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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: 41ZZ

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00131

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245441**
2.STATE VENDOR OR MEDICAID NO.
(L2) **418840300**

3. NAME AND ADDRESS OF FACILITY
(L3) **GOOD SAMARITAN SOCIETY - ALBERT LEA**
(L4) **75507 240TH STREET**
(L5) **ALBERT LEA, MN** (L6) **56007**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY 08/04/2021 (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

12.Total Facility Beds **85** (L18)
13.Total Certified Beds **85** (L17)

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

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

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

* Code: **A*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	85			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Elizabeth Silkey, Unit Supervisor 08/20/2021 (L19)

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

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
02/01/1987
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
00140
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
August 20, 2021

CMS Certification Number (CCN): 245441

Administrator
Good Samaritan Society - Albert Lea
75507 240th Street
Albert Lea, MN 56007

Dear Administrator:

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

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

Effective August 4, 2021 the above facility is certified for:

85 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 85 skilled nursing facility beds.

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

Please contact me if you have any questions.

Sincerely,

Melissa Poepping, Health Program Representative Senior
Program Assurance | Licensing and Certification
Minnesota Department of Health
P.O. Box 64970
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: melissa.poepping@state.mn.us

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
August 20, 2021

Administrator
Good Samaritan Society - Albert Lea
75507 240th Street
Albert Lea, MN 56007

RE: CCN: 245441
Cycle Start Date: June 17, 2021

Dear Administrator:

On July 12, 2021, we notified you a remedy was imposed. On August 9, 2021 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 August 4, 2021.

As authorized by CMS the remedy of:

- Discretionary denial of payment for new Medicare and Medicaid admissions effective August 11, 2021 did not go into effect. (42 CFR 488.417 (b))

However, as we notified you in our letter of July 12, 2021, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from July 2, 2021. This does not apply to or affect any previously imposed NATCEP loss.

The CMS Region V Office may notify you of their determination regarding any imposed remedies.

Feel free to contact me if you have questions.

Sincerely,

Melissa Poepping, Health Program Representative Senior
Program Assurance | Licensing and Certification
Minnesota Department of Health
P.O. Box 64970
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: melissa.poepping@state.mn.us

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

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3. Termination 4. CHOW
5. Validation 6. Complaint
7. On-Site Visit 9. Other
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

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

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2 AOA 3 Other

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FISCAL YEAR ENDING DATE: (L35)
12/31

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From (a) :
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X B. Not in Compliance with Program Requirements and/or Applied Waivers:

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

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

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	85			
(L37)	(L38)	(L39)	(L42)	(L43)

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1861 (e) (1) or 1861 (j) (1): (L15)

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

17. SURVEYOR SIGNATURE — Date :
Julie Halvorson, HFE NE II — 07/31/2021 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Melissa Poepping, Enforcement Specialist — 08/19/2021 (L20)

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

19. DETERMINATION OF ELIGIBILITY
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____ 2. Facility is not Eligible
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02/01/1987
(L24)

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(L41)

24. LTC AGREEMENT ENDING DATE
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25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
00140
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

Electronically delivered
July 12, 2021

Administrator
Good Samaritan Society - Albert Lea
75507 240th Street
Albert Lea, MN 56007

RE: CCN: 245441
Cycle Start Date: June 17, 2021

Dear Administrator:

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

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

REMEDIES

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

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

- 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 September 17, 2021.

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective September 17, 2021. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective September 17, 2021.

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.

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 $11,160; has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

If you have not achieved substantial compliance by September 17, 2021, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, Good Samaritan Society - Albert Lea will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from September 17, 2021. 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" tag), and emergency preparedness deficiencies (those preceded by an “E” tag), i.e., the plan of correction should be directed to:

Elizabeth Silkey, Unit Supervisor
Mankato District Office

Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
12 Civic Center Plaza, Suite #2105
Mankato, MN 56001
Email: elizabeth.silkey@state.mn.us
Office: (507) 344-2742 Mobile: (651) 368-3593

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 December 17, 2021 if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at § 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR § 488.412 and § 488.456.

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

APPEAL RIGHTS

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

Tamika.Brown@cms.hhs.gov

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

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
(202) 565-9462

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Tamika Brown, Principal Program Representative by phone at (312) 353-1502 or by e-mail at Tamika.Brown@cms.hhs.gov.

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

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

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

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

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

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

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

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

Feel free to contact me if you have questions.

Sincerely,

Melissa Poepping, Health Program Representative Senior
Program Assurance | Licensing and Certification
Minnesota Department of Health
P.O. Box 64970
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: melissa.poepping@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245441	A. BUILDING _____ B. WING _____	C 06/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - ALBERT LEA	**75507 240TH STREET ALBERT LEA, MN 56007**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments On 6/14/21 to 6/17/21, a survey for compliance with Appendix Z, Emergency Preparedness Requirements, §483.73(b)(6) was conducted during a standard recertification survey. The facility was NOT in compliance. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Upon receipt of an acceptable electronic POC, an onsite revisit of your	E 000		
E 041 SS=C	Hospital CAH and LTC Emergency Power CFR(s): 483.73(e) §482.15(e) Condition for Participation: (e) Emergency and standby power systems. The hospital must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section and in the policies and procedures plan set forth in paragraphs (b)(1)(i) and (ii) of this section. §483.73(e), §485.625(e) (e) Emergency and standby power systems. The [LTC facility and the CAH] must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section. §482.15(e)(1), §483.73(e)(1), §485.625(e)(1) Emergency generator location. The generator must be located in accordance with the location requirements found in the Health Care Facilities	E 041		7/30/21

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

Electronically Signed | 07/20/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245441	A. BUILDING _____ B. WING _____	C 06/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - ALBERT LEA	**75507 240TH STREET ALBERT LEA, MN 56007**

(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 041	Continued From page 1 Code (NFPA 99 and Tentative Interim Amendments TIA 12-2, TIA 12-3, TIA 12-4, TIA 12-5, and TIA 12-6), Life Safety Code (NFPA 101 and Tentative Interim Amendments TIA 12-1, TIA 12-2, TIA 12-3, and TIA 12-4), and NFPA 110, when a new structure is built or when an existing structure or building is renovated. 482.15(e)(2), §483.73(e)(2), §485.625(e)(2) Emergency generator inspection and testing. The [hospital, CAH and LTC facility] must implement the emergency power system inspection, testing, and [maintenance] requirements found in the Health Care Facilities Code, NFPA 110, and Life Safety Code. 482.15(e)(3), §483.73(e)(3), §485.625(e)(3) Emergency generator fuel. [Hospitals, CAHs and LTC facilities] that maintain an onsite fuel source to power emergency generators must have a plan for how it will keep emergency power systems operational during the emergency, unless it evacuates. *[For hospitals at §482.15(h), LTC at §483.73(g), and CAHs §485.625(g):] The standards incorporated by reference in this section are approved for incorporation by reference by the Director of the Office of the Federal Register in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. You may obtain the material from the sources listed below. You may inspect a copy at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202-741-6030, or go to:	E 041		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245441	A. BUILDING _____ B. WING _____	C 06/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - ALBERT LEA	**75507 240TH STREET ALBERT LEA, MN 56007**

(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 041	Continued From page 2 http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html. If any changes in this edition of the Code are incorporated by reference, CMS will publish a document in the Federal Register to announce the changes. (1) National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02169, www.nfpa.org, 1.617.770.3000. (i) NFPA 99, Health Care Facilities Code, 2012 edition, issued August 11, 2011. (ii) Technical interim amendment (TIA) 12-2 to NFPA 99, issued August 11, 2011. (iii) TIA 12-3 to NFPA 99, issued August 9, 2012. (iv) TIA 12-4 to NFPA 99, issued March 7, 2013. (v) TIA 12-5 to NFPA 99, issued August 1, 2013. (vi) TIA 12-6 to NFPA 99, issued March 3, 2014. (vii) NFPA 101, Life Safety Code, 2012 edition, issued August 11, 2011. (viii) TIA 12-1 to NFPA 101, issued August 11, 2011. (ix) TIA 12-2 to NFPA 101, issued October 30, 2012. (x) TIA 12-3 to NFPA 101, issued October 22, 2013. (xi) TIA 12-4 to NFPA 101, issued October 22, 2013. (xiii) NFPA 110, Standard for Emergency and Standby Power Systems, 2010 edition, including TIAs to chapter 7, issued August 6, 2009.. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview, the facility failed to implement emergency and standby power systems in compliance with Life Safety Code (6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, (NFPA 70)), this has the potential to affect all 67 residents residing in	E 041	E041: Plan of Correction: Preparation and execution of this response and plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth	

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	245441	A. BUILDING _____ B. WING _____	C 06/17/2021

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E 041	Continued From page 3 the facility, staff, and visitors. Findings Include: See K0918 During a facility tour between 8:30 a.m. and 12:30 p.m. on 6/16/21, observations, staff interview, and documentation reviewed revealed the following: During documentation review, the EPSS Maintenance Log or documentation was reviewed and the facility failed to complete monthly load testing's of the facility's emergency generator. During the walk-through inspection of the facility and review of documentation, the install date of the facility's emergency generator battery was greater than 30 months prior. This deficient practice was confirmed by the Facility Maintenance Director at the time of discovery on 6/16/21.	E 041	in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. For the purposes of any allegation that the center is not in substantial compliance with federal requirements of participation, this response and plan of correction constitutes the center's allegation of compliance in accordance with section 7305 of the State Operations Manual. It is the policy of the facility to maintain the usage of all electrical systems in accordance with standards and requirements. Corrective action: 1. The Environmental Service Director or designee contacted generator provider for battery replacement. This was completed by: Zeigler Caterpillar on 07/13/2021 Assurance of On-Going Compliance The Environmental Services Director and/or designee will update the location preventative maintenance program task timing to ensure batteries are replaced per NFPA requirements.	
F 000	INITIAL COMMENTS On 6/14/21 to 6/17/21, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was found to be IN compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities.	F 000		

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F 000	Continued From page 4 The following complaints were found to be SUBSTANTIATED, however NO deficiencies were cited due to actions implemented by the facility prior to survey: H5441053C (MN72324) H5441054C (MN69357) H5441055C (MN71230) H5441056C (MN73657) The following complaints were found to be UNSUBSTANTIATED: H5441052C (MN66750) The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.	F 000		
F 558 SS=D	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document	F 558	F558: Plan of Correction	7/30/21

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F 558	Continued From page 5 review, the facility failed to the facility failed to ensure call lights were in reach 1 of 1 residents(R21) that was reviewed for reasonable accommodation of needs. Findings include: R21's face sheet dated 6/15/21, indicated diagnoses including muscle weakness, pain, stress fracture right femur, and dependent on renal dialysis. R21's admission Minimum Data Set (MDS) assessment dated 4/6/21, indicated R21 was cognitively intact, impaired vision, two-person physical assist with bed mobility, transfers, dressing, toilet use, personal hygiene, dependent on staff for bathing, and utilized a wheelchair. R21's care plan dated 4/4/21, identified ensure residents needs are met, explain use of call light, provide reassurance. Tell resident where you are placing their items, be consistent with placement of personal items (place frequently used items on table beside him) Place frequently used items within easy reach. During an observation and interview on 6/15/21, at 9:16 a.m. R21 was seated in a wheelchair in his room. The call light was draped over a dresser on the back side, against the wall. When asked how he would he get help, he indicated the call light was unreachable, and stated he would have to yell if he needed help, and then staff would get mad at him that he yelled. NA-A was called to the room and confirmed the call light was not in the reach of R21 and indicated someone had forgot to place it close to the resident.	F 558	1. Nursing management ensured that R21 had access to his call light immediately upon notification from surveyor. 2. Nursing management ensured that all residents in the facility had access to their call lights. The behavior management committee met and reviewed R21 and all residents in the facility to ensure all residents had the appropriate type of call light to allow for easy access to the call light system. Care plans were updated as necessary. 3. To enhance current compliant operations and under the direction of the Director of Nursing, all facility staff will be provided with education on the facility's process for providing residents with access to the call light system. This education will occur at meetings to be held on 7/20/21 and 7/21/21; with all staff to be educated by 7/30/21. 4. Random observation audits to ensure compliance will be conducted by nursing management or their designee for R21 and four other random residents in the facility. Audits will be conducted weekly x 4 then monthly x 3. Audits will be brought to the Quality Assurance Performance Improvement Committee for review and further recommendations.	

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F 558	Continued From page 6 During observation and interview on 6/16/21, at 9:01 a.m., R21's call light was found attached to the rail on the back side of the bed, next to the wall. R21 could not reach the call light. RN-A was called to the room and verified R21 could not reach the call light and indicated she expected the call light to be within the resident's reach. RN-A placed the call light within reach of the resident and fastened it to the arm of the wheelchair. On 6/6/21, at 10:02 a.m., the director of nursing (DON) stated she expected the call lights to always be in the reach of residents, and further indicated it was a potential for injury. A policy titled Call Light-Rehab/Skilled dated 12/11/20, indicated: -To ensure resident always has a method of calling for assistance - When leaving the room, place call light within easy reach of resident if in bed, If out of bed, stretch call light cord across bed so resident is able to reach it.	F 558		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide nail care and grooming for 1 of 1 resident (R21) who was dependent on staff for assistance with grooming	F 677	F677: Plan of Correction 1. Nursing management reviewed R21 to ensure that they had been assisted with activities of daily living appropriately,	7/30/21

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F 677	Continued From page 7 and personal hygiene. Findings include: R21's face sheet dated 6/15/21, indicated admission date of 4/2/21, and diagnoses included muscle weakness, pain, stress fracture of the right femur, and dependent on renal dialysis. R21's admission Minimum Data Set (MDS) assessment dated 4/6/21, indicated R21 was cognitively intact, impaired vision, two-person physical assist with bed mobility, transfers, dressing, toilet use, personal hygiene, dependent on staff for bathing, and utilized a wheelchair. R21's care plan dated 4/4/21, identified R21 required staff assist of one with stand aid for transfers into drop seat shower chair. One staff assist for showering task, if he refuses, do a bed bath. Nail care and shaving of facial hair to be offered with bathing. One staff assist required for deodorant, combing hair, encourage participation by handing him prepared washcloth and have him wash hands/face. R21's Survey Report for May 2021, indicated R21 received a bath every Monday and the last documented bath was 6/3/21, and was dependent on staff with one person physical assist. On 6/10/21, documentation indicated bath did not occur and on 6/17/21, bathing was not applicable and the activity did not occur. On 6/15/21, at 8:57 a.m. R21 was in his room seated in his wheelchair and was observed with long and jagged fingernails with brown debris under his nails on both hands and unshaven with chin and facial whiskers. When asked, R21	F 677	including nail care and shaving immediately upon notification from surveyor on site. 2. All residents in the building who are dependent upon staff for grooming were reviewed/observed by nursing management to ensure they had been assisted appropriately with nail care and shaving. Resident task lists were reviewed for R21 and all residents that are dependent upon staff for grooming to ensure that direction is given to staff to assist with nail care on bath days. 3. To enhance current compliant operations and under the direction of the Director of Nursing, all CNA's participated in a skills day on 7/7/21 and 7/9/21 which included competencies on assistance with ADL's, including grooming and nail care. Further, all nursing staff will be provided with education on the facility's process for assisting with shaving daily with routing grooming tasks and nail care on bath/shower days and prn via meetings to be held on 7/20/21 and 7/21/21; with all nursing staff to be educated by 7/30/21. 4. Random observation audits to ensure compliance will be conducted by nursing management or their designee for R21 and four other residents in the facility that are dependent on grooming. Audits will be conducted weekly x 4, then monthly x 3. Audit results will be brought to the Quality Assurance Performance Improvement Committee for review and further recommendations.	

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stated his fingernails were too long and needed to be cut.

On 6/16/21, at 8:45 a.m. R21 was in his room seated in a wheelchair and fingernails were jagged on both hands and had long facial hair, R21 further indicated he did not not know who shaved him and he indicated he didn't like his whiskers that long wanted to be shaved.

During interview on 6/16/21, at 9:01 a.m. registered nurse (RN)-A indicated nail care was completed by nursing assistants on bath days and would expect R21's nails to be cut and cleaned at the last bath and expected residents to be shaved daily. RN-A observed R21's nails and facial hair and confirmed he should be shaved and his nails were jagged.

On 6/16/21, at 9:15 a.m. student nursing assistant (NA)-A and student NA-B indicated they were in training at the facility and the education instructor assisted with R21's morning cares today. Student NA-A and NA-B stated they provided R21's morning personal hygiene cares and he was not shaved today and further indicated they forgot. The educational instructor indicated the resident should have been shaved.

On 6/17/21, at 9:00 a.m. interview with the director of nursing (DON) stated she expected resident's to be shaved daily, nails assessed for cleanliness daily, and nails cut on bath days.

Facility policy titled Activities of Daily Living,-Rehab/Skilled, dated 12/28/20, indicated:

Purpose :
-To provide residents with appropriate treatment

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F 677	Continued From page 9 and services to maintain or improve abilities and activities of daily living for the well-being of mind, body and soul. Policy -Any resident who is unable to carry out activities of daily living will receive necessary services to maintain good nutrition, grooming and personal and oral hygiene -Based on the resident's comprehensive assessment ,the center will ensure the resident's ability in activities of daily living does not decline except when unavoidable for reasons of disease progression. ADLs are those necessary tasks conducted in the normal course of our residents daily life. Included in these are the following 1. General personal, daily hygiene grooming care of hair, hands, face, shaving, applying makeup, skin, nails, and oral care. 2. Bathing: preparation for and the activity of washing and drying the body as well as transferring in and out of the tub or shower.	F 677		
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention	F 880		7/30/21

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F 880	Continued From page 10 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 11 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 observation, interview and document review, the facility failed to ensure proper infection control practices were followed, including hand hygiene, for 3 of 3 residents (R58, R37, R47) who received fresh water during water pass. This had the potential to impact all 67 residents who resided in the facility. Findings include: During an observation on 6/15/21, from 3:44 p.m. to 3:58 p.m. Helper (H)-E was observed filling plastic water mugs from resident rooms with ice and water. H-E went room to room with a metal cart on wheels that had a small red and white cooler on it and a clear plastic scoop/scoop holder. Observed H-E go into R58's room, and bring her plastic mug back to the cart in the hallway. H-E removed the lid with bare hands, cupping his hand over the top of the mug and cover, touching the straw. H-E put ice from the cooler into the mug, touching the rim of the cup with the plastic scoop. In addition, H-E topped off	F 880	F880: Plan of Correction 1. R58, R37, and R47□s water pitchers were replaced immediately upon notification from surveyor on site. A root cause analysis was completed by members of the facility□s Quality Assurance Performance Improvement Committee. 2. It was determined that the facility would adopt a new water pitcher procedure to ensure compliance with infection control practices for R58, R37, R47 and all residents who are dependent on the facility staff to deliver fresh water to their rooms. 3. Facility staff will pick up all dirty mugs, return the mugs to the kitchen, sanitize the cart, and then fill and deliver clean mugs to the resident rooms. The facility staff will no longer use a cooler with ice during the water pass. To enhance current compliant operations and under the direction of the Director of	

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F 880	Continued From page 12 the mug with water from R58's bathroom before putting the cover back on, cupping the cover and touching the straw with bare hands. This was repeated with water mugs from R37 and R47's rooms. As H-E went room to room, he did not clean hands between rooms or before handling the mugs. During an interview, H-E touched his mask with bare hands and then handled a cup. H-E stated he had been working at the facility for 20 years and was from an agency. When asked about training, he was not able to articulate specific training related to infection control practices. During an interview on 6/16/21, at 11:35 a.m. registered nurse (RN)-B stated she was aware of the process for refilling resident water mugs, adding "I've seen it." Stated nursing assistants (NA's) filled the mugs each day, giving the residents a clean mug each time that had been sanitized in the kitchen. RN-B was informed of the process observed on 6/15/21, and stated "the risk for contamination was quite high" when informed H-E did not wash his hands in-between rooms, prior to handling mugs and straws, after touching his mask and after obtaining water from bathroom. RN-B stated H-E should be sanitizing his hands in and out of each room and would talk to the director of nursing (DON) about his training. "I understand the process...I thought each resident got a new mug with each water pass...they should be." During an interview on 6/16/21, at 1:36 p.m. the DON stated RN-B informed her of the findings regarding H-E refilling resident water mugs. The DON acknowledged the process was an infection control concern. The DON did not know what kind of infection control training H-E had, and stated	F 880	Nursing, all facility staff that deliver fresh water to resident rooms will be educated on the facility□s process for delivering water to resident rooms. Facility staff will also be educated and competency will be verified on proper hand hygiene. This education will be provided via meetings to be held on 7/20/21 and 7/21/21; with all facility staff who deliver fresh water to be educated by 7/30/21. 4. Random observation audits to ensure compliance will be completed for R58, R37, R47 and four other residents in the facility that are dependent on staff to deliver fresh water to them. Audits will be completed weekly x 4, then monthly x 3. Audits will be brought to the Quality Assurance Performance Improvement Committee for review and further recommendations.	

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F 880	Continued From page 13	F 880		

the dietary manager would have trained him on infection control related to water pass. The DON stated they probably should have retrained the two individuals who do water pass, both who had learning disabilities, after they returned to this role following the Covid-19 pandemic. The DON thought H-E was capable of understanding infection control practices despite a learning disability and stated RN-B would retrain him before he did another water pass.

During an interview on 6/17/21, at 9:36 a.m. dietary manager (DM)-A stated she did not have anything to do with individuals from outside agency, (local agency that provided vocational rehabilitation services for individuals with disabilities).

During an interview on 6/17/21, at 10:23 a.m. the DON stated that in the absence of the administrator, she looked and had not been able to find paperwork indicating if H-E had infection control training. The DON was asked if this role was a good fit for someone who had a development disability who may not be able to understand the concept of contamination and infection control; the DON stated she had talked to the dietary manager and to start with, the water mugs would be filled in the kitchen by H-E and then delivered to resident rooms. The DON admitted H-E would still be responsible for filling the mugs with ice and water, putting the cover on and inserting a straw prior to delivering mugs to resident rooms.

During an interview on 6/17/21, 10:30 a.m. the interim administrator was informed of findings from 6/15/21. The administrator stated it was concerning from an infection control standpoint

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - ALBERT LEA	75507 240TH STREET ALBERT LEA, MN 56007

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F 880	Continued From page 14	F 880		

and that the leadership team would discuss other options to accomplish the task of water pass to residents to ensure proper infection control practices were followed.

On 6/17/21, at 12:34 p.m., reviewed H-E's "... [name of outside agency] Training Report Sign Off Sheet" dated 1/15/21, signed by H-E and a staff person from outside agency. The document did not include training on infection control prevention, including hand washing.

During an interview on 6/17/21, at 12:31 p.m., RN-B stated when H-E arrived to work on 6/17/21, he would be informed of the identified concern and re-educated on policy and procedure for refilling water mugs, including hand hygiene. An employee would work with him and observe him as he did this work.

Facility policy titled Evening Water Pass, dated 8/2018 indicated:

Purpose: to provide residents with fresh water while maintaining infection prevention standards.
Procedure:
--Pick up cooler with ice scoop from food and nutrition storeroom.
--Fill cooler with ice.
--Keep cover on cooler when ice is not being scooped.
--Pick up mug from elder's room.
--Empty mug in elder's room.
--Fill with ice from cooler being careful not to touch the scoop to the rim of the cup or any part of the elder's mug.
--Replenish the mug with fresh water from the elder's room.
--Scoop should be placed in the holder after each

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F 880	Continued From page 15 mug is filled with ice. --Return the cooler and scoop to the dish room after water pass is complete. --Food and nutrition staff will sanitize and store equipment.	F 880		

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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 06/16/2021. At the time of this survey, Good Samaritan Society - Albert Lea 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		07/20/2021

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K 000	Continued From page 1	K 000		

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.

Good Samaritan Society - Albert Lea, is a 1-story building. The building was constructed at 6 different times. The original building was constructed in 1965 and was determined to be of Type II (111) construction. In 1968, an addition was constructed and was determined to be of Type II (111) construction. In 1975, an addition was constructed and was determined to be of Type II (111) construction. In 1980, an addition was constructed and was determined to be of Type II (111) construction. In 1997, an addition

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K 000	Continued From page 2 was constructed and was determined to be of Type II (111) construction. In 1998, an addition was constructed and was determined to be of Type II (111) construction. Because the original building and the 5 additions meet the construction type allowed for existing buildings, the facility was surveyed as one building as permitted in the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care Occupancies. The facility is fully protected throughout by an automatic sprinkler system and has a fire alarm system with smoke detection in the corridors, spaces open to the corridors, and resident rooms, that is monitored for automatic fire department notification. The facility has a capacity of 85 beds and had a census of 70 at the time of the survey.	K 000		
K 293 SS=D	The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by: Exit Signage CFR(s): NFPA 101 Exit Signage 2012 EXISTING Exit and directional signs are displayed in accordance with 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1 (Indicate N/A in one-story existing occupancies with less than 30 occupants where the line of exit travel is obvious.)	K 293		7/30/21

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K 293	Continued From page 3 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain exit sign illumination in accordance with the Life Safety Code NFPA 101-2012 edition, sections 19.2.10 and 7.10.5.1 This deficient practice could have an isolated impact on the residents within the facility. Findings Include: On facility tour between 09:00 AM and 02:00 PM on 06/17/2021, it was observed that the exit sign, located at the employee entrance corridor, was not illuminated. This deficient practice was confirmed by the Assistant Maintenance Director at the time of discovery.	K 293	Preparation and execution of this response and plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. For the purposes of any allegation that the center is not in substantial compliance with federal requirements of participation, this response and plan of correction constitutes the center's allegation of compliance in accordance with section 7305 of the State Operations Manual. K293 NFPA 101 Exit Signage It is the policy of the facility to maintain exit signage in accordance with NFPA standards and requirements. Corrective action will include: 1. The Environmental Services Director and/or designee will contract to replace the exit sign at the employee entrance corridor. Completed by Thompson Electric 6/23/21. Assurance of On-Going Compliance The Environmental Services Director and/or designee will verify and monitor exit signage per NFPA standards and requirements as identified in our preventative maintenance program. The Environmental Services Director and/or designee will audit exit signage weekly x4, Monthly x3. Any negative findings will be brought to the QAPI committee monthly.	

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K 345 SS=F	Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain ready accessibility to components of the fire alarm system in accordance with the Life Safety Code NFPA 101-2012 edition section 19.3.4.2.2 (1), and National Fire Alarm and Signal Code NFPA 72-2010, section 17.14.5, 14.4.5.3.2, 27.6.2.1.1. This deficient practice could have a widespread impact on the residents within the facility. Findings Include: On a facility tour between 09:00 AM and 02:00 PM on 06/17/2021, during a walk-through of the facility, it was observed that the fire alarm pull station at Nurses Station 1 was obstructed and not readily accessible. This deficient practice was confirmed by the Facility Maintenance Director at the time of discovery.	K 345	K345 NFPA 101 Fire Alarm Systems – Testing and Maintenance It is the policy of the facility to continuously maintain in reliable operating condition Fire Alarm Systems and to ensure Fire Alarm Systems pull stations are not obstructed. Corrective action will include: 1. Cabinet obstructing the pull station at Nurse Station 1 be removed and relocated as required. Completed on 6/23/21. Assurance of On-Going Compliance The Environmental Services Director and/or designee will audit for obstructions near pull stations weekly x4, Monthly x3. Any negative findings will be brought to the QAPI committee monthly. The Environmental Services Director or designee will educate staff on requirements of pull station access to ensure unobstructed access. 2. Staff education scheduled for 7/20/21 and 7/21 via meetings with all staff to be educated by 7/30/21.	7/30/21
K 353	Sprinkler System - Maintenance and Testing	K 353		7/30/21

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K 353 SS=F	Continued From page 5 CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain and test the sprinkler system in accordance with the Life Safety Code NFPA 101, 2012 edition, sections 9.7.5, 9.7.6, 9.7.7, and 9.7.8, and NFPA 25, 2011 edition, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, sections 5.1.1., 5.2.1. This deficient practice could have a patterned impact on the residents within the facility. Findings Include: On facility tour between 09:00 AM and 02:00 PM on 06/17/2021, the following observations were made during a walk-through of the facility:	K 353	K353 NFPA 101, 25 Sprinkler Systems It is the policy of the facility to perform and assure sprinkler systems are tested and maintained in accordance with NFPA standards and requirements. Corrective action will include: 1. Removal of items in the storage closed across from Room 1202. Completed 6/23/21. 2. Removal of items in the storage closet across from room 1301. Completed 6/23/21. 3. Replace the sprinkler head located near the scheduling office. Completed 7/12/21. 4. Replace the sprinkler head located	

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K 353	Continued From page 6 1. Storage Closet, across from Room 1202, placement of items to close to the sprinkler head 2. Storage Closet, across from Room 1301, placement of items to close to the sprinkler head 3. Scheduling Office, observed what appeared to be tape and paint residue on the sprinkler head 4. Transport Office, observed what appeared to be paint splatter on the sprinkler head 5. Transport Office corridor, observed what appeared to be paint splatter on the sprinkler head 6. Sprinkler Riser had a damaged pressure gauge This deficient practice was confirmed by the Facility Administrator at the time of discovery.	K 353	near the transport office. Completed 7/12/21. 5. Replace the sprinkler riser pressure gauge. Completed 7/12/21. 6. Replace sprinkler heads located in Transport office corridor. 7/12/21 Assurance of On-Going Compliance The Environmental Services Director and/or designee will conduct quarterly inspections to assure NFPA requirements and standards are met in accordance with the location's preventative maintenance program. The Environmental Services Director and/or designee will audit to ensure proper clearance is maintained on sprinkler heads and on the condition on sprinkler heads throughout the building weekly x4, Monthly x3. Any negative findings will be brought to the QAPI committee monthly. The Environmental Services Director and/or designee will conduct training to ensure the 18-inch clearance necessary for sprinkler heads in all areas. 1.Training scheduled for 7/20/21 and 7/21/21 via meetings with all staff to complete training by 7/30/21	
K 355 SS=D	Portable Fire Extinguishers CFR(s): NFPA 101 Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 This REQUIREMENT is not met as evidenced	K 355		7/30/21

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K 355	Continued From page 7 by: Based on observation and staff interview, the facility failed to maintain proper installation height and ready accessibility to portable fire extinguishers in accordance with the Life Safety Code NFPA 101 - 2012 edition, sections 19.3.5.12, 9.7.4.1, and NFPA 10 Standard for Portable Fire Extinguishers, 2010 edition, section 6.1.3.8. This deficient practice could have an isolated impact on the residents within the facility. Findings Include: On facility tour between 09:00 AM and 02:00 PM on 06/17/2021, During the walk-through of the facility, it was observed that the fire extinguisher located at Nurses Station #1 was: 1. Access obstructed 2. Mounted higher than five feet This deficient practice was confirmed by the Facility Administrator at the time of discovery.	K 355	K355 NFPA 101 Portable Fire Extinguishers It is the policy of the facility to continuously maintain in reliable operating portable fire extinguishers and to ensure that all fire extinguishers are installed properly and inspected, tested and maintained periodically. Corrective action will include: 1. Clear obstructions and reposition the fire extinguisher at Nurse Station 1 to the proper height not to exceed (five) 5 feet from the floor to the top of the fire extinguisher. Completed 7/13/21. Assurance of On-Going Compliance The Environmental Services Director and/or designee will conduct monthly visual inspections during monthly fire extinguisher inspection to assure NFPA requirements and standards are met in accordance with the location's preventative maintenance program. The Environmental Services Director and/or designee will audit for obstructions near fire extinguishers throughout the building weekly x4, Monthly x3. Any negative findings will be brought to the QAPI committee monthly.	
K 511 SS=F	Utilities - Gas and Electric CFR(s): NFPA 101 Utilities - Gas and Electric Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NFPA 70, National Electric Code. Existing installations can continue in service provided no	K 511		7/30/21

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K 511	Continued From page 8 hazard to life. 18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain proper security to electrical panels in a resident accessible corridor in accordance with the Life Safety Code NFPA 101-2012 edition, sections 19.5.1.1 and 9.1.2, the National Electrical Code NFPA 70-2011, section 110.26, and the Health Care Facilities Code NFPA 99, section 6.3.2.2.1.3. This deficient practice could have a widespread impact on the residents within the facility. Findings Include: On facility tour between 09:00 AM and 02:00 PM on 06/17/2021, During walk-through of the facility it was observed that unsecured electrical panels, accessible to residents were in the following locations: 1. Employee Entrance Corridor 2. 900 Corridor - Soiled Linen Area This deficient practice was confirmed by the Maintenance Director at the time of discovery.	K 511	K355 NFPA 101 Portable Fire Extinguishers It is the policy of the facility to continuously maintain in reliable operating portable fire extinguishers and to ensure that all fire extinguishers are installed properly and inspected, tested and maintained periodically. Corrective action will include: 1. Clear obstructions and reposition the fire extinguisher at Nurse Station 1 to the proper height not to exceed (five) 5 feet from the floor to the top of the fire extinguisher. Completed 7/13/21. Assurance of On-Going Compliance The Environmental Services Director and/or designee will conduct monthly visual inspections during monthly fire extinguisher inspection to assure NFPA requirements and standards are met in accordance with the location's preventative maintenance program. The Environmental Services Director and/or designee will audit for obstructions near fire extinguishers throughout the building weekly x4, Monthly x3. Any negative findings will be brought to the QAPI committee monthly.	
K 914 SS=F	Electrical Systems - Maintenance and Testing CFR(s): NFPA 101	K 914		7/30/21

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K 914	Continued From page 9 Electrical Systems - Maintenance and Testing Hospital-grade receptacles at patient bed locations and where deep sedation or general anesthesia is administered, are tested after initial installation, replacement or servicing. Additional testing is performed at intervals defined by documented performance data. Receptacles not listed as hospital-grade at these locations are tested at intervals not exceeding 12 months. Line isolation monitors (LIM), if installed, are tested at intervals of less than or equal to 1 month by actuating the LIM test switch per 6.3.2.6.3.6, which activates both visual and audible alarm. For LIM circuits with automated self-testing, this manual test is performed at intervals less than or equal to 12 months. LIM circuits are tested per 6.3.3.3.2 after any repair or renovation to the electric distribution system. Records are maintained of required tests and associated repairs or modifications, containing date, room or area tested, and results. 6.3.4 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on document review and staff interview, the facility failed to properly document the annual electrical receptacle testing in accordance with the Health Care Facilities Code NFPA 99 - 2012 edition, sections 6.3.3.2, 6.3.4.1 and 6.3.4.2. This deficient practice could have a widespread impact on the residents within the facility. Findings Include: On facility tour between 09:00 AM and 02:00 PM on 06/17/2021, during a review of the records provided, the following missing items were discovered:	K 914	K914 NFPA 101 (Electrical Systems –Maintenance and Testing) Electrical Receptacles It is the policy of the facility to maintain the usage of all electrical systems in accordance with NFPA standards and requirements. Corrective action will include: 1. Electrical Receptacle inspection will include Polarity, Grounding and Grounding tension force of not less than 4 oz. 2. The Environmental Services Director will perform annual receptacle inspections	

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	245441	A. BUILDING **01 - ALBERT LEA GOOD SAMARITAN CENTER** B. WING _____	**06/16/2021**

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K 914	Continued From page 10 1. Dates of completion 2. Proper identification of outlets located in the resident rooms This deficient practice was confirmed by the Maintenance Director at the time of discovery.	K 914	and testing: 3. Annual electrical receptacle inspection was completed on 6/25/21. Assurance of On-Going Compliance The Environmental Services Director and/or designee will conduct inspections to assure NFPA requirements and standards are met in accordance with the location's preventative maintenance program.	
K 918 SS=D	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of	K 918		7/30/21

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K 918	Continued From page 11 maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain proper maintenance records and documentation for the essential electrical system in accordance with the Health Care Facilities Code, NFPA 99, 2012 edition, section 6.4.1.1.13, and the Standard for Emergency and Standby Power Systems NFPA 110, 2010 edition, 5.6.4.5.1, A.5.6.4.5.1. This deficient practice could have a widespread impact on the residents within the facility. Findings Include: On facility tour between 09:00 AM and 02:00 PM on 06/17/2021, during a walk-through of the facility, it was observed that the generator batteries were dated as last being changed in 2018, which greater than the recommended 24 to 30 months. This deficient practice was confirmed by the Facility Administrator at the time of discovery.	K 918	K918 NFPA 101, Electrical Systems – Essential Electrical Systems It is the policy of the facility to maintain the usage of all electrical systems in accordance with standards and requirements. Corrective action: 1. The Environmental Service Director or designee has contacted generator provider to schedule battery replacement. This was completed by: Zeigler Caterpillar on 07/13/2021 Assurance of On-Going Compliance The Environmental Services Director and/or designee will update the location preventative maintenance program task timing to ensure batteries are replaced per NFPA requirements.	
K 920 SS=E	Electrical Equipment - Power Cords and Extens CFR(s): NFPA 101 Electrical Equipment - Power Cords and Extension Cords	K 920		7/30/21

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K 920	Continued From page 12 Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to properly implement the usage of power-taps in accordance with Health Care Facilities Code NFPA 99, section 10.2.3.6, 10.2.4 and the National Electrical Code NFPA 70-2011, sections 400-8, 590.3(D). This deficient practice could have a patterned impact on the residents within the facility. Findings Include: On facility tour between 09:00 AM and 02:00 PM on 06/17/2021, during a walk-through of the facility the following observations were made: 1. In the Scheduling Office, an extension cord	K 920	K920 Electrical Equipment – Power Cords and Extension Cords It is the policy of the facility to maintain the usage of all Power/extension Cords and power strips in accordance with NFPA 101 standards and requirements. Corrective action: 1. The Environmental Services Director and or designee will remove power cords and power strips from the following rooms: Scheduling Office and Nurses Station 4. Completed: 6/23/21 Assurance of On-Going Compliance The Environmental Services Director and/or designee will conduct ongoing	

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K 920	Continued From page 13 was plugged into a relocatable power tap. 2. In Nurses Station 4, a prohibited appliance was connected to a relocatable power tap. This deficient practice was confirmed by the Facility Maintenance Director at the time of discovery.	K 920	power/extension cords and power strips inspection to assure NFPA standards and requirements and as identified in our preventative maintenance program. The Environmental Services Director and/or designee will audit the use of extension cords/power strips throughout the building weekly x4, Monthly x3. Any negative findings will be brought to the QAPI committee monthly.	
K 923 SS=F	Gas Equipment - Cylinder and Container Storag CFR(s): NFPA 101 Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited- combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a	K 923		7/30/21

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K 923	Continued From page 14 minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain physical segregation of medical gas cylinders in accordance with the Health Care Facilities Code NFPA 99 - 2012 edition, section 11.6.5. This deficient practice could have a widespread impact on the residents within the facility. Findings Include: On the facility tour between 09:00 AM and 02:00 PM on 06/17/2021, it was observed that mixed storage of oxygen cylinders (empty/full) was found in the Med Gas Storage Room. This deficient practice was confirmed by the Facility Maintenance Director at the time of discovery.	K 923	K923 NFPA 101/99 Gas Equipment – Cylinder and Container Storage It is the policy of the facility to ensure proper cylinder and container storage in accordance with NFPA standards and requirements. Corrective action: 1. The Environmental Services Director and/or designee corrected and improved labeling of full/empty cylinder storage. Completed on: 07/09/2021 2. Educate staff on full/empty storage requirements. 3. Staff education scheduled for 7/20/21 and 7/21/21 Assurance of On-going Compliance: The Environmental Services Director and/or designee will conduct monthly inspections of oxygen storage rooms to assure NFPA standards and requirements are met as identified in our preventative maintenance program. The Environmental Services Director and/or designee will audit proper oxygen storage practices weekly x4, Monthly x3. Any negative findings will be brought to	

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K 923	Continued From page 15	K 923	the QAPI committee monthly.	