated 5/11/22 at 10:55 a.m., included attendance of registered nurse (RN)-A, social services (SS)-A and dietary manager (DM)-A. R5 did not attend. Progress note included code status changed to DNR in hospital. No other concerns at this time. A care conference note on 7/13/22 at 10:00 a.m., with R5 in attendance did not address code status. A care conference note with R5 in attendance dated 10/6/22 included remains a DNR per MN POLST. During an observation and interview on 6/17/25 at 8:54 a.m., SS-A entered R5's room with a POLST form. R5 choose CPR and full treatment and signed the document. SS-A confirmed R5 requested CPR and full treatment and had signed the updated POLST form. On observation and interview 6/17/25 at 8:56 a.m., R5 was sitting in his wheelchair in his room watching television. R5 stated he has always wanted to have CPR and full treatment completed. R5 stated "I think they talk about it at my care conference and I thought they knew I wanted everything done" and believed he had always been clear on wanting CPR and full treatment done. R5 stated "no" when asked if a physician had discussed his wishes for CPR versus DNR (do not resuscitate). R5 stated he was in the hospital in 2022	F0578		

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F0578 SS = J	Continued from page 4 but does not remember changing his status from CPR to a DNR status. R5 stated he would have expected staff to do CPR and full treatment since he came back from the hospital and stated "I thought they knew that". On interview 6/17/25 at 9:21 a.m., RN-A stated when residents are admitted, they are asked about their wishes for DNR versus CPR status. RN-A stated the process if a resident was found not breathing and unresponsive was to look in the EMR on the banner to find out the residents status if full code (CPR) or DNR. RN-A added they also have a book on each unit that says what residents current status is but best practice is to look in the EMR. RN-A stated she follows provider orders upon return from the hospital and doesn't routinely ask the resident or the family if that status reflects what their wishes are. RN-A confirmed she would not do CPR on R5. During an interview on 6/17/25 at 9:35 a.m., RN-B stated R5's code status was DNR, and confirmed she would not implement CPR for R5. RN-B stated they have a book at each nurses station that is run nightly by the night shift staff which identifies resident current code status. RN-B stated when residents return from the hospital, the provider orders are followed versus asking the resident or family member. The Advanced Directive book at the nurses station included all residents orders on the north wing with current code status with R5 listed as DNR status. The orders were dated 5/7/25. A care conference progress note 9/20/24 at 10:30 a.m., by RN-C included R5 and county case worker (CCW)-C were in attendance and included R5 remains DNR per MN POLST. A care conference progress note 12/19/24 at 10:30 a.m., by RN-C included R5, CCW-C and DM-A were in attendance and included remains CPR per MN POLST. A care conference progress note dated 3/6/25 at 10:29 a.m., written by SS-A, attended by RN-C, R5, CCW-C included remains DNR per MN POLST. A care conference progress note dated 4/17/25 at 10:45 a.m., written by SS-A, attended by RN-C, R5, CCW-C	F0578		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245455	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 06/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Good Samaritan Society - Jackson	601 WEST JACKSON , JACKSON, Minnesota, 56143

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F0578 SS = J	Continued from page 5 included remains DNR per MN POLST. On interview 6/17/25 at 9:59 a.m., RN-C, also identified as MDS nurse, stated resident's wishes for CPR or DNR is discussed at care conferences held quarterly. RN-C confirmed R5's most recent POLST was full code (wanting CPR) but when he went to the hospital on 4/6/22 it was changed to DNR status. RN-C stated the current provider orders would be followed versus the POLST order. RN-C stated the documentation completed "DNR per MN POLST" was a data entry error with R5's current provider order stating DNR. On 6/17/25 at 10:35 a.m., SS-A stated if a resident is hospitalized, there is a gap in the process. SS-A stated she has never addressed code status with residents upon return from a hospitalization. SS-A indicated if the resident comes back a different code status it is put in as an order and then addressed at care conferences held quarterly. SS-A confirmed R5 today stated he expected CPR to be performed, and has always thought he was CPR status. SS-A stated they always review the residents code status at the end of the care conference but added "I don't know that R5 understood what DNR status meant and has been a DNR status here for 3 years that he didn't want to be." SS-A stated there is a gap when hospitalized residents return that isn't being addressed as we just take the code status orders from wherever they were. SS-A stated we need to be sure that remains their wishes. SS-A confirmed R5 expected CPR to be performed and has thought he was a full code status while a resident at the facility since his hospitalization. SS-A stated she has gotten a new POLST completed with R5's signature and faxed it to the physician who has signed it 6/17/25. SS-A indicated the EMR has been updated to reflect R5's CPR wishes. On interview 6/17/25 at 10:46 a.m., the director of nursing (DON) indicated residents returning from a hospitalization staff are expected to verify the order and social services evaluates code status at care conferences. The DON stated if the residents status has changed the nurse updates the order and the EMR. The DON is unsure if staff verify with the resident if the order is accurate but assumes it would be clarified to be sure it is accurate. The DON would expect staff in the event a resident is found unresponsive and not breathing to verify the code status in EMR, and/or check the binders at the nurses station which should be updated by the night staff daily. The DON stated R5 had	F0578		

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F0578 SS = J	Continued from page 6 an order for DNR listed and a POLST is not a required order to have, adding the order was correct and matched the EMR status. The DON stated he would expect staff to follow the DNR/CPR order upon return to the facility but also verify with the resident or family member. On interview 6/17/25 at 2:08 p.m., R5's current medical doctor (MD)-D stated he doesn't routinely discuss code status if it has already been established. MD-D stated he would expect facility staff to acknowledge a change in code status upon return from a hospital stay and clarify it with the resident to verify if they still want that status. On interview 6/17/25 at 3:29 p.m., county caseworker (CC)-C stated she has attended R5's care conferences and stated facility staff do ask the resident to confirm if their wishes are DNR or CPR. CC-C stated on her current paper work for R5, DNR is listed, which she would have written down from the care conferences. CC-C stated generally county caseworkers don't have those conversations with the resident and expect the facility to do that. The facility Advance Directive including CPR and Automated External Defibrillator (AED) policy dated 10/29/24, indicated: -The purpose of the policy is to provide each resident the opportunity to make decisions related to medical care and select a proxy, and to define a process to make resident decisions known. - Procedure for Admission/Re-admission Advance Directive: - At the time of admission or re-admission, social services or designated staff member asks the resident/healthcare decision-maker whether the resident has prepared an advance directive such as a living will, durable power-of-attorney for healthcare decisions, guardianship, portable and enduring	F0578		

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F0578 SS = J	Continued from page 7 order form etc.. - The designated staff member will meet with the resident/healthcare decision--maker to answer questions and determine if the resident/healthcare-decision maker wishes to develop or amend advance directives. - As necessary, physicians will be contacted for orders that reflect the resident's wishes... -If a resident's medical condition or cognitive status changes, review the current advance directive orders with the resident and healthcare decision-maker to determine if they wish to make changes. - Daily print a list of all advance directive orders and keep in a three-ring binder in an area easily accessible to nursing employees. This is necessary to ensure that this important information is available if there is a power outage or other disruption in access to the EMR. A Re-Admission policy dated 10/11/24, included: - Upon re-admission, the social worker or nursing will review the advance directives to ensure the returning physician's orders reflect the resident's current wishes and this will be documented in the progress notes under advanced care planning. The IJ was removed on 6/18/25, at 10:50 a.m., when the facility developed and implemented a systemic removal plan which was verified by interview and document review. On 6/17/25 at 3:03 p.m., the facility completed an audit of all resident's code status to ensure	F0578		

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F0578 SS = J	Continued from page 8 residents wishes match the current POLST and/or physician orders, and was reflected in the EMR. The facility ran a current physician orders list and updated the Advanced Directive books on each nursing unit. The facility initiated training on 6/17/25 at 3:05 p.m., for all licensed nurses and social services and remaining staff were trained immediately or prior to their next scheduled shift regarding the Admission/Re-Admission Advance Directives procedure. On 6/18/25 at 6:00 a.m., oncoming licensed staff were educated regarding the Admission/Re-Admission Advance Directives Procedure. The facility plans to continue education process with on-coming staff and all staff are required to sign attestation on Advance Directive Policy upon completion and prior to the start of their next shift. On 6/17/25 the facility reviewed the policies for Advance Directive including CPR and AED and Re-admission. No revisions were needed.	F0578		
F0628 SS = A	Discharge Process CFR(s): 483.15(c)(2)(iii)(3)-(6)(8)(d)(1)(2); 483.21(c)(2) §483.15(c)(2) Documentation. When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider. (iii) Information provided to the receiving provider must include a minimum of the following: (A) Contact information of the practitioner responsible for the care of the resident. (B) Resident representative information including contact information (C) Advance Directive information (D) All special instructions or precautions for ongoing care, as appropriate. (E) Comprehensive care plan goals; (F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and	F0628		07/08/2025

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F0628 SS = A	Continued from page 9 effective transition of care. §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days.	F0628		

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F0628 SS = A	Continued from page 10 §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written	F0628		

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F0628 SS = A	Continued from page 11 notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. §483.21(c)(2) Discharge Summary When the facility anticipates discharge, a resident must have a discharge summary that includes, but is not limited to, the following: (i) A recapitulation of the resident's stay that includes, but is not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results. (ii) A final summary of the resident's status to include items in paragraph (b)(1) of §483.20, at the	F0628		

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F0628 SS = A	Continued from page 12 time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or resident's representative. (iii) Reconciliation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and over-the-counter). This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to ensure the resident and/or legal representative received written notice of transfer when 1 of 1 resident (R19), who was reviewed for hospitalization, was transferred to the hospital. Findings include: R19's face sheet provided on 6/18/25, included diagnoses of chronic kidney disease and dementia. R19's quarterly Minimum Data Set (MDS) assessment dated 5/1/25, indicated severe cognitive impairment, clear speech, could usually understand and was sometimes understood. R19 required substantial assistance or was dependent upon staff for activities of daily living. R19's physician orders included 1/23/25 at 7:00 a.m., call placed to on-call provider and order received to transfer to ER (emergency room) for evaluation. During an interview on 6/16/25 at 5:27 p.m., family member (FM)-A stated R19 was hospitalized in January 2025 for a urinary tract infection (UTI) and fluid in her chest. FM-A stated she received a phone call that R19 was going to the hospital, authorized a bed hold, but did not receive written notice of transfer. Progress note dated 1/23/25 at 7:00 a.m., indicated staff entered R19's room and could see she was visibly SOB (short of breath). O2 (oxygen) sat[uration] 84% on RA (room air), oxygen applied at 5 liters initially to bring sats to 90%. Noted to have harsh, non-productive cough, LS (lung sounds) coarse, and she c/o (complained of) sore throat. Progress note dated 1/28/25 at 1:32 p.m., indicated R19	F0628		

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F0628 SS = A	Continued from page 13 returned from the hospital via wheelchair van at 1:15 p.m. R19's written notice of transfer was requested. A document titled Notice of Resident/Patient Transfer or Discharge was received. The form included R19's name, date of transfer (1/23/25), location of transfer and date notice provided (1/23/25). The form did not include a prompt, nor a space to indicate a copy was given to the resident and/or resident representative, nor was there documentation this occurred. During an interview on 6/18/25 at 10:21 a.m., the director of nursing (DON) was informed there was no documentation that a copy of the transfer form was given to the resident and resident representative. The DON was unaware the form should be provided. Facility Discharge and Transfer policy dated 3/28/25, indicated the purpose of the policy was to define and meet the requirements for transfer/discharge regulations. The facility would notify the resident and the resident's representative of the transfer and the reason for the move in writing and in a language and manner they understood. When a resident was transferred on an emergency basis to an acute care center, a notice of transfer would be provided to the resident and resident representative as soon as practical before the transfer.	F0628		

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	245455	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**06/17/2025**

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GOOD SAMARITAN SOCIETY - JACKSON	**601 WEST JACKSON** **JACKSON, MN 56143**

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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 06/17/2025. At the time of this survey, Good Samaritan Society Jackson 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 | 07/08/2025

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

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K 000	Continued From page 1 Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR By email to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A detailed description of the corrective action taken or planned to correct the deficiency. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. 4. Identify who is responsible for the corrective actions and monitoring of compliance. 5. The actual or proposed date for completion of the remedy. Good Samaritan Society Jackson The facility has a capacity of 46 beds and had a census of 38 at the time of the survey. The requirements at 42 CFR, Subpart 483.70(a), are NOT MET as evidenced by:	K 000		

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K 222	Continued From page 2	K 222		
K 222 SS=E	Egress Doors CFR(s): NFPA 101 Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING ARRANGEMENTS Approved, listed delayed-egress locking systems	K 222		7/11/25

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	245455	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**06/17/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - JACKSON	**601 WEST JACKSON** **JACKSON, MN 56143**

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K 222	Continued From page 3 installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted. 18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain egress doors per NFPA 101 (2012 edition), Life Safety Code, sections 7.1.10.1, 7.2.1.5.10, and 19.2.2.2.6. This deficient finding could have a patterned impact on the residents within the facility. Findings include: On 06/17/2025 at 10:32 AM, it was revealed by observation that the gate that is used to exit the courtyard had a latching device on the exterior side of the gate and does not allow an obvious method of operation for egress.	K 222	Gate used to exit courtyard was found to impede egress from the building. Gate will be removed on 7/8/2025 until latch can be flipped or dual latched is installed to facilitate egress. All egress doors will be audited to ensure proper functioning and clear, unimpeded paths of egress from the building. The audit will be completed by maintenance staff or designee. Maintenance staff members will be educated that all egress doors can't require a tool to unlatch or unlock unless for clinical needs or security threat, which requires egress doors to have an electrical lock that fail safely and release	

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K 222	Continued From page 4 An interview with the Maintenance Supervisor verified this deficient finding at the time of discovery.	K 222	upon loss power to the device. Audits of 5 egress doors will be completed once a week x4 then monthly x2, audit will be completed by maintenance staff or designee. Audit results will be brought to the QAPI committee for further recommendations.	
K 363 SS=D	Corridor - Doors CFR(s): NFPA 101 Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In	K 363		7/11/25

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K 363	Continued From page 5 sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain corridor doors per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.6.3.1. This deficient finding could have an isolated impact on the occupants within the facility. Findings include: On 06/17/2025 at 11:02 AM it was revealed by observation that the Soiled Laundry room had two unsealed holes drilled into door. An interview with the Maintenance Supervisor verified this deficient finding at the time of discovery.	K 363	Soiled Laundry room door was found deficient. Soiled laundry room door was fixed 6/23/2025, by maintenance staff. All smoke and fire doors will be audited by maintenance staff or designee, to ensure there aren't any unsealed holes drilled into doors. Maintenance staff will be educated that smoke and fire doors can't have unsealed holes drilled into them. Audits of 3 smoke or fire doors ensuring the doors don't have unsealed holes will be completed weekly x4 and monthly x2. Audits will be completed by maintenance or designee, and the results will be brought to QAPI committee for further recommendations.	
K 918 SS=F	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches.	K 918		7/11/25

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K 918	Continued From page 6 Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to maintain generators per NFPA 99 (2012 edition), Health Care Facilities Code, section 6.4.4.1.1.3, and NFPA 110 (2010 edition), Standard for Emergency and Standby Power Systems, section 8.4.1. This deficient finding could have a widespread impact on the residents within the facility. Findings include:	K 918	On 7/7/25 a monthly inspection of the generator was completed by maintenance staff. Generator checks for the remainder of the year have been scheduled to occur and maintenance staff were educated on the process for monthly generator checks by administrator or designee. Monthly generator checks and documentation will be brought to the facility's monthly safety meetings for review, by maintenance staff or designee. This will occur for the	

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K 918	Continued From page 7 On 06/17/2025 at 10:03 AM, it was revealed by a review of available documentation that at the time of the survey the facility could not provide documentation showing that the emergency generator had been inspected during the month of May 2025. An interview with the Maintenance Supervisor verified this deficient finding at the time of discovery.	K 918	remainder of 2025. These results will then be brought to the QAPI committee for review and further recommendation. Maintenance staff or designee will be responsible for completing generator checks and completing documentation. Results of the checks will be brought to the QAPI committee for further recommendations.	