Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

November 7, 2024

Administrator
North Shore Health
515 - 5th Avenue West
Grand Marais, MN 55604

RE: CCN: 245384
Cycle Start Date: August 1, 2024

Dear Administrator:

On October 2, 2024, Center for Medicare & Medicaid Services (CMS) forwarded the results of the Federal Monitoring Survey (FMS) to you and informed you that your facility was not in substantial compliance with the applicable Federal requirements for nursing homes participating in the Medicare and Medicaid programs and imposed enforcement remedies.

On August 30, 2024, the Minnesota Department of Health completed a revisit and on October 31, 2024 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance. Based on our visit, we have determine:

As authorized by CMS the remedy of:

- Mandatory denial of payment for new Medicare and Medicaid admissions effective November 1, 2024, did not go into effect. (42 CFR 488.417 (b))

Feel free to contact me if you have questions.

Sincerely,

Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697
Email: sarah.lane@state.mn.us

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
August 8, 2024

Administrator
North Shore Health
515 - 5th Avenue West
Grand Marais, MN 55604

RE: CCN: 245384
Cycle Start Date: August 1, 2024

Dear Administrator:

On August 1, 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:

Alex Warren, Unit Supervisor
Duluth District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
11 East Superior Street, Suite 290
Duluth, MN 55082
Email: Alex.Warren@state.mn.us
Cell: 651-279-5375 Office: 218-302-6186

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 November 1, 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 February 1, 2025 (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,

Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308   Fax: 651-215-9697
Email: sarah.lane@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245384	A. BUILDING ______ B. WING ______	C 08/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTH SHORE HEALTH	515 - 5TH AVENUE WEST GRAND MARAIS, MN 55604

(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 7/29/24 to 8/1/24, 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 7/29/24 to 8/1/24, 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: H53846192C MN00105080. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulations has been attained.	F 000		
F 582 SS=D	Medicaid/Medicare Coverage/Liability Notice CFR(s): 483.10(g)(17)(18)(i)-(v)	F 582		8/16/24

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		08/16/2024

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 582	Continued From page 1	F 582		

§483.10(g)(17) The facility must--
(i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of-
(A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged;
(B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and
(ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this section.

§483.10(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate.
(i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible.
(ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change.
(iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any

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F 582	Continued From page 2 deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements. (iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility. (v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to provide the required Skilled Nursing Facility Advanced Beneficiary Notice (SNFABN) to 2 of 2 residents (R8, R26) reviewed who remained in the facility after their Medicare part A covered services ended. Findings include: R8's Center for Medicare and Medicaid Services (CMS)-10123 signed as received on 2/1/24, identified a last covered day of 2/5/24, when R8's Medicare coverage would end. R8's Census Record dated 8/1/24, identified on 2/5/24, R8's payer source changed. The record further indicated R8 remained in the facility. R26's CMS-10123 signed as received on 2/29/24, identified a last covered day of 3/2/24, when R26's Medicare coverage would end. R26's Census Record dated 8/1/24, identified on 3/2/24, R8's payer source changed. The record	F 582	F582 Preparation, submission and implementation of this Plan of Correction does not constitute an admission of, or agreement with, the facts and conclusions set forth in the statement of deficiencies. This Plan of Correction is prepared and/or executed as a means to continuously improve the quality of care, to comply with all applicable state and federal regulatory requirements and constitutes the facility�s allegation of compliance. The Skilled Nursing Facility Advanced Beneficiary Notice (SNFABN) will be issued retroactively to R8 and R26 on or before August 21, 2024. No other Residents have had their Medicare Part A covered services end since the date of the survey. The Skilled Nursing Facility Advanced Beneficiary Notice (SNFABN) of	

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F 582	Continued From page 3 further indicated R8 remained in the facility. R8's and R26's medical records were reviewed and lacked any evidence a SNFABN had been provided to explain the estimated cost per day or provide rationale or explanation of the extended care services or items to be furnished, reduced, or terminated. During interview on 7/30/24 at 1:32 p.m., administrator verified a SNFABN was not completed for R8 or R26. Administrator stated SNFABN's were not completed because they were not required. During interview on 7/31/24 at 1:59 p.m., business office accountant verified a SNFABN was not completed for R8 or R26. Explained it has never been the practice of the facility to provide a SNFABN to residents who remain in the facility when their Medicare part A covered services ended. A policy on beneficiary notices was requested and not received.	F 582	Non-coverage policy and the Medicare Notice of Non-Coverage Policy for Skilled Nursing Services have been rewritten and updated. The Social Services Designee, Business Office Manager, Health Information Management Manager, Interim Director of Nursing, Assistant Director of Nursing, Quality Improvement Coordinator and Administrator met on August 15, 2024 and reviewed the policies in detail. In addition, the CMS Beneficiary Notices Initiative (BNI) website was reviewed and Form instructions for CMS-10055 and CMA-10123 were analyzed and incorporated into the policy. North Shore Health will also provide the SNFABN as a voluntary notice for all admissions. Monitoring: The Social Services Designee will review all admissions and discharges to ensure that notifications have been provided appropriately. The results of this monitor will be reported quarterly to the Quality Improvement/Peer Review Committee.	
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices.	F 684		8/26/24

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F 684	Continued From page 4	F 684		

This REQUIREMENT is not met as evidenced by:
Based on interview and document review the facility failed to perform passive range of motion (PROM) and a walking program as ordered, as well as document correctly for 1 of 1 resident (R27) reviewed for therapy.

Findings include:

R27's quarterly minimum data set (MDS) dated 6/4/24, identified R27 had no cognitive impairment. Diagnoses included hypertension and other orthopedic conditions.

R27's provider orders date 2/27/24, indicated physical therapy (PT) to evaluate and treat if appropriate.

R27's physical therapy orders to nursing undated, indicated PROM rehab program. Orders stated to complete PROM right knee extension 3 repetitions x30-60 second holds to end range and complete daily. R27's physical therapy orders to nursing also identified a walking program, which included the following: stand pivot and short distance ambulating with nursing staff daily. Document refusals for standing and short ambulation.

R27's care plan dated 3/6/24, identified a functional mobility care plan with interventions including, "PROM rehab program - complete PROM right knee extension. 3 repetitions x30-60 second holds to end range. Complete daily." The care plan lacked information about a walking program.

R27's care guide sheet dated 7/27/24, identified

F684
Preparation, submission and implementation of this Plan of Correction does not constitute an admission of, or agreement with, the facts and conclusions set forth in the statement of deficiencies. This Plan of Correction is prepared and/or executed as a means to continuously improve the quality of care, to comply with all applicable state and federal regulatory requirements and constitutes the facility□s allegation of compliance.

On August 8, 2024, all residents□ charts were reviewed. 16 residents were identified as possibly at risk for failure of performance of restorative nursing program. Further investigation revealed current documentation practice is difficult to follow and lacks important prompts. A new intervention was developed and submitted to the facilities electronic health record IT team. This intervention is in the process of being developed and tested for use in the active chart. Once the new intervention is live in the active chart, all Restorative Nursing Program orders will be moved to the new intervention. The current interventions in place will be retired. The title of Restorative Nursing Program will be easier to identify in the electronic health record during compliance monitoring.

The restorative nursing intervention being developed will have areas which must be answered prior to saving to the chart.

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F 684	Continued From page 5 R27 was on a PROM program and a walking program that was to be completed daily. R27's Nursing Rehabilitation PROM documentation was reviewed from 7/1/24 to 7/31/24, and lacked documentation PROM was completed on 7/7/24, 7/10/24, 7/16/24, 7/19/24, 7/22/24, 7/25/24, R27's walking program documentation was reviewed from 7/1/24 to 7/31/24, and lacked documentation walking was performed on the following dates: 7/1/24 to 7/3/24, 7/7/24, 7/10/24, 7/16/24, 7/19/24, 7/22/24. During an interview on 7/29/24 at 6:28 p.m., R27 stated she was on walking and a PROM programs that was set up by PT and was to be done by the staff every day. R27 stated the staff on day shift would walk her on some days but not every day and had never done any kind of range of motion on her knee. She could tell when she did not get to do the walking because the next time they walked her after missing a session, her knee was more stiff and sore. During an interview on 7/30/24 at 3:41 p.m., physical therapist (PT)-A stated a PROM and walking program had been set up in 3/24, on R27 and it was nursing's responsibility to make sure it was done every day. It was to ensure R27 would her mobility and her right leg would get stronger, with a goal of her to walk independently with a wheeled walker. During an interview on 7/31/24 at 10:31 a.m., nurse assistant (NA)-A stated R27 was on a walking program and a PROM program that was to be performed daily. NA-A stated They try to	F 684	Both nurses and nursing assistants will have the availability to see if the restorative program was charted on as ordered. Staff will be educated on proper documentation of the restorative program. Nurses will be educated on their role and responsibilities in a successful Restorative Nursing Program. The Director of Nursing, Assistant Director of Nursing, or the MDS nurse will be notified of residents□ refusals to participate and the reason the resident refused. Monitoring: Compliance monitoring will be weekly for four weeks and monthly for four months of five random residents□ chart for documentation completion. Quarterly monitoring of section GG of the MDS will be performed with the goal to identify residents□ functional decline. The completion of the building and implementation of the new Restorative Program is expected to be completed by 08/19/2024. Staff training will be completed prior to going live. Audits will begin 08/26/24.	

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F 684	Continued From page 6	F 684		

perform the walking program and PROM but do not always have time. If the walking program or PROM is not performed we will just leave it blank or document that it was not done. Staff would also pass on to the next shift the walking program and PROM was not completed on the last shift.

During and interview on 8/1/24 at 10:01 a.m. the assistant director of nursing (ADON) stated anytime a resident is on a walking or a PROM program then it is up to the entire staff to make sure the actions are performed. If one person cannot get to it then the next shift would help out. The ADON reviewed R27's medical record and confirmed there were several days that had missing documentation, indicating that the walking and PROM programs were not completed. She also acknowledged several days were documented as "not done" with no explanation as to why. The ADON stated nurse orders that were daily needed to be completed daily, and if missed, documented with an explanation as to why it was missed.

Facility Policy Nursing Rehab last revised 4/23/17, identified the nursing rehab program was provided to maximize each patient/resident's functional independence. Nursing would follow the program as built and ordered by therapy services and document daily. If a refusal was made by the resident the reason would be indicated.

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	245384	A. BUILDING **04 - NORTH SHORE HEALTH** B. WING ______	**07/30/2024**

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NORTH SHORE HEALTH	**515 - 5TH AVENUE WEST** **GRAND MARAIS, MN 55604**

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K 000	INITIAL COMMENTS	K 000		

FIRE SAFETY

An annual Life Safety recertification survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 07/30/2024. At the time of this survey, North Shore Health 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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		08/16/2024

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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	245384	A. BUILDING **04 - NORTH SHORE HEALTH** B. WING ______	**07/30/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTH SHORE HEALTH	**515 - 5TH AVENUE WEST** **GRAND MARAIS, MN 55604**

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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. The facility was inspected as one building: North Shore Health, is a 1-story building with no basement. The 100 and 400 wings of the facility were constructed in 2016 and was determined to be of Type II(111) construction. In 2017 the 200 and 300 wings were constructed to the building that were determined to be of Type II(111) construction. The 100,200,300, & 400 wings were constructed to replace the original facility and the plans for these	K 000		

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K 000	Continued From page 2 wings were approved on 04/30/2015, prior to the 2012 code adoption and are considered to be of existing construction. The building is attached to a hospital and is properly separated by a 2 hour fire rated separation. The building is separated into 2 smoke compartments by a 1 hour fire rated smoke barrier. The building is fully sprinkled throughout, the facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors that is monitored for automatic fire department notification. It also has smoke detection in all resident rooms. The facility has a capacity of 37 beds and had a census of 32 at the time of the survey. The requirements at 42 CFR, Subpart 483.70(a), are NOT MET as evidenced by:	K 000		
K 353 SS=F	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 maintained in a secure location and readily available. a) Date sprinkler system last checked __________ b) Who provided system test __________	K 353		10/10/24

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K 353	Continued From page 3 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: 1) Based on observation, a review of available documentation, and staff interview, the facility failed to inspect and maintain the fire sprinkler system per NFPA 101 (2012 edition), Life Safety Code, section 9.7.5, and NFPA 25 (2011 edition), Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, sections 5.1.1.2, and 5.3.2.1. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 07/30/2024, Between 09:00am and 13:00pm, it was revealed by a review of available documentation the facility failed to perform the five (5) year sprinkler system testing. 2) Based on observation and staff interview, the facility failed to maintain spacing between storage and the sprinkler system per NFPA 101 (2012 edition), Life Safety Code, Section 9.7.5, NFPA 25 (2011 edition), Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, Section 5.2.1.2, and NFPA 13 (2010 edition), Standard for the Installation of Sprinkler Systems, Sections 8.6.5.3.2 and 8.15.9. These deficient findings could a patterned impact on the residents within the facility.	K 353	K353 Preparation, submission and implementation of this Plan of Correction does not constitute an admission of, or agreement with, the facts and conclusions set forth in the statement of deficiencies. This Plan of Correction is prepared and/or executed as a means to continuously improve the quality of care, to comply with all applicable state and federal regulatory requirements and constitutes the facility□s allegation of compliance. Sprinkler System - Maintenance and testing. Viking Automatic Sprinkler will complete the 5-year inspection on or before October 10, 2024. A Sprinkler System - Maintenance and testing policy has been added to electronic policy manual, PolicyStat, for annual review. A work order/asset management system is currently being implemented and all Sprinkler System Maintenance and testing requirements will be added to the new system. Sprinkler heads clearance. The storage room and salon obstructions have been removed. Storage clearance required for sprinkler heads has been added to the	

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K 353	Continued From page 4 Findings include: On 07/30/2024, Between 09:00am and 13:00pm, it was revealed by observation that storage materials had been placed on a storage rack, bringing the storage materials within the required 18 inch clearance area under the sprinkler heads. These obstructions were found in storage room / Salon. An interview with the Maintenance Director verified these deficient findings at the time of discovery.	K 353	Sprinkler System Maintenance and Testing electronic policy in PolicyStat. The Director of Facilities or designee will perform 8 random quarterly inspections of storage rooms and offices for sprinkler head clearance issues This information will be forwarded to the Quality Improvement/Peer Review Committee quarterly for one year.	
K 372 SS=F	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain their smoke barrier per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.7.1, 19.3.7.3, 8.5.2.2, and 8.5.6.5. These deficient findings could have a widespread impact on the residents within the facility. Findings include:	K 372	K372 Preparation, submission and implementation of this Plan of Correction does not constitute an admission of, or agreement with, the facts and conclusions set forth in the statement of deficiencies. This Plan of Correction is prepared and/or executed as a means to continuously	8/9/24

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K 372	Continued From page 5 On 07/30/2024, Between 09:00am and 13:00pm, it was revealed by observation that there was a penetration running from one smoke compartment to another above following doors; 1) Doors leading to 300/400 wings in the pouch 2) Main entrance to the pouch 3) Doors leading to 100/200 Wings in the pouch An interview with the Maintenance Director verified these deficient findings at the time of discovery.	K 372	improve the quality of care, to comply with all applicable state and federal regulatory requirements and constitutes the facility�s allegation of compliance. The penetration running from one smoke compartment to another in the porch area that lead to the 100/200 wings and the 300/400 wings have been sealed with an ASTM (UL 1479) Firestop sealant on August 9, 2024. An above grid permit has been implemented to prevent employees and contractors from leaving above ceiling penetrations. The Above Ceiling Grid Policy and Permit have been added to electronic policy manual in PolicyStat, for annual review. The Director of Facilities or designee will perform 8 random quarterly inspections of the above ceiling fire and smoke barriers. This information will be forwarded to the Quality Improvement/Peer Review Committee quarterly for one year.	
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	K 918		10/10/24

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K 918	Continued From page 6 NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of 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 install and maintain generators per NFPA 99 (2012 edition), Health Care Facilities Code, section 6.4.4.1.1.3, 6.4.1.1.16.2 and 6.4.1.1.17, and NFPA 110 (2010 edition), Standard for Emergency and Standby Power Systems, sections 8.4.9, 8.4.9.1, 8.4.9.2 and 8.4.9.5.1. These deficient findings could have a widespread impact on the residents within the facility. Findings include:	K 918	K918 Preparation, submission and implementation of this Plan of Correction does not constitute an admission of, or agreement with, the facts and conclusions set forth in the statement of deficiencies. This Plan of Correction is prepared and/or executed as a means to continuously improve the quality of care, to comply with all applicable state and federal regulatory requirements and constitutes the facility's allegation of compliance.	

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K 918	Continued From page 7 On 07/30/2024, Between 09:00am and 13:00pm, it was revealed by a review of available documentation of the emergency generator maintenance and testing that the facility could not provide documentation that a 36 month four (4) hour load bank test had been performed. An interview with the Maintenance Director verified these deficient findings at the time of discovery.	K 918	Electrical Systems. The 36 month - 4-hour load bank test for the Generator will be completed on or before October 10, 2024. A policy has been added to electronic policy manual, PolicyStat, for annual review. A work order/asset management system is currently being implemented and all Generator Maintenance and testing requirements will be added to the new system.	