DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435032	A. BUILDING _____ B. WING _____	R 08/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONUMENT HEALTH CUSTER CARE CENTER	1065 MONTGOMERY ST CUSTER, SD 57730

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{F 000}	INITIAL COMMENTS Surveyor: 40053 An onsite revisit health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities, was conducted on 8/23/21. Monument Health Custer Care Center was found not in compliance with the following requirements: F758, F842, F867, and F883.	{F 000}		
{F 758} SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive	{F 758}	The deficiency found in F758 (Free from Unnecessary Psychotropic Meds/PRN Use) for Resident 33 has been corrected on or prior to 9/9/21 by having the resident's attending provider review appropriateness of the PRN psychotropic and determine to discontinue the PRN psychotropic medication. Communication from Provider was conducted by DON or designee. A full review of all residents' orders was completed by the DON and any PRN medication ordered was reviewed and either scheduled or discontinued. A guide to run a report on "listing of residents on psychotropic medications" was provided to the DON. The deficiency related to F758 has the potential to impact all residents with PRN psychotropic medications. By no later than 9/9/21, all residents with PRN psychotropic medications will have their PRN psychotropic medications reviewed by DON, Pharmacy consultant or designee(s). As appropriate, DON or designee will communicate with the attending provider(s) to have the PRN	9/9/21

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Mark C. Sellwood | TITLE: President | (X6) DATE: 9/8/2021

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 758}	Continued From page 1 psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Surveyor: 40053 Based on interview, record review, policy review, and review of the 8/20/21 plan of correction for the 7/1/21 recertification survey, the provider failed to ensure: *A process had been put into place to identify resident's who had an as needed (prn) order for a psychotropic medication. *A physician included in the order a duration of time for a prn psychotropic medication for one of one (33) resident. Findings include: 1. Review of the 8/20/21 plan of correction for the 7/1/21 recertification survey revealed: *"By no later than 8/20/21 all residents with prn psychotropic medications will have their medication reviewed..." *The director of nursing (DON) or designee would	{F 758}	reviewed for discontinuation or to add a duration with a rationale. As appropriate, DON or designee will communicate with the attending provider(s) to have the PRN reviewed for discontinuation or to add a duration with a rationale. Prior to 9/9/21, a process will be implemented to have any PRN psychotropic order that is received to be entered by DON or designee as a reminder on the resident's TAR to notify the physician of need for reassessment. A copy of all orders will be provided to the DON/designee and SS/designee for review of any PRN psychotropic medication ordered. Starting no later than 9/9/21, audit will be conducted by DON or designee on a weekly basis using an audit tool. The audit will include appropriate duration and documentation in medical record for ordering/continuation of PRN psychotropic medications. To conduct the audit, DON or designee will run a weekly psychotropic report out of Point Click Care (PCC), DON or designee will review all PRN psychotropic medications that will have started during the week of the most current audit. Appropriate follow-up with the ordering provider will be conducted by DON or designee to correct any discrepancies between the written order and facility policy.	

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{F 758}	Continued From page 2 run a weekly psychotropic report from Point Click Care and review those orders for compliance. *Communication with the provider will address the need for the medication to be discontinued or to add a duration with a rationale. Interview and review of the psychotropic report on 8/23/21 at 3:10 p.m. with DON B revealed she: *Tried to print the report but was unable. *Stated she had not tried to run the report previously and social services coordinator (SSC) D runs that report on Fridays. *Had not reviewed any of the reports ran by SSC D. *Was unsure of the number of reports that had been run. Interview and review of the psychotropic report on 8/23/21 at 3:30 p.m. with DON B and SSC D revealed: *SSC D produced a psychotropic report. -She went through the instructions to produce the report with DON B. *DON B was still unable to produce that report. *When questioned whether or not all residents receiving prn psychotropic medications were on the report DON B stated "No." *She stated resident 33 was missing from the report. *SSC D stated she had not realized resident 33 was not on the report. *Both acknowledged resident 33 was currently on a prn psychotropic medication and should have been on the report. *Neither DON B nor SSC D knew why the report had not included all residents on prn psychotropic medications. 2. Review of resident 33's treatment	{F 758}	The policy "Antipsychotic/Psychotropic Drugs" was reviewed and no Recommendations for revision. Starting no later than 9/9/21, audit results will be reported by the DON or designee to facility QAPI meeting on a monthly, but no less than quarterly basis. Audits will be continued for a minimum of 3 months, at which point the QAPI committee will determine whether to continue, discontinue, or reduce frequency.	

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{F 758}	Continued From page 3 administration record revealed: *An order for lorazepam tablet 0.5 milligram (mg). -Give 0.5 mg every eight hours as needed for anxiety. *An order for lorazepam tablet 0.5 mg. -Give 1 mg every eight hours as needed for anxiety. *Order date for both medications was 8/21/20. Continued interview with DON B revealed: *She had a conversation with the physician related to the need to schedule the prn lorazepam's for resident 33. -She was unable to produce documentation of that conversation. *She stated the physician had not ordered it to be a scheduled medication or reevaluated resident 33 for the continued use of the lorazepam. *Prn medications needed to be scheduled for no longer than 14 days or a physician needed to reevaluate the resident per the providers policy. Review of the last revised August 2021 Antipsychotic/Psychotropic Drugs Policy revealed: *"4. PRN antipsychotic/psychotropic drugs can only be written for a 14-day time frame. The primary physician is required to reassess the need for ongoing prn antipsychotic/psychotropic drugs every 14 days." *"5. The primary physician is responsible for documenting in the medical record the rationale for continuation beyond the 14 days to include rationale and duration of medication."	{F 758}		
{F 842} SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is	{F 842}	DON immediately corrected the deficiency cited in F842 (Resident Records – Identifiable Information) A relook at the previous process was determined to be unobtainable due to other factors.	9/9/2021

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{F 842}	Continued From page 4 resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical	{F 842}	On 8/27/2021 a separate process was then set into place, Hospice Nurse/designee will meet with DON/Designee on each visit. Hospice will print out the visit progress note and provide to DON/Designee prior to leaving visit. The DON/designee will review the progress notes, document date received, reviewed, and if care plan was updated/revised/appropriate and date the progress notes prior to filing in Hospice binder. The DON/Designee will then document a progress note in resident medical record. All current and future residents are potentially affected by the deficiency regarding: Resident Records-Identifiable Information. All residents receiving Hospice services, to include immediately upon hospice admission and thereafter, the hospice Nurse/designee will hand deliver weekly progress notes to the DON/ designee. These records will be reviewed and integrated into the resident care plan by DON or designee. Once integrated, these records will be filed into the residents Hospice Binder for nursing review by the Heath Unit Clerk (HUC) or designee. The Hospice Agreement was reviewed and no recommendations for changes. The policy "Care plans development/revision-Baseline and comprehensive" was revised to include integration of Hospice care plan into EMR	

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{F 842}	Continued From page 5 record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Surveyor: 40053 Based on interview, record review, and review of the 8/20/21 plan of correction for the 7/1/21 recertification survey, the provider failed to ensure: *A process had been put into place so hospice notes were incorporated into a resident's care plan. *Hospice nurses had been educated on and had access to document progress notes in a resident's electronic medical record (EMR). *Care Plan Timing and Revision Policy had been revised to include integration of hospice care plan's into the EMR and the hospice binder.	{F 842}	and into the Hospice Binder. A copy of this revised care plan will be provided to the nursing staff by no later than 9/9/2021. An audit (audit Tool) was created to focus on the timeliness of filing records into the medical record to include hospice care plan integration for Hospice residents. An audit tool to review the filing of medical records and integration of hospice care plan into the resident chart/facility care plan process will be completed by the Director of Nursing or designee on Hospice Residents (3-5 residents, unless fewer residents are on hospice services) on a weekly basis and results/findings reported to the committee by the DON or designee and will be reviewed in QAPI monthly, but no less than quarterly. These audits will continue for a minimum of 3 months (quarterly QAPI meeting cycles) at which point decision to continue/discontinue/reduce frequency of the audit (audit tool) will be made by the QAPI committee.	

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{F 842}	Continued From page 6 Findings include: 1. Review of the 8/20/21 plan of correction for the 7/1/21 recertification survey revealed: *Hospice progress notes were to have been hand delivered to the director of nursing (DON) or designee. *"These records will be reviewed and integrated into the resident's care plan by the DON or designee." *"Once integrated, these records will be filed into the residents hospice binder for nursing review by the health unit clerk (HUC)." Interview on 8/23/21 at 4:10 p.m. with DON B revealed: *Hospice nurses are now hand-delivering progress notes weekly and given to HUC D. -The progress notes are for the prior week's visit and are one week old by the time they are received at the facility. *HUC D would have placed them into the resident's hospice binder which is kept at the nurses' station. *The hospice nurse also passed on information while at the time of the visit to the charge nurse verbally. Interview on 8/23/21 at 4:35 p.m. with HUC D revealed: *Hospice nurses hand-delivered progress notes weekly. *Those notes were given to the DON. -The notes had not been given directly to her. *The DON reviewed the notes. *The notes were put into the resident's hospice binder by the DON or were given to her to be placed into the binder.	{F 842}		

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{F 842}	Continued From page 7 Interview on 8/23/21 at 4:40 p.m. with DON B related to the above interview with HUC D revealed: *They were not both following or aware of the correct procedure when receiving progress notes from hospice. *There was no way to ensure the hospice notes were being incorporated into a resident's care plan. *DON B could not be sure all information from hospice was being received by all nurses. *She stated "Okay, I need a tighter process." 2. Continued interview and EMR review with DON B regarding hospice documented progress notes revealed: *Hospice nurses were to have documented a progress note into a resident's EMR while at the facility. -That would have been completed for each visit. *All nursing staff would then be able to retrieve and read those progress notes. *There were no progress notes documented by the hospice nurses in the EMR. *She stated she had educated her staff on the new process during an all-staff meeting on 8/18/21. *She had sent emails to her hospice contact to set up a time for educating the hospice nurses. -The last email that had been sent regarding the training was on 8/2/21. *She stated hospice nurses have not been trained on the new EMR progress note documentation. *There had been no date established to complete the training for the hospice nurses. *She agreed that training to hospice nurses had not been followed through or completed.	{F 842}		

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{F 842}	Continued From page 8 3. Interview on 8/23/21 at 5:00 p.m. with DON B related to the revised Care Plan Timing and Revision Policy revealed: *She searched her computer database for the policy. *She stated she had revised it. *She was unable to produce the policy prior to the end of the revisit survey on 8/24/21 at 6:00 p.m.	{F 842}		
F 867 SS=E	QAPI/QAA Improvement Activities CFR(s): 483.75(g)(2)(ii) §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; This REQUIREMENT is not met as evidenced by: Surveyor: 40053 Based on interview and review of the 8/20/21 plan of correction (PoC) for the 7/1/21 recertification survey the provider failed to ensure a form and process for audits had begun on or prior to 8/20/21 for tags F550, F758, and F812. Findings include: 1. Review of the 8/20/21 PoC for the 7/1/21 recertification survey revealed: *"On or prior to 8/20/21 audits would be conducted." *Certified dietary manager F and director of nursing B or designee had been responsible to begin and complete those audits. *Tags F550 and F812 were reviewed for completion based on the PoC and were missing the audits. *F758 was not in compliance with the PoC.	F 867	DON corrected the deficiency cited in F867 (QAPI/QAA Improvement Activities) for Cited tags F550 and F758. Dietary Manager corrected the deficiency for F812 by completing the audit as per POC. All audits for Deficiency in previous POC to include (F550, F758, F812, F842, F849, F883, and F909 were completed and documented for the week of 8/22-28/2021. All audits for deficiencies were reviewed in QAPI with the IDT for appropriateness and approved. An audit (audit tool) will be completed to review completion of current audits listed in the POC for the visits of 7/1 and 8/23/2021 on a weekly basis by the Director of Nursing or designee and results/findings reported to the committee by the DON or designee and will be reviewed in QAPI monthly, but no less than quarterly. These audits will continue for a minimum of 3 months (quarterly QAPI meeting cycles) at which point decision to continue/discontinue/reduce frequency of the audit (audit tool) will be made by the QAPI committee.	9/9/21

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F 867	Continued From page 9 -Refer to F758. Interview on 8/23/21 from 2:00 p.m. through 6:00 p.m. with the director of nursing (DON) B revealed no audits had been started on any of the federal tags from the 7/1/21 survey.	F 867	at which point decision to continue/discontinue/reduce frequency of the audit (audit tool) will be made by the QAPI committee. The QAPI plan was reviewed and no recommendations for revision.	
{F 883} SS=E	Influenza and Pneumococcal Immunizations 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	{F 883}	The deficiency found in F883 (Influenza and Pneumococcal Immunizations) were remedied by DON for Residents 2, 3, 9, 17, and 29. Review of medical records for resident 2, documentation of vaccination completed and placed in flow sheet created. Review of medical records for resident 3, documentation of vaccination completed and placed in flow sheet created. Review of medical records for resident 9, documentation of vaccination completed and placed in flow sheet created. Review of medical records for resident 17, documentation of vaccination completed and placed in flow sheet created. Review of medical records for resident 29, documentation of vaccination completed and placed in flow sheet created. Review of medical records for resident 1, resident signed declination of vaccination. This is noted in her medical record.	9/9/21

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{F 883}	Continued From page 10 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 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: Surveyor: 40053 Based on interview, record review, policy review, and review of the 8/20/21 plan of correction for the 7/1/21 recertification survey, the provider failed to ensure: *Seven of seven randomly sampled residents (1, 2, 3, 9, 17, 27, and 29) had documented pneumonia vaccination administration or refusal in their care records. *A process had been established to identify, track, and monitor residents' pneumonia vaccination status. Findings include:	{F 883}	Review of resident 27's medical record and communication with resident's POA on 7/19/21 determined resident had received the Pneumovax immunization at another facility. These records were requested. Documentation completed in progress notes in resident medical record on 7/19/21 and 8/25/2021 by DON.. All current and future residents are potentially affected by the deficiency regarding: Influenza and Pneumovax immunizations. All residents currently in the facility will have their immunization records reviewed and orders discussed with attending physician no later than 9/9/21. On admission, all residents will be asked immunization status on the nursing admission assessment. A flow sheet was created and is kept up by the DON or designee for tracking prior to 9/9/2021. An audit (audit Tool) was created to focus on the Influenza and Pneumovax immunizations timeliness and documentation in the medical record. An audit (audit tool) will be completed to review the Influenza and Pneumovax immunizations for current and future residents on a weekly basis by the Director of Nursing/designee and results/findings reported to the committee by the DON or designee and will be reviewed in QAPI	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435032	A. BUILDING _____ B. WING _____	R 08/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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{F 883}	Continued From page 11 1. Review of the randomly sampled residents' care records above revealed: *Resident 1's admission date was 5/25/21. *Resident 2's admission date was 12/24/18. *Resident 3's admission date was 12/6/18. *Resident 9's admission date was 8/15/19. *Resident 17's admission date was 11/23/20. *Resident 27's admission date was 2/23/21. *Resident 29's admission date was 10/28/19. *There was no documented pneumonia vaccination administration or refusal in any of the above residents records. Interview and record review on 8/23/21 at 4:25 p.m. with director of nursing (DON) B revealed: *Nursing supervisor C had been put in charge of identifying those residents in need of a pneumonia vaccine and administering them. -She worked part-time. *DON B produced seven pneumococcal immunization consent forms and seven physician signed pneumovax orders she stated she retrieved from nursing supervisor C's office. -Those had been for resident's 1, 2, 3, 9, 17, 27, and 29. *Resident 9 had been the only resident who had filled out and signed her consent form. -It had not been dated. *The other eight consent forms had resident's 1, 2, 3, 17, 27, and 29's names were on them but had not been filled out, signed, or dated. *DON B stated "I hadn't realized the immunizations had not been completed." 2. Continued interview with DON B regarding their process to track immunization status revealed: *She had a flow sheet that she updated with the resident's immunization status. *There was no process in place for her to be	{F 883}	monthly, but no less than quarterly. These audits will continue for a minimum of 3 months (quarterly QAPI meeting cycles) at which point decision to continue/discontinue/reduce frequency of the audit (audit tool) will be made by the QAPI committee.	

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{F 883}	Continued From page 12 notified when a resident had consented to and received an immunization or declined an immunization. *Her expectation for resident's 1, 2,3, 9, 17, 27, and 29 was that the consents for immunization were filled out, signed, and dated, and the Pneumovax would have been administered by now. Review of the October 2019 revised Pneumococcal Vaccination policy revealed: *Guidelines: -"A. Prior to or upon admission, residents will be assessed for eligibility to received the Pneumovax (pneumococcal vaccine), and when indicated, will be offered the vaccination within thirty [30] days of admission to the facility unless medically contraindicated or the resident has already been immunized."	{F 883}		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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	435032	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	R 08/23/2021

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K 000	INITIAL COMMENTS Surveyor: 40053 An onsite revisit survey for compliance with the life safety code (LSC) (2012 existing health care occupancy) was conducted on 8/23/21. Monument Health Custer Care Center was found not in compliance with 42 CFR 483.70 (a) requirements for Long Term Care Facilities. The building will meet the requirements of the 2012 LSC for existing health care occupancies upon correction of the deficiency identified at K712 in conjunction with the provider's commitment to continued compliance with the fire safety standards.	K 000		
K 712 SS=F	Fire Drills CFR(s): NFPA 101 Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 This REQUIREMENT is not met as evidenced by: Surveyor: 40053 Based on observation and interview the provider failed to ensure staff were familiar with the provider's fire drill procedures (RACE Rescue, Alarm, Contain, Extinguish). Findings include:	K 712	The deficiency identified will be corrected by conducting additional training sessions and drills to meet or exceed the minimum requirements, to increase staff knowledge of code red situations. The new employee education training will include a life safety session to focus on code red education. The Basic Fire Instructions form will be updated to cover specific areas of the drills that have been short of the expectation. It will also target specific areas of topic such as, proper evacuation procedure, staff responsibilities and processes. An instructional step by step form will be created for the Charge Nurse to refer to for process improvement.	9/9/2021

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Mark Schmidt | TITLE: President | (X6) DATE: 9/8/2021

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

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K 712	Continued From page 1 1. Observation on 8/23/21 at 2:33 p.m. revealed: *The fire alarm was sounded to initiate a drill for a simulated fire in resident room 101. *A staff member in that corridor at the time of the alarm closed doors as she left the corridor. -Except the doors for resident rooms 102 and 103. *It took the charge nurse at the nurses station approximately seven seconds to correctly use the phone overhead intercom system and then stated there was a fire in room 101. -She had not announced a Condition Red or announced it three times as the facility policy states. *RACE-Rescue, Alarm, and Extinguish were performed correctly. -Containment was not performed per their policy. *The director of nursing then gave guidance to the charge nurse at the nurses station related to: *The need to have sent two more people down that hallway to have evacuated residents and close all corridor doors. *The charge nurse then sent two more staff members down the hall. -Those two staff members reached the hallway after the first two staff members had responded to the fire, performed the closed door check, entered the room, and simulated using the fire extinguisher to extinguish the fire. Interview with the operations manager after the observation confirmed the above findings. The deficiency had the potential to affect 100% of the residents in that smoke compartment.	K 712	An aggregated report will be communicated to the scheduled Safety / QAPI committee (on a monthly not less than quarterly basis) by the Plant Operations Manager or a designee to assure staff can demonstrate the proper techniques and procedures. It shall be the departments leaders responsibility to assure that their staff are attending training sessions and understanding responsibilities. All residents have the potential to be affected by a failure to meet these requirements.	