South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	10771	A. BUILDING: _____ B. WING _____	C 10/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FAIRMONT GRAND SENIOR CARE	405 E FAIRLANE DRIVE RAPID CITY, SD 57701

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	Compliance Statement A complaint survey for compliance with the Administrative Rules of South Dakota, Article 44:70, Assisted Living Centers, requirements for assisted living centers, was conducted on 10/17/23. The area surveyed was accidents. Fairmont Grand Senior Care was found not in compliance with the following requirements: S017 and S838.	S 000		
S 017	44:70:01:05(6) Acceptance and retention of residents The facility may accept or retain residents in accordance with the services provided, determined by the governing body and with written policies and procedures for the following: (6) An assisted living center may admit and retain any resident who is able to: (a) Complete activities of daily living of mobility or ambulation, dressing, toileting, including the provision of incontinence, catheter, or ostomy care, personal hygiene, and bathing independently or with assist of staff. Assistance may be provided according to the provisions of §44:70:05:06; (b) Feed self with set up or supervision. Assistance may be provided according to the provisions of §44:70:06:16; (c) Complete own medication administration including injections or have medications administered by qualified personnel; (d) Remain free from the need for restraints, except for admission to a memory care unit; (e) Receive skilled services that may be provided by the assisted living licensed nurse, Medicare certified home health agency personnel, or a Medicare certified hospice provider; and;	S 017	S017 1. Unable to correct prior noncompliance. Resident #1 has been discharged from the facility and DON B. is no longer employed by the facility. ED/LPN and DON from sister facility will be responsible for nursing oversight until permanent placement has been secured. Both parties have been educated on deficiencies and POC expectations. 2.All residents have the potential to be affected by this deficient practice. 3.All staff will be educated on Fall Policy including mandatory documentation process at all staff meeting on 11/28. 4.ED/HR Manager or designee will review all resident LOC needs and Service Plans for accuracy and staff have/will be educated where to locate Service Plan to review the resident's current assistance needs. Staff will be notified on shift report and/or PCC Dashboard of changes When resident has change in condition and LOC needs are adjusted these changes will be relayed to staff as stated above. The staff will be educated on the process and where to find the information at the all staff meeting 11/27. This training will be included in new hire training packets. All trainings will be documented and signed to ensure staff have appropriate education. 5. ED/HR manager or designee will ensure all staff receive education on assistance required for ADL's which are documented on Service Plan and where to find the current information. This training will be included in new hire training packets. All trainings will be documented and signed to ensure all staff have appropriate documentation. 6.ED or designee will audit all current staff members files monthly to ensure all needed trainings have been completed. Results of employee file audit will be presented to QAPI monthly for 3 months. 7.ED or designee will audit 3 different resident service plans for accuracy of LOC needs weekly x4 weeks, then monthly x3 months, and monthly thereafter until substantial compliance is met. 8.The results of these audits will be brought to the QA committee monthly for their review and compliance monthly for 3 months.	12/1/2023

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Lisa Maciejewski

TITLE: Executive Director

(X6) DATE: 11/20/2023

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S 017	Continued From page 1 (f) Maintain conditions that are stable and controlled that do not require frequent nursing care or frequent visits or notifications to a physician, physician assistant, or nurse practitioner. This Administrative Rule of South Dakota is not met as evidenced by: Based on interview, record review, and policy review, the provider failed to ensure one of one sampled resident (1) who was dependent on staff for activities that of daily living (ADLs) that included showering was provided the necessary care and services to meet those needs. Findings include: 1. Review of resident 1's care record revealed: *His diagnoses included: polyosteoarthritis, macular degeneration, sciatica, chronic obstructive pulmonary disease, Meniere's disease, restless legs syndrome, repeated falls, adult failure to thrive, iron deficient anemia, and nicotine dependence. *He was hospitalized from 5/10/23 through 8/4/23 for treatment of cellulitis and a buttock abscess. -He returned to the assisted living center (ALC) on 8/4/23 after that extended hospital stay. Interview on 10/17/23 at 1:00 p.m. with director of nursing (DON) B revealed: *She and registered nurse (RN) C had assessed resident 1 in the hospital prior to his 8/4/23 hospital discharge. -He had been reluctant to get out of bed for DON B and RN C during that hospital visit but they were able to observe his mobility at that time. *Resident 1 required post-hospital physical therapy rehabilitation in a nursing home or from a	S 017		

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S 017	Continued From page 2 home health agency at the ALC after his previous hospital stays. -Neither of those options were ordered or requested at the time of resident 1's hospital discharge on 8/4/23. *DON B had known after resident 1 returned to the ALC on 8/4/23 from his hospitalization that he required increased staff assistance and supervision to complete his ADLs. -No accommodations had been implemented at the ALC to ensure he had received safe and appropriate care after his hospital discharge back to the ALC. Continued review of resident 1's care record revealed: *An 8/10/23 progress note: "Resident cannot ambulate or transfer on his own. Staff is unclear on what to do with him as far as lifting him (dead weight)." *An 8/11/23 primary medical care provider on-site visit progress note included: -The visit had been requested by nursing staff and the resident's chief complaint was pain and weakness. -"RN tells me she evaluated him in the hospital and he didn't want to get up, but she made him walk around the facility. He then did it without much problem. He has refused to be that active after returning to [the ALC]." "RN reports being frustrated by his behavioral choices, as this is exactly how he acted prior to hospitalization. He has also reportedly defecated in his trousers. Doesn't want to get up out of his wheelchair." *An 8/13/23 Emergency Department (ED) After Visit Summary indicated resident 1 had been sent to the ED for an assessment and treatment of his complaints of back pain. Home health occupational therapy and physical therapy evaluations were ordered.	S 017		

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S 017	Continued From page 3 *An 8/13/23 progress note: "Resident returned from ED; He is scheduled to start PT [physical therapy] next week, until then, reported from hospital that he is currently an assist X2" [required the help of two staff to meet his care needs]. *An 8/15/23 progress note: "Resident was c/o [complaining of] pain in right hip and leg lower right side of his back stated he had fallen in shower last night nothing was reported by previous shift. Resident screaming and hollering in pain any time we tried to push him in wheelchair or do any transfers non emergent [ambulance] was called and resident was transported to [name of the hospital] @ 1000." -He was admitted to the hospital at that time and has not returned to the ALC. Interview on 10/17/23 at 1:45 p.m. with certified nurse aide (CNA)/unlicensed medication aide (UMA) E revealed: *She was not scheduled to work but "helped out" on the evening shift (2:00 p.m. to 10:00 p.m.) staff on 8/14/23. *Resident 1 had become more incontinent of his bowel and bladder after he had returned from the hospital on 8/4/23 and needed more showers than he was regularly scheduled to receive. *She had assisted him with an extra shower on the evening of 8/14/23. -It had taken her "30 minutes or more to transfer [resident 1] from his wheelchair to the shower chair" the evening of his fall on 8/14/23. *She remained with resident 1 throughout his time in the shower until she left work prior to resident 1's shower having been completed. -Resident 1 was still in the shower at that time she "handed his care off" to licensed practical nurse (LPN) D.	S 017		

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S 017	Continued From page 4 Interview on 10/17/23 at 2:00 p.m. with LPN D regarding resident 1's 8/14/23 fall revealed: *He had worked the evening shift on 8/14/23 and had "floated" between the three buildings during that time. *He had "peeked in on resident 1" after CNA/CMA E had reported off to him that she was leaving work. -That had meant he verbally asked resident 1 if he was "okay" while he was in the shower. *He had not visibly seen resident 1 in the shower room during that verbal interaction or for the remainder of his shift which had ended on or about 10:00 p.m. *He had not known who or if anyone had supervised and assisted resident 1 in the shower after CNA/UMA E had left her shift but he had known resident 1 had required more help with his ADLs since he had returned from the hospital. *He presumed resident 1 had reported his fall to CNA F since she was scheduled to have worked the overnight shift on 8/14/23 through 8/15/23. -He had not known if the fall had occurred while he was still working on 8/14/23 but no fall had been reported to him prior to leaving his shift on or around 10:00 p.m. on 8/14/23. *One staff person was scheduled to work the overnight shift in that building. -An additional staff person was also scheduled and if available was expected to have "floated" between all three ALC buildings on the overnight shift. Interview on 10/17/23 at 2:15 p.m. with administrator A and DON B revealed: *They both had known about resident 1's needs for increased staff assistance to have completed his ADLs prior to his hospital discharge and return to the ALC. *It was their responsibility to ensure:	S 017		

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S 017	Continued From page 5 -To communicate with staff if a resident's need for support and supervision had changed and to educate them regarding the expectations of meeting the resident's needs. -To ensure the appropriate level of care and recommended staff support was provided following resident 1's hospital discharge on 8/4/23 back to the ALC including during his shower on 8/14/23. -To ensure additional interventions and staff assistance that might have prevented an unwitnessed fall from having occurred on 8/14/23. -To implement processes to ensure staff had not left resident 1 unattended while in the shower due to his increased ADL needs. *DON B had been employed for about two weeks when resident 1's fall occurred on 8/14/23. -Administrator A was responsible for ensuring DON B had sufficient training, oversight, and supervision to successfully complete her job responsibilities. Refer to S838.	S 017	S838 1. Unable to correct prior noncompliance. Resident #1 has been discharged from the facility and DON B. is no longer employed by the facility. ED/LPN and DON from sister facility will be responsible for nursing oversight until permanent placement has been secured. Both parties have been educated on deficiencies and POC expectations. 2. ED/ Interim DON or designee will implement new MD orders, hospital return orders and LOC changes and relay information to staff utilizing shift reports and/or PCC Dashboard. Changes and implementation will occur immediately upon readmission from hospital and at start of shift for LOC changes. Audit or readmission orders and LOC changes will occur monthly for 3 months and reported to QAPI committee. 3. ED/HR Manager or designees will ensure adequate staffing are available to maintain a safe care environment utilizing our facilities internal staffing matrix. Audit of the staffing matrix will be completed weekly for 4 weeks, then monthly for 3 months. Audit findings will be presented monthly to QAPI committee for review and compliance. 4.ED/ HR manager or designee will ensure all staff receive proper training on Accident Prevention and Safety Procedure. Education will take place at all staff meeting on 11/28. Education will also be added to new hire training packets. 5. ED/ HR Manager or designee will ensure All staff receive education on proper incident reporting and documentation. Education will take place at all staff meeting 11/28. Education will also be added to new hire training packets. 6. ED /HR Manager or designee will ensure all staff receive education on Elder Abuse and Neglect Policy, How and when to report suspected abuse or neglect. Education will take place at all staff meeting 11/28. Education will also be added to new hire training packets. 7. ED HR Manager or designee will ensure all staff receive education on Fall Policy. Education will take place at all staff meeting on 11/28. Education will also be added to new hire training packets. 8.ED or designee will audit all residents service plans for accuracy of current level of assistance needs for ADL's. 9. All staff education will be documented and signed to ensure all staff have received proper education. 8.ED or designee will perform an audit of all current staff members files will to ensure all trainings have been completed. Results of the audit will be reviewed by QAPI committee monthly x 3 months for compliance. 9. ED or designee will perform audit of 3 different resident service plans weekly for accuracy of LOC needs weekly x4 weeks, then monthly x3 months, and monthly thereafter until substantial compliance is met. The results of these audits will be brought to the QA committee monthly for their review for 3 months for compliance.	
S 838	44:70:09:09(4) Quality of Life A facility shall provide care and an environment that contributes to the resident's quality of life, including: (4) Freedom from verbal, sexual, physical, and mental abuse and from involuntary seclusion, neglect, or exploitation imposed by anyone, and theft of personal property. This Administrative Rule of South Dakota is not met as evidenced by: Based on observation, interview, record review, review of the South Dakota Department of Health	S 838		12/1/2023

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S 838	Continued From page 6 (SD-DOH) Required Healthcare Facility Event Reporting form, review of the provider's required staff in-service and training packet, and policy review, the provider failed to ensure resident neglect had not occurred for one of one sampled resident (1) related to the identified quality of care and quality of life concerns below. Those concerns included failing to: *Ensure staff had been made aware of and had provided the required level of care for resident 1 whose care needs had increased following a hospitalization. *Ensure sufficient staff were available to maintain a safe care environment for resident 1 related to his care needs. *Follow the provider's Fall policy after resident 1 had an unwitnessed fall. *Ensure administrator A effectively managed the overall operations of the facility to ensure appropriate and safe resident care for all residents. Findings include: 1. Review of resident 1's care record revealed: *His diagnoses included: polyosteoarthritis, macular degeneration, sciatica, chronic obstructive pulmonary disease, Meniere's disease, restless legs syndrome, repeated falls, adult failure to thrive, iron deficient anemia, and nicotine dependence. *He was hospitalized from 5/10/23 through 8/4/23 for treatment of cellulitis and a buttock abscess. -He returned to the assisted living center (ALC) on 8/4/23 after that extended hospital stay. Interview on 10/17/23 at 1:00 p.m. with director of nursing (DON) B revealed: *She and registered nurse (RN) C had assessed resident 1 in the hospital prior to his 8/4/23 hospital discharge.	S 838	10.ED/Interim DON or Designee will review all incident reports and documentation for completion and accuracy. All reports will be reviewed weekly for 4 weeks, then monthly for 3 months and monthly thereafter until substantial compliance is met. Results of these audits will be brought to QAPI Commitee monthly for their review for 3 months for compliance.	

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S 838	Continued From page 7 -He had been reluctant to get out of bed for DON B and RN C during that hospital visit but they had been able to observe his mobility at that time. *Resident 1 had required post-hospital physical rehabilitation in a nursing home or from a home health agency at the ALC after previous hospital stays. -Neither of those options had been ordered or were requested to have been ordered at the time of resident 1's hospital discharge. *DON B had known after resident 1 returned to the ALC from his hospitalization that he required increased staff assistance and supervision to complete his activities of daily living. -No accommodations had been implemented to have ensured he had received safe and appropriate care post-hospital discharge. Continued review of resident 1's care record revealed: *His care plan last reviewed on 6/27/22 revealed the goal: "Will be able to meet bathing needs with standby or set up assistance." Date initiated: 12/15/21. A 4/3/23 revised intervention: "Staff will remain with resident and give assistance requested by resident." *An 8/4/23 progress note: Resident 1 had returned to the ALC at 11:00 a.m. on that date from the hospital. "Resident was able to walk from the van to his room." *An 8/4/23 admission progress note: "Resident is independent with 2 wheeled walker with ambulation and transfer." *An 8/4/23 Fall Risk Evaluation had been completed for resident 1 by RN C: -His fall risk score was "6" which indicated he was at minimal risk for falling. -The following factors had not been accounted for in that evaluation which would have increased resident 1's fall risk score and placed him at a	S 838		

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S 838	Continued From page 8 higher risk for falls: --The use of a scheduled laxative that was ordered at the time of his hospital discharge. --His fall history. *An 8/10/23 progress note: "Resident cannot ambulate or transfer on his own. Staff is unclear on what to do with him as far as lifting him (dead weight)." *An 8/11/23 primary medical care provider on-site visit progress note: -The visit had been requested by nursing staff and the resident's chief complaint had been pain and weakness. -"RN tells me she evaluated him in the hospital and he didn't want to get up, but she made him walk around the facility. He then did it without much problem. He has refused to be that active after returning to [the ALC]." "RN reports being frustrated by his behavioral choices, as this is exactly how he acted prior to hospitalization. He has also reportedly defecated in his trousers. Doesn't want to get up out of his wheelchair." *An 8/13/23 Emergency Department (ED) After Visit Summary: Resident 1 had been sent to the ED for an assessment and treatment of his complaints of back pain. Home health occupational and physical therapy had been ordered. *An 8/13/23 progress note: "Resident returned from ED; He is scheduled to start PT [physical therapy] next week, until then, reported from hospital that he is currently an assist X2 [required the help of two staff to meet his care needs]." *An 8/15/23 progress note: "Resident was c/o [complaining of] pain in right hip and leg lower right side of his back stated he had fallen in shower last night nothing was reported by previous shift. Resident screaming and hollering in pain any time we tried to push him in wheelchair or do any transfers non emergent	S 838		

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S 838	Continued From page 9 [ambulance] was called and resident was transported to [the hospital] @ 1000." -Resident 1 was admitted to the hospital on 8/15/23 after that ED visit and had not returned to the ALC. *There was no documentation found in his care record for the following: the circumstances of the 8/14/23 fall, medical provider/nursing staff/resident representative notification of the 8/14/23 fall, a post-fall resident assessment, post-fall monitoring of the resident, or any interventions that were put in place to mitigate the resident's chances of falling again. Interview on 10/17/23 at 1:30 p.m. with administrator A and DON B regarding resident 1's falls revealed: *The DON or a nurse was expected to have been notified immediately after resident 1 had reported his fall to staff. -They were responsible for assessing him and/or providing guidance to unlicensed staff regarding documentation of that fall and post-fall monitoring responsibilities. *Resident 1's 8/14/23 fall had not been reported to administrator A or DON B until 8/15/23. -Neither administrator A nor DON B had identified what staff person resident 1 had reported his fall to or had interviewed that staff person about the fall. *Staff who had witnessed a resident fall or to whom an unwitnessed fall had been reported were expected to have initiated the completion of an Incident Report form that included spaces to have documented the following: -Immediate post-fall and 30-minute post-fall vital signs. -Extremity movement limitations post-fall. -Assessment of the resident's mentation post-fall. -A summary of the incident and an injury	S 838		

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description.
-Notifications to the DON, physician, and the resident's representative.
-If the resident's condition was stable and if emergency services were contacted.
*The completed Incident Report was expected to have been reviewed by DON B for any further required investigation and to ensure appropriate interventions were implemented to mitigate the chance of another fall having occurred.
*DON B had been unable to remember if an Incident Report was completed after resident 1's 8/14/23 fall but administrator A had thought one had been completed.
-A copy of the 8/14/23 Incident Report was requested at the time of the interview from administrator A and DON B but it had not been provided by the end of the survey on 8/17/23 at 3:30 p.m.

Interview on 10/17/23 at 1:45 p.m. with certified nurse aide (CNA)/unlicensed medication aide (UMA) E revealed:
*She had not been scheduled to work but "helped out" the evening shift (2:00 p.m. to 10:00 p.m.) staff on 8/14/23.
*Resident 1 had become more incontinent of his bowel and bladder after he had returned from the hospital on 8/4/23 and had needed more showers than he was regularly scheduled to have received.
-He had required additional staff supervision and assistance with other ADLs since he had returned from the hospital on 8/4/23.
*She had assisted him with an extra shower that evening.
-It had taken her "30 minutes or more to transfer [resident 1] from his wheelchair to the shower chair" the evening of his fall.
*She remained with resident 1 throughout his

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S 838	Continued From page 11	S 838		

time in the shower until she "handed his care off" to licensed practical nurse (LPN) D before leaving work that evening.
-She presumed LPN D would have remained in the shower room with resident 1 to have observed and helped him complete his shower after she had left.
*CNA F had been scheduled to work the overnight shift (8/14/23-8/15/23).
-A second staff person was also scheduled and if available had "floated" between all three buildings during the overnight shift.

Interview on 10/17/23 at 2:00 p.m. with LPN D regarding resident 1's fall revealed he:
*Had worked the evening shift on 8/14/23 and "floated" between the three buildings during that time.
*"Peeked in on resident 1" after CNA/CMA E had reported off to him that she was leaving work.
-That had meant he verbally asked resident 1 if he was "okay" while he was in the shower.
*He had not visibly seen resident 1 in the shower room during that verbal interaction or for the remainder of his shift which had ended on or about 10:00 p.m.
*He had not known who or if anyone had supervised and assisted resident 1 in the shower after CNA/UMA E had left her shift but he had known resident 1 had required more help with his ADLs since he had returned from the hospital.
-Staff had failed to provide adequate supervision and support for resident 1 during his shower on 8/14/23.
*He presumed resident 1 had reported his fall to CNA F since she was scheduled to have worked the overnight shift on 8/14/23 through 8/15/23.
-He had not known if the fall had occurred while he was still working on 8/14/23 but no fall had been reported to him prior to leaving his shift on

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	10771	A. BUILDING: _____ B. WING _____	C 10/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FAIRMONT GRAND SENIOR CARE	405 E FAIRLANE DRIVE RAPID CITY, SD 57701

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S 838	Continued From page 12 or around 10:00 p.m. on 8/14/23. *One staff person was scheduled to work the overnight shift in that building. -An additional staff person was also scheduled and if available was expected to have "floated" between all three ALC buildings on the overnight shift. Interview on 10/17/23 at 2:15 p.m. with administrator A and DON B regarding the Required Healthcare Facility Event Reporting form submitted to the SD-DOH regarding resident 1's 8/14/23 fall and resident 1's 8/14/23 fall revealed: *DON B completed and submitted that report to the SD-DOH. *DON B had not interviewed resident 1, LPN D, CNA/CMA E or CNA F regarding resident 1's 8/14/23 fall even though all four had direct knowledge about that event. -A thorough investigation of that fall had not occurred. *Neither Administrator A nor DON B had re-educated staff regarding the expectations for the process of reporting a fall, post-fall expectations, or Incident Report completion after it had become apparent that the process had failed. *They knew resident 1 had increased care needs and required increased staff assistance and supervision for his ADLs after he had returned to the ALC on 8/4/23 after his extended hospitalization. They neglected to have: -Ensured staff had known resident 1's level of care had increased since his hospital return. -Identified and implemented interventions in a timely manner to ensure resident 1 had the recommended staff support and supervision he required to meet his increased level of care needs post-hospitalization.	S 838		

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S 838	Continued From page 13 -Identified a root cause and implemented corrective action for resident 1's 8/14/23 unwitnessed fall to mitigate similar falls from occurring for him or another resident with similar circumstances. *DON B had been employed about two weeks when resident 1's fall had occurred. -Administrator A was responsible for ensuring she had sufficient training, oversight, and supervision to have successfully completed her job responsibilities. Review of the Care Team Required Inservice and Training packet revealed: *All staff were required to participate in: *Accident Prevention and Safety Procedures training. -Information specific to that topic revealed: "The most important reason that we ask you to report all injuries is to allow us to arrange for prompt medical treatment ..." "Accidents must be investigated and their causes found to prevent the same injuries from happening again to someone else." *Elder Abuse and Neglect training. -Information specific to that topic revealed: "Elder neglect is the failure to give proper care to a person. To give little attention or respect, to disregard; to leave undone or unattended especially through carelessness. This implies giving insufficient attention to someone or something that merits a person ' s attention." Review of the undated Falls policy revealed the following expectations after a resident fall had occurred: *Caregivers had been instructed to summon immediate assistance from the Administrator or another caregiver. *The resident was expected to have been	S 838		

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S 838	Continued From page 14 evaluated for injury and the need for medical assistance. *"The Administrator instructs caregivers to provide appropriate care and frequent resident checks." *An Incident report was to have been completed "inclusive of the following: details of the event, injuries sustained from the event, factors of the event, witnesses, actions taken, notes and signatures." *"The service plan of the resident should be updated to reflect fall risk and any needed interventions to help minimize further all risk." *"Ongoing falls may require relocation from the community."	S 838		

South Dakota Department of Health

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	10771	A. BUILDING: _____ B. WING _____	R-C 12/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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{S 000}	Compliance Statement An onsite revisit survey for compliance with the Administrative Rules of South Dakota, Article 44:70, Assisted Living Centers, requirements for assisted living centers was conducted on 12/13/23 for deficiencies cited on 10/17/23. All deficiencies have been corrected, and no new noncompliance was found. Fairmont Grand Senior Care is in compliance with all regulations surveyed.	{S 000}		

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