Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

June 3, 2026

Administrator
Ecumen Lakeshore
4002 LONDON ROAD
DULUTH, MN 55804

RE: CCN:245215
Cycle Start Date: May 21, 2026

Dear Administrator:

On May 21, 2026, a survey was completed at your facility by the Minnesota Department(s) of Health and Public Safety, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.

What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.

- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

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

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

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

DEPARTMENT CONTACT

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

Alex Warren, Regional Operations Supervisor
Duluth District Office
Health Regulation Division
Minnesota Department of Health
11 East Superior Street, Suite 290
Duluth, MN 55082
Email: Alex.Warren@state.mn.us

Cell: 651-279-5375 Office: 218-302-6186

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department

of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

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

If substantial compliance with the regulations is not verified by August 21, 2026 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by November 21, 2026 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

INFORMAL DISPUTE RESOLUTION (IDR)

In accordance with 42 CFR 488.331 and Minnesota Statute 144A.10 subd 15, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to: https://forms.web.health.state.mn.us/form/NHDisputeResolution

This request must be sent within the same ten calendar days you have for submitting an ePoC for the cited deficiencies. Please note that the failure to complete the informal dispute resolution process will

not delay the dates specified for compliance or the imposition of remedies.
A copy of the Department's informal dispute resolution policies is posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

In accordance with 42 CFR § 488.431 and Minnesota Statute 144A.10 subd 16, when a CMP subject to being collected and placed in an escrow account is imposed, you have one opportunity to question cited deficiencies through an Independent IDR process. You may also contest scope and severity assessments for deficiencies which resulted in a finding of SQC or immediate jeopardy. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to: https://forms.web.health.state.mn.us/form/NHDisputeResolution

A facility may not use both IDR and independent IDR for the same deficiency citation(s) arising from the same survey unless the IDR process was completed prior to the imposition of the CMP. This request must be sent within ten calendar days of receipt of this offer. An incomplete Independent IDR process will not delay the effective date of any enforcement action.

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

Travis Z. Ahrens
State Fire Safety Supervisor
Health Care & Correctional Facilities
MN Department of Public Safety-Fire Marshal Division
445 Minnesota St., Suite 145
St. Paul, MN 55101
Email: travis.ahrens@state.mn.us
Web: www.sfm.dps.mn.gov
Cell: 1-507-308-4189

Feel free to contact me if you have questions.

Sincerely,

Sarah Lane

Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health

P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697

Email: sarah.lane@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245215	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 05/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ecumen Lakeshore	**4002 LONDON ROAD , DULUTH, Minnesota, 55804**

(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
E0000	Initial Comments On 5/20-5/21/26, a survey for compliance with CFR §483.73, Appendix Z, Emergency Preparedness Requirements was conducted during a standard recertification survey. The facility was IN compliance. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	E0000		
F0000	INITIAL COMMENTS On 5/20-5/21/26, a federal recertification survey was conducted using the Risk-Based Survey (RBS) process at your facility. Your facility was IN compliance with §42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were reviewed: H52152521C (246602244). NO deficiencies were cited. The facility is enrolled in ePOC, therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, the facility must acknowledge receipt of the electronic documents.	F0000		

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 reverse for further 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.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245215	(X2) MULTIPLE CONSTRUCTION A. BUILDING **02 - NEW REPLAC...** B. WING	(X3) DATE SURVEY COMPLETED **05/21/2026**

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K0000 Bldg. 02	INITIAL COMMENTS FIRE SAFETY An annual Life Safety recertification survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 05/21/2026. At the time of this survey, Ecumen Lakeshore was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: IF PARTICIPATING IN THE E-POC PROCESS, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED. Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR By email to: FM.HC.Inspections@state.mn.us	K0000		07/02/2026

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K0000 Bldg. 02	Continued from page 1 THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1.A detailed description of the corrective action taken or planned to correct the deficiency. 2.Address the measures that will be put in place to ensure the deficiency does not reoccur. 3.Indicate how the facility plans to monitor future performance to ensure solutions are sustained. 4.Identify who is responsible for the corrective actions and monitoring of compliance. 5.The actual or proposed date for completion of the remedy. Ecumen Lakeshore Inc. is a two-story building of type II(222) construction that was built in 2004-2005. The building is fully sprinklered and there is supervised smoke detection located in the corridors, space open to corridor and in resident rooms. The facility has a capacity of 60 beds and had a census of 57 at the time of the survey. The requirements at 42 CFR, Subpart 483.70(a), are NOT MET as evidenced by:	K0000		07/02/2026
K0321 SS = F Bldg. 02	Hazardous Areas - Enclosure CFR(s): NFPA 101 Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9	K0321	K0321 1. Corrective Action: The wedge was immediately removed from the home delivery door identified. The EVS Director/designee will complete an audit of all storage doors in the facility to ensure they close, latch correctly, and can be secured by July 13, 2026. 2. Measures to Prevent Recurrence: Education for team members regarding the policy prohibiting wedge devices on doors and the process for reporting doors that do not close correctly will be provided by the EVS Director during the annual Town Hall, communicated via team huddles, and placed in communication binders located on each care floor. 3. Monitoring: The EVS Director/designee will monitor compliance	07/02/2026

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K0321 SS = F Bldg. 02	Continued from page 2 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) This STANDARD is NOT MET as evidenced by: Based on observation and staff interview, the facility failed to maintain hazardous storage rooms per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.2.1.3 and 7.2.1.8.1. These deficient finding could have a widespread impact on the residents within the facility. Findings include: On 05/21/2026, at the following times, it was revealed by observation that storage rooms in the following areas did not close and latch. 1) at 12:10pm, Bedding/linen closet by RM 143 2) at 12:12pm, Soiled Utility Room by RM 148 3) at 12:25pm, Fire door by RM 240 4) at 12:27pm, Bedding/linen closet by RM 238 5) at 12:31pm, Bedding/linen closet by RM 228 6) at 12:50pm, Home Delivery Service storage room was held open with wedge device An interview with the Faculty Administrator verified this deficient finding at the time of discovery.	K0321	Continued from page 2 during routine environmental rounds weekly x4 weeks, then monthly x3 months. 4. Responsible Person: EVS Director/designee. 5. Completion Date: November 1, 2026.	07/02/2026

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K0712 SS = F Bldg. 02	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 STANDARD is NOT MET as evidenced by: Based on a review of available documentation and staff interview, the facility failed to conduct fire drills under varied times and conditions per NFPA 101 (2012 edition), Life Safety Code, sections 19.7.1.6, 4.7.4, and 4.6.1.1. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 05/21/2026, at 11:21am, it was revealed by a review of available documentation that fire drills were not completed: fourth quarter (October - December) drill completely. An interview with the Faculty Administrator verified this deficient finding at the time of discovery.	K0712	K0712 – Fire Drills Findings include: On 05/21/2026, at 11:21am, it was revealed by a review of available documentation that fire drills were not completed: fourth quarter (October - December) drill completely. Detailed description of the corrective action taken or planned to correct the deficiency. A make-up fire drill is scheduled for second shift 7/20/2026 to ensure team members receive the necessary training on proper fire drill procedures along with their roles and responsibilities in the event of a fire. Documentation for correctly completed first and third shift drills are attached. Education has been provided to the EVS Director on how and when to conduct fire drills. Address the measures that will be put in place to ensure the deficiency does not reoccur: Fire drills have been added to our computerized maintenance management system quarterly on each shift at expected and unexpected times under varying conditions. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. The quarterly fire drills will be logged in the computerized maintenance management system which will be reviewed on a quarterly basis between the Facility Administrator and the EVS Director. Any late or non-compliance with these fire drills will be addressed immediately. Quarterly the computerized maintenance management system fire drills task will be reviewed by the QAPI Committee for non-compliance which will be addressed immediately if found. Identify who is responsible for the corrective actions and monitoring of compliance.	07/24/2026

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K0712 SS = F Bldg. 02		K0712	Continued from page 4 Facility Administrator, EVS Director, QAPI Committee The actual or proposed date for completion of the remedy. 07/24/2026	07/24/2026
K0920 SS = E Bldg. 02	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 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 STANDARD is NOT MET as evidenced by: Based on observation and staff interview, the facility failed to maintain the usage of electrical adaptive devices per NFPA 99 (2012 edition), Health Care Facilities Code, sections 10.5.2.3.1 and 10.2.4.2.1, NFPA 70, (2011 edition), National Electrical Code, sections 400-8, and UL 1363. This deficient finding could have a patterened impact on the residents within the facility. Findings include: On 05/21/2026, at the following times, it was revealed by observation that there were several electrical appliances plugged power-strips, multi-plug adapters and/or extension cords in the	K0920	K0920 – Electrical Equipment – Power Cords and Extension Cords Findings include: On 05/21/2026, at the following times, it was revealed by observation that there were several electrical appliances plugged power-strips, multi-plug adapters and/or extension cords in the following areas; at 12:03pm, Extension cords in Infection Office at 12:05pm, Power-strip in break room (microwave and coffeemaker) Detailed description of the corrective action taken or planned to correct the deficiency. Extension cords in Infection Office Removed immediately after survey Power strip in break room (microwave and coffeemaker) Removed immediately after survey Address the measures that will be put in place to ensure the deficiency does not reoccur: A monthly environmental life safety inspection has been established in our computerized maintenance management system to verify that extension cords, multi-plug adapters, and power strips are used in accordance with applicable Life Safety Code requirements.	07/24/2026

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K0920 SS = E Bldg. 02	Continued from page 5 following areas; 1) at 12:03pm, Extension cords in Infection Office 2) at 12:05pm, Power-strip in break room (microwave and coffeemaker) An interview with the Faculty Administrator verified this deficient finding at the time of discovery.	K0920	Continued from page 5 Education will be provided to team members regarding the proper use of extension cords and power strips, including the requirement to report electrical needs rather than using unapproved devices. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. The monthly environmental life safety inspection will be documented in the computerized maintenance management system and reviewed monthly by the Facility Administrator and EVS Director. Any deficiencies identified will be corrected immediately. Quarterly, the computerized maintenance management system environmental life safety inspection will be reviewed by the QAPI Committee for compliance. Any non-compliance identified will be addressed immediately. Identify who is responsible for the corrective actions and monitoring of compliance. Facility Administrator, EVS Director, QAPI Committee The actual or proposed date for completion of the remedy. 07/24/2026	07/24/2026
K0345 SS = D Bldg. 02	Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This STANDARD is NOT MET as evidenced by:	K0345	K0345 1. Corrective Action: The required fire alarm sensitivity report will be obtained from our vendor to demonstrate compliance and will be maintained annually by EVS director/designee. 2. Measures to Prevent Recurrence: Required fire alarm sensitivity testing was completed on 4/20/2026. 3. Monitoring:	07/02/2026

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K0345 SS = D Bldg. 02	Continued from page 6 Based on a review of available documentation and staff interview, the facility failed to maintain the fire alarm system per NFPA 101 (2012 edition), Life Safety Code, section 9.6.1.3, and NFPA 72 (2010 edition), National Fire Alarm and Signaling Code section 14.2.1.2.2. These deficient findings could have an isolated impact on the residents within the facility. Findings include: 1) On 05/21/2026 at 11:34am, it was revealed by a review of available documentation that the annual fire alarm inspection report did not have sensitivity report. The sensitivity report could not be provided at time of inspection. An interview with the Faculty Administrator verified this deficient finding at the time of discovery.	K0345	Continued from page 6 The EVS Director/designee will verify testing is completed appropriately and maintain documentation demonstrating compliance in Environmental Office. 4. Responsible Person: EVS Director/designee. 5. Completion Date: August 29, 2026.	07/02/2026
K0353 SS = D Bldg. 02	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This STANDARD is NOT MET as evidenced by: Based on a review of available documentation and staff interview, the facility failed to maintain the automatic sprinkler system per NFPA 101 (2012 edition), Life Safety Code Section 19.7.6, and 4.6.12,	K0353	K0353 1. Corrective Action: Improperly stored items were removed on May 21, 2026. Required quarterly sprinkler testing will be completed by August 29th, 2026. 2. Measures to Prevent Recurrence: Quarterly sprinkler testing will be scheduled in the facility's electronic task monitoring system by July 29, 2026. Education regarding appropriate storage practices will be provided during the annual Town Hall on July 29, 2026. 3. Monitoring: The EVS Director/designee will monitor completion of quarterly sprinkler testing and observe storage compliance during routine environmental rounds weekly x4 weeks, monthly x3 months. 4. Responsible Person: EVS Director/designee. 5. Completion Date: November 1, 2026.	07/02/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245215	(X2) MULTIPLE CONSTRUCTION A. BUILDING **02 - NEW REPLAC...** B. WING	(X3) DATE SURVEY COMPLETED **05/21/2026**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ecumen Lakeshore	**4002 LONDON ROAD , DULUTH, Minnesota, 55804**

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K0353 SS = D Bldg. 02	Continued from page 7 NFPA 25 (2011 edition), Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, section 5.1.1.2. This deficient finding could have an isolated impact on the residents within the facility. Based on observation and staff interview, the facility failed to maintain spacing between storage and the sprinkler system per NFPA 101 (2012 edition), Life Safety Code, Section 9.7.5, NFPA 25 (2011 edition), Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, Section 5.2.1.2, and NFPA 13 (2010 edition), Standard for the Installation of Sprinkler Systems, Section 8.6.5.3.2. These deficient findings could a patterned impact on the residents within the facility. Findings include: On 05/21/2026, at 11:37am, it was revealed by a review of available documentation the facility failed to provide documentation for one of the required quarterly sprinkler system testing. Findings include: On 05/21/2026, at 12:54pm, it was revealed by observation that storage materials had been placed on a storage rack, bringing the storage materials within the required 18 inch clearance area under the sprinkler heads. These obstructions were found in kitchen dry good storage area An interview with the Faculty Administrator verified this deficient finding at the time of discovery.	K0353		07/02/2026
K0761 SS = D Bldg. 02	Maintenance, Inspection & Testing - Doors CFR(s): NFPA 101 Maintenance, Inspection & Testing - Doors Fire doors assemblies are inspected and tested annually in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives. Non-rated doors, including corridor doors to patient rooms and smoke barrier doors, are routinely inspected as part of the facility maintenance program. Individuals performing the door inspections and testing possess knowledge, training or experience that demonstrates ability.	K0761	K0761 – Maintenance, Inspection & Testing - Doors Findings include: On 05/21/2026, at 11:06am, it was revealed by review of available documentation the required annual door inspection documentation the facility failed to provide a document showing all 13 points of the required door inspection was completed. On 05/21/2026, at 12:00pm, it was revealed by observation that the following fire doors and/or fire door frames had painted door/frame tags. 1) Fire doors on the first floor plaza hallway	07/24/2026

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K0761 SS = D Bldg. 02	Continued from page 8 Written records of inspection and testing are maintained and are available for review. 19.7.6, 8.3.3.1 (LSC) 5.2, 5.2.3 (2010 NFPA 80) This STANDARD is NOT MET as evidenced by: Based on a review of available documentation and staff interview, the facility failed to inspect fire doors per NFPA 101 (2012 edition), Life Safety Code section 8.3.3.1, and NFPA 80 (2010 edition), Standard for Fire Doors and Other Opening Protectives, section 5.2.5.2. This deficient finding could have an isolated impact on the residents within the facility. Based on a review of available documentation and staff interview, the facility failed to inspect fire doors per NFPA 101 (2012 edition), Life Safety Code section 8.3.3.1, and NFPA 80 (2010 edition), Standard for Fire Doors and Other Opening Protectives, section 5.2.1. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 05/21/2026, at 11:06am, it was revealed by review of available documentation the required annual door inspection documentation the facility failed to provide a document showing all 13 points of the required door inspection was completed. Findings include: On 05/21/2026, at 12:00pm, it was revealed by observation that the following fire doors and/or fire door frames had painted door/frame tags. 1) Fire doors on the first floor plaza hallway An interview with the Faculty Administrator verified this deficient finding at the time of discovery.	K0761	Continued from page 8 Detailed description of the corrective action taken or planned to correct the deficiency A vendor is scheduled to complete the required 13-point door inspection 7/15/2026. The paint was removed from the door/frame tags on fire doors on the first floor plaza hallway. Address the measures that will be put in place to ensure the deficiency does not reoccur: A task has been added to our computerized maintenance management system to ensure the annual 13-point fire door inspection has been completed. Auditing compliance for painted door/frame tags on fire doors has been added to the monthly environmental rounds checklist. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. The annual 13-point fire door inspection will be documented in the computerized maintenance management system and reviewed annually by the Facility Administrator and EVS Director. Any deficiencies identified will be corrected immediately. The computerized maintenance management system annual 13-point fire door inspection will be reviewed by the QAPI Committee for compliance. Any non-compliance identified will be addressed immediately. Deficiencies from the environmental rounds will be reviewed at each QAPI meeting. Deficiencies will be addressed immediately. Identify who is responsible for the corrective actions and monitoring of compliance. Facility Administrator, EVS Director, QAPI Committee, Safety Committee	07/24/2026

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K0761 SS = D Bldg. 02		K0761	Continued from page 9 The actual or proposed date for completion of the remedy. 07/24/2026	07/24/2026
K0914 SS = D Bldg. 02	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 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 STANDARD is NOT MET as evidenced by: Based on a review of available documentation and staff interview, the facility failed to conduct the electrical testing and maintenance per NFPA 99 Standards for Health Care Facilities 2012 edition, section 6.3.3.2, 6.3.4.1.3, and 6.3.4.2.1.2. This deficient finding could have an isolated impact on the residents within the facility. Findings include: On 05/21/2026, at 11:53am, it was revealed by review of available documentation the required annual receptacle inspection documentation was not available at the time of the survey. An interview with the Faculty Administrator verified this deficient finding at the time of discovery.	K0914	K0914 1. Corrective Action: The annual electrical outlet inspection was completed 10/14/2025 through 10/16/2025 and documentation will be submitted with this Plan of Correction. 2. Measures to Prevent Recurrence: The documentation will be maintained in the facility's Life Safety compliance records binder in environmental office for future survey review. 3. Monitoring: The EVS Director/designee will verify documentation remains current and readily available. 4. Responsible Person: EVS Director/designee. 5. Completion Date: Completed July 2, 2026.	07/02/2026

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K0918 SS = D Bldg. 02	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 STANDARD is NOT MET as evidenced by: Based on a review of available documentation and staff interview, the facility failed to maintain generators per NFPA 110 (2010 edition), Standard for Emergency and Standby Power Systems, sections 4.2. This deficient finding could have an isolated on the residents within the facility. Based on a review of available documentation and staff interview, the facility failed to maintain generators per NFPA 110 (2010 edition), Standard for Emergency and Standby Power Systems, 8.3.8 for annual fuel testing. This deficient finding could have an isolated on the residents within the facility.	K0918	K0918 – Electrical Systems – Essential Electric System Findings include: Based on a review of available documentation and staff interview, the facility failed to maintain generators per NFPA 110 (2010 edition), Standard for Emergency and Standby Power Systems, 8.3.8 for annual fuel testing. This deficient finding could have an isolated on the residents within the facility. Detailed description of the corrective action taken or planned to correct the deficiency The annual fuel testing report was obtained from the vendor which was complete on 10/27/25. Please see attached report. Address the measures that will be put in place to ensure the deficiency does not reoccur: The MDH Fire/Life Safety Documentation Guide will be used to establish a tabbed binder to ensure proper documentation is filed in a consistent manner. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. The Fire/Life Safety binder will be audited annually by the Facility Administrator and EVS Director for Compliance which will be reported to the QAPI Committee. Identify who is responsible for the corrective actions and monitoring of compliance. Facility Administrator, EVS Director, QAPI Committee. The actual or proposed date for completion of the remedy. 07/24/2026	07/24/2026