Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
January 18, 2024

Administrator
Rochester Health Services West
2215 Highway 52 North
Rochester, MN 55901

RE: CCN: 245306
Cycle Start Date: October 24, 2023

Dear Administrator:

On November 22, 2023, we notified you a remedy was imposed. On January 17, 2024 the Minnesota Departments of Health and Public Safety completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of January 9, 2024.

As authorized by CMS the remedy of:

- Mandatory denial of payment for new Medicare and Medicaid admissions effective January 24, 2024 did not go into effect. (42 CFR 488.417 (b))

In our letter of November 22, 2023, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from October 24, 2023. 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.

Your request for a continuing waiver involving the deficiency(ies) cited under K521 at the time of the October 24, 2023 standard survey has been forwarded to CMS for their review and determination. Your facility's compliance is based on pending CMS approval of your request for waiver.

Feel free to contact me if you have questions.

Sincerely,

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

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November 22, 2023

Administrator
Rochester Health Services West
2215 Highway 52 North
Rochester, MN 55901

RE: CCN: 245306
Cycle Start Date: October 24, 2023

Dear Administrator:

On November 2, 2023, we informed you that we may impose enforcement remedies.

On November 2, 2023, the Minnesota Departments of Health and Public Safety completed a revisit/survey and it has been determined that your facility is not in substantial compliance. The most serious deficiencies in your facility were found 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.

REMEDIES

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

- Mandatory Denial of Payment for new Mediare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective January 24, 2024

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective January 24, 2024. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective January 24, 2024.

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

This Department is also recommending that CMS impose a civil money penalty. You will receive a formal notice from the CMS RO only if CMS agrees with our recommendation.

- Civil money penalty. (42 CFR 488.430 through 488.444)

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than $11,995, has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

As we notified you in our letter of November 2, 2023, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from October 24, 2023. You will receive further information regarding this from the State agency. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions. However, under Public Law 105-15, you may contact the State agency and request a waiver of this prohibition if certain criteria are met.

ELECTRONIC PLAN OF CORRECTION (ePOC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved. The failure to submit an acceptable ePOC can lead to termination of your Medicare and Medicaid participation (42 CFR 488.456(b)).

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

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

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

DEPARTMENT CONTACT

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

Nicole Osterloh, RN, Unit Supervisor
Marshall District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
1400 East Lyon Street, Suite 102
Marshall, Minnesota 56258-2504
Email: nicole.osterloh@state.mn.us
Office: 507-476-4230
Mobile: (507) 251-6264 Mobile: (605) 881-6192

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

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

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by April 24, 2024, (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at § 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42

CFR § 488.412 and § 488.456.

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

APPEAL RIGHTS

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

Steven.Delich@cms.hhs.gov

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

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

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Steven Delich, Program Representative at (312) 886-5216. Information may also be emailed to Steven.Delich@cms.hhs.gov.

INFORMAL DISPUTE RESOLUTION (IDR) / 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

Please contact me with any questions regarding this letter.

Sincerely,

Lori Hagen, Compliance Analyst
Federal Enforcement
Health Regulation Division
Minnesota Department of Health
Telephone: 651-201-4306
E-Mail: Lori.Hagen@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245306	A. BUILDING _____ B. WING _____	C 11/02/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROCHESTER HEALTH SERVICES WEST	2215 HIGHWAY 52 NORTH ROCHESTER, MN 55901

(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 10/30/23 through 11/2/23, a survey for compliance with Appendix Z, Emergency Preparedness Requirements, §483.73(b)(6) was conducted during a standard recertification survey. The facility was IN compliance. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	E 000		
F 000	INITIAL COMMENTS On 10/30/23 through 11/2/23, 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: H53066250C (MN91861) and H53066252C (MN83136). The following complaints were reviewed: H53066248C (MN91466), H53066249C (MN87347), and H53066251C (MN94236), with a deficiencies cited at F610, F622, and F725. 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	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		12/01/2023

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

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F 000	Continued From page 1 onsite revisit of your facility may be conducted to validate substantial compliance with the regulations has been attained.	F 000		
F 584 SS=E	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas;	F 584		12/20/23

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F 584	Continued From page 2 §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure 1 of 1 hall (200 wing) multi-resident bathroom ceiling, 1 of 1 dining room tiles and ceiling, 1 of 1 wing (200 wing) shower tile, 1 of 1 resident (R1) room wall, 4 of 4 hallway walls which were scuffed had been painted, 2 of 2 mechanical stand-lifts were maintained to have cleanable surfaces, and 1 of 1 entryway tiles was maintained to promote a safe, sanitary, and homelike environment. Findings include: Observations on 10/31/23 from 11:15 a.m., through 11:45 a.m. of the facility identified in the 200 wing shower room, directly above the wall heater unit, 1 tile was broken and half missing. Directly adjacent to that, a piece of sheet-rock, approximately 6 inches wide by 2 inches tall was missing from the wall. There were numerous spots of missing paint noted. The shower tiles were heavily soiled with a dirt-like substance that may be stained into the tile. On the door sill, numerous rust spots and paint chips were noted, and caulk in was loose and missing from around the edges of the shower. Across from the tub room was a resident bathroom room. In that room, there was a stand lift that was stored, missing paint on the foot pedal ring, making it an un-cleanable surface as it was bare metal. On the	F 584	Resident R1 is no longer at facility. R1's room is currently empty and will be repainted prior to use by new resident. Residents within the facility have the potential to be impacted by the alleged practice. The identified areas, including but not limited to, will be painted, replaced, and/or repaired: Wing 200 hallway walls and ceilings Dining room floor tiles and ceilings Wing 200 shower room tiles Resident R1 room Entryway tiles Mechanical lifts To ensure ongoing compliance the Director of Maintenance will conduct bi-weekly preventative maintenance rounds with the Executive Director. Identified issues will be corrected by internal staff as able, and contracted labor when necessary. Staff will be re-educated on the use of TELS system for reporting maintenance issues.	

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F 584	Continued From page 3 ceiling in that room, around the vent, there was pieces of ceiling that were missing, cracked and were broken. In the dining room, several tiles were pushed back in, exposing the artificial wall behind it. Directly under that, were missing chunks of ceiling that had not been patched or puttied. Numerous unpainted spots and scuffs were noted on most resident door frames, the majority of the 200 hallway walls, and dining room tiles were pushed in and the ceiling was cracked and missing plaster. Interview on 10/31/23 at 11:20 a.m., with nurse aide (NA)-F in the common-use resident bathroom on the 200 wing identified the ceiling around the exhaust fan was chipped and crack sand some parts were missing from the plaster. "Maintenance doesn't fix them". She was unsure if any staff alerted maintenance to the needed repairs. Interview on 11/01/23 at 10:55 a.m. with the contracted housekeeping supervisor (HS)-A identified she worked for the contracted housekeeping service. Her staff never clean nor disinfect either shower room on the 100 or 200 wing. She thought it was the NA's responsibility to perform cleaning of the 2 shower rooms. Further interview on 11/1/23 at 11:21 a.m., with NA-F of the 200 wing shower room walls and floor identified she agreed the missing tiles on the wall were a hazard to all residents as the broken tile could potentially come into contact with a residents foot or leg if they brushed up against it. In the shower room, staff had stored multiple resident items like shampoos, conditioners and body wash along side a bottle of Clorox disinfectant spray. NA-F agreed co-mingling	F 584	Results of the biweekly audits and TELS reports will be reviewed at QAPI monthly. Director of Maintenance and Executive Director are responsible for compliance.	

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F 584	Continued From page 4 cleaning chemicals with resident items was a hazard as staff could inadvertently get the bottles mixed up. NA-A stated staff did not clean and disinfect the shower room, only the shower chair. Observation and interview on 11/01/23 11:34 AM with maintenance supervisor (MS) identified he had worked at the facility for approximately 2 years and was also responsible for other sister facilities in town. He trained staff to put in a fix it request using a software program called "Fix-it" The MS identified he did no maintenance rounds at the facility and only fixed any concern if it was brought to his attention. In showing him all the above mentioned concerns, he agreed he needed to perform repairs in the facility to ensure it was a safe and homelike environment. At 11:40 a.m., the regional nurse consultant (RNC) and infection preventionist joined the interview and agreed to all concerns as well as the torn padding on the stand lifts and missing paint on those lifts should be repaired to maintain those resident-use items. The MS stated he attended the Quality Assurance Performance Improvement monthly meetings, but brought no environmental concerns to the meetings. Observation on 11/1/23 at 12:50 p.m., of front entrance by the nurses station floor tiles identified a 3 in horizontal piece of tile is missing from the floor. Observation and interview on 11/01/23 1:01 p.m., with R1 in her room identified behind her bed on the wall were numerous paint chips and scrapes. R1 noted maintenance had never touched up those spots with paint. Review of the QAPI monthly meeting minutes	F 584		

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F 584	Continued From page 5 from January to September 2023 identified no environmental data related to the upkeep of the facility was brought forward to ensure QAPI was aware of the disrepair. Review of the 6/16/22, Safe and Homelike Environment policy identified the facility would provide a safe, clean and comfortable, homelike environment and the physical environment would not pose a safety risk. Maintenance services were to be provided as necessary. There was no mention the MS should perform active preventative maintenance to ensure the facility was maintained in he above mentioned manner.	F 584		
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	F 610	Resident R134 no longer in facility.	12/20/23

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F 610	Continued From page 6 facility failed to complete a thorough investigation to identify potential diversion for 1 of 1 resident (R134) whose Fentanyl narcotic pain patch was missing. Findings include: Review of 6/6/23, complaint submitted identified that on 6/5/23 at 6 a.m., nursing had discovered R134's fentanyl transdermal patch (medicated skin patch used to treat severe pain) was missing from her skin. Nurse reported that she had searched R134's skin, bedding, bathroom, and room and the fentanyl patch could not be found. The nurse applied a new patch and notified hospice. The report identified that the director of nursing (DON) requested the physician order an alternate medication regimen. The DON was notified that a Minnesota Adult Abuse Reporting Center (MAARC) report was submitted. R134's Face sheet printed 11/2/23, identified R134 was admitted to the facility in February of 2023, and was receiving hospice services while at the facility. R134's 7/5/23, quarterly Minimum Data Set (MDS) assessment identified R134's cognition was severely impaired. She had diagnosis of a blood clot, colon cancer, dementia, and required extensive assistance of staff for activities of daily living (ADL's). Review of nursing progress note entered in R134's 6/5/23, nursing progress note at 10:42 a.m., identified fentanyl patch was missing and hospice would be notified. Review of nursing progress note entered in	F 610	Residents who use topically applied pain prescriptions have the potential to be impacted by the alleged practice. Policy for investigations and narcotic accountability were reviewed by the management team and copies of policies provided for future reference. MARs were udpated to include validation of patch placement by two nurses at each shift change. The Director of Nursing will present information on validating patch placement at shift change with a second nurse. The Vice President of Success will provide education to the nurse managers on investigation of potential drug diversions. The Director of Nursing or designee will audit compliance with monitoring patch placement and completing follow up if a patch is missing. These audits will be completed three times weekly for four weeks with results forwarded to the Quality Assurance Committee for review and recommendations.	

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F 610	Continued From page 7 R134's 6/5/23, nursing progress note at 3:12 p.m., the DON reported she spoke to medical director requesting to change from a fentanyl transdermal patch to an alternative pain medication because patches have been missing and she believes R134 is removing them and throwing them away. Review of nursing progress note entered in R134's 6/5/23, nursing progress note at 3:43 p.m., the DON reported fentanyl patch was discontinued and R134 would start a different pain medication. Interview on 11/2/23 at 10:58 a.m., with the DON identified she recalled the incident of the missing fentanyl patch from R134. They had looked in R134's bed linens and garbage but did not find the patch. She did not complete an investigation and had no documentation of any interviews with staff that had been working during the time that the fentanyl patch went missing. She was unable to identify if the facility had taken any steps to review their process to ensure it was effective in lowering the risk of drug diversion. The DON reported she did not know how to do a thorough investigation and had not been trained on investigations, she identified she was currently on a performance improvement project for her organizational skills. There was no policy or procedure related to drug diversion or investigations provided by the end of the survey.	F 610		
F 622 SS=D	Transfer and Discharge Requirements CFR(s): 483.15(c)(1)(i)(ii)(2)(i)-(iii) §483.15(c) Transfer and discharge-	F 622		12/20/23

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F 622	Continued From page 8 §483.15(c)(1) Facility requirements- (i) The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless- (A) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility; (B) The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility; (C) The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident; (D) The health of individuals in the facility would otherwise be endangered; (E) The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. Nonpayment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for his or her stay. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid; or (F) The facility ceases to operate. (ii) The facility may not transfer or discharge the resident while the appeal is pending, pursuant to § 431.230 of this chapter, when a resident exercises his or her right to appeal a transfer or discharge notice from the facility pursuant to § 431.220(a)(3) of this chapter, unless the failure to discharge or transfer would endanger the health or safety of the resident or other individuals in the facility. The facility must document the danger	F 622		

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F 622	Continued From page 9 that failure to transfer or discharge would pose. §483.15(c)(2) Documentation. When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider. (i) Documentation in the resident's medical record must include: (A) The basis for the transfer per paragraph (c)(1)(i) of this section. (B) In the case of paragraph (c)(1)(i)(A) of this section, the specific resident need(s) that cannot be met, facility attempts to meet the resident needs, and the service available at the receiving facility to meet the need(s). (ii) The documentation required by paragraph (c)(2)(i) of this section must be made by- (A) The resident's physician when transfer or discharge is necessary under paragraph (c) (1) (A) or (B) of this section; and (B) A physician when transfer or discharge is necessary under paragraph (c)(1)(i)(C) or (D) of this section. (iii) Information provided to the receiving provider must include a minimum of the following: (A) Contact information of the practitioner responsible for the care of the resident. (B) Resident representative information including contact information (C) Advance Directive information (D) All special instructions or precautions for ongoing care, as appropriate. (E) Comprehensive care plan goals;	F 622		

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F 622	Continued From page 10 (F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to appropriately discharge 1 of 1 resident (R136) with known dementia with behaviors. The facility also failed to ensure policies related to discharge and transfers were reviewed yearly for appropriateness and accuracy. Findings include: R136 was admitted for respite (short period of rest and relief) stay at the facility on February 2023 with a diagnosis of Lewy body neurocognitive disorder (a progressive dementia that results from protein deposits in nerve cells of brain affecting movement, thinking skills, mood, memory, and behavior) dementia, heart failure, Parkinson's, hypertension and arthritis. R136's February 2023, medication administration record indicated clonazepam (sedative used for seizures, painic disorder and anxiety) 1 milligram (mg) at night for Parkinsons, Nuplazid (antipsychotic used to treat hallucinations and delusions cause by Parkinson's disease) 34 mg daily, Eliquis (blood thinner) 5 mg twice a day and melatonin (for sleep) 15 mg at night for insomnia. R136's 2/24/23, skilled progress note indicated R136 was alert with confusion, displayed behaviors, required observation and use of chair and bed alarm for fall prevention.	F 622	Resident R136 is no longer in facility. Residents who leave the facility for emergency medical services have the potential to be impacted by the alleged practice. Transfer and discharge policies were reviewed with the interdisciplinary team to ensure clear understanding of the policies as written. The Executive Director or designee will provide training to licensed nurses on management of emergency transfer and returns, communication with the facility leadership team and the medical director when a concern regarding returning to facility is noted. Audits will be conducted weekly for four weeks by the Executive Director or designee on transfers and discharges to ensure compliance. Emergency transfers will be reviewed by Executive Director and Vice President of Success on a case-by-case basis as they occur. Results of audits will be forwarded to the Quality Assurance/Performance Improvement committee for review and recommendations.	

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F 622	Continued From page 11 R136's 2/25/23, late entry progress note identified: 1) 10:00 to 10:50 p.m., R136 was combative, yelling and was transferred to his wheelchair by staff and placed in the lobby for observation with chair alarm. 2) 10:50 p.m., a decision was made from the provider for R136 be sent to the local ED (emergency department) for evaluation related to R136 hitting the right side of his head on wall. In addition, the facility revealed to the provider that R136 was on blood thinners. 3)11:00 p.m., local law enforcement was contacted for R136 combative behavior. 4) 11:20 p.m., director of nursing was informed of R136 transfer to ED for evaluation related to his behavior. 5)12:00 a.m., Family member (FM-F) was contacted via phone of R136 transfer to local ED. 6) 3:00 a.m., the local ED notified the facility R136 was stable and safe to discharge back to facility. 7) 3:15 a.m., local ED informed the facility R136 had no psychiatric behaviors and was stable for discharge. The facility refused to take R136 back to the facility. 8) 3:25 p.m., facility informed the nursing home administrator they would not accept R136 back to the facility. 9) 3:30 a.m., R136 FM-F was informed the facility would not accept R136 back for his behavior that was displayed at the time of transfer to the ED. FM-F agreed to take R136 home from the local ED. Interview on 11/01/23 at 10:15 a.m., with director of nursing (DON) and regional nurse consultant (RNC-A) both agreed the facility based their	F 622		

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F 622	Continued From page 12 decision to discharge and not accept R136 back to the facility on his behaviors that were displayed at the time of transfer to the ED and not after receiving medical treatment. There was no indication how the DON and RNC-A identified R136 was appropriate for admission based on criteria of the facility, or if the refusal of readmission following the ED visit was appropriate. Review of 7/15/22, Transfer and Discharge (including AMA (against medical advice) policy identified when a facility-initiated discharge occurred, the facility was to document that appropriate information was communicated to the receiving facility. The facility was able to discharge a resident if it was necessary for the resident's welfare, or their needs could not be met and must be documented by the resident's physician and be made at least 30 days before discharge or if the safety of individuals was endangered, notice was to be made as soon as possible. the facility was to document the danger the failure to discharge would pose. To discharge a resident to the hospital, the facility was required to obtain orders from the physician, provide a bed hold notice to the resident within 24 hours of transfer, and completed a Notification of Transfer or Discharge form. There was no indication the facility had reviewed the policy yearly to ensure accuracy and appropriateness.	F 622		
F 644 SS=D	Coordination of PASARR and Assessments CFR(s): 483.20(e)(1)(2) §483.20(e) Coordination. A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C	F 644		12/20/23

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F 644	Continued From page 13 of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes: §483.20(e)(1)Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care. §483.20(e)(2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to ensure a level II Pre-Admission Screening and Resident Review (PASARR) was completed for 1 of 1 resident who was admitted with a diagnosis of Schizoaffective disorder. Findings include: R18's electronic admission record identified R18 was admitted March 2020, with a diagnosis of Schizoaffective disorder upon admission and dementia. R18's admission Minimum Data Set (MDS) assessment identified that a Pre-Admission Screening was completed and that the resident had been evaluated with a Pre-Admission Screening (PAS I), dated 3/19/20, and OBRA: dated 3/23/20 on the PAS I, the option was checked which indicated that Senior LinkAge did not complete the screening, it was forwarded to a county/managed care organization for	F 644	Resident R18 s records were reviewed by Director of Social Services and an updated PASSR requested on November 6, 2023; no additional PASSR necessary per reviewing agency Olmstead County. A review of current residents will be conducted to verify residents have received a proper PASSR Level screening. The current policy was reviewed by the interdisciplinary team and will be followed going forward. Education was provided by the Executive Director to the Director of Social Services and the Business Office Manager on PASSR requirements. An audit will be done on PASSR screenings for new admissions prior to arrival to determine if residents meet the need for level II screenings. A copy of the	

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F 644	Continued From page 14 processing. The OBRA indicated that R18 did not have a major mental disorder diagnosis. Interview on 11/01/23 at 9:23 a.m., with Licensed Social Worker, (LSW) identified that the facility reviewed the pre-admission screener and PASARR Level I form when a resident was admitted. LSW also stated that R18's diagnosis was known at the facility when admitted, but a level II screening was not needed, based on the resident's provided PAS level I and OBRA screeners information. These screeners indicated that the resident did not have a mental health diagnosis, upon admission. This contradicted the resident's diagnosis. A PASARR policy was requested, however none was provided at the end of the survey.	F 644	level II screening will be validated as having been received prior to admission. Director of Social Services will be responsible for compliance.	
F 689 SS=E	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to to ensure 1 of 2 shower room wall ties were repaired to prevent potential injury for 14 of 34 residents (R1, R4, R5, R9, R10, R12, R15, R17, R19, R22, R24, R29, R334, and R335) who resided on the 200 wing and used that shower.	F 689	The 200 Wing Shower tiles will be repaired on or before 12/15/2023. To ensure ongoing compliance the Director of Maintenance will conduct bi-weekly preventative maintenance rounds with the Executive Director.	12/20/23

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F 689	Continued From page 15 Findings include: Observations on 10/31/23 from 11:15 a.m., through 11:45 a.m. of the facility identified in the 200 wing shower room, directly above the wall heater unit, 1 tile was broken and half missing. Directly adjacent to that, a piece of sheet-rock, approximately 6 inches wide by 2 inches tall was missing from the wall. Interview on 10/31/23 at 11:20 a.m., with nurse aide (NA)-F in the common-use resident bathroom on the 200 wing identified the ceiling around the exhaust fan was chipped and crack sand some parts were missing from the plaster. "Maintenance doesn't fix them". She was unsure if any staff alerted maintenance to the needed repairs. Further interview on 11/1/23 at 11:21 a.m., with NA-F of the 200 wing shower room walls and floor identified she agreed the missing tile on the wall was a hazard to all residents as the broken tile could potentially come into contact with a residents foot or leg if they brushed up against it. In the shower room, staff had stored multiple resident items like shampoos, conditioners and body wash along side a bottle of Clorox disinfectant spray. NA-F agreed co-mingling cleaning chemicals with resident items was a hazard as staff could inadvertently get the bottles mixed up. Observation and interview on 11/01/23 11:34 AM with maintenance supervisor (MS) identified he had worked at the facility for approximately 2 years and was also responsible for other sister facilities in town. He trained staff to put in a fix it	F 689	Rounds will include a review of the TELs reports for task completion. Identified issues will be corrected by internal staff as able, and contracted labor when necessary. Staff will be re-educated by the Executive Director or designee on the use of TELS system for reporting maintenance issues. Bi-weekly rounds will be completed for four weeks by the Executive Director and Maintenance Director and then weekly per routine. Results of audits will be forwarded to the Quality Assurance/Performance Improvement committee for review and recommendations. Director of Maintenance will be responsible for compliance.	

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F 689	Continued From page 16 request using a software program called "Fix-it" The MS identified he did no maintenance rounds at the facility and only fixed any concern if it was brought to his attention. In showing him all the above mentioned concern, he agreed he needed to perform repairs in the facility to ensure it was a safe and homelike environment. At 11:40 a.m., the regional nurse consultant (RNC) and infection preventionist joined the interview and agreed the broken tile was a risk to resident safety. The MS stated he attended the Quality Assurance Performance Improvement monthly meetings, but brought no environmental concerns to the meetings. Observation on 11/1/23 at 12:50 p.m., of front entrance by the nurses station floor tiles identified a 3 in horizontal piece of tile is missing from the floor. The hole was big enough where a wheelchair or walker could become stuck or unleveled if crossed over the tile posing a risk to resident safety. Review of the QAPI monthly meeting minutes from January to September 2023 identified no environmental data related to the upkeep of the facility was brought forward to ensure QAPI was aware of the disrepair. Review of the 6/16/22, Safe and Homelike Environment policy identified the facility would provide a safe, clean and comfortable, homelike environment and the physical environment would not pose a safety risk. Maintenance services were to be provided as necessary. There was no mention the MS should perform active preventative maintenance to ensure the facility was maintained in he above mentioned manner.	F 689		

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F 695	Continued From page 17	F 695		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure oxygen tubing was changed in a timely manner for 1 of 2 residents (R26) reviewed for respiratory care. Findings include: R26's Admission Record identified R26 had diagnosis which included Multiple Sclerosis, Spastic Hemiplegia, Chronic Respiratory Failure with Hypoxia and Sleep Apnea. R26's Care Plan directed staff to administer oxygen per MD orders, titrate for comfort, 1-4 liters (L). The care plan did not address oxygen tubing changes. R26's medical record lacked direction for oxygen tubing changes. On 10/30/23 at 7:26 p.m., R26 was observed in room, wearing oxygen via nasal cannula, the tubing was either dated for 10/8 or 10/18, the writing made it hard to distinguish if it was a slash between the 0 and 8 or a 1.	F 695	Resident R26's Care Plan was reviewed and is up to date. Oxygen tubing replaced immediately. Residents who have orders for supplemental oxygen have the potential to be impacted by the alleged practice. Resident TARs were reviewed and updated to include weekly change of oxygen tubing as per policy. The Director of Nursing or designee re-educated nursing staff on the oxygen administration policy with an emphasis on tubing storage and changes. Director of Nursing or designee will conduct weekly audits for four weeks to validate charting and physical audits of residents on oxygen tubing to validate tubing is changed and stored as required. Results of audits will be forwarded to the Quality Assurance/Performance Improvement committee for review and recommendations.	12/20/23

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F 695	Continued From page 18 On 10/31/23 at 10:00 a.m., R26 was observed in room, wearing oxygen via nasal cannula, that appeared to be the same the tubing that was either dated for 10/8 or 10/18, the writing made it hard to distinguish if it was a slash between the 0 and 8 or a 1. On 10/31/23 at 04:17 p.m., interview and observation with assistant director of nursing (ADON). ADON stated the facility's expectations are that the resident's oxygen tubing was changed by night nurse, at least once per week. This included oxygen tanks and nebulizers tubing. ADON further stated that the facility completed random room audits to ensure that oxygen tubing had been changed. ADON further confirmed that it was important to change the oxygen tubing to stop possible growth of bacteria and other organisms that could make the resident ill. The ADON accompanied the surveyor to R26's room to inspect R26's oxygen tubing. ADON stated it could not be determined if the date was 10/8 or 10/18, but that it should've been changed weekly. On 10/31/23 4:27 p.m., interview and observation with director of nursing (DON). The DON stated that oxygen tubing was changed by the night nurse at least once per week with a date, this was to be completed on Sunday as best practice by the facility. DON stated it was important to change the oxygen tubing to stop potential bacteria growth, and ensuring the tubing does not have a crack or hole in it that would prevent it from delivering oxygen. DON also stated that the facility conducted random room audits to check proper oxygen tubing labelling. The DON accompanied surveyor to R26's room, inspected R26's oxygen tubing. DON stated that the date	F 695	Director of Nursing Responsible for compliance.	

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F 695	Continued From page 19 listed on the tubing was vague, and could be 10/8 or 10/18, but should have been changed weekly. The facility policy on oxygen tubing was requested but the only policy provided did not mention direction for how often oxygen tubing should be replaced and/or labeled. The DON stated that while this was not indicated in the policy, it has been the best practice, and expectation, since she has been at the facility.	F 695		
F 725 SS=E	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must	F 725		12/20/23

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F 725	Continued From page 20 designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure sufficient staffing was available to provide timely assistance with personal cares for 1 of 3 residents (R185) and 2 of 8 resident council members (R1 and R29) who voiced concerns with an inadequate number of staff to routinely meet their needs in a timely manner. Findings include: Interview on 11/1/23 at 11:23 a.m., during a resident council meeting, the residents in attendance expressed concerns for sufficient staffing. There were two residents R1 and R29 who gave examples of sufficient staffing concerns. R1 reported there had been times she had not received her morning medication until 11:30 a.m. which makes her feel sick. R1 reported when that happened it was an agency staff passing medication and R1 needed to tell the agency staff that she cannot get her morning medications that late or she becomes ill. R1 further reported during the resident council meeting that there are times that she had to wait an hour after putting her call light on for someone to come and assist her to get up for the day. R29 reported that he had to wait 25 minutes to get a ride to attend the resident council meeting today. R29 expressed frustration of having to wait extended amounts of time related to the limited staff available to get his call light answered. R29 revealed sometimes he took it personally like staff did not like him or because his room was at the end of the hall. R1 reported that the residents	F 725	R1 and R335 are no longer in the facility. R29, R185 will be interviewed daily to identify concerns. Concerns will be reported to Executive Director or designee for follow-up. Residents who require staff assistance have the potential to be impacted by the alleged practice. Review of staffing patterns was completed by the Executive Director and Director of Nursing and adjustments to plan were made if indicated. Daily staffing review will be completed five times weekly during weekday morning meetings to ensure staffing plan meets resident needs. This will be an ongoing practice in the facility. The facility will continue to supplement staffing plan with contracted staff when indicated and when staff are available. The facility team will continue to review and interview applicants for open positions in an effort to fill vacancies. Distribution of staff and consideration of workload will continue to be monitored by facility team. Call light response policy, medication administration policy and ADL care policy were reviewed by the interdisciplinary team and no changes were recommended. The Director of Nursing or designee provided training to nursing assistants and licensed nurses to include expectations for call light response, ADL assistance	

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F 725	Continued From page 21 tried not to make "piddly" request for things especially in the morning as they were aware of the limited staff available to assist them. All residents that attended the resident council meeting expressed there was a greater lack of staffing on the weekends and at times there had only been 2 direct care staff on duty with the nurses. R1 revealed that the R1's 11/1/23, printed Admission Record identified diagnoses of schizoaffective disorder bipolar type, mild cognitive impairment, borderline personality disorder, rheumatoid arthritis, congestive heart failure, chronic kidney disease, tremors, anemia, hypothyroidism, solitary pulmonary nodule, gastro-esophageal reflux disease (GERD), and low back pain. R1's November 2023, Order Summary Report identified the following medication orders to treat R1's pain, rheumatoid arthritis, schizoaffective disorder, tremors, and current respiratory infection: Acetaminophen 1000 milligrams (mg) three times a day (TID), Benzonatate oral capsule 1 capsule three times a day for cough, Cefdinir 300 mg twice a day for respiratory infection last dose due 11/5/23, Divalproex Sodium ER 1500 mg three times a day for schizoaffective disorder, Divalproex Sodium 2000 mg before bed for schizoaffective disorder, gabapentin 300 mg twice a day for essential tremors, Haloperidol 5 mg five times a for schizoaffective disorder, levothyroxine sodium 175 mcg every morning for hyperthyroidism, Pantoprazole sodium 40 mg twice a day for GERD, prednisone 2.5 mg every day for rheumatoid arthritis, Rexulti 2 mg twice a day for schizoaffective disorder, sulfasalazine 1500 mg twice a day for rheumatoid arthritis, and Torsemide 20 mg every day for fluid retention.	F 725	and medication administration were reviewed. Nursing staff were also educated on the need to follow policies for breaks and lunches and to notify nurse managers when they are experiencing an unexpected increase in workload due to a call off or vacant shift. The Director of Social Services and interdisciplinary team will complete resident interviews a minimum of 5 days per week for 14 days to determine if needs are being met, then a minimum of twice a week until substantial compliance is met. Interviews will be reviewed, tracked and trended weekly. Identified issues will be addressed as needed. Results of audits will be forwarded to the Quality Assurance/Performance Improvement committee for review and recommendations.	

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F 725	Continued From page 22 R1's 9/1/23, significant change Minimum Data Set (MDS) assessment identified R1's cognition was intact, R1 required minimal assistance with cares, R1 took an antipsychotic medication routinely. R29's 11/1/23, printed Admission Record identified diagnoses of lack of coordination, unsteadiness of feet, type 2 diabetes mellitus with diabetic neuropathy, leg pain, pressure ulcers, abdominal aortic aneurysm without rupture, spinal stenosis, cervical disc disorder, and chronic kidney disease. R29's 9/7/23, care plan identified R29 was non-weight bearing and did not ambulate, R29 required two staff assistance with an EZ (easy) stand lift, and substantial assistance with cares. R29's 9/14/23, admission MDS assessment identified R29's cognition was intact, R29 required substantial assistance with cares, R29 used a manual wheelchair and was dependent on staff to move the wheelchair. R29 had been admitted with 5 venous/arterial ulcers and 1 stage 2 pressure ulcer. R29 was working with physical and occupational therapy and planned to return to the community. Review of 7/26/22, Call Light Accessibility and Timely Response policy identified residents and staff will be trained on the call light system and how to request assistance using the call light system. All staff that observe and/or hear an activated call light are responsible to address the call light. If additional assistance was needed to assist the resident staff should stay with the resident until help arrives.	F 725		

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F 725	Continued From page 23 R185's 10/18/23, admission, Minimum Data Set (MDS) assessment identified R185's cognition was moderately impaired, he had diagnosis of irregular heartbeat, recent stroke, heart failure, and weakness. R185 required staff assistance with toileting, dressing and bed mobility, and transfers. Review of R185's diagnosis list identified additional diagnosis of muscle weakness, lack of coordination, unsteady gait, chronic respiratory failure with low oxygen levels, poor vision. Interview on 10/30/23 at 2:19 p.m., with R185 identified staff do not "wash me up or brush my teeth" in the morning or at bedtime unless he requests them to. Interview on 10/31/23 at 2:30 p.m., family member (FM)-A reported R185 told her staff do not assist him with personal hygiene. She comes every morning at around 9:00 a.m., and stays until around 3:00 p.m., R185's partial dentures are still in when she arrives at the facility from the night before and have not been cleaned. "I know they are not cleaning them because they look terrible, and they are full of food". She "always" has to brush them when she gets to the facility in the morning. FM-A identified staff do change his clothes daily, but they do not wash him up. Interview on 10/31/23 at 3:04 p.m., nursing assistant (NA)-B identified nursing aid staff are supposed to wash residents up and provide oral cares every morning and at bedtime. If a resident refuses, they are supposed to make 3 attempts to re-approach and report to the charge nurse.	F 725		

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F 725	Continued From page 24 Interview on 10/31/23 at 3:10 p.m., with the director of nursing (DON) identified they verify cares are being completed by looking at point of care charting. Management does not complete competencies to ensure cares are being completed correctly. They only provide online training. The DON was unable to provide any documented competencies for the above-mentioned sampled staff. She was aware they needed some kind of orientation for new staff and stated, "I've been thinking about that and I have talked about it". The DON was unable to provide any documentation to support the facility was working on developing a new process to ensure staff were deemed competent during orientation and yearly thereafter and had no policy or procedure for ensuring competencies would be performed on staff. Observation and interview on 11/1/23 at 7:40 a.m., with R185 identified he was sitting up in his wheelchair and was dressed. He reported staff washed him up because he spilled his urinal in bed. "I don't feel like they did a good job... but at least they did something". They did not provide oral cares the night before or this morning. R185 pulled his partial out of his mouth and food particles were observed remaining in his dentures. Staff did not comb his hair, nor had they shaved him. This was not an unusual occurrence and stated, "They never do any of those things". His family member usually has to brush his teeth, shave him, and comb his hair when she came to visit. R185's hair appeared unkempt, and he had facial hair growth of approximately 1/8 to 1/4 inches. Observation on 11/1/23 at 7:45 a.m., of R185 identified staff wheeled R185 to the dining room	F 725		

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F 725	Continued From page 25 for breakfast. R185's point of care nurse aide (NA) documentation showed staff documented they had documented they had performed and completed personal hygiene, such as brushing his dentures to R185. Interview on 11/1/23 at 10:09 a.m., with NA-H identified she and another NA assisted R185 on this morning. She stated she had not brushed his teeth, combed his hair, or shaved him. NA-H identified mornings are "very busy". She worked both wings and had to run back and forth from one wing to the other to help other staff with resident transfers. "We don't have enough help...we need more help". She typically does not get a morning or lunch break because she inferred the facility did not have enough help. NA-H revealed they often do not get cares done with residents "especially in the morning" because there is not enough time. Interview on 11/1/23 at 10:22 a.m., with NA-F identified she assisted R185 with morning cares that day. She was not able to brush his teeth, comb his hair, or shave him because there was "not enough time. I do try to get everything done, but I just can't". NA-F revealed staff often only get residents dressed and up in their chairs because they don't have enough help. "It's very sad. Most residents at the facility require 2 staff assist, and we only have 3 nurse aids scheduled". Observation and interview on 10/31/23 at 5:20 p.m., with R335 in the dining room, identified he had a plate of containing one slice of pizza. R335 stated "my food ain't worth a {expletive]. my food is cold because they took me away from it".	F 725		

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F 725	Continued From page 26 Registered nurse (RN)-A had wheeled him back to his room to check his blood sugar and administer his medications and now his food was cold. He reported that was "frustrating when you have been looking forward to hot pizza all day". Interview on 10/31/23 at 5:30 p.m., with RN-A identified R335's blood sugar check was due at 4:00 p.m.. She acknowledged she should have completed the blood sugar check and medication administration earlier, but she was late with her medication administration for all her residents. She had a new admission today and also had to assist some residents with cares. "there is nobody available to help on the nursing floor if we fall behind [with her duties]". It was "impossible" to get medications admistered on time. The only time staff get help from management was when the facility had to replace a nurse when they were unavailable to work and the shift needed to be filled. The facility normally scheduled 3 nurse aids and 2 licensed nurses. She often only had 2 nurse aids to provide cares for the residents as they were commonly short staffed. If she was busy attending to nurse aid duties or admitting a resident, her routine job duties could not be accomplished. She has brought forth her concerns to facility management but in her experience the situation has never been resolved. The DON never made herself available to assist nursing staff when they were short staffed. Interview on 11/1/23 at 1:05 p.m., with nursing department scheduler identified staffing is done using a census grid, she has never been directed to consider acuity and did not know how that worked. Interview on 11/1/23 at 1:30 p.m., with DON	F 725		

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F 725	Continued From page 27 identified staff is scheduled based on census, they go by a census grid that indicates the number of staff needed related to the number of resident census. She would speak to her nurse consultant to request more staffing hours if her staff told her they were having difficulty completeing cares. There was no staffing policy or procedure related to staffing provided by the end of the survey.	F 725		
F 726 SS=E	Competent Nursing Staff CFR(s): 483.35(a)(3)(4)(c) §483.35 Nursing Services The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. §483.35(a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs. §483.35(c) Proficiency of nurse aides.	F 726		12/20/23

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F 726	Continued From page 28 The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, facility failed to ensure 5 of 5 sampled nurse aids (NA-A, NA-B, NA-C, NA-D, and NA-E) were deemed competent upon hire or yearly thereafter to provide care to residents. Findings include: R185's 10/18/23, admission, Minimum Data Set (MDS) assessment identified R185's cognition was moderately impaired, he had diagnosis of irregular heartbeat, recent stroke, heart failure, and weakness. R185 required staff assistance with toileting, dressing and bed mobility, and transfers. Review of R185's diagnosis list identified additional diagnosis of muscle weakness, lack of coordination, unsteady gait, chronic respiratory failure with low oxygen levels, poor vision. Interview on 10/30/23 at 2:19 p.m., with R185 identified staff do not "wash me up or brush my teeth" in the morning or at bedtime unless he requests them to. Interview on 10/31/23 at 2:30 p.m., family member (FM)-A reported R185 told her staff do not assist him with personal hygiene. She comes every morning at around 9:00 a.m., and stays until around 3:00 p.m.. R185's partial dentures are still in when she arrives at the facility from the	F 726	R185 will be interviewed daily to identify concerns. Concerns will be reported to Executive Director or designee for follow-up. Residents who require assistance with ADL tasks have the potential to be impacted by the alleged practice. Review of policies associated with ADL tasks was completed by the interdisciplinary team and education prepared for members of nursing staff. The orientation process will include a skills checklist that addresses ADL tasks, transfers, communication, and core nursing competencies that is reviewed upon hire and completed during the initial unit orientation. The checklist will be reviewed by the Director of Nursing or designee and additional training provided if indicated. The skills checklists will be reviewed with current employees with observations of care completed on an as needed basis to validate competency. The Director of Nursing or designee will provide training to the nursing assistant staff on the need for completion of routine ADL tasks daily and on the need for updated competencies at hire and annually.	

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F 726	Continued From page 29 night before and have not been cleaned. "I know they are not cleaning them because they look terrible and they are full of food". She "always" has to brush them when she gets to the facility in the morning. FM-A identified staff do change his clothes daily, but they do not wash him up. Interview on 10/31/23 at 3:10 p.m., with the director of nursing (DON) identified they verify cares are being completed by looking at point of care charting. Management does not complete competencies to ensure cares are being completed correctly. They only provide online training. The DON was unable to provide any documented competencies for the above-mentioned sampled staff. She was aware they needed some kind of orientation for new staff and stated, "I've been thinking about that and I have talked about it". The DON was unable to provide any documentation to support the facility was working on developing a new process to ensure staff were deemed competent during orientation and yearly thereafter and had no policy or procedure for ensuring competencies would be performed on staff. Observation and interview on 11/1/23 at 7:40 a.m., with R185 identified he was sitting up in his wheelchair and was dressed. He reported staff washed him up because he spilled his urinal in bed. "I don't feel like they did a good job... but at least they did something". They did not provide oral cares the night before or this morning. R185 pulled his partial out of his mouth and food particles were observed remaining in his dentures. Staff did not comb his hair, nor had they shaved him. This was not an unusual occurrence and stated, "They never do any of those things". His family member usually has to	F 726	Resident interviews will be conducted a minimum of 5 days per week for 14 days to determine if needs are being met, then once a week until substantial compliance met. Interviews will be reviewed, tracked and trended weekly. Identified issues will be addressed as needed. The Director of Nursing or designee will complete direct observation of care a minimum of three times weekly to validate competency of care provided. Results of audits will be forwarded to the Quality Assurance/Performance Improvement committee for review and recommendations. Reports and Audits will be made to QAPI on a monthly basis.	

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F 726	Continued From page 30 brush his teeth, shave him, and comb his hair when she came to visit. R185's hair appeared unkempt, and he had facial hair growth of approximately 1/8 to 1/4 inches. Observation on 11/1/23 at 7:45 a.m., of R185 identified staff wheeled R185 to the dining room for breakfast. R185's point of care nurse aide (NA) documentation showed staff documented they had documented they had performed and completed personal hygiene, such as brushing his dentures to R185. Interview on 11/1/23 at 10:09 a.m., with NA-H identified she and another NA assisted R185 on this morning. She stated she had not brushed his teeth, combed his hair, or shaved him. NA-H identified mornings are "very busy". She worked both wings and had to run back and forth from one wing to the other to help other staff with resident transfers. "We don't have enough help...we need more help". She typically does not get a morning or lunch break because she inferred the facility did not have enough help. NA-H revealed they often do not get cares done with residents "especially in the morning" because there is not enough time. Interview on 11/1/23 at 10:22 a.m., with NA-F identified she assisted R185 with morning cares that day. She was not able to brush his teeth, comb his hair, or shave him because there was "not enough time. I do try to get everything done, but I just can't". NA-F revealed staff often only get residents dressed and up in their chairs because they don't have enough help. "It's very sad. Most residents at the facility require 2 staff assist, and	F 726		

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F 726	Continued From page 31 we only have 3 nurse aids scheduled". There was no policy or procedure related to staff competency provided by the end of the survey.	F 726		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and	F 758		12/20/23

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F 758	Continued From page 32 §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to individualize the care plan to include target behaviors for psychotropic medication use for 1 of 1 (R12) resident. Additionally, the facility failed to have appropriate diagnoses for antipsychotic medication for 2 of 2 (R23 and R185) residents. Findings include: R12's 9/27/23, quarterly Minimum Data Set (MDS) assessment identified R12's cognition was impaired, R12 required staff assistance for cares, had one fall with minor injury since last assessment, took an antipsychotic medication on a routine basis, and had diagnoses of heart failure, hypertension, renal insufficiency, dementia, and schizoaffective disorder. R12's October 2023, Medication Administration Record (MAR) identified R12 had an order for Olanzapine 20 milligram (mg) by mouth at	F 758	R12, R23, and R185 care plans, diagnoses and medication consents were reviewed and updated if indicated. Residents who are prescribed psychotropic medications have the potential to be impacted by the alleged practice. Care plans, orders, and diagnoses were reviewed for these residents and consents were validated or updated as indicated. The Director of Nursing or designee will complete audits weekly for four weeks on residents who are prescribed psychotropic medications. Audits will include review of MAR for key behaviors being monitored, side effects monitoring, and informed consent for medications. Random audits will be completed monthly on an ongoing basis during the behavior meetings. These audits will be submitted to the	

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F 758	Continued From page 33 bedtime for schizoaffective disorder bipolar type and Sertraline HCL 150 mg by mouth every morning for schizoaffective disorder bipolar type and somatoform disorder. The MAR further identified an order for Olanzapine/Zyprexa side effect monitoring: observe for signs/symptoms these include but are not limited to: Somnolence (sleepiness), insomnia, agitation, headache, dizziness, tremor, and confusion every shift. There was also an order for antidepressant medication, monitor for sedation, drowsiness, dry mouth, blurred vision, urinary retention, tachycardia, muscle tremor, agitation, headache, skin rash, photosensitivity, excessive weight gain and if any new symptoms are observed to document in the progress notes every shift. The MAR lacked identification of individualized target symptoms that the Zyprexa or the Sertraline HCL had been prescribed to treat or alleviate. Unknown if either of the ordered medications were effective as there were no target symptoms or behaviors identified to monitor for effectiveness. R12's undated, care plan identified risk for behavior symptoms related to schizoaffective disorder bipolar type. R12 will accept care and medications from staff. Staff were to provide reassurance by answering questions with health-related concerns. Staff will use consistent approaches when assisting with cares. The care plan lacked identification of what the behavior symptoms were or had been in the past. The care plan further, identified at risk for adverse effects related to use of antidepressant medication and use of antipsychotic medication related to schizoaffective disorder. R12 would show minimal, or no side effects of medications taken. R12 would show improvement in mood and	F 758	Quality Assurance and Performance Improvement committee for review and recommendations. Director of Nursing responsible for Compliance.	

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F 758	Continued From page 34 behavior. However, there was no mention of what the individualized target symptoms or behaviors were to monitor for effectiveness. Interview on 11/1/23 at 7:21a.m., with licensed practical nurse (LPN)-A identified that R12 had no behaviors and took the psychotropic medication because of her diagnosis of Schizophrenia. Interview on 11/1/23 at 2:44 p.m., with registered nurse consultant (RNC) identified that R12 should have had target behaviors identified that the medication was prescribed to treat per the facilities policy. Interview on 11/2/23 at 8:41 a.m., with director of nursing (DON) identified all residents receiving a psychoactive medication should have individualized target behaviors identified on the MAR for monitoring. She revealed her expectation was that residents receiving psychoactive medications would be monitored for effectiveness and in order to monitor if the medication was effective or not there would need to be target behavior to monitor. She revealed that R12's care plan had just been reviewed and if there were no target behaviors identified that must have just been missed. Review of 10/24/22, Psychotropic Medications policy identified residents will only receive psychotropic medications to treat specific conditions. The medication should be beneficial to the resident as demonstrated by the facilities documentation of the response to the prescribed medication. Residents prescribed psychotropic medications will have documented indication for the medication and target symptoms will be included in the documentation. The resident	F 758		

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F 758	Continued From page 35 should have non-pharmacological interventions identified as well. Gradual dose reductions will be attempted unless contraindicated in an effort to discontinue the psychotropic medication. The effects of the psychotropic medications prescribed will be evaluated on an ongoing basis. The residents' symptoms and goals for the medication will be clearly documented. There is no indication the policy had been reviewed and updated yearly per the regulation. R185's 10/18/23, admission Minimum Data Set (MDS) assessment identified R185's cognition was moderately impaired, he had diagnosis of irregular heartbeat, recent stroke, hypertension, heart failure, kidney failure, and weakness. R185 required moderate assistance with toileting, dressing and bed mobility and was dependent on staff for transfers. R185's undated care plan identified R185 was at risk for adverse effects related to use of an antipsychotic and staff should evaluate for side effects of medication, decrease or eliminate psychotropic medication, obtain labs as ordered and notify doctor of results, provide resident teaching of risks and benefits of medications, and report to physician signs of adverse reactions such as decline in mental status, decline in positioning or ambulation ability, lethargy, complains of dizziness or tremors. Review of R185's diagnosis list identified diagnosis of muscle weakness, lack of coordination, unsteady gait, type II diabetes, chronic kidney disease, chronic respiratory failure with hypoxia, poor vision, dysphagia, and stroke. R185's diagnosis list lacked any indication of a qualifying diagnosis for the use of antipsychotic	F 758		

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F 758	Continued From page 36 medication. R23's 8/18/23, quarterly Minimum Data Set (MDS) assessment identified R1's cognition was moderately impaired, he had diagnosis of parkinson's, dementia, and chronic pain and required assistance with dressing. R23's undated care plan printed 11/2/23, identified R23 was at risk for adverse effects related to use of antipsychotic medication and staff should evaluate effectiveness and side effects of medication for possible decrease or elimination of psychotropic drugs. Care plan did not identify what symptoms or behaviors the antipsychotic medication was being used for. Review of R23's November of 2023, medication administration and treatment record identified R23 had been taking an antipsychotic Seroquel since 2/8/23, with a diagnosis listed of behavior disturbances. however, R23 did not have behavioral disturbances listed as an actual diagnosis. R23's MAR lacked identification of individualized target symptoms that the Seroquel had been prescribed to treat or alleviate. It is unknown if the ordered medications were effective as there were no target symptoms or behaviors identified to monitor for effectiveness. Interview on 11/2/23 at 1:14 p.m., with pharmacist identified she agreed with the above findings and would expect facility to ensure target behaviors are being monitored to identify the continued need and effectiveness of the antipsychotic medication. She would also have expected facility would ensure the appropriate diagnosis in place per CMS guidelines.	F 758		

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F 761	Continued From page 37	F 761		
F 761 SS=E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, and interview, the facility failed to have a method in place for timely removal of discarded medications in 3 of 3 medication containers from the facility. Findings include: Observation of the medication room on 11/1/23 at 3:23 p.m., accompanied by director of nursing	F 761	Policy on medication and destruction will be reviewed and updated as needed. Contract for medicinal waste disposal will be reviewed and updated. Current batches of medical waste were removed by stericycle on 12/5/2023. An ongoing standard schedule for medication pickup and removal will be established.	12/20/23

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F 761	Continued From page 38 (DON) identified 3 large black medication containers with lids. Each container had a label identifying they were able to hold up to 66 pounds. Interview on 11/1/23 at 3:23 p.m., with the DON identified the containers were full of discarded medications and she did not know why they had not been picked up and was uncertain how long they had been there. Interview on 11/1/23 at 4:30 p.m., with the maintnance director identified the facility had previously used Stericycle to pick up destroyed/discarded medication but they currently did not have a contract with them. He stated "it has been about 3 years" since the last time Stericycle had picked up the black bins and they had been having some difficulty renewing the contract due to missing paper work. Interview on 11/2/23, at 1:14 p.m., with the pharmacist consultant identified she did not notice the 3 full bins of destroyed medication and she only looks to see if they are using the appropriate container for disposal. She agreed that the facility should have a process in place to properly dispose of destroyed medication. A policy was requested but nothing was provided.	F 761	An audit of Medication carts and medication rooms will be conducted weekly for 4 weeks and monthly thereafter. Audit reports will be provided to QAPI for review. Director of Nursing responsible for Compliance.	
F 805 SS=D	Food in Form to Meet Individual Needs CFR(s): 483.60(d)(3) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(3) Food prepared in a form designed to meet individual needs.	F 805		12/20/23

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F 805	Continued From page 39 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide an ordered therapeutic diet for 1 of 1 resident (R138) reviewed for provision of therapeutic diets. Findings include: R138's Admission Record identified the following diagnoses history of stroke, dysphagia, type 2 diabetes mellitus, cirrhosis of the liver, fracture of left femur, muscle weakness, pulmonary fibrosis, chronic right heart failure, and anemia. R138's 8/29/23, admission Minimum Data Set (MDS) assessment identified R138's cognition was intact, he had no behaviors, required assistance with cares, took scheduled pain medication and rate pain a 5 on scale of 1 -10. R138 received daily insulin injections and was working with speech therapy, physical therapy, and occupational therapy. R138 had plans to return to the community. Review of 8/29/23, Nutritional Care Area Assessment identified R138's diet order as cardiac L2 mechanical textures (moist and soft-textured foods that are easy to chew), thin liquids. R138 had difficulty with chewing present related to edentulism (whole or partially toothless) and awaiting new dentures. R138's 8/22/23, care plan identified risk for nutritional status change related to edentulism (whole or partially toothless). Provide diet as ordered cardiac, L2 textures, thin liquids. Interview on 10/31/23 at 2:34 p.m., with therapy	F 805	R138 received the correct diet once CNA noted she had delivered the wrong tray to the resident. Caregiver immediately reported this to the DON and a discussion was held regarding the importance of double checking the name and diet matches the resident it is delivered to. Residents have the potential to receive anther's tray during meal service. Staff education given by Director of Nursing or designee of the need to identify the resident by name, compare name to diet order, and only deliver the tray if the name and diet are correct. Review therapeutic diet policy and procedure and update as needed. Educate all staff on therapeutic diets and matching the meal to the meal ticket for all residents. An audit of all meal tray tickets will be conducted to ensure proper diets and consistency. A audit of meal tray service will be conducted 5 times per week for 4 weeks, then weekly until substantial compliance is achieved. Audits will be reviewed by QAPI. Executive Director or designee will be responsible for compliance.	

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F 805	Continued From page 40 director identified that R138 was supposed to get his new dentures when he fell at home and broke his femur. She revealed that R138 had been seen by speech therapy and his diet had been addressed for safety. Observation on 11/1/23 at 8:49 a.m., of nursing assistant (NA)-G setting up R138's breakfast tray on his bedside table in his room. He had three round pieces of Canadian bacon that appear dry and overcooked, and he had a waffle. R138 took a bite of the waffle and stated, "I can't chew that". NA-G responded to R138 she could see if she could get him something softer to eat. This writer asked NA-G to double check the tray ticket and when she did, she immediately apologized and stated she had given R138 the wrong tray. NA-G then took the tray of food and said she would be back with the correct food. NA-G returned shortly with another tray that contained hot oatmeal, some pudding, a banana, and a couple glasses of juice. Interview on 11/1/23 at 2:44 p.m., with registered nurse consultant (RNC) identified her expectation was that staff provided the correct diet to the residents as ordered. Staff were to check the tray ticket and validate that they are serving the correct meal to the correct resident. There was no policy on providing a therapeutic diet provided by the end of the survey.	F 805		
F 851 SS=F	Payroll Based Journal CFR(s): 483.70(q)(1)-(5) §483.70(q) Mandatory submission of staffing information based on payroll data in a uniform format.	F 851		12/20/23

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F 851	Continued From page 41 Long-term care facilities must electronically submit to CMS complete and accurate direct care staffing information, including information for agency and contract staff, based on payroll and other verifiable and auditable data in a uniform format according to specifications established by CMS. §483.70(q)(1) Direct Care Staff. Direct Care Staff are those individuals who, through interpersonal contact with residents or resident care management, provide care and services to allow residents to attain or maintain the highest practicable physical, mental, and psychosocial well-being. Direct care staff does not include individuals whose primary duty is maintaining the physical environment of the long term care facility (for example, housekeeping). §483.70(q)(2) Submission requirements. The facility must electronically submit to CMS complete and accurate direct care staffing information, including the following: (i) The category of work for each person on direct care staff (including, but not limited to, whether the individual is a registered nurse, licensed practical nurse, licensed vocational nurse, certified nursing assistant, therapist, or other type of medical personnel as specified by CMS); (ii) Resident census data; and (iii) Information on direct care staff turnover and tenure, and on the hours of care provided by each category of staff per resident per day (including, but not limited to, start date, end date (as applicable), and hours worked for each individual). §483.70(q)(3) Distinguishing employee from	F 851		

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F 851	Continued From page 42 agency and contract staff. When reporting information about direct care staff, the facility must specify whether the individual is an employee of the facility, or is engaged by the facility under contract or through an agency. §483.70(q)(4) Data format. The facility must submit direct care staffing information in the uniform format specified by CMS. §483.70(q)(5) Submission schedule. The facility must submit direct care staffing information on the schedule specified by CMS, but no less frequently than quarterly. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to submit accurate and/or complete data for staffing information, including information for agency and contract staff, based on payroll and other verifiable and auditable data during 1 of 1 quarter reviewed Quarter 3, to the Centers for Medicare and Medicaid Services (CMS), according to specifications established by CMS. Findings include: Review of the Payroll Based Journal Report (PBJ) Casper Report 1705 D identified the following dates triggered for review: 4/22, 4/23, 4/30, 5/2, 5/4, 5/6, 5/7, 5/8, 5/10,5/11, 5/13, 5/14,5/21, 6/3, 6/4, 6/18,6/19, 6/24, and 6/25. for failure to have licensed nurse coverage 24 hours per day. Review of staffing schedules identified the facility had licensed staff identified to have worked. Review of the licensed staff timecards on the	F 851	F851 Payroll Based Journal 8 hour continuous RN coverage for all days in April, May and June were provided. During this time a change in the facility payroll systems were not properly implemented resulting in agency nursing hours not being properly reported to PBJ. Facility policies and procedures for PBJ will be reviewed and/or created. PBJ submission and validation were completed on 11/06/2023 The scheduler and Business Office manager will be educated on the policy. The ED will conduct weekly audits to identify any issues related to staffing reporting. Executive Director responsible for compliance. Completion Date: 12/20/2023	

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F 851	Continued From page 43 above-mentioned dates confirmed licensed nursing staff had worked and therefore the data submitted in the PBJ to CMS was inaccurate. Interview on 10/31/23 at 5:08 p.m., with registered nurse consultant (RNC) who identified the facility had received a report from the corporate office to review the identified of 4/22, 4/23, 4/30, 5/2, 5/4, 5/6, 5/7, 5/8, 5/10,5/11, 5/13, 5/14,5/21, 6/3, 6/4, 6/18,6/19, 6/24, and 6/25. She revealed the facility used a lot of agency staff who have not used the time clock and the facility had no system in place to monitor their time that they worked. The corporate office completes the updates after we reviewed and validated the licensed staff times. She revealed that the corporate office had reached out to the facility after an error report or a warning of some sort that we were short, licensed staff hours. The facility confirmed the licensed nursing hours and sent back the information to be updated. There was no policy related to PBJ entries provided by the end of the survey.	F 851		
F 880 SS=F	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention	F 880		12/20/23

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ROCHESTER HEALTH SERVICES WEST	2215 HIGHWAY 52 NORTH ROCHESTER, MN 55901

(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 880	Continued From page 44 and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed	F 880		

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F 880	Continued From page 45 by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to have a comprehensive infection control surveillance program to include tracking resident illnesses through to resolution and identify when employees would be able to return to work after illness, dependent upon their symptoms. The facility further failed to ensure 1 of 1 discontinued hydrocollator was drained and maintained in a sanitary manner to prevent mold-like buildup and prohibit a potential Legionella source of infection and failed to ensure staff had not stored personal items in 1 of 1 occupational therapy (OT) refridgerator and 1 of 1 family room fridge was maintained in a clean and sanitary manner, and staff food was not stored within. Additionally, the facility failed to ensure 2 of 2 mechanical stand lifts were maintained in a clean manner with washable surfaces. This had the ability to affect all 34 residents. Findings include: SURVEILLANCE	F 880	The comprehensive infection and control plan will be reviewed and updated as needed. The monthly long sheet for employee illnesses will be revised to include tracking of symptoms, follow-up testing and rationale for return to work for each identified employee illness under the infection control plan. Resident illness tracking procedures will be reviewed and updated as needed. The procedures will include tracking of both treated and untreated illnesses and include more detailed information regarding symptoms, testing, rational for treatment or lack of treatment, and resolution of illness. Weekly audits will be conducted of the resident and staff illness logs to verify capture of all pertinent illnesses with	

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F 880	Continued From page 46 Review of the May through October 2023, resident surveillance log identified two infections not treated with antibiotics, were COVID positive and they were noted to be treated at the emergency department (ED). No other non-antibiotic therapy illnesses were identified on the surveillance logs. Review of July through October 2023, employee illness logs identified the last staff call in was reported to be in August 2023. There was no determination how staff were able to come back to work or if residents were tested per CDC after COVID positive staff illness. Surveillance logs lacked identification of broad-based testing and/or contact training had occurred. Interview on 10/31/23 at 3:51 p.m., with infection preventionist (IP) confirmed resident surveillance logs lacked thorough information of antibiotic indication of use, duration, if symptoms resolved, or there was a need to contact the resident's physician to change or alter treatment if not resolved. The surveillance further lacked identification of any non-antibiotic, non-COVID illnesses. Interview and staff illness log review on 11/1/23 at 4:30 p.m., with IP who confirmed If staff were out ill, or when they were identified to be positive for COVID, he had not added how staff were able to come back to work. He further, revealed the logs lacked identification if staff were tested or if the residents were tested per CDC regulations, after a positive COVID result. The IP agreed staff illness tracking was critical to prevent potential infectious illness from staff to residents and identify potential exposure and determine when staff would be able to return to work.	F 880	appropriate level of detail is being recorded. Rational for respective actions will be provided, including staff returning to work, and the placement and lifting of isolation or quarantine of residents. The discontinued hydrocollator was and taken off line per infection control standards. All resident use refrigerators will be checked weekly for 8 weeks. Any items not meeting the infection control policies will be corrected. Mechanical lifts will be reviewed and repaired or replaced as needed to eliminate any infection control issues. Infection Control Nurse will be responsible for compliance. Audits will be reviewed at QAPI.	

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F 880	Continued From page 47 Review of October 2022, Return to Work Criteria for Healthcare Personnel and with COVID-19 Infection or Exposure to COVID-19 policy identified, employees were required to report symptoms of illness. The employee, IP, and supervisor were to collaborate to determine, if significance, of any employee health condition would require restrictions regarding direct resident contact. Review of November 2022, Antibiotic Stewardship Program identified the system was monitored facility wide under the direction of the Director of Nursing and IP. The antibiotic program was to implement protocols to determine the dose, duration, and indication for usage and if adjustments should be made, and reviewed for appropriateness of use. Review of March 2023, Infection Surveillance policy identified the intent of surveillance was to identify possible communicable disease or infections before they spread to other persons in the facility. The facility was to have established a surveillance, based on nationally recognized surveillance and standards of practice to closely monitor all residents, staff, volunteers and contract employees who exhibit signs or symptoms of infection through ongoing surveillance, including, a systemic method for collecting, analyzing and interpretation of data, followed by dissemination of that information to identify infections, infections risks and outbreaks to those who can improve the outcomes for quality. ENVIRONMENT	F 880		

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F 880	Continued From page 48 Observation on 11/1/23 at 9:30 a.m., in the physical therapy room identified a hydrocollator (heated treatment machine filled with hot packs for residents) was noted. There was a small padlock on the hydrocollator. Observation and interview on 11/01/23 at 9:34 a.m., with occupational therapist (OT)-A identified she has been at the facility and had never used the hydrocollator that she could recall. OT-A then went to find the key in her office and returned to open the hydrocollator. Once opened, it was observed to have a slimy, black and white mold-like substances in the water. OT-A stated she would notify maintenance right away to clean and disinfect the hydrocollator. Observation and interview on 11/1/23 at 9:40 a.m., with the maintenance supervisor (MS) identified he was unaware the facility's hydrocollator was in the therapy room. He agreed the presence of standing water in the hydrocollator posed an infection control hazard source such as Legionella and mold spores to affect any resident who used the therapy room. Observation on 11/1/23 at 9:50 a.m., of the occupational therapy fridge identified what appeared to be staff lunches, such as homemade salsa and a lunch box and 2 cans of pop. There were no recorded temperatures on the log on the door. Interview on 11/01/23 at 9:51 a.m., with OT-A identified therapy provides services in that room to residents. The refridgerator has not been temped and contained staff lunches and drinks. She agreed staff usage of resident care area equipment should not occur. Staff were to store	F 880		

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F 880	Continued From page 49 their personal items in their breakroom. Observation on 11/1/23 at 10:35 a.m. of the family room refridgerator identified there was food and liquid debris inside the refridgerator on the racks, shelves, and bottom. Observation and interview with the dietary manager (DM) at 10:39 a.m., identified he was unaware the refridgerator was not on the cleaning schedule and agreed it should be to prevent contamination to food stored in the refridgerator. Review of the 6/16/22, Safe and Homelike Environment policy identified the facility would provide a safe, clean and comfortable, homelike environment and the physical environment would not pose a safety risk. Review of the undated, Food: Safe Handling for Food from Visitors policy identified refrigerators were to be cleaned weekly. Review of the 10/1/23, Water Management Plan policy identified there was no mention sources of potential Legionella, like equipment with standing water were included as a potential source of Legionella risk.	F 880		
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;	F 883		12/20/23

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F 883	Continued From page 50 (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 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	F 883		

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F 883	Continued From page 51 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 on interview and document review, the facility failed to ensure 2 of 5 (R8, R12) resident were appropriately vaccinated against pneumococcal disease upon admission and/or offered updated vaccination per Centers for Disease Control (CDC) vaccination recommendations. Findings include: Review of the current CDC pneumococcal guidelines located at https://www.cdc .gov/vaccines/vpd/pneumo/hcp/pneumo-vaccine-timing.html, identified for adults 65 years of age or older, staff were to offer and/or provide based off previous vaccination status as shown below: a) If NO history of vaccination, offer and/or provide: aa) the PCV-20 OR bb) PCV-15 followed by PPSV-23 at least 1 year later. b) For PPSV-23 vaccine ONLY (at any age): aa) PCV-20 at least 1 year after prior PPSV-23 OR bb) PCV-15 at least 1 year after prior PPSV-23 c) For PCV-13 vaccine ONLY (at any age): aa) PCV-20 at least 1 year after prior PCV13 OR bb) PPSV-23 at least 1 year after prior PCV13 d) For PCV-13 vaccine (at any age) AND PPSV-23 BEFORE 65 years:	F 883	Vaccine records for R8 and R12 will be reviewed and residents will be offered opportunity to receive vaccination recommended under updated CDC guidelines. Residents who are eligible for the pneumococcal 20 vaccine have the potential to be impacted by the alleged practice. A review of current immunization records was completed by the infection preventionist and the updated vaccine offered to those eligible. The Vice President of Success educated the infection preventionist on parameters for administering PCV20 and offering the vaccine to those eligible The infection preventionist or designee will audit vaccination records for compliance with offering PCV20 and administering the vaccine. Review of new admissions will be implemented to validate compliance with offering PCV20 and administering the vaccine if indicated. Results of audits will be forwarded to the Quality Assurance/Performance Improvement committee for review and recommendations.	

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F 883	Continued From page 52 aa) PCV-20 at least 5 years after last pneumococcal vaccine dose OR bb) PPSV-23 at least 5 years after last pneumococcal vaccine dose e) Received PCV-13 at Any Age AND PPSV-23 AFTER Age 65 Years: aa) Use shared clinical decision-making to decide whether to administer PCV-20. If so, the dose of PCV-20 should be administered at least 5 years after the last pneumococcal vaccine. Review of 5 sampled residents for vaccinations identified: 1) R8 was 92 years old and was admitted in July of 2023. R8 received his PCV-13 on 10/26/15 and his PPSV-23 on 5/5/2008. There was no documentation to support R8 had been offered the PCV-20 to ensure he was updated with current CDC guidance for vaccines. 2) R12 was 93 years old and was admitted in December of 2022. R12 received his PCV-13 on 3/13/15 and his PCV-23 on 7/18/14. There was no documentation to support R12 had been offered the PCV-20 to ensure he was updated with current CDC guidance for vaccines. Interview on 11/01/23 at 4:30 p.m., with Infection Preventionist (IP) identified he confirmed residents were not offered and/administered PCV-15 or PCV-20 and lacked form of refusal of vaccine upon admission to the facility. Review of March 2023, facility Infection Prevention and Control Program policy indicates pneumococcal immunizations would be offered according to CDC recommendations upon admission.	F 883	The DON and Infection Control nurse will be responsible for compliance.	

PART III – RECOMMENDATION FOR WAIVER OF SPECIFIC LIFE SAFETY CODE PROVISIONS

For each item of the Life Safety Code recommended for waiver, list the survey report form item number and state the reason for the conclusion that: (a) the specific provisions of the code, if rigidly applied, would result in unreasonable hardship on the facility, and (b) the waiver of such unmet provisions will not adversely affect the health and safety of the patients. If additional space is required, attach additional sheet(s).

PROVISION NUMBER(S)	JUSTIFICATION
K521 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	An annual/continuing waiver is being requested for K521 A. Compliance with this provision will cost an unreasonable hardship because: 1. The most recent cost estimate dated 11/6/2023, for a complying Ducted HVAC system is $273,642.00 2. Efforts to obtain an estimate for a ducted system have been unsuccessful. 3. A ducted system would decrease the corridor headroom to less than that required by the LSC. 4. The building electrical system would need to be upgarded to support a new ducted system, which would increase the cost. 5. The ducted system would need to penetrate load bearing walls, decreasing building structural integrity. 6. Installation of a ducted system would require asbestos abatement which would increase the cost. 7. Existing non-complying HVAC system can be allowed to continue use B. There are no adverse effects on the building occupant's safety because: 1. The building is protected by a complete fire sprinkler system that complies with NFPA 13, 1999 edition. 2. The existing HVAC system ventilation fan do automatically shut down upon activation of the fire alarm system, or detection of smoke. 3. The corridors are equipped with a complying smoke detection system. 4. The facility is in compliance with all other fire safety requirements 5. This annual/continuing waiver has been approved in the past.

Surveyor *(Signature)*	Title	Office	Date
Fire Authority Official *(Signature)* *Travis J. Ahrens 49207*	Title Fire Safety Supervisor	Office MN State Fire Marshal Div.	Date 11/20/23

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	245306	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**11/02/2023**

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K 000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety Code survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 11/02/2022. At the time of this survey, ROCHESTER HEALTH SERVICES WEST was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: IF PARTICIPATING IN THE E-POC PROCESS, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED.	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		12/01/2023

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

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K 000	Continued From page 1 Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR By email to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A detailed description of the corrective action taken or planned to correct the deficiency. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. 4. Identify who is responsible for the corrective actions and monitoring of compliance. 5. The actual or proposed date for completion of the remedy. ROCHESTER HEALTH SERVICES WEST is a 1 story building with partial basement. ROCHESTER HEALTH SERVICES WEST was built in 1961 and was determined to be of Type II (111) construction. The facility is fully protected throughout by an automatic sprinkler system and has a fire alarm system with smoke detection in corridors and	K 000		

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K 000	Continued From page 2 spaces open to the corridors that is monitored for automatic fire department notification. The facility has a capacity of 48 beds and had a census of 33 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidence by:	K 000		
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 observations, documentation review and staff interview, it was revealed that the facility is using the corridors as an air plenum which is not in accordance with NFPA 101 (2012 edition), Life Safety Code, section 19.5.2 and NFPA 90A (2012 edition), Standard for the Installation of Air-Conditioning and Ventilating Systems, section 4.3.12.1.1. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 11/02/2023 between 09:00 AM to 12:00 AM, it was revealed by observation, documentation	K 521	An annual/continuing waiver is being requested for K521 A. Compliance with this provision will cost an unreasonable hardship because: 1. The most recent cost estimate dated 11/6/2023, for a complying Ducted HVAC system is $273,642.00 2. Efforts to obtain an estimate for a ducted system have been unsuccessful. 3. A ducted system would decrease the corridor headroom to less than that required by the LSC. 4. The building electrical system would need to be upgraded to support a new	12/20/23

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROCHESTER HEALTH SERVICES WEST	**2215 HIGHWAY 52 NORTH** **ROCHESTER, MN 55901**

(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
K 521	Continued From page 3 review and staff interview that the ventilation system in the 1961 building utilized the egress corridors as a return air plenum for the building HVAC system. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 521	ducted system, which would increase the cost. 5. The ducted system would need to penetrate load bearing walls, decreasing building structural integrity. 6. Installation of a ducted system would require asbestos abatement which would increase the cost. 7. Existing non-complying HVAC system can be allowed to continue use B. There are no adverse effects on the building occupant's safety because: 1. The building is protected by a complete fire sprinkler system that complies with NFPA 13, 1999 edition. 2. The existing HVAC system ventilation fan do automatically shut down upon activation of the fire alarm system, or detection of smoke. 3. The corridors are equipped with a complying smoke detection system. 4. The facility is in compliance with all other fire safety requirements 5. This annual/continuing waiver has been approved in the past.	