Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
August 10, 2023

Administrator
Cuyuna Regional Medical Center
320 East Main Street
Crosby, MN 56441

RE: CCN: 245232
Cycle Start Date: July 19, 2023

Dear Administrator:

On July 19, 2023, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

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

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

DEPARTMENT CONTACT

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

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

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

If substantial compliance with the regulations is not verified by October 19, 2023 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by January 19, 2024 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

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

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

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

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

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

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

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

Travis Z. Ahrens
Interim State Fire Safety Supervisor
Health Care & Correctional Facilities/Explosives
MN Department of Public Safety-Fire Marshal Division
445 Minnesota St., Suite 145
St. Paul, MN 55101
Cell: 1-507-308-4189

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing
Minnesota Department of Health
Health Regulation Division
Telephone: (651) 201-4112
Email: Kamala.Fiske-Downing@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245232	A. BUILDING ______ B. WING ______	C 07/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CUYUNA REGIONAL MEDICAL CENTER	**320 EAST MAIN STREET CROSBY, MN 56441**

(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 7/17/23 through 7/19/23, a survey for compliance with Appendix Z, Emergency Preparedness Requirements, §483.73(b)(6) 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 7/17/23 through 7/19/23, 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: H52323542C (MN85488), H52323511C (MN91306) & (MN91428), and H52323434C (MN91603) 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 883	Influenza and Pneumococcal Immunizations	F 883		8/25/23

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 08/11/2023

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 883 SS=E	Continued From page 1 CFR(s): 483.80(d)(1)(2) §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (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; (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; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. §483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (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; (ii) Each resident is offered a pneumococcal	F 883		

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F 883 Continued From page 2

immunization, unless the immunization is medically contraindicated or the resident has already been immunized;
(iii) The resident or the resident's representative has the opportunity to refuse immunization; and
(iv)The resident's medical record includes documentation that indicates, at a minimum, the following:
(A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and
(B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal.
This REQUIREMENT is not met as evidenced by:
Based on interview and document review, the facility failed to provide pneumococcal conjugate vaccine 20 variant (PVC20) education as directed by the Centers for Disease Control (CDC) for 5 of 5 residents (R11, R28, R36, R37, R42) reviewed for immunizations.

Findings include:

R11's quarterly Minimum Data Set (MDS) dated 6/28/23, identified a diagnosis of congestive heart failure. R11's immunization record dated 7/19/23, identified R11 received the pneumococcal 23 (PPSV23) on 10/23/14 and the pneumococcal conjugate vaccine 13 variant (PCV13) on 1/04/16. R11's medical record failed to provide evidence the PCV20 (pneumonia immunization) was offered and/or education was provided in conjunction with the provider to R11/R11's representative.

F 883

Cuyuna Regional Medical Center strives to offer and provide our residents and/or their representatives education on the risks and benefits of immunizations, per CDC guidance, including the pneumococcal vaccination PCV20. Procedures are in place to ensure pneumococcal vaccinations are offered to all eligible residents, including education on the benefits of vaccination, any potential side effects and other pertinent risks associated with receiving the PCV20.

The facility procedure Care Center Pneumococcal Immunizations for Residents was reviewed by the Director of Nursing and the Infection Preventionist on August 10, 2023. The procedure was revised to include guidance for nurses on the specific type of pneumococcal

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F 883	Continued From page 3 R28's quarterly Minimum Data Set (MDS) dated 4/20/23, identified diagnoses of anemia (low blood count) and hypertension (high blood pressure). R28's immunization record from 7/19/23, identified R28 received PPSV23 on 2/4/15, and the PCV13 on 11/11/14. R28's medical record failed to provide evidence the PCV20 was offered and/or education was provided in conjunction with the provider to R28/R28's representative. R36's quarterly Minimum Data Set (MDS) dated 4/13/23, identified a diagnoses of Parkinson's disease, heart valve replacement, and pulmonary (lung) nodule. R36's immunization record dated 7/19/23, identified R36 received the PPSV23 on 11/12/02, and the PCV13 on 9/29/17. R36's medical record failed to provide evidence the PCV20 was offered and education was provided in conjunction with the provider to R36/R36's representative. R37's quarterly Minimum Data Set (MDS) dated 5/24/23, identified a diagnosis of anorexia (not eating enough). R37's immunization record dated 7/19/23 identified R37 had not received a PPSV23 or a PCV13 and education was not given by the facility. Further, R37's medical record failed to provide evidence the PCV20 was offered and education was provided in conjunction with the provider to R37/R37's representative. R42's quarterly Minimum Data Set (MDS) dated 5/16/23, identified a diagnosis of respiratory failure (unable to breath). R42's immunization records dated 7/19/23, identified R42 received the PPSV23 on 10/11/04, and the PCV13 on 12/9/16. R42's medical record failed to provide	F 883	vaccination to offer, based on clinic record review of the resident's current pneumococcal immunization status and recommendations from CDC. New educational handout (Pneumonia Disease and Pneumococcal Vaccine Information) was developed by the Infection Preventionist to be utilized when offering and educating residents and/or resident representatives on the pneumococcal vaccination. The Vaccine Information Statement (VIS) for Pneumococcal Conjugate (dated 5/12/23) is also provided at time of vaccine administration. Immunization status of all the facility residents was reviewed by the Infection Preventionist to determine eligibility for PCV20. Shared clinical decision making between the provider and the Infection Preventionist will be completed on individual resident case-by case basis. Provider orders will be obtained for each resident determined eligible, and with consent for PCV20 on file. R11 was offered the PCV20 vaccination on August 8, 2023. The education was provided to R11 on benefits and risks of the PCV20 vaccination. R11 declined the PCV20 vaccination. The resident representative for R37 was offered the PCV20 vaccination on August 10, 2023, including education on the benefits and risks of PCV20. The resident representative for R37 declined the	

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F 883	Continued From page 4 evidence the PCV20 was offered and education was provided in conjunction with the provider to R42/R42's representative. During an interview on 7/18/23 at 3:30 p.m., registered nurse (RN)-B stated she worked with the residents and tracked the immunizations they received. When residents were admitted to the facility their immunization record was reviewed and education was provided to the residents about the PCV 20. The residents who were in the facility prior to May 2023, were not offered the PCV 20 and no education was provided. During an interview on 7/19/23 at 3:29 p.m., the director of nursing (DON) stated it was expected the recommendations from the CDC were followed. The facility policy Pneumococcal Immunizations for Residents dated 4/28/23, identified the residents would have every opportunity to receive the recommended vaccine. The CDC guidance dated 2/9/23, identified "adults 65 and older have the option to get PCV20."	F 883	PCV20 following education and has historically declined pneumococcal vaccinations offered in the past. The resident representative for R28 was offered the PCV20 vaccination, including education on the benefits and risks of PCV20R28. The resident representative consented for the PCV vaccination. The resident representative for R36 was offered the PCV20 vaccination on August 10, 2023, including education on the benefits and risks of PCV20R28. The resident representative consented for the PCV vaccination. R42 was offered the PCV20 vaccination by on August 8, 2023. The education was provided to R42 on benefits and risks of the PCV20 vaccination. R42 consented the PCV20 vaccination. PCV20 will be offered to all eligible facility residents, and/or their representatives, including education on benefits and risks of receiving the PCV20 vaccination. The facility is planning to offer vaccination clinic for all eligible residents the week of August 21, 2023. All residents not currently eligible for the PCV20 will be tracked by Infection Preventionist on the new pneumococcal vaccine matrix. The matrix will be reviewed during the Care Center’s monthly QAPI meeting for residents meeting eligibility requirements.	

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F 883	Continued From page 5	F 883	Education will be provided to Care Center nurses on the PCV20 vaccination and the revised Care Center Pneumococcal immunization procedure, including changes to the Pneumococcal consent form during team huddles the week of August 14 to August 21, 2023. Audits will be conducted weekly for 1 month (or until compliance is achieved) for all new resident admissions, to determine if the resident was offered the PCV20 vaccination, including education on benefits and risks of PVC20. If compliance is achieved, further audits will be conducted monthly for 2 months. Results of the audits will be reviewed during the facility's quarterly QAPI meeting for further recommendations.	

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	245232	A. BUILDING **02 - 2007 DAYROOM** B. WING ______	**07/19/2023**

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K 000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety recertification survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 07/19/2023. At the time of this survey, Cuyuna Regional Medical Center was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: IF PARTICIPATING IN THE E-POC PROCESS, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED.	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		08/11/2023

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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. Cuyuna Regional Medical Center is a 1-story building with a basement. The original building was constructed in 1962, attached to a hospital, separated with a 2-hour fire-rated barrier, and was determined to be of Type II (000) construction. The major addition was constructed east of the existing building in 1982 was determined to be of Type II (000) construction with additions to the main entrance area (dining room) and south wing (dayroom) in 1996 of Type II (111) construction. In 2007 a 10 foot by 30-foot	K 000		

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K 000	Continued From page 2 dayroom addition was constructed to the northwest wing, was determined to be Type II (111) construction, and separated with a 2-hour fire barrier. The building is divided into seven smoke compartments by 30 minute and 2- hour fire barriers. The entire building is protected with a complete automatic fire sprinkler system and has a fire alarm system with smoke detection throughout the corridor system, in common areas, and in the hazardous areas that is monitored for automatic fire department notification. The facility has a capacity of 54 beds and had a census of 49 at the time of the survey. The requirements at 42 CFR, Subpart 483.70(a), are NOT MET as evidenced by:	K 000		
K 281 SS=F	Illumination of Means of Egress CFR(s): NFPA 101 Illumination of Means of Egress Illumination of means of egress, including exit discharge, is arranged in accordance with 7.8 and shall be either continuously in operation or capable of automatic operation without manual intervention. 18.2.8, 19.2.8 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview the facility failed to provide the level of lighting as required by the Life Safety Code, (NFPA 101) 2012 edition section 7.8.1.4. This deficient finding could have an isolated impact on the residents within the facility.	K 281	All care center emergency exits will be inspected by the administrator with the assistance of the maintenance staff to ensure exterior lighting has more than one fixture for illumination and are not single units. The emergency exit identified on	8/25/23

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K 281	Continued From page 3 Findings include: On 07/19/2023 between 9:00am and 1:00pm, it was revealed by observation that the exterior lights for door the emergency exits are equipped with only one light. Emergency exits require illumination to be arranged so that the failure of any single lighting unit does not result in an illumination level of less than 0.2 ft-candle (2.2 lux) in any designated area. An interview with the Maintenance staff and Facility Administrator verified these deficient findings at the time of discovery.	K 281	7/19/2023 and referenced in the findings will have an additional light fixture installed, so that the emergency exit has two units that provide illumination. This work will be completed before 8/25/23.	
K 353 SS=D	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____________________ b) Who provided system test ____________________________ c) Water system supply source __________________________ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced	K 353		8/25/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245232	A. BUILDING **02 - 2007 DAYROOM** B. WING ___	**07/19/2023**

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K 353	Continued From page 4 by: Based on a review of available documentation 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, section 5.1.1.2. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 07/19/2023 between 9:00am and 1:00pm, it was revealed by a review of available documentation the facility failed to provide documentation that indicated when annual and quarterly test was preformed. An interview with the Maintenance staff and Facility Administrator verified these deficient findings at the time of discovery.	K 353	Fire sprinkler testing will be done annually and quarterly. The documentation will reflect whether the testing performed is an annual or quarterly inspection and clearly marked on the inspection report. Proper maintenance personnel will communicate this with the inspector and all appropriate forms will be updated to differentiate quarterly and annual testing.	
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)	K 372		8/25/23

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K 372	Continued From page 5 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: On 07/19/2023 between 9:00am and 1:00pm, it was revealed by observation that there was a penetration running from one smoke compartment to another above doors FD-1020, FD-1022 and FD-2032 An interview with the Maintenance staff and Facility Administrator verified these deficient findings at the time of discovery.	K 372	All smoke barriers in the care center will be inspected by a maintenance technician for penetrations. Any penetrations in the smoke barriers will be properly filled with a NFPA 101 approved material. This work will be completed before 8/25/23.	
K 712 SS=D	Fire Drills CFR(s): NFPA 101 Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 This REQUIREMENT is not met as evidenced	K 712		8/25/23

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K 712	Continued From page 6 by: Based on a review of available documentation and staff interview, the facility failed to conduct fire drills under varied times and conditions per NFPA 101 (2012 edition), Life Safety Code, sections 19.7.1.6, 4.7.4, and 4.6.1.1. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 07/19/2023 between 9:00am and 1:00pm, it was revealed by a review of available documentation that the second shift, fourth quarter fire drills were not completed. Documentation showed that second shift ended at 10:30pm and the fire drill did not occur until 11:00pm. An interview with the Maintenance staff and Facility Administrator verified these deficient findings at the time of discovery.	K 712	The appropriate maintenance personnel will be educated on fire drill compliance and the first, second and third shifts times at the care center. The maintenance director will audit the fire drill logs and documentation for 2 quarters ending 12/31/23 to ensure fire drills are being completed on the correct shifts.	