DEPARTMENT OF HEALTH AND HUMAN SERVICES — **CENTERS FOR MEDICARE & MEDICAID SERVICES**

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: TCFP

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00578N

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245616**
2.STATE VENDOR OR MEDICAID NO.
(L2) **850026600**

3. NAME AND ADDRESS OF FACILITY
(L3) **LIFECARE GREENBUSH MANOR**
(L4) **19120 200TH STREET**
(L5) **GREENBUSH, MN** (L6) **56726**

4. TYPE OF ACTION: **7** (L8)
1. Initial **2. Recertification**
3. Termination **4. CHOW**
5. Validation **6. Complaint**
7. On-Site Visit **9. Other**
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **08/16/2021** (L34)

8. ACCREDITATION STATUS: __ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY **03** (L7)

01 Hospital	**05 HHA**	**09 ESRD**	**13 PTIP**	**22 CLIA**
02 SNF/NF/Dual	**06 PRTF**	**10 NF**	**14 CORF**	
03 SNF/NF/Distinct	**07 X-Ray**	**11 ICF/IID**	**15 ASC**	
04 SNF	**08 OPT/SP**	**12 RHC**	**16 HOSPICE**	

FISCAL YEAR ENDING DATE: (L35)
09/30

11. .LTC PERIOD OF CERTIFICATION
From (a) :
To (b) :

12.Total Facility Beds **40** (L18)
13.Total Certified Beds **40** (L17)

10.THE FACILITY IS CERTIFIED AS:
X A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC

B. Not in Compliance with Program Requirements and/or Applied Waivers:

And/Or Approved Waivers Of The Following Requirements:
___ 2. Technical Personnel
___ 3. 24 Hour RN
___ 4. 7-Day RN (Rural SNF)
___ 5. Life Safety Code
__ 6. Scope of Services Limit
__ 7. Medical Director
__ 8. Patient Room Size
__ 9. Beds/Room

* Code: **A** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	20	20		
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS
1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):

See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Jennifer Bahr, Unit Supervisor 10/01/2021 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Joanne Simon, Enforcement Specialist 10/01/2021 (L20)

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY
X 1. Facility is Eligible to Participate
____ 2. Facility is not Eligible
(L21)

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

21. 1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :
_____

22. ORIGINAL DATE OF PARTICIPATION
04/13/2009
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions:
(L44)
B. Rescind Suspension Date:
(L45)

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal
INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
08/24/2021
(L33)

DETERMINATION APPROVAL

C&T REMARKS - CMS 1539 FORM **STATE AGENCY REMARKS**

CCN 245616 Lifecare Greenbush Manor

The facility has requested a Fire Safety Evaluation System survey to verify a passing score for life safety code deficiency cited at:
- K0372 Subdivision of Building Spaces = Smoke Barrier

The deficiency cited at K 0372 has been determined compliant as a result of the FSES.

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
October 1, 2021

CMS Certification Number (CCN): 245616

Administrator
Lifecare Greenbush Manor
19120 200th Street
Greenbush, MN 56726

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 September 17, 2021 the above facility is certified for:

40 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 40 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, 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

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
October 1, 2021

Administrator
Lifecare Greenbush Manor
19120 200th Street
Greenbush, MN 56726

RE: CCN: 245616
Cycle Start Date: June 17, 2021

Dear Administrator:

On September 2, 2021, we notified you a remedy was imposed. On August 16, 2021 the Minnesota Department(s) of Health and Public Safety completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of July 31, 2021.

As authorized by CMS the remedy of:

- Mandatory denial of payment for new Medicare and Medicaid admissions effective September 17, 2021 did not go into effect. (42 CFR 488.417 (b))

In our letter of July 9, 2021, 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 September 17, 2021 due to denial of payment for new admissions. Since your facility attained substantial compliance on July 31, 2021, 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, 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

DEPARTMENT OF HEALTH AND HUMAN SERVICES **CENTERS FOR MEDICARE & MEDICAID SERVICES**

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: TCFP

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Facility ID: 00578N

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3. NAME AND ADDRESS OF FACILITY
(L3) **LIFECARE GREENBUSH MANOR**
(L4) **19120 200TH STREET**
(L5) **GREENBUSH, MN** (L6) **56726**

4. TYPE OF ACTION: **2** (L8)
1. Initial **2. Recertification**
3. Termination **4. CHOW**
5. Validation **6. Complaint**
7. On-Site Visit **9. Other**
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **06/17/2021** (L34)

8. ACCREDITATION STATUS: __ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY 03 (L7)

01 Hospital	**05 HHA**	**09 ESRD**	**13 PTIP**	**22 CLIA**
02 SNF/NF/Dual	**06 PRTF**	**10 NF**	**14 CORF**	
03 SNF/NF/Distinct	**07 X-Ray**	**11 ICF/IID**	**15 ASC**	
04 SNF	**08 OPT/SP**	**12 RHC**	**16 HOSPICE**	

FISCAL YEAR ENDING DATE: (L35)
09/30

11. .LTC PERIOD OF CERTIFICATION
From (a) :
To (b) :

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10.THE FACILITY IS CERTIFIED AS:
A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC
X B. Not in Compliance with Program Requirements and/or Applied Waivers:

And/Or Approved Waivers Of The Following Requirements:
___ 2. Technical Personnel
___ 3. 24 Hour RN
___ 4. 7-Day RN (Rural SNF)
___ 5. Life Safety Code
__ 6. Scope of Services Limit
__ 7. Medical Director
__ 8. Patient Room Size
__ 9. Beds/Room

* Code: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
20		20		
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS
1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):

17. SURVEYOR SIGNATURE Date :
Amy Charais, HFE- NE II 08/06/2021 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Joanne Simon, Enforcement Specialist 08/20/2021 (L20)

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY
X 1. Facility is Eligible to Participate
____ 2. Facility is not Eligible
(L21)

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

21. 1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :

22. ORIGINAL DATE OF PARTICIPATION
04/13/2009
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions:
(L44)
B. Rescind Suspension Date:
(L45)

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal
INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

Electronically delivered
July 9, 2021

Administrator
Lifecare Greenbush Manor
19120 200th Street
Greenbush, MN 56726

RE: CCN: 245616
Cycle Start Date: June 17, 2021

Dear Administrator:

On June 17, 2021, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

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

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

DEPARTMENT CONTACT

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

Jen Bahr, RN, Unit Supervisor
Bemidji District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
705 5th Street NW, Suite A
Bemidji, MN 56601-2933
Email: Jennifer.bahr@state.mn.us
Office: (218) 308-2104 Mobile: (218) 368-3683

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 September 17, 2021 (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 December 17, 2021 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

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

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

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

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

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

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

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

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

Feel free to contact me if you have questions.

Sincerely,

Joanne Simon, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
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
	245616	A. BUILDING _____ B. WING _____	C 06/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFECARE GREENBUSH MANOR	**19120 200TH STREET GREENBUSH, MN 56726**

(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 6/13/21, through 6/17/21, 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 6/13/21, through 6/17/21, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was found NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were found to be substantiated: H5616004C(MN43732) with no deficiency cited due to actions taken by the facility prior to the survey. The following complaints were unsubstantiated H5616005C (MN60935) H5616006C (MN72511) 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		07/16/2021

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245616	A. BUILDING _____ B. WING _____	C 06/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFECARE GREENBUSH MANOR	**19120 200TH STREET GREENBUSH, MN 56726**

(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 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 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced	F 609		7/30/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245616	A. BUILDING _____ B. WING _____	C 06/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFECARE GREENBUSH MANOR	**19120 200TH STREET GREENBUSH, MN 56726**

(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 609	Continued From page 2 by: Based on interview and document review the facility failed to report bruising of unknown origin to the State Agency (SA) according to federal regulations for 1 of 2 residents (R12) reviewed for abuse. Findings include: R12's admission Minimum Data Set (MDS) dated 4/12/21, identified R12 had moderate cognitive impairment and required extensive assistance to complete activities of daily living. R12's care plan dated 5/20/21, identified a risk for bruising related to the use of aspirin. R12's progress notes identified the following: - 6/7/21, Staff identified a bruise to R12's upper inner thigh and lower perineal area. The bruise measured 7 centimeters (cm) in length and 3.5 cm wide was dark purple in color and non-blanchable. - 6/15/21, The bruising to the area between R12's right labia and buttock was healing well. During interview on 6/16/21, at 12:50 p.m. registered nurse (RN)-B stated R12 bruised easily. During assessment of a buttock wound a bruise was identified on R12 in between her labia and butt cheek. RN-B described the area as "very dark purple." RN-B stated R12 was interviewed and said no one had hurt her but stated, "we know she isn't reliable." and indicated R12 could not reliably recall events. RN-B stated the bruise had not been reported to the SA.	F 609	1.The bruising of unknown origin in R12 has been reported. 2.Staff will be reeducated on the facility vulnerable adult policy which correctly states reporting requirements to ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. 3.DON and IDT members will audit for complaints of alleged abuse or bruising of unknown origin for 6 months to ensure proper and timely reporting by daily review of nursing notes and daily report sheets. Any staff found to not be compliant with following the reporting time frame requirements will receive 1-1 reeducation and possible discipline. 4.Licensed staff will each log in to nursing home incident reporting site to make sure they know where and how to report and feel comfortable doing so. 5.Findings will be reviewed by the Quality Assurance and Performance	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245616	A. BUILDING _____ B. WING _____	C 06/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFECARE GREENBUSH MANOR	**19120 200TH STREET GREENBUSH, MN 56726**

(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 609	Continued From page 3 At 1:12 p.m. the director of nursing (DON) stated the bruising had not been reported to the SA. The DON stated they were waiting for lab results and the therapist said the pressure from R12 leaning may have cause the bruising. The DON stated the facility had a guide they used to determine if something was reportable to the SA and anytime they found something they would report right away. The DON stated R12's bruise wasn't reported because of the other reasons (referring to the therapist assessment and awaiting lab results). The facility policy Vulnerable Adult- Resident Abuse, Mistreatment and Misappropriation of Property dated 9/26/17, directed staff to report allegations of abuse including injuries of unknown origin immediately but no later than two hours after the event.	F 609	Improvement Committee for 1 year and at that time proceed with their recommendations. 6.Review of the Vulnerable Adult policy and process will be included in staff meetings every three months for 1 year.	
F 610 SS=D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the	F 610		7/30/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245616	A. BUILDING _____ B. WING _____	C 06/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 610	Continued From page 4 incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to thoroughly investigate bruising of unknown origin for 1 of 2 residents (R12) reviewed for abuse. Findings include: R12's admission Minimum Data Set (MDS) dated 4/12/21, identified moderate cognitive impairments and indicated she required extensive assistance to complete activities of daily living. R12's care plan dated 5/20/21, identified a risk for bruising related to the use of aspirin. R12's progress notes identified the following: - 6/7/21, Staff identified a bruise to R12's upper inner thigh and lower perineal area. The bruise measured 7 centimeters (cm) in length and 3.5 cm wide was dark purple in color and non-blanchable. - 6/15/21, The bruising to the area between R12's right labia and buttock was healing well. During interview on 6/16/21, at 12:50 p.m. registered nurse (RN)-B stated R12 bruised easily. During assessment of a buttock wound a bruise was identified on R12 in between her labia and butt cheek. RN-B described the area as "very dark purple." RN-B stated R12 was interviewed and said no one had hurt her but stated, "we know she isn't reliable" and indicated R12 could not reliably recall events. R12's bruise was	F 610	1.The bruising of unknown origin in R12 has been reported and investigated. Staff working 48 hours prior to the incident were interviewed. The husband of R12 was also interviewed. 2.The VA Grievance Checklist has been implemented. This checklist further breaks down the investigative process, including interviewing staff/residents that could have potentially been involved/affected at least, but not limited to, 48 hours prior to the incident 3.Continue to use the VA Grievance Checklist with all future incidences, updating the checklist PRN or until policy changes to ensure an overall thorough investigative process. 4.LSW/DON to consult with Risk Management each case within the five day investigative period. Risk Management to review/advise upon investigative process to ensure a complete and thorough investigative process has been followed. Will continue x6 months. If after 6 months, if no recommendations from Risk Management, facility will resume prior investigative process, consulting with Risk Management on a PRN basis. 5.Findings will continue to be reviewed by the Quality Assurance and Performance Improvement Committee on a quarterly basis.	

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F 610	Continued From page 5	F 610		

discussed at IDT and labs were ordered. RN-B stated they had looked at all angles as to what may have caused the bruising. RN-B did not have any information related to an investigation but stated the social worker may have written something down.

At 1:12 p.m. the director of nursing (DON) stated they were waiting for lab results and stated the therapist said the pressure from R12 leaning "may" have cause the bruising. Usually the facility went through the process of interviewing everybody but said there was no investigation into the bruising.

On 6/17/21, at 9:47 a.m. the social worker (SW) stated she did not have any documentation of an investigation related to R12's bruise. The SW stated a thorough investigation included interviewing the resident and any staff involved in the alleged incident.

A facility policy Vulnerable Adult- Resident Abuse, Mistreatment and Misappropriation of Property dated 9/26/17, indicated an investigation would include contain at least: a review of the complaint, interviews with the resident, witnesses and staff having contact with the resident.

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F 000	INITIAL COMMENTS On 6/13/21, through 6/17/21, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was found NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were found to be substantiated: H5616004C(MN43732) with no deficiency cited due to actions taken by the facility prior to the survey. The following complaints were unsubstantiated H5616005C (MN60935) H5616006C (MN72511) 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 that substantial compliance with the regulations has been attained.	F 000		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must:	F 609		7/30/21

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

Electronically Signed | 07/16/2021

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 609	Continued From page 1 §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to report bruising of unknown origin to the State Agency (SA) according to federal regulations for 1 of 2 residents (R12) reviewed for abuse. Findings include: R12's admission Minimum Data Set (MDS) dated 4/12/21, identified R12 had moderate cognitive impairment and required extensive assistance to complete activities of daily living.	F 609	1.The bruising of unknown origin in R12 has been reported. 2.Staff will be reeducated on the facility vulnerable adult policy which correctly states reporting requirements to ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or	

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F 609	Continued From page 2 R12's care plan dated 5/20/21, identified a risk for bruising related to the use of aspirin. R12's progress notes identified the following: - 6/7/21, Staff identified a bruise to R12's upper inner thigh and lower perineal area. The bruise measured 7 centimeters (cm) in length and 3.5 cm wide was dark purple in color and non-blanchable. - 6/15/21, The bruising to the area between R12's right labia and buttock was healing well. During interview on 6/16/21, at 12:50 p.m. registered nurse (RN)-B stated R12 bruised easily. During assessment of a buttock wound a bruise was identified on R12 in between her labia and butt cheek. RN-B described the area as "very dark purple." RN-B stated R12 was interviewed and said no one had hurt her but stated, "we know she isn't reliable." and indicated R12 could not reliably recall events. RN-B stated the bruise had not been reported to the SA. At 1:12 p.m. the director of nursing (DON) stated the bruising had not been reported to the SA. The DON stated they were waiting for lab results and the therapist said the pressure from R12 leaning may have cause the bruising. The DON stated the facility had a guide they used to determine if something was reportable to the SA and anytime they found something they would report right away. The DON stated R12's bruise wasn't reported because of the other reasons (referring to the therapist assessment and awaiting lab results). The facility policy Vulnerable Adult- Resident	F 609	not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. 3.DON and IDT members will audit for complaints of alleged abuse or bruising of unknown origin for 6 months to ensure proper and timely reporting by daily review of nursing notes and daily report sheets. Any staff found to not be compliant with following the reporting time frame requirements will receive 1-1 reeducation and possible discipline. 4.Licensed staff will each log in to nursing home incident reporting site to make sure they know where and how to report and feel comfortable doing so. 5.Findings will be reviewed by the Quality Assurance and Performance Improvement Committee for 1 year and at that time proceed with their recommendations. 6.Review of the Vulnerable Adult policy and process will be included in staff meetings every three months for 1 year.	

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F 609	Continued From page 3 Abuse, Mistreatment and Misappropriation of Property dated 9/26/17, directed staff to report allegations of abuse including injuries of unknown origin immediately but no later than two hours after the event.	F 609		
F 610 SS=D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to thoroughly investigate bruising of unknown origin for 1 of 2 residents (R12) reviewed for abuse. Findings include: R12's admission Minimum Data Set (MDS) dated 4/12/21, identified moderate cognitive impairments and indicated she required extensive	F 610	1.The bruising of unknown origin in R12 has been reported and investigated. Staff working 48 hours prior to the incident were interviewed. The husband of R12 was also interviewed. 2.The VA Grievance Checklist has been implemented. This checklist further breaks down the investigative process, including interviewing staff/residents that could have potentially been	7/30/21

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F 610	Continued From page 4 assistance to complete activities of daily living. R12's care plan dated 5/20/21, identified a risk for bruising related to the use of aspirin. R12's progress notes identified the following: - 6/7/21, Staff identified a bruise to R12's upper inner thigh and lower perineal area. The bruise measured 7 centimeters (cm) in length and 3.5 cm wide was dark purple in color and non-blanchable. - 6/15/21, The bruising to the area between R12's right labia and buttock was healing well. During interview on 6/16/21, at 12:50 p.m. registered nurse (RN)-B stated R12 bruised easily. During assessment of a buttock wound a bruise was identified on R12 in between her labia and butt cheek. RN-B described the area as "very dark purple." RN-B stated R12 was interviewed and said no one had hurt her but stated, "we know she isn't reliable" and indicated R12 could not reliably recall events. R12's bruise was discussed at IDT and labs were ordered. RN-B stated they had looked at all angles as to what may have caused the bruising. RN-B did not have any information related to an investigation but stated the social worker may have written something down. At 1:12 p.m. the director of nursing (DON) stated they were waiting for lab results and stated the therapist said the pressure from R12 leaning "may" have cause the bruising. Usually the facility went through the process of interviewing everybody but said there was no investigation into the bruising.	F 610	involved/affected at least, but not limited to, 48 hours prior to the incident 3.Continue to use the VA Grievance Checklist with all future incidences, updating the checklist PRN or until policy changes to ensure an overall thorough investigative process. 4.LSW/DON to consult with Risk Management each case within the five day investigative period. Risk Management to review/advise upon investigative process to ensure a complete and thorough investigative process has been followed. Will continue x6 months. If after 6 months, if no recommendations from Risk Management, facility will resume prior investigative process, consulting with Risk Management on a PRN basis. 5.Findings will continue to be reviewed by the Quality Assurance and Performance Improvement Committee on a quarterly basis.	

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F 610	Continued From page 5 On 6/17/21, at 9:47 a.m. the social worker (SW) stated she did not have any documentation of an investigation related to R12's bruise. The SW stated a thorough investigation included interviewing the resident and any staff involved in the alleged incident. A facility policy Vulnerable Adult- Resident Abuse, Mistreatment and Misappropriation of Property dated 9/26/17, indicated an investigation would include contain at least: a review of the complaint, interviews with the resident, witnesses and staff having contact with the resident.	F 610		

Electronically delivered
July 9, 2021

Administrator
Lifecare Greenbush Manor
19120 200th Street
Greenbush, MN 56726

Re: State Nursing Home Licensing Orders
Event ID: TCFP11

Dear Administrator:

The above facility was surveyed on June 14, 2021 through June 17, 2021 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:

Jen Bahr, RN, Unit Supervisor
Bemidji District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
705 5th Street NW, Suite A
Bemidji, MN 56601-2933
Email: Jennifer.bahr@state.mn.us
Office: (218) 308-2104 Mobile: (218) 368-3683

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 note it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

Please feel free to call me with any questions.

Sincerely,

Joanne Simon, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
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
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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 6/14/21, through 6/17/21, a licensing survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was found 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	2 000		

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2 000	Continued From page 1 these orders and identify the date when they will be completed. In addition, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was found NOT in compliance with the MN State Licensure. Please indicate in your electronic plan of correction you have reviewed these orders and identify the date when they will be completed. The following complaints were found to be SUBSTANTIATED: H5616004C (MN43732) with no licensing orders issued. The following complaints were found to be unsubstantiated H5616005C (MN60935) H5616006C (MN72511) 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	2 000		

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(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) COMPLETE DATE
2 000	Continued From page 2 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. 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		
21980	MN St. Statute 626.557 Subd. 3 Reporting - Maltreatment of Vulnerable Adults Subd. 3. Timing of report. (a) A mandated reporter who has reason to believe that a vulnerable adult is being or has been maltreated, or who has knowledge that a vulnerable adult has sustained a physical injury which is not reasonably explained shall immediately report the information to the common entry point. If an individual is a vulnerable adult solely because the individual is admitted to a facility, a mandated reporter is not required to report suspected maltreatment of the individual that occurred prior to admission, unless:	21980		7/30/21

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	00578N	A. BUILDING: _____ B. WING _____	C 06/17/2021

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21980	Continued From page 3 (1) the individual was admitted to the facility from another facility and the reporter has reason to believe the vulnerable adult was maltreated in the previous facility; or (2) the reporter knows or has reason to believe that the individual is a vulnerable adult as defined in section 626.5572, subdivision 21, clause (4). (b) A person not required to report under the provisions of this section may voluntarily report as described above. (c) Nothing in this section requires a report of known or suspected maltreatment, if the reporter knows or has reason to know that a report has been made to the common entry point. (d) Nothing in this section shall preclude a reporter from also reporting to a law enforcement agency. (e) A mandated reporter who knows or has reason to believe that an error under section 626.5572, subdivision 17, paragraph (c), clause (5), occurred must make a report under this subdivision. If the reporter or a facility, at any time believes that an investigation by a lead agency will determine or should determine that the reported error was not neglect according to the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5), the reporter or facility may provide to the common entry point or directly to the lead agency information explaining how the event meets the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5). The lead agency shall consider this information when making an initial disposition of the report under subdivision 9c. This MN Requirement is not met as evidenced by: Based on interview and document review the facility failed to report bruising of unknown origin	21980	Corrected	

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21980	Continued From page 4 to the State Agency (SA) for 1 of 2 residents (R12) reviewed for abuse. Findings include: R12's admission Minimum Data Set (MDS) dated 4/12/21, identified R12 had moderate cognitive impairment and required extensive assistance to complete activities of daily living. R12's care plan dated 5/20/21, identified a risk for bruising related to the use of aspirin. R12's progress notes identified the following: - 6/7/21, Staff identified a bruise to R12's upper inner thigh and lower perineal area. The bruise measured 7 centimeters (cm) in length and 3.5 cm wide was dark purple in color and non-blanchable. - 6/15/21, The bruising to the area between R12's right labia and buttock was healing well. During interview on 6/16/21, at 12:50 p.m. registered nurse (RN)-B stated R12 bruised easily. During assessment of a buttock wound a bruise was identified on R12 in between her labia and butt cheek. RN-B described the area as "very dark purple." RN-B stated R12 was interviewed and said no one had hurt her but stated, "we know she isn't reliable." and indicated R12 could not reliably recall events. RN-B stated the bruise had not been reported to the SA. At 1:12 p.m. the director of nursing (DON) stated the bruising had not been reported to the SA. The DON stated they were waiting for lab results and the therapist said the pressure from R12 leaning may have cause the bruising. The DON stated	21980		

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21980	Continued From page 5 the facility had a guide they used to determine if something was reportable to the SA and anytime they found something they would report right away. The DON stated R12's bruise wasn't reported because of the other reasons (referring to the therapist assessment and awaiting lab results). The facility policy Vulnerable Adult- Resident Abuse, Mistreatment and Misappropriation of Property dated 9/26/17, directed staff to report allegations of abuse including injuries of unknown origin immediately but no later than two hours after the event. SUGGESTED METHOD OF CORRECTION: The administrator or designee could develop/revise policies or procedures to ensure timely reporting of all allegations of abuse or neglect are within appropriate timeframes for reporting. The facility could re-educate staff to policies and procedures, and audit all complaints of alleged abuse or neglect for a set determined time. The results of those audits should be taken to the Quality Assurance Performance Improvement (QAPI) committee to determine the need for further monitoring or compliance. TIME PERIOD FOR CORRECTION: 21 DAYS	21980		

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	245616	A. BUILDING **02 - GREENBUSH MANOR** B. WING _____	**06/15/2021**

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K 000	INITIAL COMMENTS FIRE SAFETY A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, Fire Marshal Division on November 14, 2017. At the time of this survey, LifeCare Greenbush Manor 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) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of the Health Care Facilities Code (NFPA 99). THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENTS 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. IF OPTING TO USE AN EPOC, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED. PLEASE RETURN THE PLAN OF	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		07/16/2021

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 CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K TAGS) TO: HEALTH CARE FIRE INSPECTIONS STATE FIRE MARSHAL DIVISION 445 MINNESOTA STREET, SUITE 145 ST. PAUL, MN 55101-5145, or By e-mail 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. LifeCare Greenbush Manor was built in 2010, is a 1-story building without a basement and was determined to be Type V(111) construction, A clinic and an assisted living building are attached and separated with 2-hour fire barriers between the Manor and the clinic, and the Manor and the assisted living building.	K 000		

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K 000	Continued From page 2 The facility is divided into 4 smoke compartments with 1-hour and 2-hour fire barriers. The facility is fully protected with an automatic sprinkler system installed in accordance with NFPA 13 The Standard for the Installation of Sprinkler Systems 1999 edition. The facility has a fire alarm system which includes corridor smoke detection throughout and in all common areas, installed in accordance with NFPA 72 "The National Fire Alarm Code" 1999 edition. All sleeping rooms have smoke detection and hazardous areas have automatic fire detection.. The fire alarm system is monitored for automatic fire department notification. The facility has a capacity of 40 beds and had a census of 40 at the time of the survey. The facility was surveyed as one building.	K 000		
K 132 SS=D	The requirements at 42 CFR, Subpart 483.70(a) are NOT MET. Multiple Occupancies - Contiguous Non-Health CFR(s): NFPA 101 Multiple Occupancies - Contiguous Non-Health Care Occupancies Non-health care occupancies that are located immediately next to a Health Care Occupancy, but are primarily intended to provide outpatient services are permitted to be classified as Business or Ambulatory Health Care Occupancies, provided the facilities are separated by construction having not less than 2-hour fire resistance-rated construction, and are not intended to provide services simultaneously for	K 132		7/30/21

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K 132	Continued From page 3 four or more inpatients. Outpatient surgical departments must be classified as Ambulatory Health Care Occupancy regardless of the number of patients served. 18.1.3.4.1, 19.1.3.4.1 This REQUIREMENT is not met as evidenced by: Based on observations and staff interview, it was revealed that 1 of 2 - two hour fire separation was found not in compliance with NFPA 101 "The Life Safety Code" 2012 edition (LSC) sections 8.2.1.3 and 19.1.3.4. These deficient conditions could allow the products of combustion to travel from one building to another, which could negatively affect 20 of 40 residents. Findings include: On 06/15/2021, at 2:02 p.m., during the facility tour it was observed that above the cross-corridor doors located on the 2nd floor by the kitchen serving area there was non-fire rated expanding foam used to fill the annular spaces around through penetrations in the 2 hour fire barrier. This deficient condition was verified by a Maintenance Supervisor.	K 132	On 7/14/2021, Brett Dallager, the Maintenance Supervisor of LifeCare Greenbush Manor, removed the non-rated expanding foam and replaced it with the 3M Fire Barrier Sealant (FD 150+). LifeCare Greenbush Manor will discontinue the use of the expanding foam and continue the use of 3M's Fire Barrier Sealant. LifeCare Greenbush Manor Maintenance staff will investigate for any other areas that the expanding foam was used and replace it with the proper fire barrier. This investigation will be completed by 7/30/2021.	
K 291 SS=D	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:	K 291		7/30/21

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K 291	Continued From page 4 Based on observation and staff interview, the facility has failed to ensure that 1 of 6 emergency lights in operable condition in accordance with the NFPA 101 "The Life Safety Code" 2012 edition (LSC) section 7.9.3. This deficient practice could affect residents in the event of an emergency evacuation during a power outage. Findings include: On 06/15/2021, at 1:50 p.m, during the facility tour, it was observed that the batter powered emergency light located in by room E108 was inoperable when tested at the time of the inspection. It was further verified through staff interview, by the Maintenance Supervisor, to the best of his knowledge, that that specific emergency light had been worked during the prior months 30 second monthly test. This deficient condition was verified by a Maintenance Supervisor.	K 291	On 6/25/2021 the Emergency Light in Room E108 was replaced by a LifeCare Greenbush Manor Maintenance staff member. Brett Dallager, the LifeCare Greenbush Manor Maintenance Supervisor will continue monthly monitoring.	
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 staff interview and a review of all	K 345	1. On 07/15/2021, Brett Dallager, the	7/30/21

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K 345	Continued From page 5 available documentation, the facility has not maintained the fire alarm system testing and maintenance documentation in accordance with NFPA 101 "The Life Safety Code" 2012 edition (LSC) section 9.6.1.3, and .NFPA 72 National Fire Alarm Code 2010 edition, sections 10.10.3, 14.3.1, and 14.6.2. This deficient practice could affect 40 of 40 residents. Findings include: 1. On 06/15/2021, at 11:40 a.m. during a review of all available fire alarm maintenance and testing documentation for the last 12 months, and an interview with the Maintenance Supervisor, it was revealed that at the time of the inspection the facility had completed the annual fire alarm system testing; but upon further review of the annual fire alarm testing documentation it was found that the inspection report did not contain a detailed list of all the individual initiating devices that had been tested and the results of the testing completed on each individual device. 2. On 06/15/2021, at 11:45 a.m., during the review of all available fire alarm maintenance and testing documentation for the last 12 months, and an interview with the Maintenance Supervisor it was revealed that the facility could not provide documentation for a current sensitivity test of the smoke alarms. The last sensitivity test was conducted on 09/12/2018. 3. On 06/15/2021, at 1:55 p.m., during the facility tour it was observed that the fire alarm panel was not secured within a locked room or cabinet.	K 345	LifeCare Greenbush Manor Maintenance Supervisor, received the detailed list on individual initiating devices with functional and sensitivity that was completed on 09/02/2020. Brett Dallager, the LifeCare Greenbush Manor Maintenance Supervisor, will monitor that all Sensitivity and Functional Test reports are issued and completed properly from the vendor. 2. On 7/15/2021, Brett Dallager, the LifeCare Greenbush Manor Maintenance Supervisor, received the Sensitivity and Functional Test report from Protection Systems that was completed on 09/02/2020. 3. Brett Dallager, the LifeCare Greenbush Manor Maintenance Supervisor, will monitor Room E108 with the Fire Alarm Panel that the door is locked at all times.	

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K 345	Continued From page 6 These deficient condition was verified by a Maintenance Supervisor.	K 345		
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 system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on staff interview and a review of the available fire sprinkler test and inspection documentation, the automatic sprinkler system is not maintained in accordance with NFPA 25 the Standard for the Inspection, Testing, and Maintenance of Water Based Fire Protection Systems 2011 edition section 5.2.5 and 5.3.2.1. The failure to maintain the sprinkler system in compliance with NFPA 25 (11) could allow system being place out of service causing a decrease in the fire protection system capability in the event of an emergency that could affect 40 of 40	K 353	New pressure gauges will be installed by Brett Dallager, LifeCare Greenbush Manor Maintenance Supervisor. Work will be completed by 7/30/2021. Brett Dallager, LifeCare Greenbush Manor Maintenance Supervisor, will monitor that the vendor will replace gauges at or before the 5 years of use.	7/30/21

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K 353	Continued From page 7 residents. Findings include: On 06/15/2021, at 1:40 p.m., the gauge that is on the main fire sprinkler riser in the mechanical room are older than 5 years and the gauge did not have any annotation that it had been re-calibrated within the last 5 years This deficient condition was verified by a Maintenance Supervisor.	K 353		
K 372 SS=F	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS. This REQUIREMENT is not met as evidenced by: Based on observations and staff interview, it was determined that the facility failed to maintain smoke barrier walls in accordance with NFPA 101-2012 edition, Sections 8.3.1.2, 19.3.7.1, and 19.3.7.2 . This deficient practice could allow the	K 372	LifeCare Greenbush Manor has contracted with Fire Safety Resources, LLC, to have an FSES evaluation conducted to demonstrate that the facility has an overall level of safety equivalent to	8/31/21

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K 372	Continued From page 8 products of combustion spread throughout the facility in the event of a fire which could affect 40 of 40 residents. Findings include: On 06/15/2021, at 2:36 p.m., it was observed that the smoke barrier walls do not extend thought the attic space above the ceiling. This observed configuation of the smoke barrier wall is not covered by the NFPA 101 (12) 8.3.1.2 required condition for a smoke barrier wall. This deficient condition was verified by a Maintenance Supervisor.	K 372	that required by the Life Safety Code. The FSES evaluation report will be submitted to the MN State Fire Marshal Division when completed. The FSES evaluation will be completed by 08/31/2021.	
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 staff interview and a review of the available documentation, the facility did not maintain the heating, ventilation, and air conditioning in accordance with the NFPA 101 "The Life Safety Code" 2012 edition, section 9.2, 19.5.2.1., NFPA 90A "Standard for the Installation of Air-Conditioning and Ventilation Systems" 2012	K 521	On 07/15/2021, Brett Dallager, LifeCare Greenbush Manor Maintenance Supervisor, received documentation on the Fire Damper test that was completed on 09/11/2019. All dampers passed. Brett Dallager, LifeCare Greenbush Manor Maintenance Supervisor, will	7/30/21

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	245616	A. BUILDING **02 - GREENBUSH MANOR** B. WING _____	**06/15/2021**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFECARE GREENBUSH MANOR	**19120 200TH STREET GREENBUSH, MN 56726**

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K 521	Continued From page 9 edition, section 5.4.8.1., and NFPA 80 "Standard for Fire doors and Other Opening Protectives" 2010 edition, section 19.4.1.1. This deficient condition could effect 40 of 40 residents. Findings include: On 06/15/2021, at 11:55 a.m., during a review of all available fire and smoke damper maintenance and testing documentation for the last 4 years, and an interview with the Maintenance Supervisor, it was revealed that at the time of the inspection the facility last fire and smoke damper test was completed on 09/15/2015 and that they had completed an inspection of the fire and smoke dampers in the last four years. This deficient condition was verified by a Maintenance Supervisor.	K 521	monitor that all Fire Damper Test Reports are issued and completed properly from the vendor.	
K 712 SS=F	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 staff interview and a review of the	K 712	Brett Dallager, LifeCare Greenbush	7/30/21

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K 712	Continued From page 10 available documentation, it was determined that the facility failed to vary the times of the fire drills in accordance with the NFPA 101 "The Life Safety Code" 2012 edition, sections 19.7.1.2 and 19.7.1.6, during the last 12 months. Theses deficient conditions could affect 40 of 40 residents. Findings include: On 05/15/2021, at 11:20 a.m., during the review of all available fire drill documentation and an interview with the Maintenance Supervisor the following deficient conditions were found: 1. The facility failed to vary the times of the evening shift fire drills by conducting 4 fire drills in the 4 p.m. hour. 2. The facility failed to vary the times of the night shift fire drills by conducting 3 fire drills in the 11 p.m. hour. These deficient condition was verified by a Maintenance Supervisor.	K 712	Manor Maintenance Supervisor, will vary the times on all fire drills on all shifts. Brett Dallager, LifeCare Greenbush Manor Maintenance Supervisor, will vary the time of fire drills by using a matrix spreadsheet. The spreadsheet will eliminate repeating the same time a drill is done in the same year. The fire drill reports will be turned into the Environmental Safety Committee for further monitoring.	
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)	K 901		7/30/21

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K 901	Continued From page 11 This REQUIREMENT is not met as evidenced by: Based on staff interview and a review of all available documentation, the facility has failed to provide a complete and current facility Risk Assessment in accordance with NFPA 101 "The Life Safety Code" 2012 edition, chapter 3 referenced codes, and NFPA 99 "Health Care Facilities Code" 2012 edition section 4.1. This deficient condition could affect 40 of 40 residents. Findings include: On 06/15/2021, at 12:50 p.m. during the documentation review and an interview with the Maintenance Supervisor it was revealed that the facility could not provide a completed utility risk assessment document at the time of the inspection. The utility risk assessment that was provided at the time of the inspection did not cover patient care equipment as detailed in NFPA 99 "Health Care Facilities Code" 2012 edition Chapter 10 - Electrical Equipment, and Chapter 11 - Gas Equipment. This deficient condition was verified by a Maintenance Supervisor.	K 901	0n 07/15/2021, the Utility Risk Assessment was updated by Brett Dallager, LifeCare Greenbush Manor Maintenance Supervisor. The Utility Risk Assessment will be assessed annually by Brett Dallager, the Maintenance Supervisor of LifeCare Greenbush Manor.	
K 923 SS=D	Gas Equipment - Cylinder and Container Storag CFR(s): NFPA 101 Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and	K 923		7/30/21

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K 923	Continued From page 12 ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited- combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observations and staff interview, the oxygen storage room was not identified in accordance with NFPA 101 "The Life Safety Code" 2012 edition, chapter 3 referenced codes	K 923	On 7/15/2021, signage was ordered for the Oxygen Supply Room door. It will be installed by Brett Dallager, LifeCare Greenbush Manor Maintenance	

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K 923	Continued From page 13 and NFPA 99 Standards for Health Care Facilities 2012 Edition section 11.3.4.1 and 11.3.4.2 This deficient practice could create an oxygen enriched atmosphere that could contribute to rapid fire growth. This could negatively affect 10 of 40 residents. Findings include: On 06/15/2021 at 1:17 p.m., during the facility tour, observations revealed that the oxygen storage room did not have the correct code required language and labeling on the room identifying signage indicating that the area/room was used for the storage of both gaseous and liquid oxygen cylinders. This deficient condition was verified by a Maintenance Supervisor.	K 923	Supervisor, by 07/30/2021. Brett Dallager, LifeCare Greenbush Manor Maintenance Supervisor, will monitor Oxygen storage signage on Environmental Safety Rounds.	