Electronically delivered
July 29, 2022

Administrator
Villa St. Vincent
516 Walsh Street
Crookston, MN 56716

RE: CCN: 245484
Cycle Start Date: July 21, 2022

Dear Administrator:

On July 21, 2022, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

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

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

DEPARTMENT CONTACT

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

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

If substantial compliance with the regulations is not verified by October 21, 2022 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by January 21, 2023 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

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

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

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

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

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

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

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

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

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245484	A. BUILDING _____ B. WING _____	C 07/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VILLA ST VINCENT	516 WALSH STREET CROOKSTON, MN 56716

(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 7/18/22 through 7/22/22, a survey for compliance with Appendix Z, Emergency Preparedness Requirements, §483.73(b)(6) was conducted during a standard recertification survey. The facility was 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 facility may be conducted to validate substantial compliance with the regulation has been attained.	E 000		
F 000	INITIAL COMMENTS On 7/18/22 through 7/21/22, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was found to be not in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were found to be UNSUBSTANTIATED: H54843374C (MN85245) H54843292C (MN84581) H54843291C (MN85004) H54843280C (MN84517) 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	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		08/05/2022

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

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F 000	Continued From page 1 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 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment	F 580		8/17/22

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F 580	Continued From page 2 as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on interview, and document review the facility failed to notify the medical provider of weights outside of the identified parameters for 1 of 2 residents (R10) reviewed for medication management and had identified parameters. Findings include: R10's admission Minimum Data Set (MDS) dated 4/28/22, identified R10 was cognitively intact and had diagnoses that included congestive heart failure (CHF) and type 2 diabetes. R10's care plan dated 5/2/22, identified R10 received medications which placed her at high risk for adverse reactions including diuretics (any substance that promotes the increased production of urine. A diuretic tablet is sometimes called a water tablet.) for CHF.	F 580	F580 Notify of Changes This plan of correction constitutes the facility's credible allegation of compliance. Preparation and/or execution of this plan does not constitute admission or agreement by the provider of the truths or facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed in accordance with federal and state law requirements. 1. Corrective Action for Resident Affected: R10’s physician was updated on weights and MD provided new orders for frequency of weights and parameters for updating. Care plan reviewed updated to reflect these changes. 2. Action as it applies to others: All residents with both a diagnosis of CHF	

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F 580	Continued From page 3 R10's Physician orders identified the following: - 4/21/22, directed staff to adminster furosemide [Lasix, a diuretic] 40 milligram (mg) by mouth once a day on Monday, Wednesday, and Friday - 6/27/22, directed staff to weight R10 daily and to notify the physician if the weight was greater than 2.5 pounds (lbs.) in 48 hours or greater than 5 lbs. from baseline weight. R10's weights dated 7/7/22 to 7/11/22, identified the following: - On 7/7/22, R10's weight was 198 lbs. - On 7/8/22, R10's weight was not collected. - On 7/9/22, R10's weight was 204.8 lbs. (a weight gain of 6.8 lbs. in 2 days). - On 7/10/22, R10's weight was 205.8 lbs. (a weight gain of 7.8 lbs. in 3 days). - On 7/11/22 R10's weight was 206.8 lbs. (a weight gain of 8.8 lbs. in 4 days). R10's weights dated 7/15/22 to 7/20/22 identified the following: - On 7/15/22, R10's weight was 202.2 lbs. - On 7/16/22, R10's weight was 205.2 lbs. (a weight gain of 3 lbs. in 1 day). - On 7/17/22, R10's weight was not collected. - On 7/18/22 R10's weight was 206.2 lbs. (a weight gain of 4 lbs. in 3 days). - On 7/19/22, R10's weight was 207 lbs. (a weight gain of 4.8 lbs. in 4 days). - On 7/20/22, R10's weight was 207.6 lbs. (a weight gain of 5.4 lbs. in 5 days). R10's medical record lack evidence R10's medical provider was notified of the weight gains as ordered. During an interview with registered nurse (RN)-A	F 580	and on a diuretic identified and orders reviewed individually for appropriateness. Updated frequency of weighing and notification parameters to ensure compliance with standing orders and/or physician specific orders based on resident's individual needs and history. Reviewed care plans to ensure aligns with orders. Reviewed Weight Monitoring and Documentation policy dated August 2019. 3. Measures put into place to prevent further issues: Nursing staff will be educated on Weight Monitoring and Documentation policy, process for updating physicians and examples of when the physician should be notified. 4. How the facility will monitor: Audits will be performed on patients with CHF and weight monitoring for appropriate physician notification. Audits will include 5 residents weekly x 4 weeks and 3 residents weekly x 4 weeks. Results of monitoring shall be reported at the facility Quality Council meeting with ongoing frequency and duration to be determined through analysis and review of results.	

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F 580	Continued From page 4 and RN-B on 7/21/22, at 12:46 p.m. RN-A stated R10 was seen by her medical provider on 7/6/22 and no changes were made at that time. RN-A then stated she was going to reach out to the medical provider for a change to R10's weights parameters on 7/21/22. However, both RN-A and RN-B stated R10's provider should have been notified of the fluctuation in weight. During an interview with the director of nursing (DON) and RN-C on 7/21/22, at 12:49 p.m. the DON stated whenever a resident was admitted to the facility with orders for diuretics, staff completed edema checks, lung sounds, oxygen saturations, and this monitoring was also care planned. Staff also collected daily weights unless the physician directed otherwise. The provider was notified depending on what the nursing staff assessed. - At 12:57 p.m. RN-C stated R10's medical provider did not like to be notified of R10's weight gains unless R10 had a symptomatic issue. However, the DON stated R10's order for daily weight parameters needed to reflect that directive. A facility policy related to weight monitoring and physician notification was requested, but not received.	F 580		
F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical	F 688		8/17/22

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F 688	Continued From page 5 condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to implement an ordered range of motion program for 1 of 2 residents (R36) reviewed for ROM. Findings include: R36's quarterly Minimum Data Set (MDS) dated 5/26/22, identified R36 had intact cognition, demonstrated no rejection of cares and required extensive assistance with all activities of daily living (ADLs). Diagnoses included an injury of ulnar nerve of right wrist and hand, deformity of right finger(s), deviation of right finger, acquired claw hand and trigger finger. R36's occupational therapy (OT) Treatment Encounter Note dated 5/11/22, identified R36 would be discharged from therapy with a goal met. A functional maintenance program (FMP) was developed and training was provided to maintain functional strength and range of motion to R36's right hand and wrist.	F 688	F688 Increase/Prevent Decrease in ROM/Mobility This plan of correction constitutes the facility's credible allegation of compliance. Preparation and/or execution of this plan does not constitute admission or agreement by the provider of the truths or facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed in accordance with federal and state law requirements. 1. Corrective Action for Resident Affected: R36 was started on FMP for passive ROM to affected hand per OT FMP on 8/01/22. 2. Actions as it applies to others: Reviewed charts of residents for FMPs not in place. Reviewed residents with contractures for appropriate FMPs in place. Changes made to residents' plans regarding restorative nursing based on individual plan of care and FMPS decided by IDT consisting of nursing, therapy and	

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F 688	Continued From page 6 R36's care plan with reviewed 5/27/22, identified R36 had impaired mobility to her right hand and deformity to fingers of the right hand and directed staff to provide passive range of motion and stretching to fingers of her right hand. On 7/19/22, at 8:15 a.m. R36 was sitting in a chair in her room. R36 had visible contractures (abnormal shortening of muscle tissue, rendering the muscle highly resistant to stretching) on the third, fourth and fifth digits of her right hand, with her fingers bent halfway toward her palm. The pointer finger of her right hand was locked in a extended position and was unable to bend. R36 stated she was unable to move her fingers independently or fully straighten three of her fingers on her right hand; however, it had improved since she had surgery in February 2022, to loosen the contractures. It did not cause any pain to stretch or move her fingers. R36 did not receive any stretching exercises or positioning devices to her hand and could not remember what the doctor told her to do with her hand following her surgery. On 7/21/22, at 9:45 a.m. licensed practical nurse (LPN)-A stated R36's splint was stopped on 5/9/22 and was not able to find any evidence range of motion exercises were completed. LPN-A was not sure what was being done to maintain R36's functional range of motion to her right hand. The wellness department implemented and provided range of motion to residents and R36's range of motion exercises would be documented in their program. On 7/21/22, at 1:33 p.m. occupational therapy aide (OTA)-B stated OT saw R36 following her surgery and set up a FMP to maintain her surgery	F 688	restorative staff as needed. 3. Measures put into place to prevent further issues: Reviewed Restorative Nursing Policy dated 6/9/2020. Process for receiving FMPs reviewed. Therapy will now physically bring the new FMPs on residents to the Restorative staff as they are initiated instead of waiting for Restorative to pick up the new plans. Education given to Restorative staff on new process of initiating FMPs. 4. How the facility will monitor: Audits will be completed on residents with new FMPs in place. Audits will be performed weekly x4 weeks and then twice a month x 1 month on new FMPs to ensure implementation. These audits will be performed by DON or designee. Results of monitoring shall be reported at the facility Quality Council meeting with ongoing frequency and duration to be determined through analysis and review of results.	

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F 688	Continued From page 7 ROM gains. The FMP went to the wellness program and was handled from there. The OT department did not do anymore with it at that point. During joint interview with the wellness coordinator and nursing assistant (NA)-D on 7/21/22, at 1:49 p.m. NA-D stated she assisted residents with their FMP and identified she did not assist R36 with any type of exercises and there was no ROM directive in the restorative assignment book. The wellness coordinator indicated R36 was on their program prior to her surgery, but it was not restarted following her surgery in February 2022. When interviewed on 7/21/22, at 2:30 p.m. the director of nursing (DON) verified R36 was not receiving ROM exercises to her right hand. The wellness program should have been completing a FMP for R36's right hand as directed by OT to maintain her surgery ROM gains and to prevent further contractures and it had been missed. The facility's undated policy Benedictine Health Services Restorative Program, indicated residents would be assessed for their restorative needs and analysis of assessments would determine which restorative interventions were indicated. Upon establishing the residents individualized restorative program, staff would be trained to carry out interventions specific to the resident.	F 688		

Electronically delivered
July 29, 2022

Administrator
Villa St Vincent
516 Walsh Street
Crookston, MN 56716

Re: State Nursing Home Licensing Orders
Event ID: W5N611

Dear Administrator:

The above facility was surveyed on July 18, 2022 through July 21, 2022 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

To assist in complying with the correction order(s), a "suggested method of correction" has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the order within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html. The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute or rule after the

statement, "This MN Requirement is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.

THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact:

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

You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00815	A. BUILDING: _____ B. WING _____	C 07/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VILLA ST VINCENT	516 WALSH STREET CROOKSTON, MN 56716

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 7/18/22 through 7/21/22, a licensing survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was found not in compliance with the MN State Licensure and the following correction orders are issued. Please indicate in your electronic plan of correction you have reviewed	2 000		

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2 000	Continued From page 1 these orders and identify the date when they will be completed. The following complaints were found to be UNSUBSTANTIATED: H54843374C (MN85245) H54843292C (MN84581) H54843291C (MN85004) H54843280C (MN84517) Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading	2 000		

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2 000	Continued From page 2 completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000		
2 265	MN Rule 4658.0085 Notification of Chg in Resident Health Status A nursing home must develop and implement policies to guide staff decisions to consult physicians, physician assistants, and nurse practitioners, and if known, notify the resident's legal representative or an interested family member of a resident's acute illness, serious accident, or death. At a minimum, the director of nursing services, and the medical director or an attending physician must be involved in the development of these policies. The policies must have criteria which address at least the appropriate notification times for: A. an accident involving the resident which results in injury and has the potential for requiring physician intervention; B. a significant change in the resident's physical, mental, or psychosocial status, for example, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications;	2 265		8/17/22

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2 265	Continued From page 3 C. a need to alter treatment significantly, for example, a need to discontinue an existing form of treatment due to adverse consequences, or to begin a new form of treatment; D. a decision to transfer or discharge the resident from the nursing home; or E. expected and unexpected resident deaths. This MN Requirement is not met as evidenced by: Based on interview, and document review the facility failed to notify the medical provider of weights outside of the identified parameters for 1 of 2 residents (R10) reviewed for medication management and had identified parameters. Findings include: R10's admission Minimum Data Set (MDS) dated 4/28/22, identified R10 was cognitively intact and had diagnoses that included congestive heart failure (CHF) and type 2 diabetes. R10's care plan dated 5/2/22, identified R10 received medications which placed her at high risk for adverse reactions including diuretics (any substance that promotes the increased production of urine. A diuretic tablet is sometimes called a water tablet.) for CHF. R10's Physician orders identified the following: - 4/21/22, directed staff to adminster furosemide [Lasix, a diuretic] 40 milligram (mg) by mouth once a day on Monday, Wednesday, and Friday - 6/27/22, directed staff to weight R10 daily and to notify the physician if the weight was greater than	2 265	corrected	

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2 265	Continued From page 4 2.5 pounds (lbs.) in 48 hours or greater than 5 lbs. from baseline weight. R10's weights dated 7/7/22 to 7/11/22, identified the following: - On 7/7/22, R10's weight was 198 lbs. - On 7/8/22, R10's weight was not collected. - On 7/9/22, R10's weight was 204.8 lbs. (a weight gain of 6.8 lbs. in 2 days). - On 7/10/22, R10's weight was 205.8 lbs. (a weight gain of 7.8 lbs. in 3 days). - On 7/11/22 R10's weight was 206.8 lbs. (a weight gain of 8.8 lbs. in 4 days). R10's weights dated 7/15/22 to 7/20/22 identified the following: - On 7/15/22, R10's weight was 202.2 lbs. - On 7/16/22, R10's weight was 205.2 lbs. (a weight gain of 3 lbs. in 1 day). - On 7/17/22, R10's weight was not collected. - On 7/18/22 R10's weight was 206.2 lbs. (a weight gain of 4 lbs. in 3 days). - On 7/19/22, R10's weight was 207 lbs. (a weight gain of 4.8 lbs. in 4 days). - On 7/20/22, R10's weight was 207.6 lbs. (a weight gain of 5.4 lbs. in 5 days). R10's medical record lack evidence R10's medical provider was notified of the weight gains as ordered. During an interview with registered nurse (RN)-A and RN-B on 7/21/22, at 12:46 p.m. RN-A stated R10 was seen by her medical provider on 7/6/22 and no changes were made at that time. RN-A then stated she was going to reach out to the medical provider for a change to R10's weights parameters on 7/21/22. However, both RN-A and RN-B stated R10's provider should have been notified of the fluctuation in weight.	2 265		

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2 265	Continued From page 5 During an interview with the director of nursing (DON) and RN-C on 7/21/22, at 12:49 p.m. the DON stated whenever a resident was admitted to the facility with orders for diuretics, staff completed edema checks, lung sounds, oxygen saturations, and this monitoring was also care planned. Staff also collected daily weights unless the physician directed otherwise. The provider was notified depending on what the nursing staff assessed. - At 12:57 p.m. RN-C stated R10's medical provider did not like to be notified of R10's weight gains unless R10 had a symptomatic issue. However, the DON stated R10's order for daily weight parameters needed to reflect that directive. A facility policy related to weight monitoring and physician notification was requested, but not received. SUGGESTED METHOD OF CORRECTION: The DON or designee could update policies and procedures and then educate staff on examples on when the physician should be notified. The DON or designee could perform audits of medical records to determine if the physician had been notified appropriately. TIME PERIOD FOR CORRECTION: Twenty One (21) days.	2 265		
2 890	MN Rule 4658.0525 Subp. 2 A Rehab - Range of Motion Subp. 2. Range of motion. A supportive program that is directed toward prevention of deformities	2 890		8/17/22

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2 890	Continued From page 6 through positioning and range of motion must be implemented and maintained. Based on the comprehensive resident assessment, the director of nursing services must coordinate the development of a nursing care plan which provides that: A. a resident who enters the nursing home without a limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to implement an ordered range of motion program for 1 of 2 residents (R36) reviewed for ROM. Findings include: R36's quarterly Minimum Data Set (MDS) dated 5/26/22, identified R36 had intact cognition, demonstrated no rejection of cares and required extensive assistance with all activities of daily living (ADLs). Diagnoses included an injury of ulnar nerve of right wrist and hand, deformity of right finger(s), deviation of right finger, acquired claw hand and trigger finger. R36's occupational therapy (OT) Treatment Encounter Note dated 5/11/22, identified R36 would be discharged from therapy with a goal met. A functional maintenance program (FMP) was developed and training was provided to maintain functional strength and range of motion to R36's right hand and wrist.	2 890	corrected	

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2 890	Continued From page 7 R36's care plan with reviewed 5/27/22, identified R36 had impaired mobility to her right hand and deformity to fingers of the right hands and directed staff to provide passive range of motion and stretching to fingers of her right hand. On 7/19/22, at 8:15 a.m. R36 was sitting in a chair in her room. R36 had visible contractures (abnormal shortening of muscle tissue, rendering the muscle highly resistant to stretching) on the third, fourth and fifth digits of her right hand, with her fingers bent halfway toward her palm. The pointer finger of her right hand was locked in a extended position and was unable to bend. R36 stated she was unable to move her fingers independently or fully straighten three of her fingers on her right hand; however, it had improved since she had surgery in February 2022, to loosen the contractures. It did not cause any pain to stretch or move her fingers. R36 did not receive any stretching exercises or positioning devices to her hand and could not remember what the doctor told her to do with her hand following her surgery. On 7/21/22, at 9:45 a.m. licensed practical nurse (LPN)-A stated R36's splint was stopped on 5/9/22 and was not able to find any evidence range of motion exercises were completed. LPN-A was not sure what was being done to maintain R36's functional range of motion to her right hand. The wellness department implemented and provided range of motion to residents and R36's range of motion exercises would be documented in their program. On 7/21/22, at 1:33 p.m. occupational therapy aide (OTA)-B stated OT saw R36 following her surgery and set up a FMP to maintain her surgery	2 890		

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2 890	Continued From page 8 ROM gains. The FMP went to the wellness program and was handled from there. The OT department did not do anymore with it at that point. During joint interview with the wellness coordinator and nursing assistant (NA)-D on 7/21/22, at 1:49 p.m. NA-D stated she assisted residents with their FMP and identified she did not assist R36 with any type of exercises and there was no ROM directive in the restorative assignment book. The wellness coordinator indicated R36 was on their program prior to her surgery, but it was not restarted following her surgery in February 2022. When interviewed on 7/21/22, at 2:30 p.m. the director of nursing (DON) verified R36 was not receiving ROM exercises to her right hand. The wellness program should have been completing a FMP for R36's right hand as directed by OT to maintain her surgery ROM gains and to prevent further contractures and it had been missed. The facility's undated policy Benedictine Health Services Restorative Program, indicated residents would be assessed for their restorative needs and analysis of assessments would determine which restorative interventions were indicated. Upon establishing the residents individualized restorative program, staff would be trained to carry out interventions specific to the resident. SUGGESTED METHOD OF CORRECTION: The DON or designee could audit all residents to ensure ordered FMP's were being implemented. The DON or designee could review the process for implementing FMP's and how that is communicated, then educate the staff on the	2 890		

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2 890	Continued From page 9 process. The DON or designee could perform audits to ensure the FMP's were completed as ordered. TIME PERIOD FOR CORRECTION: Twenty One (21) days.	2 890		

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	245484	A. BUILDING **02 - 1975 EAST BUILDING** B. WING _____	**07/20/2022**

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K 000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety Code survey was conducted on 07/20/2022, by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey, Villa St Vincent 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 | 08/04/2022

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

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K 000	Continued From page 1 Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR By email to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A detailed description of the corrective action taken or planned to correct the deficiency. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. 4. Identify who is responsible for the corrective actions and monitoring of compliance. 5. The actual or proposed date for completion of the remedy. Villa St Vincent was built at 4 different times. The 1975 (original) building is 1-story, does not have a basement, was determined to be Type II(000) construction and is separated from the multi-story senior apartment building (1950 building) with at least a 3-hour fire barrier. In 1988 a chapel addition was added to the south west of the original building, is 1-story, no basement, Type V (111) construction and separated with a 2-hour fire barrier. In 1993 a 1-story addition was constructed to the north east of the original	K 000		

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K 000	Continued From page 2 building, is separated with a 2-hour fire barrier, does not have a basement and was determined to be Type II(111) construction. In 2003 a 1-story addition was constructed to the south of the original building, does not have a basement and was determined to be a Type II (000) construction and is not separated from the original building. The building is divided into 5 smoke zones with 2-hour and 1-hour fire rated barriers. The facility is protected with a complete automatic sprinkler system and also has a fire alarm system with corridor smoke detection and smoke detectors in all common areas that is monitored for automatic fire department notification. The facility has a capacity of 104 beds and had a census of 90 at the time of the survey. The requirements at 42 CFR, Subpart 483.70(a) are NOT MET.	K 000		
K 291 SS=F	Emergency Lighting CFR(s): NFPA 101 Emergency Lighting Emergency lighting of at least 1-1/2-hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to test the battery-operated emergency lights per per NFPA 101 (2012 edition) Life Safety Code, sections 7.9.2.1, 7.9.3.1.1, and 19.2.9.1. This deficient finding could have a widespread impact on the residents within the facility.	K 291	The 90 minute test was completed on July 25th. The Maintenance Supervisor will enter the tasks into our Direct Supply TELS App so it is scheduled on a re-occurring basis.	8/8/22

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 291	Continued From page 3 Findings include: On 07/20/2022, at 11:57 AM, it was revealed by observation that there are battery-operated emergency lights that are located within the facility. It was also revealed during the review of all available battery operated emergency light test/inspection documentation and interview with the Maintenance Supervisor, that these battery operated emergency lights had not be tested annually for 90 minutes. An interview with the Maintenance Supervisor verified this deficient finding at the time of discovery.	K 291		
K 345 SS=F	Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation, staff interview, and observations, the facility failed to maintain the fire alarm system per NFPA 101 (2012 edition), Life Safety Code, sections 9.6.1.3, 9.6.7.5, and NFPA 72 (2010 edition), National Fire Alarm and Signaling Code, sections 10.12.4, 14.3.1, 14.4.5.3, and 14.6.2.4. These deficient findings could have a widespread impact on the residents within the facility.	K 345	Semi-Annual: The Semi-Annual inspection was completed by Summit Fire Protection Company on 7/29/2022. The Maintenance Supervisor will enter this task into our Direct Supply TELS App so it is scheduled on a re-occurring basis. Annual: The Annual inspection was completed by Summit Fire Protection	8/8/22

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	245484	A. BUILDING **02 - 1975 EAST BUILDING** B. WING _____	**07/20/2022**

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K 345	Continued From page 4 Findings include: 1. On 07/20/2022, at 10:30 AM, it was revealed by a review of available fire alarm test and inspection documentation and an interview with the Maintenance Supervisor that the facility could not provide any current documentation verifying that a semiannual inspection of all initiating devices had been completed. 2. On 07/20/2022, at 10:30 AM, it was revealed by a review of available fire alarm test and inspection documentation and an interview with the Maintenance Supervisor that the facility could not provide a current annual fire alarm testing documentation that provided a complete listing of each individual device tested, to include device type, address, location and the test results for each individual device. The last annual fire alarm testing documentation was dated 05/01/2021 and it did not have an annotated listing of all of the devices that were tested. 3. On 07/20/2022, at 10:30 AM, it was revealed by a review of available fire alarm test and inspection documentation and an interview with the Maintenance Supervisor that the facility could not provide any current documentation verifying that the smoke detector sensitivity testing has been completed. 4. On 07/20/2022, at 12:40 PM, it was revealed by observation that the facility's fire alarm control panel was showing a trouble alarm for a dirty smoke detector. It was also noticed that the fire alarm was not sounding an audible trouble alarm nor was there notification from the monitoring company to the facility to inform them that their	K 345	Company on 8/1/2022. The Maintenance Supervisor will enter this task into our Direct Supply TELS App so it is scheduled on a re-occurring basis. Sensitivity Testing: The sensitivity Testing was completed by Summit Fire Protection Company on 8/1/2022. The Maintenance Supervisor will enter this task into our Direct Supply TELS App so it is scheduled on a re-occurring basis. Audible Notification of Trouble Alarm: The audible notification was confirmed to work by the Summit Fire Protection Company□s Technician for the dirty Smoke Detector 200. Signs have been placed at each nurse□s station fire panel to remind them to call the maintenance technician that is on call before clearing the alarm. Daily rounds by the maintenance department will be done to make sure that any alarms are not missed. We will provide education to our staff on the proper way to respond to an audible alarm.	

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K 345	Continued From page 5 fire alarm panel was in a trouble alarm. The smoke detector identified was located and had a solid red LED indicating that the detector was causing the trouble alarm at the fire alarm control panel. An interview with the Maintenance Supervisor verified these deficient findings at the time of discovery.	K 345		
K 351 SS=D	Sprinkler System - Installation CFR(s): NFPA 101 Spinkler System - Installation 2012 EXISTING Nursing homes, and hospitals where required by construction type, are protected throughout by an approved automatic sprinkler system in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. In Type I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where state or local regulations prohibit sprinklers. In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area of the closet does not exceed 6 square feet and sprinkler coverage covers the closet footprint as required by NFPA 13, Standard for Installation of Sprinkler Systems. 19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1) This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to install and maintain fire sprinkler system per per NFPA 101 (2012 edition) Life Safety Code, sections 9.7.1.1, and the NFPA 13 (2010 edition), Standard for the Installation of	K 351	The Summit Fire Protection Company will replace the 4 sprinkler heads and inspect the remaining sprinklers to be compliant. This has been quoted and approved and the work will be completed in August of	9/30/22

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K 351	Continued From page 6 Sprinkler Systems, section 8.3.3.2. This deficient finding could have an isolated impact on the residents within the facility. Findings include: On 07/20/2022 at 12:20 PM, it was revealed by observation that in the Benedictine Way corridor area there are 4 standard response fire sprinkler heads that are mixed in with quick response type of fire sprinkler heads within the same compartment. An interview with the Maintenance Supervisor verified this deficient finding at the time of discovery.	K 351	2022. The Maintenance Supervisor will enter this task into our Direct Supply TELS App so it is scheduled on a re-occurring basis. Maintenance Supervisor has been in contact with Summit Fire Protection Company and they have us on their schedule for September. The Summit Fire Protection Company is not able to come until September due to staffing.	
K 521 SS=F	HVAC CFR(s): NFPA 101 HVAC Heating, ventilation, and air conditioning shall comply with 9.2 and shall be installed in accordance with the manufacturer's specifications. 18.5.2.1, 19.5.2.1, 9.2 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to test and inspect the fire and smoke damper systems per NFPA 101 (2012 edition) Life Safety Code, sections 9.2 and 19.5.2.1, NFPA 80 (2010 edition) the Standard for Fire Doors and Other Opening Protectives, sections 19.4.9, 19.4.10 and 19.5.5,	K 521	Johnson Controls (JCI) will have a technician perform the damper inspection, cleaning and any maintenance that need to be done to our fire dampers. This will be done in August of 2022. The Maintenance Supervisor will enter this task into our Direct Supply TELS App so it	8/12/22

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K 521	Continued From page 7 NFPA 90A (2012 edition) the Standard for the Installation of Air-Conditioning and Ventilating Systems, section 5.4.8.1, and NFPA 105 (2010 edition) the Recommended Practice for the Installation of Smoke-Control Door Assemblies, sections 6.5.11, 6.5.12 and 6.6.6. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 07/20/2022 at 12:08 PM, it was revealed by a review of available damper test and inspection documentation and an interview with the Maintenance Supervisor, that the facility could not provide any current documentation verifying that the fire and smoke damper testing and inspections have been completed within the last 4 years. The last documented fire and smoke damper testing was dated 12/15/2017. An interview with the Maintenance Supervisor verified this deficient finding at the time of discovery.	K 521	is scheduled on a re-occurring basis.	
K 918 SS=F	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.	K 918		8/4/22

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K 918	Continued From page 8 Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to test and inspect the generator per NFPA 101 (2012 edition), Life Safety Code, section 9.1.3.1, NFPA 99 (2012 edition), Health Care Facilities Code, section 6.4.4.1.1.4, and NFPA 110 (2010 edition), Standard for Emergency and Standby Power Systems, section 8.4.1 through 8.4.2. These deficient findings could have a widespread impact on the residents within the facility. Findings include: 1) On 07/20/2022 at 11:57 AM, it was revealed by	K 918	We were conducting bi-monthly generator testing and inspection. We have the correct forms now and will conduct weekly inspection of our generators. We have also met with our generator technician from Ziegler Power Systems and went over the formula to verify that we are running at, at least a 30% capacity. Our full load amps are 528 amps and 226 amps. Our generators run at 210 Amps which is well above the 162 Amps and 68 Amps need to meet the 30% criteria. This is based on the manufactures guidelines and the	

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K 918	Continued From page 9 a review of available emergency generator test and inspection documentation and an interview with the Maintenance Supervisor, that facility had not conducted or documented that any weekly generator inspections were performed during the last 12 months 2) On 07/20/2022 at 11:57 AM, it was revealed by a review of available emergency generator test and inspection documentation and an interview with the Maintenance Supervisor that the facility had not documented if the generator was being run at 30% of the load during monthly testing, nor if the generator had an annual load bank test conducted on the emergency generator. An interview with the Maintenance Supervisor verified these deficient findings at the time of discovery.	K 918	technician□s instruction. We will also submit a quote to have Ziegler Power Systems conduct a full load bank test (4-hour) test and schedule that test to meet the requirement and be compliant. The Maintenance Supervisor will enter this task into our Direct Supply TELS App so it is scheduled on a re-occurring basis. An organized binder will be created to hold the necessary documentation to verify this plan and will be audited on a monthly basis by the Maintenance Supervisor.	