DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
May 11, 2022

Administrator
Mission Nursing Home
3401 East Medicine Lake Boulevard
Plymouth, MN 55441

RE: CCN: 245546
Cycle Start Date: March 24, 2022

Dear Administrator:

Please Note: The health and life safety code revisit findings will be processed under separate enforcement cycles. This letter addresses the Health survey only.

On April 11, 2022, we notified you a remedy was imposed. On May 4, 2022 the Minnesota Department of Health 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 April 19, 2022.

As authorized by CMS the remedy of:

- Discretionary denial of payment for new Medicare and Medicaid admissions effective May 11, 2022 did not go into effect. (42 CFR 488.417 (b))

In our letter of April 11, 2022, 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 May 11, 2022 due to denial of payment for new admissions. Since your facility attained substantial compliance on April 19, 2022, 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 Therefore, the NATCEP prohibition is rescinded.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 Region V Office may notify you of their determination regarding any imposed remedies.

Feel free to contact me if you have questions.

Sincerely,

Joanne Simon, Compliance Analyst
Minnesota Department of Health
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
May 11, 2022

CMS Certification Number (CCN): 245546

Administrator
Mission Nursing Home
3401 East Medicine Lake Boulevard
Plymouth, MN 55441

Dear Administrator:

The Minnesota Department of Health assists the Centers for Medicare and Medicaid Services (CMS) by surveying skilled nursing facilities and nursing facilities to determine whether they meet the requirements for participation. To participate as a skilled nursing facility in the Medicare program or as a nursing facility in the Medicaid program, a provider must be in substantial compliance with each of the requirements established by the Secretary of Health and Human Services found in 42 CFR part 483, Subpart B.

Based upon your facility being in substantial compliance, we are recommending to CMS that your facility be recertified for participation in the Medicare and Medicaid program.

Effective April 19, 2022 the above facility is certified for:

65 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 65 skilled nursing facility beds.

You should advise our office of any changes in staffing, services, or organization, which might affect your certification status. If, at the time of your next survey, we find your facility to not be in substantial compliance your Medicare and/or Medicaid provider agreement may be subject to non-renewal or termination.

Please contact me if you have any questions.

Sincerely,

Joanne Simon, Compliance Analyst
Minnesota Department of Health
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

Electronically delivered
April 11, 2022

Administrator
Mission Nursing Home
3401 East Medicine Lake Boulevard
Plymouth, MN 55441

RE: CCN: 245546
Cycle Start Date: March 24, 2022

Dear Administrator:

Please Note: The health and life safety code survey findings will be processed under separate enforcement cycles. This letter addresses the Health survey only.

On March 24, 2022, a survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be a pattern of deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level E), as evidenced by the electronically 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 Region V Office for imposition. The CMS Region V Office 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 11, 2022.

- Directed plan of correction (DPOC), Federal regulations at 42 CFR § 488.424. Please see electronically attached documents for the DPOC.

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective May 11, 2022.. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective May 11, 2022.
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.

This Department is also recommending that CMS impose:

• Civil money penalty (42 CFR 488.430 through 488.444). You will receive a formal notice from the CMS RO only if CMS agrees with our recommendation.

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 $11,292; 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 11, 2022, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, Mission Nursing Home will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from May 11, 2022. 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 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 an "E" tag), i.e., the plan of correction should be directed to:

Judy Loecken, Unit Supervisor
St. Cloud B District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Midtown Square
3333 Division Street, Suite 212
Saint Cloud, Minnesota 56301-4557
Email: judy.loecken@state.mn.us
Office: (320) 223-7300 Mobile: (320) 241-7797

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health - 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

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 September 24, 2022 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:

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) 565-9462

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, Principal Program Representative by phone at (312) 353-1502 or by e-mail at Tamika.Brown@cms.hhs.gov.

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

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

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

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

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

Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

Feel free to contact me if you have questions.

Sincerely,

Joanne Simon, Enforcement Specialist
Minnesota Department of Health
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245546	A. BUILDING _____ B. WING _____	C 03/24/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MISSION NURSING HOME	**3401 EAST MEDICINE LAKE BOULEVARD PLYMOUTH, MN 55441**

(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 3/21 to 3/24/22, a survey for compliance with Appendix Z, Emergency Preparedness Requirements, §483.73(b)(6) 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 3/21/22 to 3/24/22, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was found to be NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaint was found to be SUBSTANTIATED: H5546120C (MN79058) with deficiencies cited at F657 and H5546120C (MN79058) was substantiated with a deficieincy issed at F657. AND The following complaint was found to be UNSUBSTANTIATED: H5546100C (MN61898) The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		04/13/2022

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

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F 000	Continued From page 1 be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.	F 000		
F 582 SS=D	Medicaid/Medicare Coverage/Liability Notice CFR(s): 483.10(g)(17)(18)(i)-(v) §483.10(g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and (ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this section. §483.10(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate. (i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible.	F 582		4/13/22

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F 582	Continued From page 2 (ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change. (iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements. (iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility. (v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to issue a Skilled Nursing Facility Advanced Beneficiary Notice (SNFABN) to 2 of 3 residents (R48 and R49) when their Part A Medicare services were ending, and they remained in the facility. This failure left the residents or their responsible parties without information related to continuing to receive Part A Medicare services, the cost, and their appeal rights. Findings include: R48's undated Face Sheet located in the resident's electronic medical record (EMR) under the "Face Sheet" tab revealed admission 2/22/22	F 582	F582 Medicaid/ Medicare Coverage/Liability Notice R49 status was that the EMR reflected planned discharge however, unable to locate the NOMNC form in the MDS nurses file system. All residents with an end-of-skilled coverage are issued a NOMNC Form informing them of the last covered day for therapy or skilled nursing services. Presently the triple check system (see attached) is in place between the Business Office, MDS/DON, and Director of Therapy Services to be completed weekly at Medicare meeting. Audits will be conducted on all residents	

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F 582	Continued From page 3 for skilled therapy after a hospital stay. R48's Notice of Medicare Non-Coverage (NOMNC] revealed last covered day (LCD) was 03/26/22 and signed by R48 on 03/24/22 acknowledging information was provided. However, R48's record lacked evidence a SNFABN explaining Medicare A rights related to remaining in the facility and continuing to receive the same services and bill Medicare A, continue to receive the services and not bill Medicare A, or not to receive the services. R49's undated Face Sheet located in the resident's EMR under the "Face Sheet" tab revealed admission 10/22/21 for skilled therapy after a hospital stay. Review of R49's NOMNC revealed LCD was 02/08/22 and signed on 02/04/22. However, R49 record lacked evidence an SNFABN was issued. During an interview on 3/24/22, at 4:00 p.m. the Director of Nursing (DON) stated she was not aware of a facility policy related to completing NOMNCs and SNFABNs. The DON confirmed the facility failed to issue the residents' required SNFABN.	F 582	ending services to ensure completion/administration of the NOMNC form. These audits will be completed monthly x 3 until 100% compliance is observed. Findings will be reported to quarterly QAPI team. Responsible person(s): DON/designee Date of compliance/correction: 4/13/2022	
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to--	F 657		4/19/22

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F 657	Continued From page 4 (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to revise and implement careplan interventions for 2 of 5 residents (R26 & R53) reviewed for abuse. Findings Include: R26's face sheet, printed 3/24/22, indicated R26 was admitted to facility on 04/02/19, with diagnoses including dementia, major depressive disorder, post-traumatic stress disorder (PTSD), personal history of self-harm, and suicidal ideation. Review of R26's quarterly minimum data set (MDS), dated 01/11/22, indicated R26's indicated R26's cognition is was moderately impaired.	F 657	Resident re-assessment for R26 and R53 were reviewed and corrected. The facility social workers expectations in regards to immediate care plan revisions and updates following any behavioral altercations, has been reviewed. Any new behaviors, changes, or updates with behaviors will be reviewed daily at the IDT meetings. Each resident's behavioral concern on the care plans will be reviewed and updated as needed. Completion date: 4/20/2022 Audits will be conducted for completion. These audits will be completed daily for 1 week, then weekly x 4, then monthly x 3 until 100% compliance is observed. Findings will be reported to QAPI team.	

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F 657	Continued From page 5 Review R26's "Care Plan" dated 06/14/19, indicated "problem" was cognitive loss/dementia: alteration in cognition: carries a diagnosis of MS [multiple sclerosis], suicidal ideations, major depressive disorder, and anxiety. R26 was oriented to person and surroundings but intermittently oriented to the day, date, and time. He had episodes of impaired judgement and short-term memory deficits. Approach dated 06/14/19: one-to-one visits to remind resident of the rules, etc. There were no other interventions included on the care plan addressing dementia care. R26's "Care Plan" located in R26's EMR under the "Care Plan" tab indicated there was no documentation of R26's "inappropriate sexual behaviors." During an interview conducted on 03/23/22 at 9:33 a.m. with Trained Medication Aide (TMA)-A, TMA-A stated R26 required two people due to making accusations and sexually inappropriate comments. Further, TMA-A stated administration was aware. During an interview on 03/24/22, at 9:51 a.m. Registered Nurse (RN)-A, stated R26 would comment on how pretty you look today, had tried to grab staff members, and has mentioned "come lay down with me". RN-A stated R26 was redirected, reminded of inappropriate behavior and incident was reported to psych. During an interview on 03/24/22 at 11:26 a.m. Social Worker (SW) stated "I wasn't able to locate if the care plan had been updated to include sexually inappropriate comments to staff	F 657	Responsible person(s): NHA/designee Date of compliance/correction: 4/19/2022	

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F 657	Continued From page 6	F 657		

and visitors." Further, SW stated it should have been on the care plan.

During an interview on 03/24/22, at 12:47 p.m. the director of nursing (DON) stated she was not aware of R26's inappropriate comments made towards the staff. Further, she indicated this should be on the care plan.

R53's undated "Face Sheet" located in R53's EMR, under the "Face Sheet" tab, indicated R53 was initially admitted to the facility on 04/23/18 and readmitted on 06/28/18 with diagnoses including dementia with behavioral disturbance, psychosis, major depressive disorder, restlessness, and agitation.

Review of R53's quarterly "MDS," located in R53's with an ARD of 12/19/21, indicated no BIMS score or staff assessments were conducted. R53 was assessed to have exhibited physical behavioral symptoms directed toward others such as hitting, kicking, pushing, scratching, grabbing, abusing others sexually during one to three days of the assessment. Other behavioral symptoms not directed toward others such as hitting or scratching self, pacing, rummaging, public sexual acts, disrobing in public, throwing, or smearing food or bodily wastes, or verbal/vocal symptoms like screaming, disruptive sounds.

Review of R53's current, undated "Care Plan" located in R53's EMR under the "Care Plan" tab, revealed R53's care plan problem for behavioral symptoms had not been updated since the incident on 06/13/21.

During an interview conducted on 03/24/22 at

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	245546	A. BUILDING _____ B. WING _____	C 03/24/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MISSION NURSING HOME	**3401 EAST MEDICINE LAKE BOULEVARD PLYMOUTH, MN 55441**

(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 657	Continued From page 7 1:47 p.m. DON confirmed the care plans should have been reviewed and revised for R26, and R53. After each altercation, each resident's care plan should have included what action was put into place. Review of the facilities policy titled, "Comprehensive Care Plans" dated 01/01/18, indicated " [facility] develops and implements comprehensive, person-centered care plans that include measurable objectives and timetables to meet each resident's physical, psychosocial, and functional needs ...the interdisciplinary team must review and update the care plan: when there has been a significant change in the resident's condition, when the desired outcome has not met ..."	F 657		
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals	F 880		4/13/22

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F 880	Continued From page 8 providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens.	F 880		

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F 880	Continued From page 9 Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, and record review, the facility failed to ensure staff sanitized hands during meal service in 1 of 2 dining rooms (DR2) observed during mealtimes. This failure had the potential to affect 24 residents served in DR2. Findings include: During observation of DR2 on 03/21/22, at 5:39 PM, Nurse Assistant Registered (NAR)-B moved between 2 residents that required assistance with eating/plate service, however, NAR-B did not sanitize hands. During observation of DR2 on 03/24/22, at 11:52 AM, NAR-A assisted two residents with eating and plate service, and then proceeded to a second table, however NAR-A did not sanitize hands. During interview on 03/24/22, at 12:27 p.m. NAR-A stated " I should have sanitized my hands." During interview on 03/24/22, at 12:28 p.m. dietary director (DD) stated she expected staff to sanitize their hands between assisting residents with their meals.	F 880	Infection control policies were reviewed and found to be consistent with current guidelines. Covid 19 policy reviewed and remains unchanged. Residents will be monitored according to COVID 19 policies and infection control policies. A root cause analysis has been completed. The clinical staff will be re-educated at change of shift daily x 7 days. Department heads will re-educate their staff on infection control with daily reminders of the principles of PPE, monitoring of VS: P, RR, 02 sats (surveillance screening), and more specifically, hand hygiene. The known employee noted in the SOD has been re-trained. This one individual immediately knew he had made an error when he moved onto the next table to feed without washing his hands, and he corrected himself. He noted he was nervous with this particular surveyor. The second employee is unknown and the surveyor did not mention two occurrences took place with respect to handwashing at the exit summary meeting. Therefore, we have audited all employees house wide on the practice of handwashing, and educated on when to perform and complete hand washing. Handwashing audits will occur daily in	

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F 880	Continued From page 10 During interview on 03/24/22, at 1:03 p.m. the director of nursing (DON) stated, "both those staff members know better. I expect them to sanitize their hands between residents." Review of the facility's policy titled "Handwashing/Hand Hygiene" dated 08/21, indicated "the facility considers hand hygiene the primary means to prevent the spread of infections ...Use an alcohol-based hand rub containing at least 62% alcohol; or alternatively, soap (antimicrobial or non-antimicrobial) and water for the following situations ...before and after assisting a resident with meals ..."	F 880	both dining rooms x 5 days, then weekly x 4 weeks in both dining rooms, monthly x 3 months, and quarterly x 1 year. Results and findings to be reported at the QAPI meeting for performance improvement and any additional actions needed based on findings of audits. Responsible person(s): DON/designee Date of compliance/correction: 4/13/2022	

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
April 19, 2022

Administrator
Mission Nursing Home
3401 East Medicine Lake Boulevard
Plymouth, MN 55441

RE: CCN: 245546
Cycle Start Date: April 5, 2022

Dear Administrator:

Please Note: The health and life safety code survey findings will be processed under separate enforcement cycles. This letter addresses the LSC survey only.

On April 5, 2022, a survey was completed at your facility by the Minnesota Departments of Public Safety, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

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

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

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

DEPARTMENT CONTACT

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

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:

William Abderhalden, Fire Safety Supervisor
Deputy State Fire Marshal
Health Care/Corrections Supervisor – Interim
Minnesota Department of Public Safety
445 Minnesota Street, Suite 145
St. Paul, MN 55101-5145
Cell: (507) 361-6204
Email: william.abderhalden@state.mn.us
Fax: (651) 215-0525

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

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

If substantial compliance with the regulations is not verified by July 5, 2022 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by October 5, 2022 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

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

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

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

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

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

Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

Feel free to contact me if you have questions.

Sincerely,

Joanne Simon, Enforcement Specialist
Minnesota Department of Health
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

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	245546	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**04/05/2022**

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MISSION NURSING HOME	**3401 EAST MEDICINE LAKE BOULEVARD** **PLYMOUTH, MN 55441**

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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 04/05/2022. At the time of this survey, Mission Nursing Home was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: IF PARTICIPATING IN THE E-POC PROCESS, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED.	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		04/20/2022

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. Mission Nursing Home 2-story building was constructed in 1995 and was determined to be of Type II (111) construction. It has a full basement and is automatic sprinkler protected throughout. The facility has a fire alarm system that is monitored for fire department notification. The facility has a capacity of 65 beds and had a census of 58 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is	K 000		

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K 000	Continued From page 2 NOT MET as evidenced by:	K 000		
K 345 SS=F	Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to test and inspect the fire alarm system per NFPA 101 (2012 edition), Life Safety Code, section 9.6.1.3, and NFPA 72 (2010 edition), National Fire Alarm and Signaling Code, sections 14.3.1 and 14.4.5.3 through 14.4.5.3.3. These deficient findings could have a widespread impact on the residents within the facility. Findings include: 1. On 04/05/2022 at 09:10 AM, it was revealed by a review of available documentation that the facility did not have a current annual fire alarm inspection report. 2. On 04/05/2022 at 09:10 AM, it was revealed by a review of available documentation that the facility did not have a current semi-annual fire alarm inspection report. 3. On 04/05/2022 at 09:10 AM, it was revealed by	K 345	1. Detailed description of the corrective action taken or planned to correct deficiency • Annual fire alarm inspection reports found and placed in Life Safety manual. Last three dates inspected were 4/17/19, 6/23/20 and 5/5/21. Next scheduled inspection is 4/22/22 • Semiannual fire alarm testing will be completed and documented in the Life Safety manual. Nest semiannual testing is scheduled for 5/3/22 • Sensitivity testing will be completed every other year and increased to every 5 years if the device remains within its sensitivity range. The testing log will be completed and placed in the Life Safety manual. A scheduled test will be completed on 5/3/22 2. Address the measures that will be put in place to ensure the deficiency does not recur • A log has been created to schedule	5/3/22

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K 345	Continued From page 3 a review of available documentation that the facility did not have a copy of a current smoke detector sensitivity test. An interview with the Facility Maintenance Director verified these deficient findings at the time of discovery.	K 345	and track annual fire alarm inspections and placed in Life Safety manual 3. Indicate how the facility plans to monitor future performance to ensure solutions as are sustained • Annual fire alarm inspection will be added to the Safety Committee audit tool 4. Identify who is responsible for the corrective actions and monitoring of compliance • Maintenance Director is responsible for monitoring and compliance 5. The actual or proposes date for completion of the remedy • Date of completion: 5/3/22	
K 346 SS=F	Fire Alarm System - Out of Service CFR(s): NFPA 101 Fire Alarm - Out of Service Where required fire alarm system is out of services for more than 4 hours in a 24-hour period, the authority having jurisdiction shall be notified, and the building shall be evacuated or an approved fire watch shall be provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service. 9.6.1.6 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 alarm system out-of-service policy per NFPA 101 (2012 edition), Life Safety Code section 9.6.1.6. This deficient finding could have a widespread impact on the residents within the facility.	K 346	1. Detailed description of the corrective action taken or planned to correct deficiency • An Out of Service policy for the fire alarm system has been created and placed in Life Safety manual 2. Address the measures that will be put in place to ensure the deficiency does not	4/8/22

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K 346	Continued From page 4 Findings include: On 04/05/2022 at 09:15 AM, it was revealed by a review of available documentation that the facility did not have an out-of-service policy for the fire alarm system. An interview with the Facility Director verified this deficiency finding at the time of discovery.	K 346	recur • Maintenance staff trained on out of service policy and will review annually 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained • Log created with quarterly and annual inspection requirements and kept in the Life Safety manual 4. Identify who is responsible for the corrective actions and monitoring of compliance • Maintenance Director is responsible for monitoring and compliance 5. The actual or proposes date for completion of the remedy • 4/8/22	
K 353 SS=F	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler	K 353		4/11/22

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K 353	Continued From page 5 system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to test and inspect the fire sprinkler system per NFPA 101 (2012 edition), Life Safety Code, section 9.7.5, and NFPA 25 (2011 edition), Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, section 5.1.1.2. These deficient findings could have a widespread impact on the residents within the facility. Findings include: 1. On 04/05/2022 at 09:20 AM, it was revealed by a review of available documentation that the facility did not have a copy of the annual fire sprinkler inspection report. 2. On 04/05/2022 at 09:20 AM, it was revealed by a review of available documentation that the facility did not have copies of any quarterly fire sprinkler tests being completed. An interview with the Facility Maintenance Director verified these deficient findings at the time of discovery.	K 353	1. Detailed description of the corrective action taken or planned to correct deficiency • Annual fire sprinkler system inspection report was found and placed in Life Safety manual. Last three dates inspected were 4/17/19, 6/23/20 and 4/20/21. Next scheduled inspection is 4/28/22 2. Address the measures that will be put in place to ensure the deficiency does not recur • A log has been created to schedule and track annual and quarterly fire sprinkler inspections and placed in Life Safety manual 3. Indicate how the facility plans to monitor future performance to ensure solutions as are sustained • Annual fire sprinkler inspection will be added to the Safety Committee audit tool 4. Identify who is responsible for the corrective actions and monitoring of compliance • Maintenance Director is responsible for monitoring and compliance 5. The actual or proposed date for completion of the remedy • 4/11/22	
K 354 SS=F	Sprinkler System - Out of Service CFR(s): NFPA 101 Sprinkler System - Out of Service	K 354		4/11/22

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	245546	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**04/05/2022**

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K 354	Continued From page 6 Where the sprinkler system is impaired, the extent and duration of the impairment has been determined, areas or buildings involved are inspected and risks are determined, recommendations are submitted to management or designated representative, and the fire department and other authorities having jurisdiction have been notified. Where the sprinkler system is out of service for more than 10 hours in a 24-hour period, the building or portion of the building affected are evacuated or an approved fire watch is provided until the sprinkler system has been returned to service. 18.3.5.1, 19.3.5.1, 9.7.5, 15.5.2 (NFPA 25) 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 sprinkler system out-of-service policy per NFPA 101 (2012 edition), Life Safety Code section 9.7.6 and NFPA 25 (2011 edition), Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, Chapter 15. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 04/05/2022 at 09:25 AM, it was revealed by a review of available documentation that the facility did not have an out-of-service policy for the fire sprinkler system. An interview with the Facility Maintenance Director verified this deficient finding at the time of discovery.	K 354	1 Detailed description of the corrective action taken or planned to correct deficiency • An Out of Service policy for the fire sprinkler system has been created and placed in Life Safety manual. Policy and fire watch tools will be available at the nursing stations in case the system is out of service and a fire watch is required 2 Address the measures that will be put in place to ensure the deficiency does not recur • Maintenance staff trained on out of service policy and will review annually 3 Indicate how the facility plans to monitor future performance to ensure solutions as are sustained • Log created with annual inspection requirements kept in Life Safety manual 4 Identify who is responsible for the corrective actions and monitoring of compliance	

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K 354	Continued From page 7	K 354	• Maintenance Director is responsible for monitoring and compliance 5 The actual or proposed date for completion of the remedy • 4/11/22	
K 521 SS=F	HVAC CFR(s): NFPA 101 HVAC Heating, ventilation, and air conditioning shall comply with 9.2 and shall be installed in accordance with the manufacturer's specifications. 18.5.2.1, 19.5.2.1, 9.2 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to test and inspect the heating, ventilation, and air conditioning system per NFPA 101 (2012 edition), Life Safety Code, sections 19.5.2.1 and 9.2, NFPA 90A (2012 edition), Standard for the Installation of Air-Conditioning and Ventilating Systems, section 5.4.7.1, and NFPA 80 (2010 edition), Standard for Fire Doors and Other Opening Protectives, section 19.4.1.1. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 04/05/2022 at 09:20 AM, it was revealed by a review of available documentation that the facility did not have a record of the last time the fire	K 521	1 Detailed description of the corrective action taken or planned to correct deficiency • A fire damper testing policy and audit log has been created and placed in the Life Safety manual. Testing of fire dampers was completed on 4/20/22 and will be tested every four years per requirement 2 Address the measures that will be put in place to ensure the deficiency does not recur • Maintenance staff trained on fire damper testing policy and will ensure mechanical contractors test the dampers every four years. The mechanical contractor will be inspecting on 4/22/22 and will continue inspections every four	4/22/22

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K 521	Continued From page 8 dampers were inspected and tested. An interview with the Facility Maintenance Director verified this finding at the time of discovery.	K 521	years 3 Indicate how the facility plans to monitor future performance to ensure solutions as are sustained • Log created with every four-year inspection requirements 4 Identify who is responsible for the corrective actions and monitoring of compliance • Maintenance Director is responsible for monitoring and compliance 5 The actual or proposed date for completion of the remedy • 4/22/22	
K 712 SS=C	Fire Drills CFR(s): NFPA 101 Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to conduct fire drills per NFPA 101 (2012 edition), Life Safety Code section 19.7.1. This deficient finding could have a widespread impact on the residents within the facility.	K 712	1 Detailed description of the corrective action taken or planned to correct deficiency • Fire drill logs were found for the first shift during the fourth quarter of 2021 and the second shift during the first quarter of	4/8/22

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K 712	Continued From page 9 Findings include: On 04/05/2022 at 09:35 AM, it was revealed by a review of available documentation that the facility was missing fire drills for the 1st shift during the 4th quarter of 2021 and the 2nd shift during the 1st quarter of 2022. An interview with the Facility Maintenance Director verified this deficiency finding at the time of discovery.	K 712	2022. Dates competed were 10/17/21 at 11:37 AM and 2/11/22 at 8:56 PM. 2 Address the measures that will be put in place to ensure the deficiency does not recur • A schedule and log is in place with the maintenance department to schedule at least quarterly fire drills on each shift. 3 Indicate how the facility plans to monitor future performance to ensure solutions are sustained • Follow the schedule for fire drills and keep employee log in the Life Safety manual 4 Identify who is responsible for the corrective actions and monitoring of compliance • Maintenance Director is responsible for monitoring and compliance 5 The actual or proposed date for completion of the remedy • 4/8/22	
K 761 SS=F	Maintenance, Inspection & Testing - Doors CFR(s): NFPA 101 Maintenance, Inspection & Testing - Doors Fire doors assemblies are inspected and tested annually in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives. Non-rated doors, including corridor doors to patient rooms and smoke barrier doors, are routinely inspected as part of the facility maintenance program. Individuals performing the door inspections and testing possess knowledge, training or experience that demonstrates ability. Written records of inspection and testing are	K 761		4/20/22

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K 761	Continued From page 10 maintained and are available for review. 19.7.6, 8.3.3.1 (LSC) 5.2, 5.2.3 (2010 NFPA 80) This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to inspect fire-rated door assemblies per NFPA 101 (2012 edition), Life Safety Code, sections 19.7.6 and 8.3.3.1, and NFPA 80 (2010 edition), Standard for Fire Doors and Other Opening Protectives, section 5.2.1. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 04/05/2022 at 09:40 AM, it was revealed by a review of available documentation that the facility did not complete an annual fire door inspection for 2021. An interview with the Facility Maintenance Director verified this deficient finding at the time of discovery.	K 761	1 Detailed description of the corrective action taken or planned to correct deficiency • A fire door annual inspection form has been created and placed in the Life Safety manual which includes a drawing/layout of the facility to track inspections Inspection. Door inspection was completed on 4/20/22. Logs will be kept for three years 2 Address the measures that will be put in place to ensure the deficiency does not recur • A fire door inspection log has been created and an inspection will be completed annually 3 Indicate how the facility plans to monitor future performance to ensure solutions as are Sustained • An audit log has been created and will be added to the safety committee calendar annually 4 Identify who is responsible for the corrective actions and monitoring of compliance • Maintenance Director is responsible for monitoring and compliance 5 The actual or proposed date for completion of the remedy • 4/20/22	
K 918 SS=C	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101	K 918		4/19/22

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K 918	Continued From page 11 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. 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 test and maintain the essential electrical system per NFPA	K 918	1 Detailed description of the corrective action taken or planned to correct deficiency	

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K 918	Continued From page 12 99 (2012 edition), Health Care Facilities Code, section 6.4.4.1.1.4 and NFPA 110 (2010 edition), Standard for Emergency and Standby Power Systems, sections 7.9.10 and 8.4.2. These deficient findings could have a widespread impact on the residents within the facility. Findings include: 1. On 04/05/2022 at 09:45 AM, it was revealed by a review of available documentation that the monthly generator run test records did not show the minimum 30 percent load capacity rating of the nameplate. 2. On 04/05/2022 at 09:45 AM, it was revealed by a review of available documentation that the facility did not have a letter from the natural gas provider that proved reliable fuel service An interview with the Facility Maintenance Director verified these findings at the time of discovery.	K 918	• A generator log which includes the minimum 30% load capacity rating of the nameplate has been added to the monthly log completed by maintenance staff • The monthly full load test will continue to be completed by maintenance staff • The annual level 5 test 30% of load will be completed on 5/10/22 by Ziegler and annually thereafter • Facility obtained a letter from Center Point Energy, the natural gas provider, of a reliable fuel source 2 Address the measures that will be put in place to ensure the deficiency does not recur • Monthly log to be completed by maintenance staff 3 Indicate how the facility plans to monitor future performance to ensure solutions as are sustained • An updated audit log has been created to include the 30% load and will be added to the safety committee quarterly calendar 4 Identify who is responsible for the corrective actions and monitoring of compliance • Maintenance Director is responsible for monitoring and compliance 5 The actual or proposes date for completion of the remedy • 4/19/22	