Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
February 9, 2024

Administrator
Benedictine Care Community
201 9th Street West
Ada, MN 56510

RE: CCN: 245502
Cycle Start Date: February 8, 2024

Dear Administrator:

On February 8, 2024, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be 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:

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, Minnesota 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 May 8, 2024 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by August 8, 2024 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

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

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

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

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

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

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

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

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

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245502	A. BUILDING _____ B. WING _____	02/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BENEDICTINE CARE COMMUNITY	201 9TH STREET WEST ADA, MN 56510

(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 2/5/24 - 2/7/24, a survey for compliance with Appendix Z, Emergency Preparedness Requirements, §483.73 was conducted during a standard recertification survey. The facility was in compliance. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	E 000		

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

Electronically Signed | 02/15/2024

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

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F 000	INITIAL COMMENTS On 2/5/24 - 2/7/24, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was not in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were reviewed with no deficiencies cited: H55029324C (MN99551), H55029325C (MN99550), H55029326C (MN99549), H55029327C (MN99548), H55029362C (MN94115), H55029362C (MN94128) , and H55029363C (MN99114) The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulations has been attained.	F 000		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to accurately medication use in the Minimum Data Set (MDS) for 1 of 1 resident	F 641	Based on interview and document review, the facility failed to accurately medication use in the Minimum Data Set (MDS) for 1	2/16/24

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F 641	Continued From page 1 (R12) reviewed for MDS accuracy. Findings include: R12's annual MDS dated 12/29/23, identified no cognitive impairment. Diagnosis included diabetes mellitus type 2 (DM 2) (A long-term condition in which the body has trouble controlling blood sugar) and identified R12 was receiving insulin 7 days a week during the look back period. R12's physician order report dated 2/7/24, identified R12 received Victoza (a non-insulin, injectable medicine that may improve blood sugar in adults with DM 2). R12 did not have insulin listed in the orders, including the look back period of the MDS. During an interview on 2/7/24 at 2:11 p.m., registered nurse (RN)-A stated RN-A completed the annual MDS for R12 dated 12/29/23. R12 had not received insulin and the MDS coded incorrectly. The facility's Comprehensive Assessment and Care Planning policy dated 7/2/18, identified the assessment must accurately reflect the resident's status.	F 641	of 1 resident (R12) reviewed for MDS accuracy. The R12□s orders were reviewed and confirmed that the resident is receiving Victoza. MDS modified and resubmitted on R12 to identify insulin given zero days per week rather than seven days per week. Initially, all resident charts will be audited to identify those that have orders for a diabetic injectable medication that have had a quarterly MDS completed in the last 3 months. Modifications and resubmissions will be completed for any affected residents. The consultant pharmacist has been contacted and provided the facility a list of non-insulin diabetic injectable medications. The MDS nurse has been educated on 2/12/24 that Victoza is not insulin but is a non-insulin diabetic injectable medication. The MDS nurse has received additional education on a list of diabetic injectable medications that are not insulin as received by the consultant pharmacist. The admission and quarterly chart audits as indicated above will be done x3 months. Audits will be conducted on admission and quarterly MDS reviews to identify residents receiving insulin or another diabetic injectable medication for proper MDS coding x3 months and as needed thereafter as reviewed through quality	

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F 641	Continued From page 2	F 641	council for compliance. The individual responsible for compliance with this action plan: DON or designee	
F 883 SS=D	Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2) §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. §483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal	F 883		2/16/24

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F 883	Continued From page 3 immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. This REQUIREMENT is not met as evidenced by: Based interview and document review, the facility failed to follow the most recent Centers for Disease Control (CDC) standards for offering and educating on pneumococcal vaccinations for 1 of 5 residents (R2) reviewed for immunizations. This had the potential to affect all residents who were eligible for the pneumococcal booster. Findings include: R2's annual Minimum Data Set (MDS) dated 12/29/23, identified R2 was 65 years old and had a diagnosis of Parkinson's disease. R2's undated, immunization record, identified R2 received the pneumococcal polysaccharide	F 883	Based interview and document review, the facility failed to follow the most recent Centers for Disease Control (CDC) standards for offering and educating on pneumococcal vaccinations for 1 of 5 residents (R2) reviewed for immunizations. This had the potential to affect all residents who were eligible for the pneumococcal booster. R2 was educated and offered the appropriate pneumococcal vaccine that he is now eligible for on 2/14/24. R2 received the PVC20 one-time dose on 2/14/24.	

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F 883	Continued From page 4 vaccine (PPSV23) on 2/14/17. The immunization record did not identify R2 had received the pneumococcal conjugate vaccines (PCV13) vaccine. R2's medical record did not include evidence R2 or R2's representative received education regarding pneumococcal vaccine booster. There was no evidence R2 was offered the pneumococcal vaccine(s) per CDC guidance, in conjuction with shared clinical decision making with their provider, after R2 turned 65 yeard of age. On 2/6/24 at 11:26 a.m., registered nurse (RN)-A stated R2 was 65 years old and it was greater than one year since R2 received the pneumococcal vaccine. R2 should have been offered the pneumococcal booster at least one year after R2's last pneumococcal vaccine. The facility had no system in place to track when current residents were due for the pneumococcal vaccine or booster. The facility policy Pneumococcal Vaccines for Residents dated 9/23, identified all eligible residents shall be offered and educated on the pneumococcal vaccine. The facility will refer to the current CDC recommended adult immunization schedule to determine recommended vaccines. The CDC PneumoRecs Vax Advisor updated 9/12/23, those 65 years of age and older who have received previous doses of PPSV23, no prior doses of PCV13, should give one dose of PCV15 or PCV20 at least 1 year after the last dose of PPSV23. Regardless of which vaccine is used (PCV15 or PCV20), their pneumococcal vaccinations are complete.	F 883	Initially, all resident charts will be audited to identify those that are eligible for a pneumococcal vaccine. If any residents are currently eligible for a pneumococcal vaccine; consents and education will be provided to them to offer the eligible vaccine. After identifying at risk residents, audits will be conducted on admission and quarterly at care conferences to identify residents that are eligible for a pneumococcal vaccine on an ongoing basis. The nurse managers and social services designee will be educated on the new process of monitor of pneumococcal eligibility with care conferences and how to determine eligibility. Consent forms will identify the VIS provided to the resident or resident representative when offering the pneumococcal vaccine. The admission and quarterly chart audits will be returned to the DON or designee and reported at Quality Council and/or QAPI on a quarterly basis. Audits will be reviewed in Quality Council for continued compliance until deemed necessary by Quality Council. The individual responsible for compliance with this action plan: DON or designee	

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	245502	A. BUILDING **01 - NURSING HOME 01** B. WING _____	**02/07/2024**

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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 02/07/2024. At the time of this survey, Benedictine Care Community - Ada 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	K 000		

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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 IS NOT REQUIRED. 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. Benedictine Care Community is a 1-story building without a basement. The building was constructed in 2000 and was determined to be of Type I(222) construction. The building is separated from the Hospital Building with a 2-hour fire barrier and the nursing home is divided into 3 smoke compartments with 1-hour fire barriers. The building is fully sprinkler protected with quick	K 000		

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K 000	Continued From page 2 response sprinklers and has a fire alarm system with smoke detection in the corridors and spaces open to the corridors that is monitored for automatic fire department notification. Because the main facility and the chapel addition are both conforming contrstuction types for a 1-story building, the entire facility will be surveyed as one Type V(111) building. The facility has a capacity of 46 beds and had a census of 40 at the time of the survey. The requirements at 42 CFR, Subpart 483.70(a), are NOT MET as evidenced by:	K 000		
K 324 SS=D	Cooking Facilities CFR(s): NFPA 101 Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the	K 324		2/16/24

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K 324	Continued From page 3 corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2 This REQUIREMENT is not met as evidenced by: Based on documentation review and staff interview, the facility failed to test and inspect the kitchen hood ventilation and fire suppression system per NFPA 101 (2012 edition), Life Safety Code, section 9.2.3 and NFPA 96 (2011 edition), Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, section 11.2.1. This deficient finding could have an isolated impact on the residents within the facility. Findings Include: On 02/07/2024 at 09:40am it was revealed by a review of available documentation that inspection documentation for the kitchen hood ventilation and fire suppression system was not available. The facility could not provide completed test/inspection documentation for the previous 6 month semi-annual kitchen hood suppression system inspections for the last 12 months. An interview with the Maintenance Director and Administrator verified these deficient findings at the time of discovery.	K 324	The facility will maintain current documentation on all kitchen hood ventilation and fire suppression systems. When this equipment is inspected, 2 associates will sign off that the documentation is complete, current, and placed in the appropriate binder. This process will be audited quarterly and reported at QAPI.	
K 353 SS=F	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are	K 353		2/16/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245502	A. BUILDING **01 - NURSING HOME 01** B. WING _____	**02/07/2024**

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K 353	Continued From page 4 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 observation, a review of available documentation, and staff interview, the facility failed to inspect and maintain 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, sections 5.1.1.2, and 5.3.2.1. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 02/07/2024 at 09:40am it was revealed by a review of available documentation the facility failed to perform the five (5) year sprinkler system testing. An interview with the Maintenance Director and	K 353	The facility will maintain current documentation on all sprinkler system testing. When testing occurs, 2 associates will sign off that the documentation is complete, current, and placed in the appropriate binder. This process will be audited quarterly and reported at QAPI.	

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	245502	A. BUILDING **01 - NURSING HOME 01** B. WING _____	**02/07/2024**

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K 353	Continued From page 5 Administrator verified these deficient findings at the time of discovery.	K 353		
K 372 SS=D	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain their smoke barrier per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.7.1, 19.3.7.3, 8.5.2.2, and 8.5.6.5. These deficient findings could have an isolated impact on the residents within the facility. Findings include: On 02/07/2024 at 10:24am, it was revealed by observation that there was a penetration running from one smoke compartment to another above door leading to hospital. An interview with the Director of Maintenance verified these deficient findings at the time of discovery.	K 372	Penetration in smoke compartment was sealed on 2/12/2024. The observation of this smoke compartment for penetrations has been added to the facility monthly safety walk checklist. It will be audited monthly and reported immediately if there is a penetration. All audits will be reported at quarterly QAPI meeting.	2/12/24

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K 914	Continued From page 6	K 914		
K 914 SS=F	Electrical Systems - Maintenance and Testing CFR(s): NFPA 101 Electrical Systems - Maintenance and Testing Hospital-grade receptacles at patient bed locations and where deep sedation or general anesthesia is administered, are tested after initial installation, replacement or servicing. Additional testing is performed at intervals defined by documented performance data. Receptacles not listed as hospital-grade at these locations are tested at intervals not exceeding 12 months. Line isolation monitors (LIM), if installed, are tested at intervals of less than or equal to 1 month by actuating the LIM test switch per 6.3.2.6.3.6, which activates both visual and audible alarm. For LIM circuits with automated self-testing, this manual test is performed at intervals less than or equal to 12 months. LIM circuits are tested per 6.3.3.3.2 after any repair or renovation to the electric distribution system. Records are maintained of required tests and associated repairs or modifications, containing date, room or area tested, and results. 6.3.4 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to conduct the electrical testing and maintenance per NFPA 99 Standards for Health Care Facilities 2012 edition, section 6.3.3.2, 6.3.4.1.3, and 6.3.4.2.1.2. This deficient findings could have a widespread impact on the residents within the facility. Findings include: On 02/07/2024 at 09:15am, it was revealed by review of available documentation the required	K 914	The facility will maintain current documentation on all annual receptacle inspections. When this receptacles are inspected, 2 associates will sign off that the documentation is complete, current, and placed in the appropriate binder. This process will be audited quarterly and reported at QAPI.	2/16/24

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K 914	Continued From page 7 annual receptacle inspection documentation was not available at the time of the survey. An interview with the Maintenance Director and Administrator verified these deficient findings at the time of discovery.	K 914		