STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465079	A. BUILDING _____ B. WING _____	02/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNSHINE TERRACE SKILLED NURSING	248 WEST 300 NORTH LOGAN, UT 84321

(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
F 000	INITIAL COMMENTS A Recertification Survey was completed from 02/19/2024 to 02/22/2024. The facility was not in substantial compliance with the requirements of 42 CFR Part 483, Subpart B, for Long Term Care Facilities. Deficiencies were cited for this survey.	F 000		
F 585 SS=E	Grievances CFR(s): 483.10(j)(1)-(4) §483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay. §483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph. §483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident. §483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include: (i) Notifying resident individually or through	F 585 PoC Accepted GB 3/15/2024	585 Grievances 483.10(j)(1)-(4) The following policy and procedure have been and will be implemented and utilized to ensure that the residents have the right to voice grievances to the facility or other agency or entities that hears grievances anonymously and will be given a written response in a timely manner in accordance with the above state regulation. 1. A prominent location has been identified in the facility which will facilitate the ability to submit a grievance anomalously. 2. All grievances will be promptly investigated and will be given a written response. Residents will be notified of any grievance reported anomalously on their behalf and will receive a written response to that grievance. 3. Education will be provided to residents and their representatives in regards to ways grievances can be submitted anonymously.	04/15/2024

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

NHA — ADMINISTRATOR — 3/15/24

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 585	Continued From page 1 postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system; (ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations; (iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated; (iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law;	F 585	Monitor: 1. Monthly audits will be completed to ensure that each grievance submitted was responded to in writing. Date integrated into QA system March 18, 2024 Persons to ensure: SSW and Administrator Compliance Date: April 15, 2024	

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F 585	Continued From page 2 (v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued; (vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision. This REQUIREMENT is not met as evidenced by: Based on interview and facility policy review, the facility failed to ensure the provision of the right to file grievances anonymously. This failure had the potential to impact facility residents who were able to execute their right to file grievances. Findings included: A review of a facility policy titled "Grievances/Complaints, Filing," revised in April 2017, revealed, "5. Grievances and/or complaints may be submitted orally or in writing and may be filed anonymously." The policy revealed, "13. If the grievance was filed anonymously, the grievance officer will inform the resident that a	F 585		

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F 585	Continued From page 3 grievance has been anonymously filed on his or her behalf and the steps that will be taken to investigate the grievance(s) and report the findings." During an interview on 02/22/2024 at 9:35 AM, Social Worker (SW) #5 stated she was the grievance official, and when residents or family members wanted to file a grievance, they would come to her. SW #5 stated she would be notified if a resident or family member wished to file a grievance, and she conducted the investigation, resolved the grievance, and provided a verbal follow-up with whoever filed the grievance. SW #5 stated the grievances were written in a notebook, and the facility did not have a form to file a grievance anonymously. She stated she guessed there was no way to file a grievance anonymously. During an interview on 02/22/2024 at 10:52 AM, the Director of Nursing (DON)/Infection Preventionist (IP) stated that anyone could file grievances. The DON/IP stated grievances were sent to SW #5 and the Administrator. He stated that the grievances were then investigated, and a resolution determined. The DON/IP stated he was unaware of how grievances got filed anonymously and was unsure if there was an official form for filing grievances anonymously. During an interview on 02/22/2024 at 11:05 AM, the Administrator stated the facility did not have a grievance form for filing grievances anonymously. The Administrator stated an anonymous grievance could be typed up and slid under the social worker's door or emailed to the social worker. The Administrator stated SW #5 would follow up with the complainant afterward with an	F 585		

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F 585	Continued From page 4 in-person visit, telephone call, or text.	F 585		
F 609 SS=E	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview, record review, and facility document and policy review, the facility failed to report allegations of abuse within two hours for 2 (Resident #28 and Resident #39) of 2 residents	F 609	F 609 Reporting of Alleged Violations 483.12(b)(5)(i)(A)(B)(c)(1)(4) The following policy and procedure have been and will be implemented and utilized to ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported in accordance with the above regulation. 1. Ongoing education will be provided to all staff in regards to the reporting of alleged violations with specific attention to timeliness. 2. All alleged violations will be reported immediately to the Administrator or designee. Alleged violations will then be reported to the state and local agencies in accordance with the above regulation.	4/15/24

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F 609	Continued From page 5 reviewed for abuse prohibition. Findings included: Review of a facility policy titled, "Abuse Investigating and Reporting" revised in 12/2016, revealed, "All reports of abuse, neglect, exploitation, misappropriation of resident property, mistreatment and/or injuries of unknown source ("abuse") shall be promptly reported to local, state and federal agencies" and "Reporting 2. Suspected abuse, neglect, exploitation or mistreatment (including injuries of unknown source and misappropriation of resident property) will be reported within two hours." Review of a facility policy titled, "Grievances/Complaints -Staff Responsibility," revised in 10/2017, revealed, "Staff members are encouraged to guide residents about where and how to file a grievance and/or complaint when the resident believes that his/her rights have been violated" and "4. Any alleged abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, must be reported to the administrator immediately, but not later than 2 hours after the allegation is made if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury." 1. Review of a quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 01/08/2024, revealed Resident #28 was admitted to the facility on 10/05/2023 with diagnoses including depression, chronic respiratory failure, obstructive sleep apnea, and	F 609	3. All alleged violations will be reviewed monthly in our QA meetings to ensure that our policies and procedures are being followed in accordance with the above regulations specific to timely reporting. 4. A calling tree has been created to ensure that someone will always be available to file a report in the event that the Administrator is unnavigable to ensure that state regulations are being met. 5. Employee training on abuse is mandatory for all staff and will be conducted on hire and every 6 months ongoing. Resident specific: A follow up interview was conducted with resident #28 on 3/14/2024 in regards to her allegation made on 1/16/2024. The resident stated that she has had no further concerns and feels that staff are treating her well. The CNA that was investigated in this allegation is no longer employed with us. A follow up interview was conducted with resident # 39 on 3/14/2024 in regards to her allegations made on 1/27/2024. The resident did not recall the indecent due to her mild cognitive issues but did say that she is happy here and she "likes the nurses". In reviewing our grievance log, there were no other residents identified who were affected by the deficient practice.	

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F 609	Continued From page 6 restless leg syndrome. The review revealed Resident #28 had a Brief Interview for Mental Status (BIMS) score of 15, which indicted the resident had intact cognition. Review of Resident #28's "Care Plan" revealed Resident #28 had the potential for depression due to their current medical condition and placement in the facility. Interventions initiated on 10/05/2023 directed staff to listen attentively and attempt to resolve or discuss areas of upset, use reassurance, and offer support. A review of a facility "Grievance Log January 2024" revealed Resident #28 filed a grievance dated 01/16/2024 that indicated "[Resident #28] stated the CNA [Certified Nursing Assistant] that helped clean [them] up after a BM [bowel movement] was rough with [them]. Abuse investigation was done and reported." A review of a "DLBC [Division of Licensing and Background Checks]-Form #358: Facility Reported Incidents," revealed the facility Administrator reported Resident #28's allegation of abuse to the State Survey Agency (SSA) on 01/17/2024 at 2:16 PM. The review revealed Social Worker (SW) #5 became aware of the allegation on 1/17/2024 at 12:00 PM and the facility Administrator became aware of the allegation on 01/17/2024 at 12:45 PM. During an interview on 02/19/2024 at 12:35 PM, Resident #28 stated they reported an allegation of abuse to SW #5 regarding an incident that occurred approximately three weeks prior between 8:30 PM and 10:30 PM. Resident #28 stated CNA #4 was rough with them when providing incontinence care and again in the	F 609	Monitor: 1. All reported violations will be audited and reviewed in our monthly QA meetings to ensure that they were reported in accordance with the state regulation for timeliness. 2. Monthly audits will be completed to ensure that all new hires have completed their abuse training as part of their orientation. 3. Random monthly staff interviews will be completed to ensure that staff understand abuse reporting procedures in accordance with state regulations. 4. Audits will be completed every 6 months to ensure that staff have completed their required abuse training. Date integrated into the QA system: March 18, 2024 Persons to ensure: Administrator and HR Compliance date: April 15, 2024	

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F 609	Continued From page 7 shower room when the CNA was trying to further clean the resident. Resident #28 stated CNA #4 returned the resident to their room and yelled at the resident. Continued interview with Resident #28 revealed CNA #10 "was sent to my room to calm me down" and stated Registered Nurse (RN) #9 also came to the resident's room. Resident #28 stated they were crying due to the interaction with CNA #4. Further interview revealed SW #5 spoke to the resident about the incident the next day. During an interview on 02/21/2024 at 3:32 PM, CNA #10 stated he was asked by CNA #11 to assist with Resident #28 the night of the allegation, noting that Resident #28 was crying. Continued interview revealed Resident #28 reported to him that CNA #4 was rough with the resident and said rude things to the resident when CNA #4 provided care to the resident. CNA #10 stated he reported Resident #28's allegations to CNA #11 after he finished caring for the resident. During an interview on 02/22/2024 at 9:35 AM, SW #5 indicated staff should report potential abuse within two hours of receiving the allegation. SW #5 reviewed the facility "Grievance Log January 2024" and confirmed Resident #28 filed the grievance on 01/16/2024, but SW #5 was not notified of the allegation of abuse until 01/17/2024 at 9:00 AM. Interview with the Director of Nursing/Infection Preventionist (DON/IP) on 02/22/2024 at 10:52 AM revealed the DON/IP expected staff to report an allegation of abuse to a nurse, the DON/IP, and then to the Administrator when made aware of an allegation of abuse.	F 609		

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F 609	Continued From page 8 During an interview with the Administrator on 02/22/2024 at 11:05 AM, the Administrator stated the Administrator expected the first staff member who became aware of an allegation of abuse to report the allegation to their direct supervisor, noting the direct supervisor should report the allegation to nursing, and then the allegation should be reported to the Administrator. Continued interview revealed CNA #10, who cared for Resident #28, was aware of the allegation of abuse on 01/16/2024 at 8:00 PM. 2. Review of a quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 12/13/2023, revealed Resident #39 was admitted to the facility on 09/27/2023 with diagnoses including peripheral vascular disease and kidney disease. The review revealed Resident #39 scored a 1 on the BIMS, indicating the resident had severe cognitive impairment. A review of a facility reported incident form titled, "DLBC Form 358: Facility Reported Incidents," revealed the facility reported an allegation of mental and verbal abuse to the State Survey Agency (SSA) on 01/28/2024 at 1:04 PM. The review revealed Resident #39's family member reported to a staff member an allegation of abuse to facility staff on 01/27/2024 at 8:00 PM, and the DON was notified of the incident on 01/27/2024 at 8:23 PM. During an interview with the Administrator on 02/22/2024 at 1:52 PM, the Administrator stated they were sent a text message from the DON on 01/27/2024 at 8:23 PM to notify the Administrator of the abuse allegation pertaining to Resident #39. Continued interview revealed the	F 609		

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F 609	Continued From page 9 Administrator did not see the text message until 01/28/2024 at 8:23 AM and the allegation of abuse was not reported to the SSA until 01/28/2024 at 1:04 PM. The Administrator confirmed the allegation of abuse was not reported timely.	F 609		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on interview, record review, and facility policy review, the facility failed to ensure residents received treatment and care in accordance with professional standards of practice for 2 (Resident #50 and Resident #3) of 7 residents. Specifically, the facility failed to provide wound care per physician orders for Resident #50 and failed to verify an order for antibiotic use with the ordering physician for Resident #3. Findings included: 1. Review of a facility policy titled, "Wound Care," revised in 10/2010, revealed "The purpose of this procedure is to provide guidelines for the care of wounds to promote healing." Under a "Documentation" section, the policy identified	F 684	684 Quality of Care 483.25 The following policy and procedure have been and will be implemented and utilized to ensure residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan and the residents choices. 1. Residents will receive treatments, including wound care according to physicians orders. Particular attention will be given to resident #50. 2. Residents will receive medications according to physicians orders. Particular attention will be given to resident #3. 3. Education will be done with nurses on providing cares according to physician orders, professional standards of practice and their comprehensive person-centered care plan. Particular attention will be given to resident #50 and resident #3.	04/15/2024

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F 684	Continued From page 10 information that should be recorded in the resident's medical record, including "2. The date and time the wound care was given." A review of Resident #50's "Detailed Summary" revealed the facility originally admitted the resident on 01/03/2024 with diagnoses including venous insufficiency, peripheral vascular disease, and history of ulcer formation on the lower leg. A review of Resident #50's admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 01/05/2024, revealed the resident had a Brief Interview for Mental Status (BIMS) score of 14, which indicated the resident had intact cognition. The review revealed the resident had active diagnoses including heart failure, peripheral vascular disease, and renal insufficiency, and was at risk of developing pressure ulcers/injuries. A review of Resident #50's "Care Plan" revealed the resident had statis ulcers (slow-healing wounds occurring on the lower half of the legs due to blood flow problems in leg veins) to the lower extremities, initiated on 01/16/2024. In part, the plan directed staff to provide treatments as ordered. A review of "Physician's Orders" for Resident #50 revealed an order dated 02/01/2024 directing staff to cleanse the resident's lower left extremity (LLE) wound with Puracyn wound cleanser or equivalent, to use plain alginate (an absorbent wound dressing usually containing calcium and sodium fibers) as the primary dressing on the LLE wound, and apply a two-layer compression wrap to the bilateral lower extremities on Mondays.	F 684	4. Education will be done with nurses on ensuring we verify and receive an order for antibiotic from a residents physician. Particular attention will be given to resident #3. Resident Specific; Resident #50 was discharged from the facility to home. Resident #3 was on hospice at the time of survey and has since passed away. Monitor: 1. Weekly random audits will be done on treatments to ensure that wound care has been provided according to physicians orders. 2. Weekly random audits will be done on medication orders and medication deliveries from pharmacy to ensure that antibiotics have been ordered and verified by physician, and given in accordance with their orders.	

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F 684	Continued From page 11 A review of Resident #50's "Treatment Record" revealed Registered Nurse (RN) #8's initials were documented in the column for the date 02/19/2024 to indicate wound care was provided to Resident #50 on 02/19/2024. During an interview on 02/19/2024 at 10:23 AM, Resident #50 stated they had a wound on their left leg, noting they went to a wound care facility weekly for treatment. The resident stated facility staff had twice provided wound care in between trips to the wound clinic. During an interview on 02/20/2024 at 11:22 AM, Resident #50 stated staff did not provide wound care or a dressing change the day prior (on Monday, 02/19/2024). The resident stated the last time wound care was provided was at the wound care clinic the prior Thursday. During an interview on 02/21/2024 at 11:20 AM, RN #8 stated Resident #50 went to a wound care clinic every Thursday and was supposed to have dressing changes done every Monday at the facility. When asked if the ordered dressing change was performed on Monday, 02/19/2024, RN #8 stated she documented the wound care was provided, but noted Resident #50 was at an appointment when RN #8 documented the care was provided, confirming she should have updated the treatment record documentation before leaving her shift to show the wound care and dressing change had not been completed. During an interview on 02/21/2024 at 2:14 PM, the Director of Nursing (DON) stated Resident #50 went to a wound care clinic on Thursdays, noting wound care was provided at the facility on	F 684	Date integrated into QA system: March 18, 2024 Person to Ensure: DON and ADON Compliance Date April 15, 2024	

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F 684	Continued From page 12 Mondays. The DON stated he expected staff to document wound care after it was provided to the resident. During an interview on 02/21/2024 at 3:37 PM, the Administrator stated she expected staff to correct documentation of care if that care was not completed. 2. Review of an admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 10/27/2023, revealed Resident #3 was admitted to the facility on 10/24/2023 with diagnoses including progressive neurologic conditions. The review revealed Resident #3 had a Brief Interview for Mental Status (BIMS) score of 6, which indicated the resident had severe cognitive impairment. Review of a "Facility Delivery Log" from the facility's pharmacy revealed Bactrim (antibiotic) DS (meaning double strength containing sulfamethoxazole and trimethoprim) was delivered to the facility on 01/26/2024 for Resident #3. The review revealed the prescriber was Medical Doctor #6. The document contained a date and time of 01/26/2024 at 2:35 PM. Review of Resident #3's "Physician's Telephone Orders" revealed a verbal order for one tablet of oral Bactrim DS twice daily for seven days, dated 01/26/2024 at 4:50 PM and signed by Registered Nurse (RN) #7. The prescribing physician was documented as Medical Doctor #6. Review of Resident #3's "Physician's Orders for 02/22/2024" revealed the 01/26/2024 order for twice daily oral Bactrim DS now contained information regarding the strength of the	F 684		

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F 684	Continued From page 13 medication at 800 milligrams (mg) sulfamethoxazole-160 mg trimethoprim. The document indicated Medical Doctor #6 ordered the medication. During an interview on 02/20/2024 at 3:46 PM, the Director of Nursing/Infection Preventionist (DON/IP) stated that, in "January," Resident #3 completed the course of Bactrim DS for the treatment of a urinary tract infection (UTI). During an interview on 02/21/2024 at 12:05 PM, RN #7 stated there was confusion surrounding Resident #3's Bactrim DS order because the resident's family member called the facility multiple times and "insisted" that Resident #3 needed an antibiotic. Per RN #7, the facility's pharmacy delivered Bactrim DS for Resident #3. RN #7 noted she then called the facility's pharmacy, who identified they had received an order for Bactrim DS for Resident #3 from Medical Doctor #6. RN #7 confirmed she did not contact Medical Doctor #6 to verify the order as it was "after hours," noting she did not know if anyone contacted Medical Doctor #6 in the following days. On 02/21/2024 at 1:23 PM, interview with the DON/IP revealed Resident #3's family member contacted Medical Doctor #6 because the family member believed Resident #3 had a UTI. Per the DON/IP, Medical Doctor #6 sent a Bactrim DS order to a non-contracted pharmacy that the facility did not use. According to the DON/IP, when the Bactrim DS was not received from the non-contracted pharmacy, the family member in question called the facility's contracted pharmacy regarding the status of the Bactrim DS. In turn, the facility's contracted pharmacy contacted	F 684		

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F 684	Continued From page 14 Medical Doctor #6, who identified that the outside pharmacy had the order. Per the DON/IP, the facility's pharmacy then had the Bactrim DS order transferred to them, filled the prescription, and delivered the medication to the facility. During an interview on 02/22/2024 at 2:51 PM, the DON/IP confirmed the telephone order written by RN #7 on 01/26/2024 at 4:50 PM was written after RN #7 contacted the facility's pharmacy, noting the facility had no direct order from Medical Doctor #6 of which they were aware. The DON/IP confirmed that, after the Bactrim DS was delivered to the facility, RN #7 clarified the associated order for the medication with the pharmacy and not the ordering physician (Medical Doctor #6). The surveyor left messages for Medical Doctor #6 on 02/21/2024 at 1:46 PM and on 02/22/2024 at 10:53 AM with no return call. On 02/22/2024 at 1:51 PM, Medical Doctor #6 could not be reached.	F 684		
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable	F 812	F 812 Food Procurement, Store/Prepare/Serve-Sanitary 483.60(i)(1)(2) The following policy and procedure have been and will be implemented and utilized to ensure that we adhere to professional standards for food safety when preparing, storing, and distributing food to residents who are served food from the facility's kitchen.	04/15/2024

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F 812	Continued From page 15 safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and facility policy review, the facility failed to adhere to professional standards for food safety when preparing, storing, and distributing food to residents who were served food from the facility's kitchen. This failure had the potential to affect 50 of 50 residents who received nutrition from the kitchen. Findings included: Review of a facility policy titled, "Preventing Foodborne Illness - Employee Hygiene and Sanitary Practices," revised in November 2022, revealed, "Food and nutrition services employees follow appropriate hygiene and sanitary procedures to prevent the spread of foodborne illness." Under a "Policy Interpretation and Implementation" section, the policy noted "1. All employees who handle, prepare or serve food are trained in the practices of safe food handling and preventing foodborne illness. Employees will demonstrate knowledge and competency in these practices prior to working with food or serving food to residents." Under a "Hand Washing/Hand Hygiene section, the policy noted "6. Employees must wash their hands: a. after personal body functions (i.e., toileting, blowing/wiping nose, coughing, sneezing, etc.);" "d. before coming in	F 812	1. Employees will be educated on infection control principles and how to help prevent the development and transmission of communicable diseases and infections. Particular attention will be given to housekeeping, laundry and dietary staff. 2. Employees will be educated on policies and procedures of hand hygiene and how it helps prevent the development and transmission of communicable diseases and infections. Particular attention will be given to the housekeeping, laundry and dietary staff. 3. Employees will be educated in regards to policies and procedures on receiving and storage of food in accordance with the above regulation. 4. Employees will be educated on policies and procedures in regards to checking food temperatures to ensure that they are within the required limits in accordance with the above regulation. 5. All dietary staff will be required to have a current food handlers permit to ensure proper training.	

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F 812	Continued From page 16 contact with any food surfaces;" "f. after handling soiled equipment or utensils; g. during food preparation, as often as necessary to remove soil and contamination and to prevent cross contamination when changing tasks; and/or h. after engaging in other activities that contaminate the hands." Under a "Hair Nets" section, the policy noted "15. Hair nets or caps and/or beard restraints are worn when cooking, preparing or assembling food to keep hair from contacting exposed food, clean equipment, utensils and linens." Under a section regarding "Washing Hands," the policy directed staff to "1. Wet hands first with water, then apply an amount of product recommended by the manufacturer to hands. 2. Rubs hand together vigorously for at least 15 seconds, covering all surfaces of the hands and fingers. 3. Rinse hands with water and dry thoroughly with a disposable towel. 4. Use towel to turn off the faucet." Review of a facility policy titled, "Handwashing/Hand Hygiene," revised in October 2023, revealed, "This facility considers hand hygiene the primary means to prevent the spread of healthcare-associated infections." Under a "Policy Interpretation and Implementation" section, the policy noted "2. All personnel are expected to adhere to hand hygiene policies and practices to help prevent the spread of infections to other personnel, residents, and visitors." Under an "Indications for Hand Hygiene" section, the policy noted that hand hygiene was indicated, in part, "g. immediately after glove removal" and that "5. The use of gloves does not replace hand washing/hand hygiene." Under a "Washing Hands" section, the policy directed staff to "1. Wet hands first with warm water, then apply an amount of product recommended by the	F 812	Monitors: 1. Weekly random audits will be done on infection prevention procedures to include hand hygiene, cross contamination, proper wearing of PPE, proper donning and doffing of PPE and the handling of linens and garbages. 2. Weekly random audits will be done to ensure proper receiving and storage of food which includes making sure food is covered, labeled and dated ("use by" date)." 3. Weekly random audits will be done to ensure Temperatures are being taken on food in accordance with the regulation. 4. Monthly audits will be completed to ensure all dietary staff are up to date with their food handlers permits. Date integrated into QA system: March 18, 2024 Persons to Ensure: Dietary manager; Administrator; DON Compliance Date: April 15, 2024	

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F 812	Continued From page 17 manufacturer to hands. 2. Rub hands together vigorously for at least 15 seconds, covering all surfaces of the hands and fingers. 3. Rinse hands with water and dry thoroughly with a disposable towel. 4. Use towel to turn off the faucet." Under an "Applying and Removing Gloves" section, the policy directed staff, in part, to "1. Perform hand hygiene before applying non-sterile gloves" and "4. Hold the removed glove in the gloved hand and remove the other glove by rolling it down the hand and folding it into the first glove. 5. Perform hand hygiene." Review of a facility policy titled, "Food Receiving and Storage," revised in November 2022, revealed, "Foods shall be received and stored in a manner that complies with safe food handling practices." Under a "Refrigerated/Frozen Storage" section, the policy noted, in part, "1. All foods stored in the refrigerator or freezer are covered, labeled and dated ("use by" date)." Review of a facility policy titled, "Operation and Sanitation for Surfaces," updated in December 2019, revealed, "Operating instructions are made available and cleaning procedures are developed for all Dietary Department Equipment. Sanitation will follow CMS [Center for Medicare and Medicaid Services] and Health Department rules per COVID-19 precautions." During an initial tour conducted in the kitchen on 02/19/2024 at 10:22 AM, an undated and opened gallon of vitamin D milk, an undated and opened gallon of 2% milk, a tray of thirty-one undated and unlabeled 3.25-ounce (oz) portion cups containing an off-white liquid, twelve undated and unlabeled 3.25 oz portion cups containing an off-white liquid, and an undated and opened 18.5	F 812		

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F 812	Continued From page 18 oz bottle of tea were all observed in a walk-in cooler called a "dairy cooler." During an observation of a walk-in refrigerator, a pan of French toast blended eggs mix was undated. Observation of a reach-in "bread fridge" revealed two undated and unlabeled 2 oz portion cups containing a tartar sauce-like substance and 10 undated and unlabeled 1 oz portion cups with a mustard-like substance in them. On 02/20/2024 at 10:23 AM, Dietary Aide (DA) #14 was observed preparing food. DA #14 walked to a handwashing station, wet their hands, applied soap, and scrubbed for approximately 20 seconds. DA #14 then turned off the water faucet handles with their wet, bare hands and then dried their hands with a paper towel and continued to prepare food. On 02/20/2024 at 10:25 AM, Cook #15 prepared pureed and mechanical soft foods while wearing gloves. Cook #15 wiped their nose with the back of their gloved hand and continued to prepare food without changing gloves or performing hand hygiene. On 02/20/2024 at 10:32 AM, Cook #15 was observed wearing gloves. Cook #15 took a tray of au gratin style potatoes from the oven and placed them on the steam table, then removed their gloves but did not wash their hands. Cook#15 then picked up plastic wrapping from the cooking preparation area and threw it away in the trash and used their bare hands to clean up chunks of meat debris from the food preparation area and threw them away in the trash. Cook #15 was then observed wiping the surface of the food preparation area with a towel they had taken out of a sanitizer bucket. Cook #15 then took a dry	F 812		

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F 812	Continued From page 19 towel that was in the corner of the same food preparation area, folded it, and dried the preparation surface area with that towel. During a combined observation and interview on 02/20/2024 at 10:42 AM, Cook #15 was observed taking temperature of foods at the tray line while wearing gloves. Cook #15 was observed touching the back of their hand to their eyeglasses and pushing the glasses up on their face. Cook #15 did not then change their gloves or perform hand hygiene and continued preparing food and serving items at the tray line. Cook #15 stated they did not obtain final cooking temperatures and did not take the temperatures of cold food items, noting they only obtained the holding temperatures of foods on the steam table. Cook #15 denied knowledge of who obtained dessert or cold food temperatures, if anyone. Cook #15 stated only temperatures on the facility's meal temperature log were obtained. On 02/20/2024 at 10:54 AM, Cook #15 walked to a three-compartment sink, rinsed some dirty dishes, then took the dirty dishes to the dishwasher and placed them on the dirty side of the dishwasher in a rack. Cook #15 then walked to the food preparation area and picked up a disinfectant bucket, walked back over to the three-compartment sink, dumped the bucket of disinfectant solution into the sink, and set the bucket and a towel within the bucket on the three-compartment dirty dish area. Cook #15 wiped their bare hands on the back of their pants and picked up a clean knife and cutting board and put them on the tray line. On 02/20/2024 at 11:03 AM, Cook #15 started serving at the tray line and was observed using	F 812		

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F 812	Continued From page 20 the same cutting board and knife during meal service they had recently placed on the tray line. On 02/20/2024 at 11:06 AM, DA #14 was observed placing a cellphone, pen, and a meal log on top of a rolling plastic cart tray that had bowls of covered soup on it. During a concurrent interview and observation on 02/20/2024 at 11:11 AM, a tray of grapes, cottage cheese, blueberries, raspberries, canned peaches, apple sauce, and a tray of bread and butter in sandwich bags were prepared with no observation of temperatures taken during the preparation. DA #16 stated that she prepared ready-to-eat cold foods for meal service and that ready-to-eat cold food temperatures were not taken by staff. During an observation on 02/20/2024 at 11:17 AM, DA #14 placed a bowl of chicken noodle soup that came from a small can and cooked it in a microwave. DA #14 did not take the final cooking temperature of the soup. DA #14 served the soup to a resident. The microwave was observed to be dirty with dried food debris on the microwave tray and food splattered on the interior microwave walls. On 02/20/2024 at 11:36 AM, Safety Director (SD) #17 was observed entering the kitchen area without wearing a hairnet. On 02/20/2024 at 11:38 AM, DA #14 was observed at the tray line placing soups, desserts, breads, and drinks on resident trays. With gloved hands, DA #14 bent down and touched the floor with their left gloved fingertips and picked up portion cup lids that had fallen to the floor. DA	F 812		

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F 812	Continued From page 21 #14 threw the lids away in a trash bin, then walked over to a drink cart and took a covered cup of juice from the beverage cart and placed the covered cup on a tray in the bakery rack that had ready-to-eat foods stored on it. DA #14 then walked over to the handwashing station and wet their hands, applied soap, scrubbed for approximately 20 seconds, turned off the water faucet handles with their wet bare hands, and dried their hands with a paper towel. During an interview on 02/22/2024 at 9:34 AM, the Director of Nursing and Infection Preventionist (DON/IP) stated he did not have oversight of handwashing or other hand hygiene of the kitchen staff. The DON/IP stated that Dietary Manager (DM) #12 was responsible for handwashing/hand hygiene oversight of the kitchen staff. During an interview on 02/22/2024 at 10:11 AM, Cook #15 stated she should have washed her hands after touching her mask. Cook #15 stated that food preparation surfaces should be air dried and not contaminated by a towel. During an interview on 02/22/2024 at 10:15 AM, DA #14 stated they had received training on hand hygiene and should have washed their hands after picking up items off the kitchen floor. During an interview on 02/22/2024 at 10:18 AM, DM #12 stated staff were educated on hand hygiene yearly, noting reminders are provided when needed. DM #12 stated she expected staff to perform hand hygiene correctly, which included turning on the water at the handwashing station, applying soap to the hands, scrubbing for 20 seconds, drying the hands, and turning the water off using a paper towel. DM #12 stated that, when	F 812		

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F 812	Continued From page 22 food items were received, the received date was to be placed on food items, and it was expected for stored foods to be dated and labeled by staff. DM #12 stated, "If you can tell what it is, no labeling needed." DM #12 stated she expected the temperatures for all food items served at mealtimes to be taken and documented, including ready-to-eat soup and cold foods. DM #12 stated she expected food preparation surface areas to be air dried instead of towel dried to prevent cross contamination. During an interview on 02/22/2024 at 11:05 AM, the Administrator stated she expected kitchen staff to sanitize and wash their hands the same as non-kitchen staff. During a follow-up interview on 02/22/2024 at 12:58 PM, DM #12 stated kitchen staff were not following through with obtaining temperatures of meal items as expected.	F 812		
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:	F 880	880 Infection Prevention and Control 483.80 (a)(1)(2)(4)(e)(f) The following policy and procedure have been and will be implemented and utilized to ensure the facility establishes and maintains an infection control program designed to provide a safe, sanitary	04/15/2024

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F 880	Continued From page 23 §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents	F 880	and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. 1. Employees will be educated on infection control principles and how to help prevent the development and transmission of communicable diseases and infections. Particular attention will be given to housekeeping, laundry and dietary staff. 2. Employees will be educated on policies and procedures of hand hygiene and how it helps prevent the development and transmission of communicable diseases and infections. Particular attention will be given to the housekeeping, laundry and dietary staff. 3. Education will be done with employees regarding policies and procedures for when to wear additional PPE and proper donning and doffing procedures. Particular attention will be given to housekeeping and laundry staff.	

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	465079	A. BUILDING _____ B. WING _____	02/22/2024

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F 880	Continued From page 24 identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, facility policy review, and review of the Centers for Disease Control and Prevention (CDC) guideline documents, the facility failed to ensure sanitary cleaning practices of its housekeeping staff, including the correct usage of personal protective equipment (PPE) between cleaning resident rooms, the correct usage of PPE for cleaning rooms with transmission-based precautions (TBP), and correct hand hygiene practices on 2 (Wing 2 and Wing 3) of 3 wings observed for infection control practices. This failure had the potential to affect 37 of 50 residents. Findings included: A review of a CDC document titled "Use Personal Protective Equipment (PPE) When Caring for Patients with Confirmed or Suspected COVID-19," dated 06/03/2020, revealed that the guidelines for doffing (taking off) PPE included, "1. Remove gloves. Ensure glove removal does not cause additional contamination of hands. Gloves can be removed using more than one technique (e.g. [exempli gratia; for example], glove-in-glove or bird beak). 2. Remove gown.	F 880	4. Education will be done with employees on policies and procedures for wearing and removing gloves. Particular attention will be given to housekeeping. 5. Education will be done with employees on policies and procedures for handling linens and garbages to prevent the development and transmission of communicable diseases and infections. Resident Specific: Particular attention will be given to the residents residing on wings 2 and 3. Monitor: 1. Weekly random audits will be done on infection prevention procedures to include hand hygiene, proper wearing of PPE, proper donning and doffing of PPE and the handling of linens and garbages. treatments to ensure that wound care has been provided according to physicians orders.	

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F 880	Continued From page 25 Untie all ties (or unsnap all buttons). Some gown ties can be broken rather than untied. Do so in gentle manner, avoiding a forceful movement. Reach up to the shoulders and carefully pull gown down and away from the body. Rolling the gown is an acceptable approach. Dispose in trash receptacle. 3. HCP [healthcare provider] may now exit patient room." A review of an undated CDC document titled "How to Safely Remove Personal Protective Equipment (PPE) Example 2" revealed that the guidelines were to "Remove all PPE before exiting the patient room except a respirator, if worn." 1. On 02/20/2024 at 12:36 PM, observation of Housekeeper #1 revealed she stepped outside of a room with a sign indicating COVID-19 precautions were in place. Housekeeper #1 stepped outside of the room with her PPE still on, including gloves and gown. She then removed her gloves, but kept on her gown as she handled the cleaning cart. At 12:38 PM, with new gloves donned, Housekeeper #1 removed the gown she had worn while in the room under COVID-19 precautions. With these same gloves, Housekeeper #1 continued to handle the cleaning equipment (broom, dustpan, wipes container, and cleaning cart). She ultimately removed the gloves at 12:41 PM. Housekeeper #1 did not sanitize her hands at any point during these observations. During an interview on 02/20/2024 at 12:48 PM, Housekeeper #1, facilitated by translation from Certified Nursing Aide (CNA) #2, revealed she had not had formal PPE training. Housekeeper #1 stated she worked during the COVID-19 pandemic, and her only training consisted of the	F 880	Date integrated into QA system: March 18, 2024 Person to Ensure: DON, ADON, Administrator, Housekeeping Director and Dietary Director. Compliance Date: April 15, 2024	

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F 880	Continued From page 26 signs/bulletins that were posted at that time indicating what order PPE should be donned and doffed. Housekeeper #1 stated she had been told to doff PPE prior to exiting a room under TBP. Housekeeper #1 confirmed she removed the PPE incorrectly by taking off the gown and gloves after exiting the room (rather than prior). Housekeeper #1 stated she worked on Wing 3 in the facility. During an interview on 02/21/2024 at 8:58 AM, Housekeeper #3 revealed she had been trained to remove PPE before leaving a room under TBP. During an interview on 02/21/2024 at 10:15 AM, the Housekeeping/Laundry Manager stated she had worked at the facility for four years. She stated the housekeeping staff were expected to don PPE before entering a room with TBP and doff PPE before exiting the room. She stated the staff were expected to discard the PPE used in the TBP rooms into biohazard bags. The Housekeeping/Laundry Manager stated she had previously explained this to Housekeeper #1, but noted they needed to use a language translation application to communicate with Housekeeper #1. During an interview on 02/22/2024 at 9:34 AM, the Director of Nursing (DON)/Infection Preventionist (IP) stated he expected staff to remove PPE before exiting a room under TBP and to put used PPE in the appropriate bin or trash. 2. A review of a facility policy titled, "Handwashing/Hand Hygiene," revised in October 2023, revealed, "This facility considers hand hygiene the primary means to prevent the spread of healthcare-associated infections." The policy revealed, "2. All personnel are expected to	F 880		

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F 880	Continued From page 27 adhere to hand hygiene policies and practices to help prevent the spread of infections to other personnel, residents, and visitors." Under a section titled "Indications for Hand Hygiene," the policy noted, in part, "1. Hand hygiene is indicated: a. immediately before touching a resident;" "c. after contact with blood, body [sic] fluids, or contaminated surfaces; d. after touching a resident; e. after touching the resident's environment;" and "g. immediately after glove removal." Further review revealed "5. The use of gloves does not replace hand washing/hand hygiene." During observations on 02/20/2024 starting at 8:58 AM, Housekeeper #3 traveled down the Wing 2 hall with blue gloves on both hands, pushing a large laundry bin on wheels. Housekeeper #3 entered occupied resident Room #38 and Room #35 with the laundry bin. She removed dirty laundry from each room without removing her gloves or performing hand hygiene before entering and exiting the rooms. Housekeeper #3 entered the garbage/dirty laundry room, where she threw away the trash; she did not remove her gloves or perform hand hygiene before entering or exiting the room. Housekeeper #3 entered Room #20 with the laundry bin; she emptied the trash bins but did not remove her gloves or perform hand hygiene before entering or exiting the room. She then entered the shower room, reached into a dirty laundry bin, pulled out dirty linens, and placed them into the large rolling laundry bin; she did not remove her gloves or perform hand hygiene before entering or exiting the shower room. Housekeeper #3 pushed the dirty laundry cart down the hall and to double doors leading to the facility's kitchen, dry food storage, and elevator.	F 880		

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F 880	Continued From page 28 Housekeeper #3 entered the dirty laundry sorting room. She reached inside the rolling laundry bin, removed soiled linens, and placed them into the dirty laundry cart until the bin was empty. She removed her gloves, disposed of them into the garbage bin, and left the dirty laundry sorting room. Housekeeper #3 did not perform hand hygiene. Housekeeper #3 opened the double doors leading from the facility's kitchen, dry food storage, and elevator using dirty hands and rolled the laundry bin into the garbage/dirty laundry room. Housekeeper #3 did not perform hand hygiene after exiting the garbage/dirty laundry room. With dirty hands, Housekeeper #3 opened the door to the housekeeping closet, pulled out the housekeeping cart, and pushed the housekeeping cart down the hall. While pushing the cart, Housekeeper #3's surgical mask slid down her face. Housekeeper #3 reached up to her surgical mask, pinched the outside fabric of the mask, and reapplied it over her nose. Housekeeper #3 did not perform hand hygiene. Housekeeper #3 applied gloves without performing hand hygiene and entered resident Room #25 while carrying two cleaning spray bottles. Housekeeper #3 touched the light switch to turn the bathroom light on, sprayed some of the contents of the cleaning bottles, and exited the resident's room without removing gloves or performing hand hygiene. During an interview on 02/20/2024 at 9:23 AM, Houskeeper #3 confirmed she did not change her gloves between resident rooms, noting she should have changed her gloves. Housekeeper #3 stated she did not know what should be done after removing her gloves and stated, "I just put another pair on." Houskeeper #3 stated she should wash her hands after breaks and after	F 880		

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F 880	Continued From page 29 using the bathroom. Housekeeper #3 confirmed that she touched her face and face mask but did not wash or sanitize her hands, noting she should have. During an interview on 02/21/2024 at 10:15 AM, the Housekeeping/Laundry Manager stated she did not train the housekeeping staff to wash their hands but did train them regarding how to change their gloves. She stated no one trained the housekeeping staff on hand hygiene. She stated that staff should have sanitized their hands and changed gloves between resident rooms. The Housekeeping/Laundry Manager said she expected staff not to wear dirty gloves in the hallway or roll laundry bins into resident rooms. During an interview on 02/22/2024 at 9:34 AM, the Director of Nursing (DON)/Infection Preventionist (IP) stated he expected staff to perform hand hygiene when entering and exiting a resident's room. The DON/IP stated staff were expected to don new gloves when entering a resident's room, dispose of gloves when exiting resident rooms, and sanitize their hands after removing gloves. The DON/IP stated there was no monitoring of hand hygiene practices for the housekeeping staff. During an interview on 02/22/2024 at 11:05 AM, the Administrator stated she expected staff to perform hand hygiene after removing gloves, when they traveled from one room to the next, and if they touched bodily fluids.	F 880		

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E 000	Initial Comments Emergency preparedness E-000 Initial Comments: Statutory and regulatory authority for this Emergency preparedness survey that was conducted on 02-26-2024 in the presence of the Administrator and the facility manager are found in 42 Code of Federal Regulations, Section 483.73 The facility was found to be in compliance with the requirements for participation in Medicare and Medicaid. No deficiencies were cited for emergency preparedness during this survey.	E 000	Cole Julian Approved 03-19-2024 POC Date:04-15-2024	
K 000	INITIAL COMMENTS K-000 Initial Comments. Statutory and regulatory authority for this Life Safety Code survey that was conducted on 02-26-2024 in the presence of the Administrator and the facility manager are found in 42 Code of Federal Regulations, Section 483.70, (a) and the 2012 Edition, NFPA 101 Life Safety Code including NFPA publications referenced therein. The facility was found not to be in compliance with the requirements for participation in Medicare and Medicaid. The findings that follow demonstrate noncompliance with Title 42, Code of Federal Regulations, 483.70 (a) Life Safety from fire.	K 000		
K 291 SS=D	Emergency Lighting CFR(s): NFPA 101 Emergency Lighting Emergency lighting of at least 1-1/2-hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1 This REQUIREMENT is not met as evidenced	K 291	See attached	04/15/2024

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

ADMINISTRATOR 3/15/2024

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

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K 291	Continued From page 1 by: K-291 Based upon observations made during the record review made in the presence of the Administrator and the facility manager on 02-26-2024 it was determined that the facility did not provide an emergency lighting system in accordance with NFPA 101 20.2.9.1. This deficiency affected the monthly required tests. Findings include: During the record review the facility failed to provide documentation of the emergency lighting testing of the 90 min annual test of the emergency lighting system. Functional testing shall be conducted monthly, with a minimum of 3 weeks and a maximum of 5 weeks between tests, for not less than 30 seconds and a 90-minute annual in accordance with NFPA 101 20.2.9.1, 7.9.3.1.1(1).	K 291	See attached	
K 324 SS=D	Cooking Facilities CFR(s): NFPA 101 Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with	K 324	See attached	04/15/2024

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K 324	Continued From page 2 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2 This REQUIREMENT is not met as evidenced by: K-324 Based upon record review made in the presence of the Administrator and the facility manager on 02-26-2024, it was determined that the facility did not maintain the kitchen hood fire suppression system in accordance with NFPA 19.3.2.6 and NFPA 96. Findings include: During the record review the facility failed to provide documentation that the kitchen hood fire suppression system was inspected twice annually. NFPA 101 18 or 19.3.2.6, 9.2.3 and NFPA 96 11.2.1	K 324	See attached	
K 353	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,	K 353	See attached	04/15/2024

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K 353	Continued From page 3 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 by: K-353 Based upon observations made in the presence of the Administrator and the facility manager on 02-26-2024, it was determined that the facility did not maintain the fire sprinkler system in accordance with NFPA 101, 9.7.5., NFPA 25 5.2.1.1,25 5.2.2.2 This deficiency affected one of several fire sprinklers heads. Findings include 1-During the facility tour the fire sprinkler head located in wing 7 in the communication closet had paint and or foreign material on the body of the head. Sprinklers shall not show signs of leakage; shall be free of corrosion, foreign materials, paint, and physical damage; and shall be installed in the correct orientation in accordance with NFPA 25 5.2.1.1. 2-During the facility tour the fire sprinkler head located in the resident room 105 was physically damaged and or missing three of the deflectors on the head of the sprinkler. Sprinklers shall not show signs of leakage; shall be free of corrosion,	K 353	See attached	

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K 353	Continued From page 4 foreign materials, paint, and physical damage; and shall be installed in the correct orientation in accordance with NFPA 25 5.2.1.1.	K 353	See attached	
K 355 SS=F	Portable Fire Extinguishers CFR(s): NFPA 101 Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 This REQUIREMENT is not met as evidenced by: K-355 Based upon observations made in the presence of the Administrator and the facility manager on 02-26-2024, it was determined that the facility did not maintain portable fire extinguishers in accordance with NFPA 10.7.2.1.1 and NFPA 101 21.3.5., 9.7.4.1 . This deficiency affected 1 of the required tests. Findings include: 1-During the facility tour it was discovered that the facility did not complete the required heft tests on the portable fire extinguishers in accordance with NFPA 10.7.2.1.1 and NFPA 101 21.3.5.	K 355	See attached	04/15/2024
K 914 SS=D	Electrical Systems - Maintenance and Testing CFR(s): NFPA 101 Electrical Systems - Maintenance and Testing Hospital-grade receptacles at patient bed locations and where deep sedation or general anesthesia is administered, are tested after initial installation, replacement or servicing. Additional testing is performed at intervals defined by documented performance data. Receptacles not	K 914	See attached	04/15/2024

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K 914	Continued From page 5 listed as hospital-grade at these locations are tested at intervals not exceeding 12 months. Line isolation monitors (LIM), if installed, are tested at intervals of less than or equal to 1 month by actuating the LIM test switch per 6.3.2.6.3.6, which activates both visual and audible alarm. For LIM circuits with automated self-testing, this manual test is performed at intervals less than or equal to 12 months. LIM circuits are tested per 6.3.3.3.2 after any repair or renovation to the electric distribution system. Records are maintained of required tests and associated repairs or modifications, containing date, room or area tested, and results. 6.3.4 (NFPA 99) This REQUIREMENT is not met as evidenced by: K-914 Based on observations made in the presence of the facility manager on 02-26-2024 it was determined that the facility did not perform Maintenance and testing on the receptacles at the patient bed locations for integrity, continuity, polarity, and retention force of the grounding blades in accordance with NFPA 99,2012,6.3.3.2.1, 6.3.3.2.2, 6.3.3.2.3, and 6.3.3.2.4. This deficiency could affect all patients. Findings include: During the facility tour it was observed that all of the receptacles at the resident beds were not hospital grade, at the time of this survey the facility had not performed and/or tested all of the electrical receptacles near resident beds and exam rooms that he knew of in accordance with NFPA 99,2012 ,6.3.3.2.1, 6.3.3.2.2, 6.3.3.2.3, and 6.3.3.2.4.	K 914	See attached	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465079	A. BUILDING 01 B. WING	02/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNSHINE TERRACE SKILLED NURSING	248 WEST 300 NORTH LOGAN, UT 84321

(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
K 918 K 918 SS=F	Continued From page 6 Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This REQUIREMENT is not met as evidenced by:	K 918 K 918	See attached	04/15/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465079	A. BUILDING 01 B. WING	02/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNSHINE TERRACE SKILLED NURSING	248 WEST 300 NORTH LOGAN, UT 84321

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K 918	Continued From page 7 K-918: During the record review made in the presence of the Administrator and the facility manager on 02-26-2024, it was determined that the facility did not maintain, inspect and exercise the facilities emergency generator set in accordance with NFPA 99 6.4.4 and NFPA 110 8.4.2.3. This deficiency affected the required tests for the emergency generator. Findings include: 1-During the record review it was discovered that the facility did not have any records to indicate that all of the weekly testing of the generator had been completed. 2- During the record review it was discovered that the facility did not have any records to indicate that all of the monthly load tests had been completed. 3- During the record review the facility failed to provide documentation that the Maintenance of the generator batteries had been conducted. Maintenance of Lead-acid batteries shall include the monthly testing and recording of electrolyte specific gravity. Battery conductance testing shall be permitted in lieu of the testing of specific gravity when applicable or warranted in accordance with NFPA 110 8.3, 8.3.7	K 918	See attached	
K 920 SS=D	Electrical Equipment - Power Cords and Extens CFR(s): NFPA 101 Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled	K 920	See attached	04/15/2024

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	465079	A. BUILDING 01 B. WING	02/27/2024

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SUNSHINE TERRACE SKILLED NURSING	248 WEST 300 NORTH LOGAN, UT 84321

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K 920	Continued From page 8 by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 This REQUIREMENT is not met as evidenced by: K-920 Based upon observations made in the presence of the Administrator and the facility manager on 02-26-2024, it was determined that the facility did not maintain electrical equipment in accordance with NFPA 101 19.5.1 and 9.1.2. This deficiency affected several smoke compartments. Findings include: 1- During the facility tour it was observed that the outlets in treatment room #5 were not GFIC protected and were observed to be within 6ft of the sink and not GFCI protected. The plant manager confirmed these findings. GFCI outlets are required where the receptacles are installed to serve the countertop surfaces and are located within 6 ft. (1.83 m) of the outside edge of the sink. NFPA 101 Section 19.5.1, 9.1.2; 1999 NFPA	K 920	See attached	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465079	A. BUILDING 01 B. WING	02/27/2024

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K 920	Continued From page 9 70 Article 210-8(7) 2- During the facility tour it was observed that the outlets in the wing 4 staff restroom sink were not GFIC protected and were observed to be within 6ft of the sink and not GFCI protected. The plant manager confirmed these findings. GFCI outlets are required where the receptacles are installed to serve the countertop surfaces and are located within 6 ft. (1.83 m) of the outside edge of the sink. NFPA 101 Section 19.5.1, 9.1.2; 1999 NFPA 70 Article 210-8(7) 3- During the facility tour it was observed that the outlets RT at the sink were not GFIC protected and were observed to be within 6ft of the sink and not GFCI protected. The plant manager confirmed these findings. GFCI outlets are required where the receptacles are installed to serve the countertop surfaces and are located within 6 ft. (1.83 m) of the outside edge of the sink. NFPA 101 Section 19.5.1, 9.1.2; 1999 NFPA 70 Article 210-8(7) 4- During the facility tour it was observed that the outlets at the Home Health sink were not GFIC protected and were observed to be within 6ft of the sink and not GFCI protected. The plant manager confirmed these findings. GFCI outlets are required where the receptacles are installed to serve the countertop surfaces and are located within 6 ft. (1.83 m) of the outside edge of the sink. NFPA 101 Section 19.5.1, 9.1.2; 1999 NFPA 70 Article 210-8(7) 5- During the facility tour it was observed that the outlets at the basement men's restroom sink were not GFIC protected and were observed to be within 6ft of the sink and not GFCI protected. The plant manager confirmed these findings. GFCI outlets are required where the receptacles are installed to serve the countertop surfaces and are located within 6 ft. (1.83 m) of the outside	K 920		

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K 920	Continued From page 10 edge of the sink. NFPA 101 Section 19.5.1, 9.1.2; 1999 NFPA 70 Article 210-8(7) 6- During the facility tour it was observed that the outlets at the basement housekeeping closet sink were not GFIC protected and were observed to be within 6ft of the sink and not GFCI protected. The plant manager confirmed these findings. GFCI outlets are required where the receptacles are installed to serve the countertop surfaces and are located within 6 ft. (1.83 m) of the outside edge of the sink. NFPA 101 Section 19.5.1, 9.1.2; 1999 NFPA 70 Article 210-8(7)	K 920		
K 921 SS=F	Electrical Equipment - Testing and Maintenanc CFR(s): NFPA 101 Electrical Equipment - Testing and Maintenance Requirements The physical integrity, resistance, leakage current, and touch current tests for fixed and portable patient-care related electrical equipment (PCREE) is performed as required in 10.3. Testing intervals are established with policies and protocols. All PCREE used in patient care rooms is tested in accordance with 10.3.5.4 or 10.3.6 before being put into service and after any repair or modification. Any system consisting of several electrical appliances demonstrates compliance with NFPA 99 as a complete system. Service manuals, instructions, and procedures provided by the manufacturer include information as required by 10.5.3.1.1 and are considered in the development of a program for electrical equipment maintenance. Electrical equipment instructions and maintenance manuals are readily available, and safety labels and condensed operating instructions on the appliance are legible. A record of electrical equipment tests, repairs, and modifications is maintained for a	K 921	See Attached	04/15/2024

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	465079	A. BUILDING 01 B. WING _____	02/27/2024

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K 921	Continued From page 11 period of time to demonstrate compliance in accordance with the facility's policy. Personnel responsible for the testing, maintenance and use of electrical appliances receive continuous training. 10.3, 10.5.2.1, 10.5.2.1.2, 10.5.2.5, 10.5.3, 10.5.6, 10.5.8 This REQUIREMENT is not met as evidenced by: K-921 Based on records review, observation, and an interview with the Administrator and the facility manager on 02-26-2024 the facility failed to maintain documentation of the inspections for the Patient-Care Related Electrical equipment (PCREE). This deficiency affected all residents. Findings include: During the record review there was no documentation of the inspections of the Patient Care Related Electrical Equipment in use throughout the facility as required by section 10.5.6.2 of NFPA 99, Health Care Facility Code 2012. 3.3.137. NFPA 99 10.3 through 10.5.8. An interview on 11-27-2023 with the facility Manager confirmed these findings.	K 921		

Plan of Correction for Life Safety Survey completed

2/27/2024

K 291 Emergency Lighting

NFPA 101

We will provide documentation of the emergency lighting testing of the 90 min annual test of the emergency lighting system. Functional testing will be conducted monthly, with a minimum of 3 weeks and a maximum of 5 weeks between tests, for not less than 30 seconds and a 90-minute annual in accordance with NFPA 101 20.2.9.1, 7.9.3.1.1(1).

1. Maintenance will perform emergency lighting testing in accordance with NFPA 101 20.2.9.1, 7.9.3.1.1(1).
2. A documentation log will be maintained and reviewed at our monthly QA and safety committee meetings to ensure compliance with NFPA 101 20.2.9.1, 7.9.3.1.1(1).

Monitors:

1. Monthly audits will be completed to ensure that documentation and testing is being performed in accordance with NFPA 101 20.2.9.1, 7.9.3.1.1(1).
2. The documentation log will reviewed at our monthly QA and safety committee meetings to ensure compliance with NFPA 101 20.2.9.1, 7.9.3.1.1(1).

Integrated into the QA system:

March 18, 2024

Persons to ensure:

Maintenance director; Administrator.

Date of Compliance:

April 15, 2024

K 324 Cooking Facilities

NFPA 101

We will maintain the kitchen hood fire suppression system in accordance with NFPA 19.3.2.6 and NFPA 96.

1. We will ensure that the kitchen hood system has been cleaned and the required fire suppression system has been inspected and maintained in accordance with NFPA 101 18 or 19.3.2.6, 9.2.3 and NFPA 96 11.2.1.
2. We will ensure that the required testing and documentation is done in accordance with NFPA 19.3.2.6 and NFPA 96.

Monitors:

1. Bi annually audits will be complete to ensure that the required testing and documentation has been completed twice annually in accordance with NFPA 101 18 or 19.3.2.6, 9.2.3 and NFPA 96 11.2.1.
2. This will be monitored monthly in our QA meeting to ensure compliance with NFPA 101 18 or 19.3.2.6, 9.2.3 and NFPA 96 11.2.1.

Integrated into the QA system:

March 18, 2024

Persons to ensure:

Maintenance director; Administrator.

Date of Compliance:

April 15, 2024

K 353 Sprinkler System - Maintenance and Testing

NFPA 101

We will maintain the fire sprinkler system in accordance with NFPA 101, 9.7.5., NFPA 25 5.2.1.1,25 5.2.2.2

1. The fire sprinkler head located in wing 7 in the communication closet has been cleaned of paint and or foreign material on the body of the head. Sprinklers do not show signs of leakage; they are free of corrosion, foreign materials, paint, and physical damage; and are installed in the correct orientation in accordance with NFPA 25 5.2.1.1.

2. The fire sprinkler head located in the resident room 105 will be replaced before 4/15/2024. Sprinklers do not show signs of leakage; they are free of corrosion, foreign materials, paint, and will not be physical damaged; and shall be installed in the correct orientation in accordance with NFPA 25 5.2.1.1.
3. A bi-annual inspection of all sprinkler heads will be entered into our preventative maintenance program to ensure the inspections and maintenance is being completed in accordance with NFPA 25 5.2.1.1.

Monitors:

1. All sprinkler heads will be inspected by maintenance bi-annually to ensure that Sprinklers do not show signs of leakage; they are free of corrosion, foreign materials, paint, and physical damage; and are installed in the correct orientation in accordance with NFPA 25 5.2.1.1.
2. This inspection will reviewed during our monthly QA meetings to ensure compliance.

Integrated into the QA system:

March 18, 2024

Persons to ensure:

Maintenance director; Administrator.

Date of Compliance:

April 15, 2024

K 355 Portable Fire Extinguishers

NFPA 101

We will maintain portable fire extinguishers in accordance with NFPA 10.7.2.1.1 and NFPA 101 21.3.5., 9.7.4.1

1. We will complete the required heft tests on all of the portable fire extinguishers in accordance with NFPA 10.7.2.1.1 and NFPA 101 21.3.5.
2. Evidence of the required heft test will be maintained on the attached extinguisher tag.
3. An additional tracking form has been implemented to ensure that the monthly testing is being completed and documented in accordance with NFPA 10.7.2.1.1 and NFPA 101 21.3.5., 9.7.4.1

Monitors:

1. Random monthly audits will be complete to ensure that the required testing and documentation is being complete in accordance with NFPA 10.7.2.1.1 and NFPA 101 21.3.5., 9.7.4.1

2. A monthly review of the required testing will be done in our QA meeting to ensure compliance with NFPA 10.7.2.1.1 and NFPA 101 21.3.5., 9.7.4.1

Integrated into the QA system:

March 18, 2024

Persons to ensure:

Maintenance director; Administrator.

Date of Compliance:

April 15, 2024

K 914 Electrical Systems - Maintenance and Testing

NFPA 101

We will perform Maintenance and testing on the receptacles at the patient bed locations for integrity, continuity, polarity, and retention force of the grounding blades in accordance with NFPA 99,2012,6.3.3.2.1, 6.3.3.2.2, 6.3.3.2.3, and 6.3.3.2.4.

1. We will perform maintenance and/or test all of the electrical receptacles near resident beds and exam rooms in accordance with NFPA 99,2012 ,6.3.3.2.1, 6.3.3.2.2, 6.3.3.2.3, and 6.3.3.2.4.
2. We will provide documentation on any performed maintenance and annual testing in accordance with NFPA 99,2012 ,6.3.3.2.1, 6.3.3.2.2, 6.3.3.2.3, and 6.3.3.2.4.

Monitors:

1. A monthly review of all required maintenance and testing will be done in our QA and safety committee meetings to ensure compliance with NFPA 99,2012 ,6.3.3.2.1, 6.3.3.2.2, 6.3.3.2.3, and 6.3.3.2.4

Integrated into the QA system:

March 18, 2024

Persons to ensure:

Maintenance director; Administrator.

Date of Compliance:

April 15, 2024

K 918 Electrical Systems - Essential Electric System

NFPA 101

We will maintain, inspect and exercise the facilities emergency generator set in accordance with NFPA 99 6.4.4 and NFPA 110 8.4.2.3.

1. We will maintain records to indicate that all of the weekly testing of the generator had been completed.
2. We will maintain records to indicate that all of the monthly load tests had been completed.
3. We will provide documentation that the Maintenance of the generator batteries had been conducted. Maintenance of Lead-acid batteries shall include the monthly testing and recording of electrolyte specific gravity. Battery conductance testing shall be permitted in lieu of the testing of specific gravity when applicable or warranted in accordance with NFPA 110 8.3, 8.3.7

Monitors:

1. Monthly audits will be completed by the administrator to ensure that all of the above testing and documentation are being complete in accordance with NFPA 99 6.4.4 and NFPA 110 8.4.2.3.
2. Monthly testing will be monitored and reviewed in our monthly safety and QA meetings to ensure compliance with NFPA 99 6.4.4 and NFPA 110 8.4.2.3.

Integrated into the QA system:

March 18, 2024

Persons to ensure:

Maintenance director; Administrator.

Date of Compliance:

April 15, 2024

K 920 Electrical Equipment - Power Cords and Extension cords

NFPA 101

We will maintain electrical equipment in accordance with NFPA 101 19.5.1 and 9.1.2.

1. The outlet near the sink in treatment room #5 has been replaced with a GFIC outlet.
2. The outlet near the sink in the wing 4 staff restroom has been replaced with a GFIC outlet.
3. The outlet near the sink in the RT room has been replaced with a GFIC outlet.
4. The outlet near the Home Health sink has been replaced with a GFIC outlet.
5. The outlet in the basement men's restroom has been replaced with a GFIC outlet.

6. The outlets in the basement housekeeping closet near the sink has been replaced with a GFIC outlet.
7. An inspection of the entire facility will be completed before 4/15/ 2024 to ensure that all other outlets within the facility are in accordance with NFPA 101 19.5.1 and 9.1.2.

Monitors:

1. An annual inspection will be completed by maintenance to ensure that all electrical outlets are in accordance with NFPA 101 19.5.1 and 9.1.2.

Integrated into the QA system:

March 18, 2024

Persons to ensure:

Maintenance director; Administrator.

Date of Compliance:

April 15, 2024

K 921 Electrical Equipment - Testing and Maintenance

NFPA 101

All PCREE used in patient care rooms will be tested in accordance with 10.3.5.4 or 10.3.6 before being put into service and after any repair or modification. We will maintain documentation of the inspections for the Patient-Care Related Electrical equipment (PCREE).

1. Testing intervals will be established with policies and protocols.
2. All PCREE used in patient care rooms will be tested in accordance with 10.3.5.4 or 10.3.6 before being put into service and after any repair or modification.
3. Any system consisting of several electrical appliances demonstrates compliance with NFPA 99 as a complete system. Service manuals, instructions, and procedures provided by the manufacturer include information as required by 10.5.3.1.1 and will be considered in the development of a program for electrical equipment maintenance.
4. Electrical equipment instructions and maintenance manuals will be readily available, and safety labels and condensed operating instructions on the appliance are legible.
5. A record of electrical equipment tests, repairs, and modifications will be maintained.
6. We will implement this testing into our preventative maintenance program to ensure compliance.
7. We will create an inventory of all of our PCREE to ensure we are in compliance with NFPA 10.3, 10.5.2.1, 10.5.2.1.2, 10.5.2.5, 10.5.3, 10.5.6, 10.5.8 .

8. Personnel responsible for the testing, maintenance and use of electrical appliances will receive continuous training in accordance with NFPA 10.3, 10.5.2.1, 10.5.2.1.2, 10.5.2.5, 10.5.3, 10.5.6, 10.5.8 .

Monitors:

1. Monthly audits will be completed on testing; maintenance and inventory to ensure compliance in accordance with NFPA 10.3.5.4 or 10.3.6.
2. Monitoring of this process will be done in our monthly QA and safety committee meetings to ensure compliance in accordance with NFPA 10.3.5.4 or 10.3.6.

Integrated into the QA system:

March 18, 2024

Persons to ensure:

Maintenance director; Administrator.

Date of Compliance:

April 15, 2024