*Protecting, Maintaining and Improving the Health of All Minnesotans*

Electronically delivered
August 6, 2024

Administrator
Cura of Willmar
1801 Willmar Avenue Southwest
Willmar, MN  56201

RE: CCN: 245410
Cycle Start Date: May 22, 2024

Dear Administrator:

On June 11, 2024, we notified you a remedy was imposed. On July 3, 2024, and August 5, 2024, the Minnesota Departments of Health and Public Safety completed revisits to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of July 12, 2024.

As authorized by CMS the remedy of:

- Discretionary denial of payment for new Medicare and Medicaid admissions effective July 11, 2024, be discontinued as of July 12, 2024. (42 CFR 488.417 (b))

In our letter of June 11, 2024, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from July 11, 2024. This does not apply to or affect any previously imposed NATCEP loss.

The CMS Location may notify you of their determination regarding any imposed remedies.

Feel free to contact me if you have questions.

Sincerely,

Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
Orville L. Freeman Building | HRD 3A 3rd Floor
Office: 651-201-4384
Email: holly.zahler@state.mn.us

DEPARTMENT OF HEALTH

*Protecting, Maintaining and Improving the Health of All Minnesotans*

Electronically delivered
June 11, 2024

Administrator
Cura of Willmar
1801 Willmar Avenue Southwest
Willmar, MN  56201

RE: CCN: 245410
Cycle Start Date: May 22, 2024

Dear Administrator:

On May 22, 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 constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), as evidenced by the electronically delivered CMS-2567, whereby significant corrections are required.

REMEDIES

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

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective July 11, 2024.

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

The CMS location will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective July 11, 2024.  They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective July 11, 2024.

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

**The CMS location may determine to impose other remedies such as a Civil Money Penalty.**

## NURSE AIDE TRAINING PROHIBITION

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

If you have not achieved substantial compliance by July 11, 2024, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, Cura of Willmar will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from July 11, 2024. You will receive further information regarding this from the State agency. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions.

However, under Public Law 105-15, you may contact the State agency and request a waiver of this prohibition if certain criteria are met.

## ELECTRONIC PLAN OF CORRECTION (ePOC)

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

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

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

## DEPARTMENT CONTACT

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

Nikki Sassen, Unit Supervisor
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
3333 Division Street, Suite 212
Saint Cloud, Minnesota 56301-4557
Email: Nicole.Sassen@state.mn.us
Office: (320) 223-7318 Mobile: (320) 216-5631

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

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

We will also recommend to the CMS location and/or the Minnesota Department of Human Services that your provider agreement be terminated by November 22, 2024 if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at § 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR § 488.412 and § 488.456.

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

APPEAL RIGHTS

If you disagree with this action imposed on your facility, you or your legal representative may request a

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

Steven.Delich@cms.hhs.gov

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

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

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

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

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

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

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

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,

Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
Orville L. Freeman Building | HRD 3A 3rd Floor
Office: 651-201-4384
Email: holly.zahler@state.mn.us

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245410 | A. BUILDING _____ B. WING _____ | C 05/22/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| CURA OF WILLMAR | 1801 WILLMAR AVENUE SOUTHWEST WILLMAR, MN 56201 |

| (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 |
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| E 000 | Initial Comments<br><br>On 5/20/24 to 5/22/24, a survey for compliance with Appendix Z, Emergency Preparedness Requirements, §483.73 was conducted during a standard recertification survey. The facility was IN compliance.<br><br>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<br><br>On 5/20/24 to 5/22/24, 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.<br><br>The following complaints were reviewed with NO deficiencies cited:<br>H54103563C (MN00103069)<br>H54108043C (MN00099273)<br>H54103782C (MN00099790)<br>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.<br><br>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 | | |

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

Electronically Signed | 06/21/2024

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 684 SS=D | Quality of Care<br>CFR(s): 483.25<br><br>§ 483.25 Quality of care<br>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.<br>This REQUIREMENT is not met as evidenced by:<br>Based on interview and document review, the facility failed to ensure as needed (PRN) medications were administered per physician's order for 1 of 1 resident (R20) reviewed for unnecessary medications.<br><br>Findings include:<br><br>R20's quarterly Minimum Data Set (MDS) dated 5/16/24, identified R20 had moderate cognitive impairment and required assistance with all activities of daily living (ADL)'s. R20's diagnoses included chronic diastolic congestive heart failure (type of heart failure that occurs when the heart's left ventricle is unable to fill with blood properly during the diastolic phase, when the heart relaxes), hypertension, peripheral vascular disease (chronic, progressive condition that occurs when blood circulation to a body part other than the heart or brain is reduced), Non-Alzheimer's Dementia, seizure disorder, anxiety disorder, asthma (inflammation and narrowing of the small airways in the lungs), respiratory failure (serious condition that make it difficult to breathe on your own), permanent atrial fibrillation (when atrial fibrillation is present all the | F 684 | Corrective Action: Review resident orders to ensure PRN medications are administered per physician's orders.<br>Corrective Action- Identify other residents: A comprehensive review was done for all PRN orders to current residents to ensure proper administration per physician's orders will be achieved.<br>Corrective action to Prevent Reoccurrence: Email sent to nursing staff to review medication guideline policy. Also, education will be provided at the next all nurse meeting to review documentation expectations for change in condition ex. Actions taken for weight gain, s/s observed or not observed, change in vitals, notification of MD with changes etc. Education will also be provided on new process with receiving PRN medication orders to include adding a task in EMAR to correlate with specific instructions as ordered by physician.<br><br>Audit: DON and Clinical Coordinator will do weekly audits x3, biweekly audits x2 and monthly x3 months or until average of | 7/1/24 |

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| F 684 | Continued From page 2<br>time and no more attempts to restore normal heart rhythm will be made), and benign prostatic hyperplasia (non-cancerous condition in men where the prostate gland increases in size).<br><br>R20's electronic health record (EHR) indicated a signed physician's order for Metolazone 5 mg (milligram) to be given by mouth as needed once daily for fluid retention/weight gain of three pounds overnight or five pounds in seven days related to chronic diastolic congestive heart failure. EHR lacked documentation of administration of PRN medication on 3/27/24, 3/31/24, 4/2/24, 4/10/24, 4/17/24 and 5/4/24.<br><br>R20's weight documentation, in EHR, indicated increased weight gain overnight on the following dates:<br>- 3/26/24 at 8:57 a.m., weight was documented as 165.6 lbs (pounds)<br>- 3/27/24 at 9:04 a.m., weight was documented as 169.1 lbs - based on order PRN metolozone should have been administered due to weight gain of over three pounds.<br>- 3/30/24 at 1:31 p.m., weight was documented as 167.8 lbs<br>- 3/31/24 at 10:31 a.m., weight was documented as 183.4 lbs - based on order PRN metolozone should have been administered due to weight gain of over three pounds.<br>- 4/1/24 at 8:47 a.m., weight was documented as 174.2 lbs<br>- 4/2/24 at 9:30 a.m., weight was documented as 186.4 lbs - based on order PRN metolozone should have been administered due to weight gain of over three pounds.<br>- 4/9/24 at 1:50 p.m., weight was documented as 175.2 lbs<br>- 4/10/24 at 1:30 p.m., weight was documented | F 684 | 90% or greater compliance is achieved.<br>QA: The audit results for compliance with be reported and reviewed quarterly at Quality Assurance Committee. | |

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| F 684 | Continued From page 3<br>at 186.4 lbs - based on order PRN metolozone should have been administered due to weight gain of over three pounds.<br>- 4/16/24 at 9:13 a.m.., weight was documented at 168.0 lbs<br>- 4/17/24 at 12:39 p.m., weight was documented at 172.2 lbs - based on order PRN metolozone should have been administered due to weight gain of over three pounds.<br>- 5/3/24 at 2:21 p.m., weight was documented at 171.0 lbs<br>- 5/4/24 at 12:17 p.m., weight was documented at 175.0 lbs - based on order PRN metolozone should have been administered due to weight gain of over three pounds.<br><br>R20's progress notes lacked documentation of increased weight and if R20 was experiencing any signs or symptoms related to the increased weight.<br><br>During observation on 5/21/24 at 1:34 p.m., R20 did not have any edema noted in his lower extremities.<br><br>During interview on 5/22/24 at 9:40 a.m., licensed practical nurse (LPN)-A stated R20 did not have a PRN order related to his daily weights. LPN-A stated if R20's daily weights were up three pounds in a day or seven pounds in a day they would notify the provider. LPN-A accessed R20's medical chart and stated that it does look like R20 has an PRN order for metolazone that should be used is weight is up.<br><br>During interview on 5/22/24 at 9:47 a.m., registered nurse care coordinator (RN)-B stated residents with daily weights has the weights obtained and if they have parameters and/or PRN | F 684 | | |

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| F 684 | Continued From page 4<br>medications to be utilized, licensed nursing staff should administer PRN medication and then notify provider of weight gain and PRN usage. RN-B confirmed R20 had an order for PRN Metolazone to be administered for increased weight gain. RN-B stated licensed nursing staff probably do not know that R20 has this order as it is not linked to the daily weight task. RN-B stated that in the daily weight task it should prompt licensed nursing staff that resident has a PRN order that can be utilized. RN-B stated this was important because it is a provider's order and should be followed. RN-B stated medication is important due to fluid retention due to his congestive heart failure.<br><br>During interview on 5/22//24 at 11:46 a.m., director of nursing (DON) stated she expected provider's orders to be followed with PRN medications. DON confirmed PRN medication should have been administered with the increased weight gain. DON stated this was important as R20 needs these monitoring/medications for his congestive heart failure and physician's orders need to be followed<br><br>During interview on 5/22/24 at 12:38 p.m., consultant pharmacist (CP) stated metolazone should have been administered to R20 with the increased weight gain overnight. CP stated it is important to follow provider orders as they are ordered for management of congestive heart failure.<br><br>On 5/22/24 at 2:07 p.m., call was placed to primary doctor with no return response.<br><br>The facilities Medication Guidelines policy dated 5/24, indicated the facility would ensure the | F 684 | | |

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| F 684 | Continued From page 5<br>accurate storage and safe/effective administration of medications by qualified personnel. Medications are administered by qualified personnel who perform ongoing monitoring of the resident's response to medications administered. Medications are to be administered in a timely manner, accurately and in a way to allow for maximum benefit. Medication orders are to be administered as ordered by the provider. | F 684 | | |
| F 880 SS=D | Infection Prevention & Control<br>CFR(s): 483.80(a)(1)(2)(4)(e)(f)<br><br>§483.80 Infection Control<br>The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.<br><br>§483.80(a) Infection prevention and control program.<br>The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:<br><br>§483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;<br><br>§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, | F 880 | | 7/1/24 |

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| F 880 | Continued From page 6<br>but are not limited to:<br>(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;<br>(ii) When and to whom possible incidents of communicable disease or infections should be reported;<br>(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;<br>(iv)When and how isolation should be used for a resident; including but not limited to:<br>(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and<br>(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.<br>(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and<br>(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.<br><br>§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.<br><br>§483.80(e) Linens.<br>Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.<br><br>§483.80(f) Annual review.<br>The facility will conduct an annual review of its IPCP and update their program, as necessary. | F 880 | | |

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| | 245410 | A. BUILDING _____ B. WING _____ | C 05/22/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| CURA OF WILLMAR | 1801 WILLMAR AVENUE SOUTHWEST WILLMAR, MN 56201 |

| (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 |
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| F 880 | Continued From page 7<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview and document review, the facility failed to perform hand hygiene after high contact direct cares for 1 of 3 residents (R114) reviewed for infection control.<br><br>Findings include:<br><br>R114's admission Minimum Data Set (MDS) and Care Area Assessment (CAA) dated 5/8/24, identified an admission date of 5/2/24, moderately impaired cognition, diagnoses of end stage renal disease with need for hemodialysis, diabetes, and pressure ulcers. The MDS/CAA also identified R114 had a recent extensive hospital stay related to diabetic ketoacidosis and inflammation of the colon caused by the bacteria Clostridium difficile (C. Diff.), had frequent bowel incontinence, was very deconditioned and dependent for transfers and mobility.<br><br>During observation on 5/20/24 at 12:29 p.m., a sign identifying the need for transmission-based precautions (TBP) was placed on the wall in the alcove outside R114's room with a cart of personal protective equipment (PPE). The sign specified contact enteric precautions (intended to prevent transmission of intestinal pathogens that are spread by direct or indirect contact with the resident or environment) and instructed staff to wash hands or use hand sanitizer, don gown and gloves prior to entry at the door and to wash hands upon leaving the room.<br><br>During observation on 5/20/24 at 5:33 p.m., nursing assistant (NA)-B communicate the need for resident transfer assist via walkie, donned gloves and a gown then entered R114's room. | F 880 | Corrective Action: Hand Hygiene education to all staff for review of proper hand hygiene techniques required after high contact direct care of patients<br>Corrective action to prevent reoccurrence: Education provided to staff at mandatory education in services held May 29- June 3rd. Staff required to review hand hygiene policy and sign completion of review.<br>Audit: DON and Clinical Coordinator will do hand hygiene weekly audits x3, biweekly audits x2 and monthly x3 months or until average of 90% or greater compliance is achieved.<br>QA: The audit results for compliance with be reported and reviewed quarterly at Quality Assurance Committee.<br><br>Date of completion 7/1/2024 | |

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| F 880 | Continued From page 8<br>NA-A arrived and donned gloves and gown and entered the room. NA-A and NA-B proceeded to assist R114 with sitting up in bed and then transferred her to the recliner using a sit to stand mechanical lift that was being stored in the resident bathroom. When finished NA-A doffed and disposed of her gown and gloves in the covered waste basket in R114's room near the door, opened the door and proceeded down the hall to the unit dining room, retrieved a meal tray off the kitchenette counter then walked back to R114's room and handed the tray to NA-B who was still in the room. No handwashing was observed after leaving R114's room.<br><br>When interviewed on 5/20/24 at 5:41 p.m., NA-A stated she did not know why R114 required contact/enteric precautions and acknowledged she had not sanitized or washed her hands after assisting with R114's transfer but should have. NA-A stated usually staff could use the hand sanitizer when leaving a resident room until they could get to a nearby sink on the unit to wash their hands with soap and water.<br><br>When interviewed on 5/22/24 at 7:46 a.m., registered nurse (RN)-A stated with residents on any type of infection precautions staff are informed of why and what control measure to take in shift-to-shift communications, through residents' electronic medical record and paper care sheets. RN-A stated hand sanitizer is available to use until staff can go to a sink to wash their hands with soap and water.<br><br>When interviewed on 5/22/24 at 10:32 a.m., the director of nursing (DON) stated any need for TBP is tracked through the admission process and with any signs or symptoms of infection in | F 880 | | |

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| F 880 | Continued From page 9<br>residents and the licensed nurses can determine what type to implement then inform and communicate to other nursing staff. The DON stated all staff are educated on the importance of hand hygiene upon hire then routinely or as needed thereafter. The DON stated R114 was on contact enteric precautions related to C. Diff. diagnosis and a sign had been placed over the hand sanitizer dispenser in her room to wash hands with soap and water because hand sanitizer does not kill the C. Diff. organism. The DON stated routine hand washing by staff was important to protect residents and themselves from spreading infections.<br><br>The facility policy Handwashing/Hand Hygiene dated 1/2023, identified the need for washing hands with soap and water after contact with a resident with infectious diarrhea including, but not limited to infections caused by norovirus, salmonella, shigella and C. Diff. | F 880 | | |
| F 883 SS=D | Influenza and Pneumococcal Immunizations<br>CFR(s): 483.80(d)(1)(2)<br><br>§483.80(d) Influenza and pneumococcal immunizations<br>§483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that-<br>(i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization;<br>(ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period;<br>(iii) The resident or the resident's representative | F 883 | | 7/1/24 |

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| F 883 | Continued From page 10<br>has the opportunity to refuse immunization; and<br>(iv)The resident's medical record includes documentation that indicates, at a minimum, the following:<br>(A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and<br>(B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal.<br><br>§483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that-<br>(i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization;<br>(ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized;<br>(iii) The resident or the resident's representative has the opportunity to refuse immunization; and<br>(iv)The resident's medical record includes documentation that indicates, at a minimum, the following:<br>(A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and<br>(B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. | F 883 | | |

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| F 883 | Continued From page 11<br>This REQUIREMENT is not met as evidenced by:<br>Based on interview and document review, the facility failed to ensure 1 of the 5 residents (R55) reviewed for immunizations were offered and/or provided the pneumococcal vaccination series as recommended by the Centers for Disease Control (CDC) to help reduce the risk of associated infection(s).<br><br>Findings include:<br><br>A CDC Pneumococcal Vaccine Timing for Adults feature, dated 3/15/2023, identified various tables when each (or all) of the pneumococcal vaccinations should be obtained. This identified when an adult over 65 years old had received the complete series (i.e., PPSV23 and PCV13; see below) then the patient and provider may choose to administer Pneumococcal 20-valent Conjugate Vaccine (PCV20) for patients who had received Pneumococcal 13-valent Conjugate Vaccine (PCV13) at any age and Pneumococcal Polysaccharide Vaccine 23 (PPSV23) at or after 65 years old.<br><br>R55's significant change Minimum Data Set (MDS) dated 5/2/24, indicated moderately impaired cognition and diagnoses of hypertension, peripheral vascular disease and diabetes.<br><br>R55's face sheet, dated 5/22/24, indicated he was 80 years old. The immunization record, dated 5/22/24, indicated he received a PPSV23 on 7/13/2017 and a PCV13 on 4/20/16. The record lacked evidence of shared clinical decision making with the physician for a PCV20 at least 5 years after the last pneumococcal dose. The | F 883 | Corrective action: Resdient G.L was given education and informed consent on 5/21/24. Provider notified and receipt of order obtained on 5/22/24. Review of all current residents for immunization status done on 5/21/24.. Ensured those who are eligible for pneumococcal and influenza immunizations receive education and obtain consent to administer or decline vaccine. Influenza immunizations will be assessed during appropriate designated times per CDC recommendations.<br><br>Prevent reoccurrence: Per new EMR process, new admission checklist added to admission list- added line for review MIIC for eligible residents and provide consent/education of pneumococcal or influenza immunization if applicable. Education provided at next nursing meeting on new process in 07/2024. All nurses will need to review policy for immunizations and sign for receipt/acknowledgment of policy review. Facility will participate with contracted Guardian pharmacy to have annual influenza vaccine clinic at appropriate designated time per CDC recommendations<br><br>Audit: DON and Clinical Coordinator will do immunization audits weekly x3, biweekly audits x2 and monthly x3 months or until average of 90% or greater compliance is achieved.<br>QA: The audit results for compliance with be reported and reviewed quarterly at | |

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| F 883 | Continued From page 12<br>record lacked evidence that R55 or representative was offered or received a PCV20.<br><br>During an interview with the director of nursing (DON) who is also the infection preventionist (IP), on 5/22/24 at 10:32 a.m., the DON/IP indicated immunizations are verified upon admission through MIIC (Minnesota Immunization Information Connection) and resident medical records. The DON/IP stated residents and/or their representatives would be offered and educated on the risk/benefit of the PCV20, and consents are obtained if eligible. The DON/IP stated it is a collaboration for determining eligibility and administration of the vaccines including the facility pharmacy and resident providers. The DON/IP stated they follow their policies for immunization guidelines, and they are based on CDC recommendations. The DON/IP verified R55's pneumococcal immunizations as listed above. The DON/IP verified R55 had not been offered or provided education on PCV20.<br><br>The facility policy Pneumococcal Immunization, Long Term Care dated 4/2024 identified "Residents will be offered the pneumococcal vaccinations and administered, according to the MDH and CDC recommended interval for the vaccines, unless contraindicated, already immunized, or the resident and/or the resident representative declines the vaccine." | F 883 | Quality Assurance Committee.<br><br>Date of completion 7/1/2024 | |
| F 887 SS=D | COVID-19 Immunization<br>CFR(s): 483.80(d)(3)(i)-(vii)<br><br>§483.80(d) (3) COVID-19 immunizations. The LTC facility must develop and implement policies and procedures to ensure all the following:<br>(i) When COVID-19 vaccine is available to the | F 887 | | 7/1/24 |

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| F 887 | Continued From page 13<br>facility, each resident and staff member is offered the COVID-19 vaccine unless the immunization is medically contraindicated or the resident or staff member has already been immunized;<br>(ii) Before offering COVID-19 vaccine, all staff members are provided with education regarding the benefits and risks and potential side effects associated with the vaccine;<br>(iii) Before offering COVID-19 vaccine, each resident or the resident representative receives education regarding the benefits and risks and potential side effects associated with the COVID-19 vaccine;<br>(iv) In situations where COVID-19 vaccination requires multiple doses, the resident, resident representative, or staff member is provided with current information regarding those additional doses, including any changes in the benefits or risks and potential side effects associated with the COVID-19 vaccine, before requesting consent for administration of any additional doses;<br>(v) The resident, resident representative, or staff member has the opportunity to accept or refuse a COVID-19 vaccine, and change their decision;<br>(vi) The resident's medical record includes documentation that indicates, at a minimum, the following:<br>(A) That the resident or resident representative was provided education regarding the benefits and potential risks associated with COVID-19 vaccine; and<br>(B) Each dose of COVID-19 vaccine administered to the resident; or<br>(C) If the resident did not receive the COVID-19 vaccine due to medical contraindications or refusal; and | F 887 | | |

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| F 887 | Continued From page 14<br>(vii) The facility maintains documentation related to staff COVID-19 vaccination that includes at a minimum, the following:<br>(A) That staff were provided education regarding the benefits and potential risks associated with COVID-19 vaccine;<br>(B) Staff were offered the COVID-19 vaccine or information on obtaining COVID-19 vaccine; and<br>(C) The COVID-19 vaccine status of staff and related information as indicated by the Centers for Disease Control and Prevention's National Healthcare Safety Network (NHSN).<br>This REQUIREMENT is not met as evidenced by:<br>Based on interview and document review, the facility failed to ensure education on benefits and potential side effects of COVID-19 booster vaccination and administration of the vaccination to 1 of 5 residents (R55) reviewed for COVID-19 vaccination status.<br><br>Findings include:<br><br>The most recent Centers for Disease Control (CDC) Covid-19 vaccine guidance dated 2/7/24, recommends everyone aged 65 years and older, including people who live in Long-Term Care (LTC) settings who received one dose of any updated 2023-2024 Covid -19 vaccine (Pfizer-BioNTech, Moderna or Novavax) should receive one additional dose of an updated Covid-19 vaccine at least four months after the previous updated dose.<br><br>R55's significant change Minimum Data Set (MDS) dated 5/2/24 indicated moderately impaired cognition and diagnoses of hypertension, peripheral vascular disease and diabetes. | F 887 | Corrective action: Resdient G.L was given education and informed consent on 5/21/24 for COVID and pneumoccal vaccine. Provider notified and receipt of order obtained on 5/22/24. Review of all current residents for immunization status for COVID, Influenza, pneumoccalc done on 5/21/24. Reviewed all current residents for immunization status completed on 5/21/24. Ensured those who are eligible for COVID/influenza/pneumococcal immunizations receive education and obtain consent to administer or decline vaccine.<br><br>Prevent reoccurrence: Per new EMR process, new admission checklist added to admission list- added line for review MIIC for eligible residents and provide consent/education of pneumococcal or influenza immunization if applicable. Education provided at next nursing meeting on new process. All nurses will need to review policy for immunizations and sign for receipt/acknowledgment of | |

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| F 887 | Continued From page 15<br>R55's face sheet indicated R31 had admitted to the facility on 2/23/24 and was 80 years old. R55's electronic medical record (EMAR) indicated he had last received a Covid-19 booster vaccination on 3/15/23. R55's lacked documentation of any additional COVID-19 booster vaccination and evidence of education regarding the benefits and potential side effects of additional COVID-19 booster vaccination. R55's EMR lacked evidence of any contraindication to Covid-19 vaccination.<br><br>During an interview with the director of nursing (DON) who is also the infection preventionist (IP), on 5/22/24 at 10:32 a.m., the DON/IP indicated immunizations are verified upon admission through MIIC (Minnesota Immunization Information Connection) and resident medical records. The DON/IP stated residents and/or their representatives should be offered and educated on the risk/benefit of the Covid-19 booster, and consents are obtained if eligible. The DON/IP stated it is a collaboration for determining eligibility and administration of the vaccines including the facility pharmacy and resident providers. The DON/IP stated they follow their policies for immunization guidelines, and they are based on CDC recommendations. The DON stated this process was missed for R55.<br><br>The facility policy Covid-19 Vaccine Policies and Procedures dated 10/2023, identified "Covid-19 vaccinations will be offered to all staff and residents (or their representative if they cannot make health care decisions) unless such immunization is medically contraindicated, per CDC guidance, or the individual has already received all recommended doses." | F 887 | policy review. Facility will participate with contracted Guardian pharmacy to have annual COVID vaccine clinic at appropriate designated time per CDC recommendations.<br><br>Audit: DON and Clinical Coordinator will do weekly audits x3, biweekly audits x2 and monthly x3 months or until average of 90% or greater compliance is achieved.<br>QA: The audit results for compliance with be reported and reviewed quarterly at Quality Assurance Committee.<br><br>Date of completion 7/1/2024 | |

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| | 245410 | A. BUILDING **01 - MAIN BUILDING 01**<br>B. WING _____ | **05/21/2024** |

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| **CURA OF WILLMAR** | **1801 WILLMAR AVENUE SOUTHWEST**<br>**WILLMAR, MN 56201** |

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| K 000 | INITIAL COMMENTS<br><br>FIRE SAFETY<br><br>An annual Life Safety Code survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 05/21/2024. At the time of this survey, Cura of Willmar 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.<br><br>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.<br><br>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.<br><br>PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO:<br><br>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 | 06/21/2024

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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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.

Cura of Willmar is a 1-story building with no basement that was constructed at 6 different times. The original building was constructed in 1965 and was determined to be of Type II(111) construction. In 1995, an addition was constructed on the south side of the original building and was determined to be of Type II(111) construction. Since the original building and the 1995 addition are both Type II (111) construction they were both

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| K 000 | Continued From page 2<br>inspected as buildings under Existing Healthcare requirements. The first addition was built in 2011, and is a 1-story addition without a basement that is located on the south side and was determined to be of Type V(111) construction. The second addition was built in 2012, and is a 1-story addition without a basement that is located on the south side of the northeast wing and was determined to be of Type V(111) construction. The third addition was built in 2013, and is a 1-story addition without a basement that is located on the south side of the northwest wing and was determined to be of Type V(111) construction. The fourth addition to the facility consisted of two buildings that were both built in 2014; both additions are 1-story additions without basements that are located on the west side of the 2011 addition. It was determined that both 2014 additions are of Type V(111) construction. Surveyed as one building.<br><br>The facility is equipped with a fire alarm system that has smoke detection in the corridors and in spaces that are open to the corridors, and that is monitored for automatic fire department notification. The facility is fully protected by an automatic fire sprinkler system.<br><br>The facility has a capacity of 78 beds and had a census of 59 at the time of the survey.<br><br>The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by: | K 000 | | |
| K 324 SS=F | Cooking Facilities<br>CFR(s): NFPA 101<br><br>Cooking Facilities<br>Cooking equipment is protected in accordance | K 324 | | 7/12/24 |

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| K 324 | Continued From page 3<br>with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless:<br>* 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<br>* cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or<br>* cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4.<br>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.<br>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<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, and staff interview, the facility failed to install proper protection for cooking equipment per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.2.5.1, 19.3.2.5.3 (9). These deficient findings could have a widespread impact on the residents within the facility.<br><br>Findings include:<br><br>On 05/21/2024 between 8:30 and 10:45 AM, it was revealed by observation that a stoves in the Therapy Room, TS1, TS2, Cushman, and Sophia did not have a timer, not exceeding 120 minutes, | K 324 | 120 minute timers for 5 stoves will be installed by July 12, 2024. Timers are back ordered and scheduled to be installed by 7/12/2024. | |

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| K 324 | Continued From page 4<br>that automatically deactivates the cooktop or range, independent of staff action.<br><br>An interview with the Maintenance Director verified these deficient findings at the time of discovery. | K 324 | | |
| K 353 SS=E | Sprinkler System - Maintenance and Testing<br>CFR(s): NFPA 101<br><br>Sprinkler System - Maintenance and Testing<br>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.<br>a) Date sprinkler system last checked<br>_____<br>b) Who provided system test<br>_____<br>c) Water system supply source<br>_____<br>Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system.<br>9.7.5, 9.7.7, 9.7.8, and NFPA 25<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation and staff interview, the facility failed to maintain the automatic sprinkler system per NFPA 101 (2012 edition), Life Safety Code Section 19.7.6, and 4.6.12, NFPA 25 (2011 edition), Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, sections 5.2.1.2, and 5.2.2.2. These deficient findings could have a widespread impact on the residents within the facility. | K 353 | Deficiency (sprinkler system)- Removed garbage can that was within 18” of the sprinkler head. Cleaned sprinkler head that was dirty on 5/21/2024. A preventative maintenance order was created for a semi-annual work order to check and clean sprinkler heads. Created a second Preventative Maintenance to check for objects that may be within the 18” distance | 5/21/24 |

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| K 353 | Continued From page 5<br><br>Findings include:<br><br>1. On 05/21/2024, between 8:30 and 10:45 AM, it was revealed by observation that plastic garbage cans were being stored within 18" of the sprinkler head in the soiled linen closet by Room 116.<br><br>2. On 05/21/2024, between 8:30 and 10:45 AM, it was revealed by observation that the sprinkler head in the dry storage room near the kitchen was covered with lint.<br><br>An interview with the Maintenance Director verified these deficient findings at the time of discovery. | K 353 | of the sprinkler heads. Compliance Date: 05/21/2024 | |
| K 363 SS=D | Corridor - Doors<br>CFR(s): NFPA 101<br><br>Corridor - Doors<br>Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no | K 363 | | 5/21/24 |

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| K 363 | Continued From page 6<br>impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies.<br><br>19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485<br>Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, the facility failed to maintain corridor doors per NFPA 101 (2012 edition), Life Safety Code, section 19.3.6.3.5. This deficient finding could have a pattewrened impact on the residents within the facility.<br><br>Findings include:<br><br>On 05/21/2024 between 8:30 and 10:45 AM, it was revealed by observation that the door to the Copy Room with a self-closing device was blocked open with a door wedge. When the wedge was removed, the door did not properly latch.<br><br>An interview with the Maintenance Director verified this deficient finding at the time of discovery. | K 363 | Deficiency( Corridor- door)- Removed door stop holding door open and adjusted door closer so door closes properly on 5/21/2024. Preventative Maintenance order made for inspecting fire door operations and blockages monthly. Compliance Date: 05/21/2024 | |
| K 914 SS=F | Electrical Systems - Maintenance and Testing<br>CFR(s): NFPA 101 | K 914 | | 5/23/24 |

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| K 914 | Continued From page 7<br>Electrical Systems - Maintenance and Testing<br>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.<br>6.3.4 (NFPA 99)<br>This REQUIREMENT is not met as evidenced by:<br>Based on a review of available documentation and staff interview, the facility failed to conduct the electrical testing and maintenance per NFPA 99 Standards for Health Care Facilities 2012 edition, section 6.3.3.2 , 6.3.4.1.3, and 6.3.4.2.1.2. This deficient finding could have a widespread impact on the residents within the facility.<br><br>Findings include:<br><br>On 05/21/2024 between 08:30 AM and 10:45 AM, it was revealed by a review of available documentation that at the time of the survey the facility could not provide documentation showing that they have tested the electrical receptacles in | K 914 | Deficiency (electrical systems)- All electrical receptacles tested and recorded in book by 5/23/2024. Annual Preventative Maintenance order was created to ensure testing is not missed | |

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| K 914 | Continued From page 8<br>resident rooms.<br><br>An interview with the Maintenance Director verified this deficient finding at the time of discovery. | K 914 | | |
| K 918<br>SS=F | Electrical Systems - Essential Electric Syste<br>CFR(s): NFPA 101<br><br>Electrical Systems - Essential Electric System Maintenance and Testing<br>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.<br>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 | K 918 | | 5/29/24 |

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| K 918 | Continued From page 9<br>installations.<br>6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70)<br>This REQUIREMENT is not met as evidenced by:<br>Based on a review of available documentation and staff interview, the facility failed to maintain the emergency generator per NFPA 99 (2012 edition), Health Care Facilities Code, section 6.4.4.1.1.3, and NFPA 110 (2010 edition), Standard for Emergency and Standby Power Systems, sections 8.4.9, 8.4.9.1, 8.4.9.2, 8.4.9.5.3, and 8.4.9.7. This deficient finding could have a widespread impact on the residents within the facility.<br><br>Findings include:<br><br>On 05/21/2024 between 8:30 and 10:45 AM, it was revealed by a review of available documentation that at the time of the survey the facility could not provide documentation showing a four (4) hour load bank test has been completed within the last 36 months.<br><br>An interview with the Maintenance Director verified this deficient finding at the time of discovery. | K 918 | Deficiency (4hr Generator Test)- Ziegler preformed the 4hr load test on 5/29/2024. Ziegler had made a mistake and preformed a 2hr load test earlier in the year. These tests are on contract and scheduled annually. Compliance date: 05/29/24 | |