DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
May 29, 2024

Administrator
Whitewater Health Services
525 Bluff Avenue
St Charles, MN 55972

RE: CCN: 245270
Cycle Start Date: April 11, 2024

Dear Administrator:

On May 28, 2024, the Minnesota Departments of Health and Public Safety completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Feel free to contact me if you have questions.

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

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
April 22, 2024

Administrator
Whitewater Health Services
525 Bluff Avenue
St Charles, MN 55972

RE: CCN: 245270
Cycle Start Date: April 11, 2024

Dear Administrator:

On April 11, 2024, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

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

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

DEPARTMENT CONTACT

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

Jennifer Kolsrud Brown, RN, Unit Supervisor
Rochester District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
18 Wood Lake Drive Southeast
Rochester, Minnesota 55904-5506
Email: jennifer.kolsrud@state.mn.us
Office: (507) 206-2727

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 July 11, 2024 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by October 11, 2024 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

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

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

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

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

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

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

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

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

Feel free to contact me if you have questions.

Sincerely,

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245270	A. BUILDING _____ B. WING _____	C 04/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WHITEWATER HEALTH SERVICES	525 BLUFF AVENUE ST CHARLES, MN 55972

(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 4/8/24-4/11/24, a survey for compliance with Appendix Z, Emergency Preparedness Requirements, §483.73 was conducted during a standard recertification survey. The facility was IN compliance. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	E 000		
F 000	INITIAL COMMENTS On 4/8/24-4/11/24, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were reviewed with NO deficiencies cited: H52702828C (MN00102220) H52702882C (MN00102217) H52702941C (MN00102218) H52702797C (MN00100140) H52702750C (MN00098342) 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.	F 000		

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

Electronically Signed | 05/01/2024

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

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F 000	Continued From page 1 Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulations has been attained.	F 000		
F 851 SS=F	Payroll Based Journal CFR(s): 483.70(q)(1)-(5) §483.70(q) Mandatory submission of staffing information based on payroll data in a uniform format. Long-term care facilities must electronically submit to CMS complete and accurate direct care staffing information, including information for agency and contract staff, based on payroll and other verifiable and auditable data in a uniform format according to specifications established by CMS. §483.70(q)(1) Direct Care Staff. Direct Care Staff are those individuals who, through interpersonal contact with residents or resident care management, provide care and services to allow residents to attain or maintain the highest practicable physical, mental, and psychosocial well-being. Direct care staff does not include individuals whose primary duty is maintaining the physical environment of the long term care facility (for example, housekeeping). §483.70(q)(2) Submission requirements. The facility must electronically submit to CMS complete and accurate direct care staffing information, including the following: (i) The category of work for each person on direct care staff (including, but not limited to, whether the individual is a registered nurse, licensed practical nurse, licensed vocational nurse, certified nursing assistant, therapist, or other type	F 851		5/6/24

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F 851	Continued From page 2 of medical personnel as specified by CMS); (ii) Resident census data; and (iii) Information on direct care staff turnover and tenure, and on the hours of care provided by each category of staff per resident per day (including, but not limited to, start date, end date (as applicable), and hours worked for each individual). §483.70(q)(3) Distinguishing employee from agency and contract staff. When reporting information about direct care staff, the facility must specify whether the individual is an employee of the facility, or is engaged by the facility under contract or through an agency. §483.70(q)(4) Data format. The facility must submit direct care staffing information in the uniform format specified by CMS. §483.70(q)(5) Submission schedule. The facility must submit direct care staffing information on the schedule specified by CMS, but no less frequently than quarterly. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to submit accurate and/or complete data for staffing information at least quarterly or more often, including information for agency and contract staff, for 1 of 1 quarter reviewed (Quarter 2) in Federal Fiscal Year 2024, to the Centers for Medicare and Medicaid Services (CMS), according to specifications established by CMS. Findings include:	F 851	This Plan of Correction is submitted solely as required under Federal and State regulation and statutes applicable to long term care providers. The submission of the plan does not constitute an agreement by the facility that the allegations of noncompliance or conclusions are accurate, that the allegations constitute noncompliance, or that the scope or severity regarding any of the deficiencies cited are correctly	

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F 851	Continued From page 3 CMS Payroll Based Journal (PBJ) Staffing Report for Fiscal Year 2024 Quarter 2 (January 1-March 31) results listed Excessively Low Weekend Staffing as triggered due to data submitted by the facility to CMS. Review of daily staff postings for this time period, which listed the number of staff and total hours worked was not found to be drastically different on the weekends versus the weekdays. Census for this time period was also compared and not found to fluctuate significantly. Review of staffing schedules and staff timecards identified the facility had 1 or more licensed nursing staff present on the days during the referenced time period. During interview on 4/11/24 at 10:48 a.m., Corporate Vice President of Customer Success, stated staffing needs were determined based on resident acuity and census. These needs were determined on a daily basis Monday through Friday. Level of staffing on the weekends was the same as the weekdays. Further stated that past interim administrators were incorrectly not adding in the agency pool staff hours to the required staffing reports, thus causing it to look like the facility had low weekend staff. That has been corrected, both on the direct facility level, with training and our new permanent administrator knowing to count those hours if needed, but also by the corporate office going back to correct the reporting/filing mistakes and submit new, corrected reporting forms. As a proactive plan of correction. A facility policy was requested and was not received.	F 851	applied. The submission of this required Plan of Correction does not constitute an admission or acknowledgement of noncompliance or liability on the part of the facility, and any such noncompliance or liability is hereby specifically denied. No residents were identified as having been impacted by the alleged practice. Residents have the potential to be at risk if the number of hours of staffing is not sufficient to meet residents□ needs. Review of these hours and of licensed nurse hours during quarter 2 of the fiscal year, January 1-March 31, 2024, was completed during the survey and hours were noted to be sufficient for resident care. The information received by CMS for this quarter was received by the support center office and sent to the facility for review and updates on April 19, 2024. The hours were updated where needed and form 1702D was updated. The Executive Director was re-educated by the Vice President of Success on the need to include agency staffing hours in his daily review of facility direct care hours on April 12, 2024. It was validated this task is being completed. A new scheduler is being trained at this time and as part of her orientation has been shown how to add agency staff to the time clock platform and how to add agency hours if they are not captured on the day an agency staff worked. Audits for compliance with entering hours	

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F 851	Continued From page 4	F 851	will be completed 3 times weekly for a minimum of four weeks during staffing calls. Audits will continue until compliance is achieved. Results of audits will be forwarded to the QAPI committee for review and recommendations.	

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	245270	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**04/09/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WHITEWATER HEALTH SERVICES	**525 BLUFF AVENUE** **ST CHARLES, MN 55972**

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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 04/09/2024. At the time of this survey, WHITEWATER HEALTH SERVICES was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: IF PARTICIPATING IN THE E-POC PROCESS, A PAPER COPY OF THE PLAN OF CORRECTION	K 000		

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

Electronically Signed | 05/01/2024

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

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K 000	Continued From page 1 IS NOT REQUIRED. Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR By email to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A detailed description of the corrective action taken or planned to correct the deficiency. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. 4. Identify who is responsible for the corrective actions and monitoring of compliance. 5. The actual or proposed date for completion of the remedy. WHITEWATER HEALTH SERVICES is a 1 story building with partial basements. The building was constructed at 2 different times. The original building was constructed in 1967 and is a 1 structure with partial basement and was determined to be Type II (111) construction. In	K 000		

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K 000	Continued From page 2 1969 a 1 story addition with partial basement was constructed and determined to be of Type II (111) construction. Because the original building and additions are compatible construction types allowed for existing buildings of this height, the facility was surveyed as one building as allowed 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 corridors and spaces open to the corridors which is monitored for automatic fire department notification. The facility has a capacity of 42 beds and had a census of 28 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidence by:	K 000		
K 324 SS=F	Cooking Facilities CFR(s): NFPA 101 Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply	K 324		5/9/24

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K 324	Continued From page 3 with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain proper inspection and safety measures associate to residential cooking devices in accordance with NFPA 101 (2012 edition), Life Safety Code, section 19.3.2.5.3(9). This deficient finding could have a widespread impact on the residents within the facility. Findings Include: On 04/09/2024 between 9:00 AM and 1:00 PM, it was revealed by observation that the residential stove-range located in West Wing Kitchenette was not outfitted with lock-out, disconnect, 120 min max timeout hardware. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 324	The Maintenance Director removed the oven power cord while considering future lockout options such as a timer controlled, or locked, power on/off switch. The Maintenance Director or Executive Director will ensure oven either is electrically deactivated and unable to operate, or that the that once a lockout system is installed, the timer is installed, will monitor quarterly that the lock out system works properly.	
K 346 SS=C	Fire Alarm System - Out of Service CFR(s): NFPA 101 Fire Alarm - Out of Service	K 346		5/9/24

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K 346	Continued From page 4 Where required fire alarm system is out of services for more than 4 hours in a 24-hour period, the authority having jurisdiction shall be notified, and the building shall be evacuated or an approved fire watch shall be provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service. 9.6.1.6 This REQUIREMENT is not met as evidenced by: Based on available documentation and staff interview, the facility failed to maintain a fire alarm out of service policy per NFPA 101 (2012 edition), Life Safety Code, section 9.6.1.6. This deficient finding a widespread impact on the residents within the facility. Findings include: On 04/09/2024 between 9:00 AM and 1:00 PM, it was revealed by a review of available documentation that the fire alarm out-of-service policy did not include in the notification listing the MN Department of Public Safety - Fire Marshal Division (point of contact and phone #). An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 346	The Maintenance Director revised our Emergency Operation Plan (E.O.P) on 4/17/2024 to include MN Department of Public Safety Fire Marshal Division point of contact, phone number in our fire alarm system policies. The Maintenance Director or Executive Director will review and revise these policies annually.	
K 353 SS=D	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are	K 353		5/9/24

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	245270	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**04/09/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WHITEWATER HEALTH SERVICES	**525 BLUFF AVENUE ST CHARLES, MN 55972**

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K 353	Continued From page 5 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 documentation review, and staff interview the facility failed to inspect and maintain the sprinkler system in accordance with NFPA 101 (2012 edition), Life Safety Code, sections 4.6.12, 9.7.5, 9.7.6, NFPA 25 (2011 edition) Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, section(s), 4.1.1, 5.1, 5.2, NFPA 13 (2010 edition) Standard for the Installation of Sprinkler Systems, section(s) 8.5.5, 8.5.5.2.1. This deficient finding could have an isolated impact on the residents within the facility. Findings include: On 04/09/2024 between 9:00 AM and 1:00 PM, it was revealed by observation that item(s) were found to vertically stacked or stored closer than 18 inches to sprinkler head(s) in the Basement - Wheelchair Storage Closet. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 353	The Maintenance Director removed items blocking sprinkler head coverage area on 4/10/2024. Red warning tape has been installed with a warning message not to stack above that line. Staff have been trained regarding clearance issues and hanging materials on sprinkler systems. This training will be included in employee orientation packets/training. The Maintenance Director or Executive Director will inspect monitor and ensure all sprinkler heads are clear of any obstruction.	
K 354	Sprinkler System - Out of Service	K 354		5/9/24

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K 354 SS=C	Continued From page 6 CFR(s): NFPA 101 Sprinkler System - Out of Service Where the sprinkler system is impaired, the extent and duration of the impairment has been determined, areas or buildings involved are inspected and risks are determined, recommendations are submitted to management or designated representative, and the fire department and other authorities having jurisdiction have been notified. Where the sprinkler system is out of service for more than 10 hours in a 24-hour period, the building or portion of the building affected are evacuated or an approved fire watch is provided until the sprinkler system has been returned to service. 18.3.5.1, 19.3.5.1, 9.7.5, 15.5.2 (NFPA 25) This REQUIREMENT is not met as evidenced by: Based on available documentation and staff interview, the facility failed to maintain a sprinkler system out of service policy per NFPA 101 (2012 edition), Life Safety Code, section 19.3.5.1, 9.7.5, 9.7.6 and NFPA 25 (2011 edition) Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, section 15.5.2(6). This deficient finding a widespread impact on the residents within the facility. Findings include: On 04/09/2024 between 9:00 AM and 1:00 PM, it was revealed by a review of available documentation that the fire sprinkler system out-of-service policy did not include in the notification listing the MN Department of Public Safety - Fire Marshal Division (point of contact and phone #).	K 354	The Maintenance Director revised our Emergency Operation Plan (E.O.P) on 4/17/2024 to include MN Department of Public Safety Fire Marshal Division point of contact and phone number in our sprinkler service and out of service policies. The Maintenance Director or Executive Director will review and revise these policies annually.	

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K 354	Continued From page 7 An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 354		
K 712 SS=F	Fire Drills CFR(s): NFPA 101 Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to conduct fire drills per NFPA 101 (2012 edition), Life Safety Code, sections 19.7.1. These deficient findings could have a widespread impact on the residents within the facility. Findings include: On 04/09/2024 between 9:00 AM and 1:00 PM, it was revealed by review of available documentation that documentation presented for review did not confirm that fire drills were conducted for 1st shift - 1st Quarter and 3rd shift - 1st Quarter. An interview with Maintenance Director verified these deficient findings at the time of discovery.	K 712	A new correct Fire Drill schedule has been created for the next 12 months. The Maintenance Director or Executive Director will ensure all fire drills are completed, as necessary.	5/9/24
K 914 SS=F	Electrical Systems - Maintenance and Testing	K 914		5/9/24

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K 914	Continued From page 8 CFR(s): NFPA 101 Electrical Systems - Maintenance and Testing Hospital-grade receptacles at patient bed locations and where deep sedation or general anesthesia is administered, are tested after initial installation, replacement or servicing. Additional testing is performed at intervals defined by documented performance data. Receptacles not listed as hospital-grade at these locations are tested at intervals not exceeding 12 months. Line isolation monitors (LIM), if installed, are tested at intervals of less than or equal to 1 month by actuating the LIM test switch per 6.3.2.6.3.6, which activates both visual and audible alarm. For LIM circuits with automated self-testing, this manual test is performed at intervals less than or equal to 12 months. LIM circuits are tested per 6.3.3.3.2 after any repair or renovation to the electric distribution system. Records are maintained of required tests and associated repairs or modifications, containing date, room or area tested, and results. 6.3.4 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to conduct electrical receptacle testing in resident rooms per NFPA 99 (2012 edition), Health Care Facilities Code, section(s) 6.3.3.2, 6.3.4, 6.3.4.1.3, 6.3.4.2. This deficient condition could have a widespread impact on the residents within the facility. Findings include: On 04/09/2024 between 9:00 AM and 1:00 PM, it was revealed by a review of available documentation that the documentation presented	K 914	All outlets will be inspected for polarity and tension by 5/9/2024. The Maintenance Director or Executive Director will ensure, or perform, Electrical Receptacle Inspections annually.	

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K 914	Continued From page 9 for review was incomplete as it did not capture information and findings for each outlet located in resident / client rooms. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 914		
K 920 SS=F	Electrical Equipment - Power Cords and Extens CFR(s): NFPA 101 Electrical Equipment - Power Cords and Extension Cords 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 manage usage electrical devices in accordance with NFPA 99 (2012 edition), Health Care Facilities Code, section 10.2.3.6, 10.2.4,	K 920	The Fire Marshal found three deficiencies including: 1) a power lift chair connected to a non-compliant relocatable power tap in use; 2) a 1-to-3 multitap adapter in use;	5/9/24

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K 920	Continued From page 10 10.5.2.3 and NFPA 70, (2011 edition), National Electrical Code, sections 110.3(B), 400.8 (1) and UL 1363. These deficient findings could have a widespread impact on the residents within the facility. Findings include: 1. On 04/09/2024 between 9:00 AM and 1:00 PM, it was revealed by observation that in the West Common Area a power-lift chair was connected to a non-compliant relocatable power tap. 2. On 04/09/2024 between 9:00 AM and 1:00 PM, it was revealed by observation that in RM 305 a 1-to-3 multitap adapter was found in use. 3. On 04/09/2024 between 9:00 AM and 1:00 PM, it was revealed by observation that in the Social Services Office a 2-to-6 multi-tap adapter was found in use. An interview with the Maintenance Director verified these deficient findings at the time of discovery.	K 920	and 3) a 2-to-6 multi-tap adapter in use. The Maintenance Director corrected these deficiencies by taking them out of service on 4/9/2024. Current staff will be trained on these deficiencies by 5/9/2024. This training will be included in employee orientation packets/training.	
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	K 923		5/9/24

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K 923	Continued From page 11 are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain proper medical gas storage and management per NFPA 99 (2012 edition), Health Care Facilities Code, sections 9.3.7, 11.6.5. This deficient finding could have a widespread impact on the residents within the facility. Findings include:	K 923	The Maintenance Director corrected the deficiency on 4/9/2024. Current staff will be trained in correct handling of Med Gas storage room by 5/9/2024. This training will be included in employee orientation packets/training. The Director of Nursing, or her delegates, will verify compliance with Med Gas storage room policies monthly.	

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K 923	Continued From page 12 On 04/09/2024 between 9:00 AM and 1:00 PM, it was revealed by observation in the Med Gas (O2) Storage Room that there was mixed storage of empty / full cylinders. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 923		