Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
November 15, 2024

Administrator
Benedictine Health Center
935 Kenwood Avenue
Duluth, MN 55811

RE: CCN: 245236
Cycle Start Date: November 7, 2024

Dear Administrator:

On November 7, 2024, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

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

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

DEPARTMENT CONTACT

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

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 February 7, 2025 (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 May 7, 2025 (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

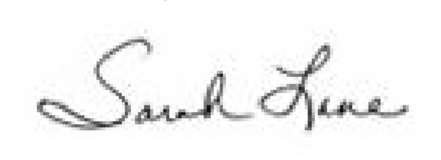
A facility may not use both IDR and independent IDR for the same deficiency citation(s) arising from the same survey unless the IDR process was completed prior to the imposition of the CMP. This request must be sent within ten calendar days of receipt of this offer. An incomplete Independent IDR process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

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November 15, 2024

Administrator
Benedictine Health Center
935 Kenwood Avenue
Duluth, MN 55811

Re: Event ID: 9IMO11

Dear Administrator:

The above facility survey was completed on November 7, 2024 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted no violations of these rules promulgated under Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10.

Electronically posted is the Minnesota Department of Health order form stating that no violations were noted at the time of this survey. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Please disregard the heading of the fourth column which states, "Provider's Plan of Correction." This applies to Federal deficiencies only. There is no requirement to submit a Plan of Correction.

Please feel free to call me with any 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 CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00861	A. BUILDING: _____ B. WING _____	C 11/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BENEDICTINE HEALTH CENTER	935 KENWOOD AVENUE DULUTH, MN 55811

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 11/4/24-11/7/24, a licensing survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was IN compliance with the MN State Licensure. The following complaints were reviewed during	2 000		

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2 000	Continued From page 1 the survey: H52369986C (MN00103717) H52369987C (MN00102493), H52369988C (MN00107816) H52369989C (MN00099449) NO licensing orders were issued. The Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	2 000		

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	245236	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**11/05/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BENEDICTINE HEALTH CENTER	**935 KENWOOD AVENUE** **DULUTH, MN 55811**

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K 000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety recertification survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 11/05/2024. At the time of this survey, Benedictine Health Center was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: IF PARTICIPATING IN THE E-POC PROCESS, A PAPER COPY OF THE PLAN OF CORRECTION	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		11/23/2024

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 000	Continued From page 1 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 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. Benedictine Health Center is a three story building with no basement. The original building was constructed in 1980 with an addition in 1990. Both buildings are of type II (111) construction. Because the original building and the addition are of the same type of construction allowed for existing buildings, the facility was surveyed as one building.	K 000		

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K 000	Continued From page 2 The building is fully fire sprinkler protected. The facility has a complete fire alarm system with smoke detection in the corridors and spaces open to the corridor that is monitored for automatic fire department notification. The facility has a capacity of 97 beds and had a census of 92 at the time of the survey.	K 000		
K 223 SS=D	The requirements at 42 CFR, Subpart 483.70(a), are NOT MET as evidenced by: Doors with Self-Closing Devices CFR(s): NFPA 101 Doors with Self-Closing Devices Doors in an exit passageway, stairway enclosure, or horizontal exit, smoke barrier, or hazardous area enclosure are self-closing and kept in the closed position, unless held open by a release device complying with 7.2.1.8.2 that automatically closes all such doors throughout the smoke compartment or entire facility upon activation of: * Required manual fire alarm system; and * Local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system; and * Automatic sprinkler system, if installed; and * Loss of power. 18.2.2.2.7, 18.2.2.2.8, 19.2.2.2.7, 19.2.2.2.8 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to install self-closing device per NFPA 101 (2012 edition), Life Safety Code, section 19.3.2.1.3 and 19.3.2.1.5. These deficient findings could have an isolated impact on the residents	K 223	This plan of correction constitutes the facility's credible allegation of compliance. Preparation and/or execution of this plan does not constitute admission or agreement by the provider of the truths or	11/25/24

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K 223	Continued From page 3 within the facility. Findings include: On 11/05/2024 between 8.00am and 12:00pm, it was revealed by observation that smoke barrier door 317 has a broken self closing device. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 223	facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed in accordance with federal and state law requirements. K223 □ Doors with Self-Closing Devices Northern Door adjusted self-closing mechanism on 11/20/24 to smoke barrier door 317. There are no other smoke barrier doors with a broken self-closing mechanism. EVS Director or designee will audit 10 smoke barrier doors once a month for 2 months to ensure smoke barrier doors self-closing mechanism working correctly. Findings will be presented to facility□s Quality Council by DON or designee. Results of monitoring shall be reported at the facility Quality Council meeting with ongoing frequency and duration to be determined through analysis and review of results. EVS Director or Administrator is responsible for ongoing compliance. Compliance achieved 11/25/24.	
K 291 SS=E	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 by: Based on observation the facility failed to maintain emergency lighting system per NFPA 101 (2012	K 291	K291 □ Emergency Lighting The Emergency Lighting System for BHC	11/25/24

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K 291	Continued From page 4 edition), Life Safety Code sections 19.2.9.1 and 7.9.1.3. This deficient practice could have a patterned impact on the residents within the facility. Findings include: On 11/05/2024 between 8.00am and 12:00pm, it was revealed by observation that the facility failed to conduct the annual 90 minute required Emergency Lighting test. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 291	is connected to Emergency Generator and is a Type 10 emergency power supply system, which restores all power for the entire building within 10 seconds of power failure. No further correction needed	
K 353 SS=F	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by:	K 353		11/25/24

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K 353	Continued From page 5 1) Based on observation, a review of available documentation, and staff interview, the facility failed to inspect and maintain the fire sprinkler system per NFPA 101 (2012 edition), Life Safety Code, section 9.7.5, and NFPA 25 (2011 edition), Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, sections 5.1.1.2, and 5.3.2.1. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 11/05/2024 between 8.00am and 12:00pm, it was revealed by a review of available documentation the facility failed to perform the five (5) year sprinkler system testing. 2) 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, Sections 8.6.5.3.2 and 8.15.9. These deficient findings could a patterned impact on the residents within the facility. Findings include: On 11/05/2024 between 8.00am and 12:00pm, 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	K 353	K353 Sprinkler System-Maintenance and Testing Hydrostatic test is scheduled for December 3rd 2024 weather permitting, if unable to complete 12/3/24 will schedule in Spring 2025. Scheduled next 5-year sprinkler test with Viking Sprinkler and added due dates to EVS Director and Administrators calendar to serve as a back up to ensure inspections occur timely. EVS Director or Administrator is responsible for ongoing compliance and scheduling with Sprinkler company every 5-years. Compliance achieved 11/25/24. K353 Sprinkler System-Maintenance and Testing All Materials in room 203A, 218G and Third Floor Records Room were removed. All storage rack walls were labeled with a sticker/sign indicating 18 inches from the ceilings. EVS Director or designee will audit all storage racks once a week for 4 weeks, then monthly for 2 months to ensure items are not stored less than 18 inches from the ceiling. Findings will be presented to facility□s Quality Council by DON or designee. Results of monitoring shall be reported at the facility Quality Council meeting with ongoing frequency and duration to be determined through analysis and review of results. EVS Director or Administrator is responsible for ongoing compliance.	

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K 353	Continued From page 6 obstructions were found in: 1) 203A Clean Linen storage 2) 218G Nurse supply Room 3) Third Floor Records Room An interview with the Maintenance Director verified this deficient finding at the time of discovery	K 353	Compliance achieved 11/25/24.	
K 363 SS=D	Corridor - Doors CFR(s): NFPA 101 Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the	K 363		11/25/24

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BENEDICTINE HEALTH CENTER	**935 KENWOOD AVENUE** **DULUTH, MN 55811**

(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 363	Continued From page 7 smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain corridor doors per NFPA 101 (2012 edition), Life Safety Code, section 19.3.6.3.5. This deficient finding could have an isolated impact on the residents within the facility. Findings include: 1) On 11/05/2024 between 8.00am and 12:00pm, it was revealed by observation that the following doors did not latch when tested: 1) Electrical room 219A 2) On 11/05/2024 between 8.00am and 12:00pm, it was revealed by observation that the following corridor patient room doors have interference issues with interior bathroom doors in the following rooms: 1) Patient room 305 2) Patient room 332 3) Patient room 354 An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 363	K363 Corridor Doors Northern Door adjusted door 219A to ensure door latched correctly on 11/20/24. Patient rooms 305, 332, 354 were labeled with a sign to close bathroom door when not in use temporarily. Northern Door to provide quote for alternative doors or hinge placement. EVS Director or designee will audit 219A, 305, 332, 354 once a week for 4 weeks, then monthly for 2 months to ensure bathroom doors are closed when not in use. Results of monitoring shall be reported at the facility Quality Council meeting with ongoing frequency and duration to be determined through analysis and review of results. EVS Director or Administrator is responsible for ongoing compliance. Compliance achieved 11/25/24.	

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	245236	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**11/05/2024**

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K 372 SS=F	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain their smoke barrier per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.7.1, 19.3.7.3, 8.5.2.2, and 8.5.6.5. These deficient findings could have a widespread impact on the residents within the facility. Findings include: On 11/05/2024 between 8.00am and 12:00pm, it was revealed by observation that there was a penetration running from one smoke compartment to another above doors 109D and 262. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 372	K372 Subdivision of Building Spaces-Smoke Barrier Penetration from smoke compartment 109D and 262 were filled with correct caulking on 11/19/24. All other smoke compartments were checked to ensure no other open penetration from one smoke compartment to another. Policy/agreement created for contractors doing work in the future to agree to prior to start of a project that leads to wall penetrations that they agree to fill any newly created penetrations appropriately. Contractor will sign once completed and EVS Director will verify that the work has been completed appropriately. EVS Director will sign off that penetrations have been completed with future projects. EVS Director or Administrator is responsible for ongoing compliance.	11/25/24

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K 372	Continued From page 9	K 372	Compliance achieved 11/25/24.	
K 541 SS=F	Rubbish Chutes, Incinerators, and Laundry Chu CFR(s): NFPA 101 Rubbish Chutes, Incinerators, and Laundry Chutes 2012 EXISTING (1) Any existing linen and trash chute, including pneumatic rubbish and linen systems, that opens directly onto any corridor shall be sealed by fire resistive construction to prevent further use or shall be provided with a fire door assembly having a fire protection rating of 1-hour. All new chutes shall comply with 9.5. (2) Any rubbish chute or linen chute, including pneumatic rubbish and linen systems, shall be provided with automatic extinguishing protection in accordance with 9.7. (3) Any trash chute shall discharge into a trash collection room used for no other purpose and protected in accordance with 8.4. (Existing laundry chutes permitted to discharge into same room are protected by automatic sprinklers in accordance with 19.3.5.9 or 19.3.5.7.) (4) Existing fuel-fed incinerators shall be sealed by fire resistive construction to prevent further use. 19.5.4, 9.5, 8.4, NFPA 82 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to secure the laundry chute door per NFPA 101 (2012 edition), Life Safety Code section 19.5.4.1. These deficient findings could have a widespread impact on the residents within the facility. On 11/05/2024 between 8.00am and 12:00pm, it was revealed by observation that the laundry chute door located on second floor was missing	K 541	K541 Rubbish Chutes, Incinerators, Laundry Chutes. A latch was added to the laundry chute door on 11/19/24. Education completed to EVS on 11/22/24. EVS Director or designee will audit both laundry chute latches once a week for 4 weeks, then monthly for 2 months to ensure latches on laundry chutes are latching. Results of monitoring shall be	11/25/24

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K 541	Continued From page 10 self-closing device and/or a device to secure chute door in the closed position. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 541	reported at the facility Quality Council meeting with ongoing frequency and duration to be determined through analysis and review of results. EVS Director or Administrator is responsible for ongoing compliance. Compliance achieved 11/25/24.	
K 712 SS=F	Fire Drills CFR(s): NFPA 101 Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 This REQUIREMENT is not met as evidenced by: 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 11/05/2024 between 8.00am and 12:00pm, it was revealed by a review of available documentation that fire drills did not meet the varying time requirement: second shift - Second, Third and Fourth quarter drills missing. Third shift -	K 712	K712 Fire Drills A spreadsheet was created to log fire drills and to be able to view times to meet the varying requirement of NFPA guidelines. Education provided to EVS team on appropriate times on 11/22/24. EVS Director or Administrator will audit monthly Fire Drills completed to ensure fire drills completed to meet the time requirement. EVS Director or Administrator is responsible for ongoing compliance. Compliance achieved 11/25/24.	11/25/24

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K 712	Continued From page 11 First, Second and Fourth Quarter drills were missing. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 712		
K 753 SS=E	Combustible Decorations CFR(s): NFPA 101 Combustible Decorations Combustible decorations shall be prohibited unless one of the following is met: o Flame retardant or treated with approved fire-retardant coating that is listed and labeled for product. o Decorations meet NFPA 701. o Decorations exhibit heat release less than 100 kilowatts in accordance with NFPA 289. o Decorations, such as photographs, paintings and other art are attached to the walls, ceilings and non-fire-rated doors in accordance with 18.7.5.6(4) or 19.7.5.6(4). o The decorations in existing occupancies are in such limited quantities that a hazard of fire development or spread is not present. 19.7.5.6 This REQUIREMENT is not met as evidenced by: Based on observation or a review of available documentation and staff interview, the facility failed to prohibit combustible decorations per NFPA 101 (2012 edition), Life Safety Code, sections 19.7.5.6 and 19.7.5.6 (4). These deficient findings could have a patterned on the residents within the facility. Findings include: On 11/05/2024 between 8.00am and 12:00pm, it	K 753	K753 Combustible Decorations All 3 candles in the chapel were put away following the end of the religious service. Spiritual Care team educated on 11/19/24 to put away candles following end of religious service. EVS Director or designee will audit the chapel once a week for 4 weeks, then monthly for 2 months to ensure candles are put away and secured following	11/25/24

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K 753	Continued From page 12 was revealed by observation that three (3) candles were located in chapel area. This candles can be used during mass or religious events, but must be secured after uses. An interview with the Maintenance Director verified this deficient finding at the time of discovery	K 753	religious service. Results of monitoring shall be reported at the facility Quality Council meeting with ongoing frequency and duration to be determined through analysis and review of results. EVS Director or Administrator is responsible for ongoing compliance. Compliance achieved 11/25/24.	
K 761 SS=F	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. 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 REQUIREMENT 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 5.2.1. This deficient finding could have a widespread impact on the residents within the facility. Findings include:	K 761	K761 Maintenance, Inspection and Testing □ Doors EVS Director or designee completed annual door inspection on 11/25/24. EVS Director or designee remove paint on door rating tag on door 229. Norther Door adjust the gap of door 261 on 11/20/24. Annual Door Inspection Task added to TELs as re-occurring task each year and	11/27/24

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K 761	Continued From page 13 1) On 11/05/2024 between 8.00am and 12:00pm, it was revealed by review of available documentation the required annual door inspection documentation was not available at the time of the survey. 2) On 11/05/2024 between 8.00am and 12:00pm, it was revealed by observation that the following fire doors and/or fire door frames have painted over door rating tags. Door 229. 3) On 11/05/2024 between 8.00am and 12:00pm, it was revealed by observation that the following fire doors and/or fire door frames have a gap that exceeds the maximum allowable: door 261. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 761	scheduled to re-occur annually each November. Education provided to EVS team to ensure door rating tags remain visible and not covered and maintain appropriate gap space. EVS Director or Administrator is responsible for ongoing compliance. Compliance achieved 11/27/24.	
K 781 SS=E	Portable Space Heaters CFR(s): NFPA 101 Portable Space Heaters Portable space heating devices shall be prohibited in all health care occupancies, except, unless used in nonsleeping staff and employee areas where the heating elements do not exceed 212 degrees Fahrenheit (100 degrees Celsius). 18.7.8, 19.7.8 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to implement its portable space heater policy per NFPA 101 (2012 edition), Life Safety Code, section 19.7.8. These deficient findings could have a patterned impact on the residents within the facility. Findings include:	K 781	K781 Portable Space Heater Upon inspection of room 332 and the removal of the suspected space heater. The object was not a space heater, it was a fan. No further correction needed.	11/15/24

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K 781	Continued From page 14 On 11/05/2024 between 8.00am and 12:00pm, it was revealed by observation of portable space heater in patients room 332. space heaters are prohibited in patients areas. This heater was removed at time of inspection. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 781		
K 914 SS=F	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 REQUIREMENT 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	K 914	K914 Electrical Systems EVS Director or designee completed annual receptacle inspection on 11/27/24.	11/27/24

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K 914	Continued From page 15 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 a widespread impact on the residents within the facility. Findings include: On 11/05/2024 between 8.00am and 12:00pm, it was revealed by review of available documentation the required annual receptacle inspection documentation was not available at the time of the survey. Test was last completed October 2023. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 914	Receptacle inspection was added as a task in TELs to be completed annually each February. Inspection due dates will be on EVS Director and Administrators calendar to serve as a back up to ensure inspections occur timely. EVS Director or Administrator is responsible for ongoing compliance. Compliance achieved by 11/27/2024.	
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 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	K 920		11/25/24

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K 920	Continued From page 16 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: 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 an isolated impact on the residents within the facility. Findings include: On 11/05/2024 between 8.00am and 12:00pm, 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; 1) Patients room 332 2) Laundry room on wooden shelf 3) Activities Office - third floor An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 920	K920 Electrical Equipment-Power Cords and Extensions EVS Director removed extension cords and multi-plug adapters in room 332, laundry room and 3rd floor activities office. Added power cords and extensions task in TELs to re-occur monthly. Education completed for all EVS staff. EVS Director or designee will audit 10 rooms once a week for 4 weeks, then 5 rooms for 2 weeks to ensure no additional extension cords or multi-plug adapters not in use. Results of monitoring shall be reported at the facility Quality Council meeting with ongoing frequency and duration to be determined through analysis and review of results. EVS Director or Administrator is responsible for ongoing compliance. Compliance achieved by 11/25/2024.	