Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
June 24, 2025

Administrator
Cura Of Monticello
1104 East River Street
Monticello, MN 55362

RE: CCN: 245511
Cycle Start Date: April 16, 2025

Dear Administrator:

On April 25, 2025, we notified you a remedy was imposed. On June 3, 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 May 27, 2025.

As authorized by CMS the remedy of:

- Discretionary denial of payment for new Medicare and Medicaid admissions effective May 10, 2025 be discontinued as of May 27, 2025. (42 CFR 488.417 (b))

In our letter of April 25, 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 is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from May 10, 2025. 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.

Your plan of correction for these deficiencies, including your request for a temporary waiver with a date of completion of September 22, 2025, has been approved. Failure to come into substantial compliance with this deficiency by the date indicated in your plan of correction may result in the imposition of enforcement remedies.

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Compliance Analyst | Federal Enforcement
Health Regulation Division
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Office: 651-201-4112

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

June 24, 2025

Administrator
Cura Of Monticello
1104 East River Street
Monticello, MN 55362

Re: Reinspection Results
Event ID: PUO612

Dear Administrator:

On June 3, 2025 survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on April 16, 2025. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Compliance Analyst | Federal Enforcement
Health Regulation Division
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Office: 651-201-4112

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
April 25, 2025

Administrator
Cura Of Monticello
1104 East River Street
Monticello, MN 55362

RE: CCN: 245511
Cycle Start Date: April 16, 2025

Dear Administrator:

On April 16, 2025, a survey was completed at your facility by the Minnesota Department(s) of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G), as evidenced by the electronically delivered CMS-2567, whereby significant corrections are required.

REMEDIES

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

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective May 10, 2025.

The CMS location will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective May 10, 2025. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective May 10, 2025.

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

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

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 May 10, 2025, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, Cura Of Monticello will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from May 10, 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)

The purpose of the ePoC submission is to confirm your allegation of compliance and preparedness for a revisit.

Within ten (10) calendar days after your receipt of this notice, a provider should develop and submit an effective ePOC for the deficiencies cited. A revisit will determine if substantial compliance has been achieved.

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 an "E" tag), i.e., the plan of correction should be directed to:

Nikki Harvey, Regional Operations Supervisor
St. Cloud A District Office
Health Regulation Division
Minnesota Department of Health
4140 Thielman Lane
Saint Cloud, Minnesota 56301-4557
Email: nikki.harvey@state.mn.us

Office: (320) 223-7318 Mobile: (320) 216-5631

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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 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 location and/or the Minnesota Department of Human Services that your provider agreement be terminated by October 16, 2025 if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at § 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR § 488.412 and § 488.456.

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

APPEAL RIGHTS

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

Steven.Delich@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 Steven Delich, Program Representative at (312) 886-5216. Information may also be emailed to Steven.Delich@cms.hhs.gov.

INFORMAL DISPUTE RESOLUTION (IDR)

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

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

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

INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

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

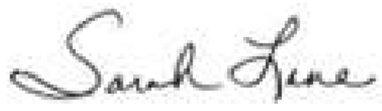
A facility may not use both IDR and independent IDR for the same deficiency citation(s) arising from the same survey unless the IDR process was completed prior to the imposition of the CMP. This request must be sent within ten calendar days of receipt of this offer. An incomplete Independent IDR process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

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,



Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697
Email: sarah.lane@state.mn.us

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
April 25, 2025

Administrator
Cura Of Monticello
1104 East River Street
Monticello, MN 55362

Re: State Nursing Home Licensing Orders
Event ID: PUO611

Dear Administrator:

The above facility was surveyed on April 14, 2025 through April 16, 2025 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

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

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

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

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

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

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

Nikki Harvey, Regional Operations Supervisor
St. Cloud A District Office
Health Regulation Division
Minnesota Department of Health
4140 Thielman Lane
Saint Cloud, Minnesota 56301-4557
Email: nikki.harvey@state.mn.us
Office: (320) 223-7318 Mobile: (320) 216-5631

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

Please feel free to call me with any questions.

Sincerely,

Sarah Lane

Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697
Email: sarah.lane@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245511	A. BUILDING _____ B. WING _____	C 04/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CURA OF MONTICELLO	1104 EAST RIVER STREET MONTICELLO, MN 55362

(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 4/14/25 to 4/16/25, a survey for compliance with §483.73, Appendix Z, Emergency Preparedness Requirements for Long Term Care Facilities was conducted during a standard recertification survey. The facility was IN compliance. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	E 000		
F 000	INITIAL COMMENTS On 4/14/25 to 4/16/25, 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 following complaints were reviewed: H55112300C/MN00111683 with a deficiency cited at F689 and Deficient practice was identified related to incidental finding at F686. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulations has been attained.	F 000		

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

Electronically Signed | 05/02/2025

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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CURA OF MONTICELLO	1104 EAST RIVER STREET MONTICELLO, MN 55362

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F 686 SS=G	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, that facility failed to comprehensively assess and implement interventions for 1 of 2 residents (R26) reviewed for pressure ulcers. R26 developed pressure ulcers after splint placement for ankle fracture resulting in actual harm when the facility did not clarify orders for monitoring or when to remove the splint. Findings include: R26's significant change Minimum Data Set (MDS) dated 3/31/25, indicated R26 was cognitively intact and received extensive assistance to complete activities of daily living (ADL's) including dressing, grooming and bathing, R26 required extensive assistance of two staff with transfers and toileting. R26's care plan, also indicated a self-care deficit related to weakness, unsteady balance, impaired cognition, tends to fatigue easily, and history of knee	F 686	R26's current order for cast boot has orders that includes clarification of when to wear and remove. An audit will be conducted of current residents with a splint to assure that orders include instructions on the use, wear and removal of that device. The policy for Transcription Processing Provider Orders – Long Term Care will be updated to address clarifying orders, especially for wear and removal of devices. Nursing staff and the HUC (health unit coordinator) will be educated on the importance of obtaining or seeking clarification to obtain complete orders that include instructions for appropriate use, wear and removal of splints. Nursing staff	5/27/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245511	A. BUILDING _____ B. WING _____	C 04/16/2025

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F 686	Continued From page 2 buckling. The care plan dated 2/5/25, directed staff to provide extensive assistance of two staff with transfers and toileting. Progress note dated 3/12/2025 at 5:59 p.m., indicated at 5:15 p.m. R26 was lowered to the ground after twisting ankle during assisted transfer. R26 was transferred by ambulance to the emergency room (ER) due to right ankle pain, swelling and decreased ability to move the ankle. Progress note dated 3/12/2025 at 11:43 p.m., R26 returned from the hospital with no new medication orders. R26 rated pain eight out of 10, ice was applied to right ankle. After Visit Summary dated 3/12/25, identified R26 was diagnosed with sprain of right ankle with instructions to wear air splint for comfort and stability, elevate, ice and rest, take pain medication as needed, return to the emergency room if symptoms worsen. Progress noted dated 3/20/2025 at 11:00 p.m., indicated R26's ankle was noted to be weepy, had been wearing a splint since the fall on 3/12/25. R26 had increased pain and swelling, when splint was removed to assess, was noted to have open areas on both sides of the ankle. R26 had a temperature of 99.4. Orders were obtained from the nurse practitioner (NP) to send R26 to the ER. Progress note dated 3/21/2025 2:37 a.m., indicated R26 was admitted to the hospital with cellulitis (bacteria infection of the skin and underlying tissue), pressure injury, and closed fracture of the right ankle.	F 686	will also be educated on the need to assess for any potential skin impairments related to the use of those devices. The Director or Nursing and/or designee will conduct audits of resident with splints to assure that orders include instructions on the use, wear and removal of that device. Audits will be completed weekly for four weeks then monthly until the next Quality Assurance and Performance Improvement Committee at which time results will be reviewed for ongoing oversight and adjustment as necessary.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 686	Continued From page 3 Review of R26's progress notes, physician orders and care plan, identified an order to wear air splint for comfort and stability. However, R26's electronic medical record failed to identify any indication or physician order to assess/monitor right ankle and splint between placement of splint on 3/12/25 and 3/20/25 when facility removed the splint after R26 had increased pain and swelling. Emergency Department note encounter date 3/20/25, indicated R26 was last in the ER on 3/12/25, after twisting her ankle. R26 was advised symptomatic treatment and ankle brace. it appears that the ankle brace had not been removed since then. Today when brace removed, R26 noted to have redness and ulcer on both medial aspect (inner) and lateral aspect (outside) of right ankle. Progress note dated 3/24/2025 at 3:05 p.m., R26 readmitted from hospital with diagnosis of ankle fracture, open area on right ankle When observed on 4/14/25 at 6:58 p.m., R26 had a cast on right foot, when asked R26 stated "I fractured my ankle". When interviewed on 4/16/2025 at 10:57 a.m., licensed practical nurse (LPN)-B stated if an order was not clear or parts were missing, the nurse needed to call the provider to clarify the orders. When interviewed on 4/16/25 10:59 a.m., LPN-A stated orders from a hospital return are entered by the health unit coordinator (HUC) and checked by two nurses or entered by a nurse and checked by another nurse. If an order does not make sense or is missing information, the nurse is	F 686		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 686	Continued From page 4 responsible to contact the provider to get directions. LPN-A confirmed the order for R26's splint should have been clarified for specific instructions. When interviewed on 4/16/25 at 12:45 p.m., nurse practitioner (NP) stated the air splint should have been removed to provide cares, however, NP did not clarify how often the splint should have been removed for cares. If the staff had any questions about the splint they should have called and asked for clarification. Based on what was on the ER note the cause of the cellulitis and pressure sores resulted from the air splint not being removed. When interviewed on 4/16/25 at 2:52 p.m. the director of nursing (DON) stated no order was entered to remove the splint and check the skin. DON stated she expected when a resident returned with a removable device the nurses should get parameters/orders to remove and check the skin underneath, this was not done for R26. DON was unable to locate any procedure or process changes that were made to ensure that this did not occur again. Facility provided policy Transcription Processing Provider Orders - Long Term Care dated 1/2025, indicated transcribe order to the electronic medication administration record (EMAR)/electronic treatment administration record (ETAR). However the policy did not address clarifying orders.	F 686		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents.	F 689		5/27/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CURA OF MONTICELLO	1104 EAST RIVER STREET MONTICELLO, MN 55362

(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
F 689	Continued From page 5 The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to comprehensively investigate a fall for 1 of 3 residents (R26), who had a fall while being transferred. Findings include: R26's significant change Minimum Data Set (MDS) dated 3/31/25, indicated R26 was cognitively intact and received extensive assistance to complete activities of daily living (ADL's) including dressing, grooming and bathing, R26 required extensive assistance to 2 staff with transfers and toileting. R26's care plan, also indicated a self-care deficit related to weakness, unsteady balance, impaired cognition, tends to fatigue easily, and history of knee buckling. The care plan dated 2/5/25, directed staff to provide extensive assitance of two staff with transfers and toileting. Progress note dated 3/12/2025 at 5:15 p.m., indicated R26 had a staff assisted fall at 1715 (5:15 p.m.) resident was lowered to the ground after twisting ankle during assisted pivot transfer with two staff. Injuries: right ankle pain and swelling after twisting it during transfer. R26 did not have full range of motion in right foot. R26 transferred to the hospital.	F 689	R26's fall was investigated at the time the resident was admitted to the hospital. An audit will be conducted for all current residents with a witnessed fall within the last 30 days to ensure the investigation of the fall includes witness statements when applicable. The facility policy on Fall Management – Long Term Care will be reviewed and revised as appropriate. Nursing staff will be educated on the importance of gathering and investigating information pertaining to resident falls which includes obtaining witness statements from those involved or witnessing the fall. The Director of Nursing and/or designee will conduct an audit of resident falls to ensure that the fall is properly investigated and include witness statements when applicable. Audits will be completed weekly for four weeks then monthly until the next Quality Assurance and Performance Improvement Committee at which time results will be reviewed for ongoing oversight and adjustment as	

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	245511	A. BUILDING _____ B. WING _____	C 04/16/2025

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CURA OF MONTICELLO	1104 EAST RIVER STREET MONTICELLO, MN 55362

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F 689	Continued From page 6 R26's post-fall investigation form indicated R26 had a fall on 3/12/25 at 5:15 p.m., while being assisted to the bathroom, when ankle twisted during the transfer and R26 was lowered to the floor. The provided recap of the incident indicated R26 was lowered to the ground after twisting ankle during assisted pivot transfer with two staff. R26 was transferred to the hospital emergency room. However, there was no interviews with the staff involved during the transfer included with the investigation. Progress note dated 3/20/2025, at 11:00 p.m. Indicated R26 had increased pain and swelling in ankle, R26 was transferred to the hospital emergency room for evaluation. Progress note dated 3/21/2025, 2:37 a.m. indicated R26 was admitted to the hospital with cellulitis (bacteria infection of the skin and underlying tissue), pressure injury, and closed fracture of the right ankle. Facility reported incident to state agency 3/21/25, facility then completed investigation into R26's fall which occurred 3/12/25. During facility investigation was found during transfer on 3/12/25, R26 received assistance of one staff during pivot transfer resulting in R26 twisting ankle requiring being lowered to the floor. During interview on 4/16/25 at 10:58 a.m., trained medication aid (TMA)-A stated R26 needed assistance of two staff during transfers prior to her fall when she broke her ankle. During Interview on 4/16/25 at 10:59 a.m., licensed practical nurse (LPN)-A stated before R26 had the fall R26 required assistance of two	F 689	necessary.	

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F 689	Continued From page 7 staff with transferring and toileting. During interview on 4/16/25 12:27 p.m., nursing assistant (NA)-A stated she was transferring the resident herself, during the transfer R26 was unable to move her foot when she attempted to assist R26 to the wheelchair. NA-A stated R26 was then lowered to the floor, NA-A then called for assistance. During interview on 4/16/25 2:52 p.m., director of nursing (DON) stated at the time of the fall R26 required assist of two with transfers and toileting needs. When DON initially was informed of the fall, she was told there were two staff when R26 was transferred. DON stated she did not ask staff that were there what happened until after R26 had been admitted to the hospital with an ankle fracture. During the investigation at that time it was discovered R26's care plan was not followed and had been transferred by one person. Facility policy Fall Management - Long Term Care dated 2/2025, indicated responding to a resident fall obtain information from the resident and/or any witnesses's pertaining to the circumstances of the fall, obtain information from the staff on the unit/within the area prior to or during the fall.	F 689		

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 4/14/25 to 4/16/25, a licensing survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was NOT in compliance with the MN State Licensure and the following correction orders are issued. Please indicate in your electronic plan of correction you have reviewed these orders and	2 000		

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2 000	Continued From page 1 identify the date when they will be completed. The following complaints were reviewed: H55112300C/MN00111683 with with licensing orders issued at 0900 identified related to incidental finding. Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled " ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin <https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html> The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health.	2 000		

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2 000	Continued From page 2 PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000		
2 900	MN Rule 4658.0525 Subp. 3 Rehab - Pressure Ulcers Subp. 3. Pressure sores. Based on the comprehensive resident assessment, the director of nursing services must coordinate the development of a nursing care plan which provides that: A. a resident who enters the nursing home without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates, and a physician authenticates, that they were unavoidable; and B. a resident who has pressure sores receives necessary treatment and services to promote healing, prevent infection, and prevent new sores from developing. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, that facility failed to comprehensively assess and implement interventions for 1 of 2 residents (R26) reviewed for pressure ulcers. R26 developed pressure ulcers after splint placement for ankle fracture resulting in actual	2 900	Corrected	5/27/25

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2 900	Continued From page 3 harm. Findings include: R26's significant change Minimum Data Set (MDS) dated 3/31/25, indicated R26 was cognitively intact and received extensive assistance to complete activities of daily living (ADL's) including dressing, grooming and bathing, R26 required extensive assistance of two staff with transfers and toileting. R26's care plan, also indicated a self-care deficit related to weakness, unsteady balance, impaired cognition, tends to fatigue easily, and history of knee buckling. The care plan dated 2/5/25, directed staff to provide extensive assistance of two staff with transfers and toileting. Progress note dated 3/12/2025 at 5:59 p.m., indicated at 5:15 p.m. R26 was lowered to the ground after twisting ankle during assisted transfer. R26 was transferred by ambulance to the emergency room (ER) due to right ankle pain, swelling and decreased ability to move the ankle. Progress note dated 3/12/2025 at 11:43 p.m., R26 returned from the hospital with no new medication orders. R26 rated pain eight out of 10, ice was applied to right ankle. After Visit Summary dated 3/12/25, identified R26 was diagnosed with sprain of right ankle with instructions to wear air splint for comfort and stability, elevate, ice and rest, take pain medication as needed, return to the emergency room if symptoms worsen. Progress noted dated 3/20/2025 at 11:00 p.m., indicated R26's ankle was noted to be weepy, had been wearing a splint since the fall on	2 900		

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2 900	Continued From page 4 3/12/25. R26 had increased pain and swelling, when splint was removed to assess, was noted to have open areas on both sides of the ankle. R26 had a temperature of 99.4. Orders were obtained from the nurse practitioner (NP) to send R26 to the ER. Progress note dated 3/21/2025 2:37 a.m., indicated R26 was admitted to the hospital with cellulitis (bacteria infection of the skin and underlying tissue), pressure injury, and closed fracture of the right ankle. Review of R26's progress notes, physician orders and care plan, identified an order to wear air splint for comfort and stability. However, R26's electronic medical record failed to identify any indication or physician order to assess/monitor right ankle and splint between placement of splint on 3/12/25 and 3/20/25 when facility removed the splint after R26 had increased pain and swelling. Emergency Department note encounter date 3/20/25, indicated R26 was last in the ER on 3/12/25, after twisting her ankle. R26 was advised symptomatic treatment and ankle brace. it appears that the ankle brace had not been removed since then. Today when brace removed, R26 noted to have redness and ulcer on both medial aspect (inner) and lateral aspect (outside) of right ankle. Progress note dated 3/24/2025 at 3:05 p.m., R26 readmitted from hospital with diagnosis of ankle fracture, open area on right ankle When observed on 4/14/25 at 6:58 p.m., R26 had a cast on right foot, when asked R26 stated "I fractured my ankle".	2 900		

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2 900	Continued From page 5 When interviewed on 4/16/2025 at 10:57 a.m., licensed practical nurse (LPN)-B stated if an order was not clear or parts were missing, the nurse needed to call the provider to clarify the orders. When interviewed on 4/16/25 10:59 a.m., LPN-A stated orders from a hospital return are entered by the health unit coordinator (HUC) and checked by two nurses or entered by a nurse and checked by another nurse. If an order does not make sense or is missing information, the nurse is responsible to contact the provider to get directions. LPN-A confirmed the order for R26's splint should have been clarified for specific instructions. When interviewed on 4/16/25 at 12:45 p.m., nurse practitioner (NP) stated the air splint should have been removed to provide cares, however, NP did not clarify how often the splint should have been removed for cares. If the staff had any questions about the splint they should have called and asked for clarification. Based on what was on the ER note the cause of the cellulitis and pressure sores resulted from the air splint not being removed. When interviewed on 4/16/25 at 2:52 p.m. the director of nursing (DON) stated no order was entered to remove the splint and check the skin. DON stated she expected when a resident returned with a removable device the nurses should get parameters/orders to remove and check the skin underneath, this was not done for R26. DON was unable to locate any procedure or process changes that were made to ensure that this did not occur again. Facility provided policy Transcription Processing	2 900		

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2 900	Continued From page 6 Provider Orders - Long Term Care dated 1/2025, indicated transcribe order to the electronic medication administration record (EMAR)/electronic treatment administration record (ETAR). However the policy did not address clarifying orders. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could in-service all staff responsible for giving cares/services on following the care plan and assess for interventions to promote prevent pressure ulcers from developing. The DON or designee could then conduct audits to ensure care and serves were being followed. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 900		

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	245511	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**04/16/2025**

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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 04/16/2025. At the time of this survey, Cura Of Monticello 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		05/02/2025

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. Cura Of Monticello is a 2-story building with a Sub-basement built in 1986 and was determined to be of Type II(222) construction. The facility is fully fire sprinkler protected and has a fire alarm system with smoke detection in corridors and spaces open to the corridor that is monitored for automatic fire department notification. The facility has a capacity of 67 beds and had a census of 62 at the time of the survey.	K 000		

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K 000	Continued From page 2	K 000		
K 225 SS=E	The requirements at 42 CFR, Subpart 483.70(a), are NOT MET as evidenced by: Stairways and Smokeproof Enclosures CFR(s): NFPA 101 Stairways and Smokeproof Enclosures Stairways and Smokeproof enclosures used as exits are in accordance with 7.2. 18.2.2.3, 18.2.2.4, 19.2.2.3, 19.2.2.4, 7.2 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain emergency egress doors per NFPA 101 (2012 edition), Life Safety Code, sections 19.2.2.2.1 and 7.2.1.4.5.1. This deficient finding could have a patterned impact on the residents within the facility. Findings include: On 04/16/2025 at 12:59 PM, it was revealed by observation that stairwell door B12 was difficult to open. An interview with the Director of Maintenance verified this deficient finding at the time of discovery.	K 225	Facility ordered parts for the stairwell door B12. Parts were ordered on 4/25/2025. Entire completion of project expecting 60 days June 15th, 2025. Once completed, once a week audits for four weeks, and randomly thereafter.	6/15/25
K 271 SS=E	Discharge from Exits CFR(s): NFPA 101 Discharge from Exits Exit discharge is arranged in accordance with 7.7, provides a level walking surface meeting the	K 271		5/12/25

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K 271	Continued From page 3 provisions of 7.1.7 with respect to changes in elevation and shall be maintained free of obstructions. Additionally, the exit discharge shall be a hard packed all-weather travel surface. 18.2.7, 19.2.7 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain exit discharges per NFPA 101 (2012 edition), Life Safety Code, sections 19.2.1, 7.1.10.1, 7.1.6.1.1, 7.1.6.2, and 7.1.6.3. This deficient finding could have a patterned impact on the residents within the facility. Findings include: On 04/16/2025 at 01:05 PM, it was revealed by observation that a large section of concrete was missing on the sidewalk outside stairwell door B8, causing a hole that was 3" deep. An interview with the Director of Maintenance verified this deficient finding at the time of discovery.	K 271	Facility maintenance director to fix the large section of concrete that is missing on the sidewalk outside the stairwell door. The expected completion date is 5/12/2025. Audit to be completed once a week for four weeks, to ensure there is no holes or considerable cracking and random audits thereafter.	
K 291 SS=E	Emergency Lighting CFR(s): NFPA 101 Emergency Lighting Emergency lighting of at least 1-1/2-hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to test emergency lighting per NFPA 101 (2012 edition), Life Safety Code, sections 19.2.9.1 and 7.9.3.1.1. This deficient finding could have a patterned	K 291	Facility corrected the exit areas where light bulbs needed to be replaced. The maintenance director will audit the facility light bulbs to ensure that they are all in operational order. The audit will include	4/17/25

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	245511	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**04/16/2025**

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K 291	Continued From page 4 impact on the residents within the facility. Findings include: 1. On 04/16/2025 at 12:44 PM, it was revealed by observation that the emergency light near the care center conference room on the second floor was non-operational. 2. On 04/16/2025 at 12:47 PM, it was revealed by observation that the emergency light near resident room 217 on the second floor was non-operational. 3. On 04/16/2025 at 01:06 PM, it was revealed by observation that the emergency light in the sub-basement near the stairwell door was non-operational. An interview with the Director of Maintenance verified these deficient findings at the time of discovery.	K 291	checking the lights two times a week for four weeks and then once a week for four weeks and randomly thereafter.	
K 345 SS=D	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 observation and staff interview, the facility failed to maintain the fire alarm system per	K 345	Facilities maintenance director removed the factory seal immediately on 4/16/25.	4/16/25

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K 345	Continued From page 5 NFPA 101 (2012 edition), Life Safety Code, section 9.6.1.3, and NFPA 72 (2010 edition), National Fire Alarm and Signaling Code sections 14.2.1.1, 14.2.1.1.1, 14.2.1.1.2, and 14.2.1.2.2. This deficient finding could have an isolated impact on the residents within the facility. Findings include: On 04/16/2025 at 01:01 PM, it was revealed by observation that smoke detector near resident room 101 had the factory dust cover installed on it. An interview with the Director of Maintenance verified this deficient finding at the time of discovery.	K 345	The maintenance director will conduct one time weekly audits for four weeks and randomly thereafter.	
K 372 SS=E	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain smoke barriers per NFPA	K 372	The facility maintenance director filled gaps to seal the duct work above the	5/12/25

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K 372	Continued From page 6 101 (2012 edition), Life Safety Code, sections 19.3.7.1, 19.3.7.3, 8.5.2.2, and 8.5.6.2. This deficient finding could have a patterned impact on the residents within the facility. Findings include: On 04/16/2025 at 12:38 PM, it was revealed by observation that the smoke barrier was not fully sealed around duct work above the ceiling on the second floor living room above the couch. An interview with the Director of Maintenance verified this deficient finding at the time of discovery.	K 372	ceiling on the second floor living room above the couch, with fire caulking. Completed 5/1/2025. The Maintenance Director will audit the other smoke barrier locations to ensure there is a barrier between the two sides. This will be completed by 5/12/2025.	
K 711 SS=F	Evacuation and Relocation Plan CFR(s): NFPA 101 Evacuation and Relocation Plan There is a written plan for the protection of all patients and for their evacuation in the event of an emergency. Employees are periodically instructed and kept informed with their duties under the plan, and a copy of the plan is readily available with telephone operator or with security. The plan addresses the basic response required of staff per 18/19.7.2.1.2 and provides for all of the fire safety plan components per 18/19.2.2. 18.7.1.1 through 18.7.1.3, 18.7.2.1.2, 18.7.2.2, 18.7.2.3, 19.7.1.1 through 19.7.1.3, 19.7.2.1.2, 19.7.2.2, 19.7.2.3 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to implement a fire safety plan per NFPA 101 (2012 edition), Life Safety Code, section 19.7.2.2. This deficient	K 711	Facilities Administrator updated the internal fire policy to include step three, to call the local fire department and ensured that appropriate staffing is available 24	5/1/25

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K 711	Continued From page 7 finding could have a widespread impact on the residents within the facility. Findings include: On 04/16/2025 between 11:15 AM and 01:30 PM, it was revealed by a review of available documentation that the fire safety plan that the facility provided at the time of the survey did not include step 3, Emergency phone call to fire department. An interview with the Director of Maintenance verified this deficient finding at the time of discovery.	K 711	hours per day. Updated fire policy will be reviewed in facilities next QAPI.	
K 901 SS=F	Fundamentals - Building System Categories CFR(s): NFPA 101 Fundamentals - Building System Categories Building systems are designed to meet Category 1 through 4 requirements as detailed in NFPA 99. Categories are determined by a formal and documented risk assessment procedure performed by qualified personnel. Chapter 4 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to provide a Risk Assessment per NFPA 99 (2012 edition), Health Care Facilities Code, section 4.2. This deficient finding could have a widespread impact on the residents within the facility.	K 901	Facility Administrator updated chapters 10 and 11 of the NFPA 99 Risk Assessment to reflect the required information. Completed 5/2/2025. Updated chapters 10 and 11 will be reviewed in facilities next QAPI.	5/2/25

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K 901	Continued From page 8 Findings include: On 04/16/2025 between 11:15 AM and 01:30 PM, it was revealed by a review of available documentation that the NFPA 99 risk assessment that the facility provided at the time of the survey did not include chapters 10 and 11 of NFPA 99 (2012 edition), Health Care Facilities Code. An interview with the Director of Maintenance verified this deficient finding at the time of discovery.	K 901		
K 920 SS=D	Electrical Equipment - Power Cords and Extens CFR(s): NFPA 101 Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8	K 920		4/16/25

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K 920	Continued From page 9 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain the usage of electrical adaptive devices NFPA 99 (2012 edition), Health Care Facilities Code, sections 10.5.2.3.1 and 10.2.4.2.1, NFPA 101 (2012 edition), Life Safety Code, section 9.1.2, NFPA 70, (2011 edition), National Electrical Code, sections 400.8, and UL 1363. This deficient finding could have a patterned impact on the residents within the facility. Findings include: On 04/16/2025 at 01:09 PM, it was revealed by observation that there was a power strip plugged into another power strip under the desk behind the nurses' station on the first floor. An interview with the Director of Maintenance verified this deficient finding at the time of discovery.	K 920	The facilities maintenance director took the power strip plugged into another power strip under the desk behind the nursing station on the first floor immediately upon discovery during survey. Director of maintenance to audit common areas for this deficiency twice a week for four weeks, 1x per week for four weeks, and randomly thereafter.	