Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
November 3, 2023

Administrator
Ecumen Lakeshore
4002 London Road
Duluth, MN 55804

RE: CCN: 245215
Cycle Start Date: September 8, 2023

Dear Administrator:

On October 11, 2023, the Minnesota Departments of Health and Public Safety, completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Health Regulation Division
Telephone: (651) 201-4112
Email: Kamala.Fiske-Downing@state.mn.us

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

November 3, 2023

Administrator
Ecumen Lakeshore
4002 London Road
Duluth, MN 55804

Re: Reinspection Results
Event ID: JBF612

Dear Administrator:

On October 11, 2023 survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on September 8, 2023. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Health Regulation Division
Telephone: (651) 201-4112
Email: Kamala.Fiske-Downing@state.mn.us

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
September 19, 2023

Administrator
Ecumen Lakeshore
4002 London Road
Duluth, MN 55804

RE: CCN: 245215
Cycle Start Date: September 8, 2023

Dear Administrator:

On September 8, 2023, 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, Unit Supervisor
Duluth District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
11 East Superior Street, Suite 290
Duluth, MN 55082
Email: Alex.Warren@state.mn.us
Mobile: 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 December 8, 2023 (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 March 8, 2024 (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) / INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

In accordance with 42 CFR 488.331, 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:

Nursing Home Informal Dispute Process
Minnesota Department of Health
Health Regulation Division
P.O. Box 64900
St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: https://mdhprovidercontent.web.health.state.mn.us/ltc_idr.cfm

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

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.

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
Interim State Fire Safety Supervisor
Health Care & Correctional Facilities/Explosives
MN Department of Public Safety-Fire Marshal Division
445 Minnesota St., Suite 145
St. Paul, MN 55101
travis.ahrens@state.mn.us
Cell: 1-507-308-4189

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing
Minnesota Department of Health
Health Regulation Division
Telephone: (651) 201-4112
Email: Kamala.Fiske-Downing@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245215	A. BUILDING _______ B. WING _______	C 09/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ECUMEN LAKESHORE	**4002 LONDON ROAD DULUTH, MN 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
E 000	Initial Comments On 9/5/23 through 9/8/23, a survey for compliance with Appendix Z, Emergency Preparedness Requirements, §483.73(b)(6) 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.	E 000		
F 000	INITIAL COMMENTS On 9/5/23 through 9/8/23, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was not in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaint was reviewed: H52154967 (MN96271) The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.	F 000		
F 582 SS=D	Medicaid/Medicare Coverage/Liability Notice CFR(s): 483.10(g)(17)(18)(i)-(v)	F 582		10/9/23

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		09/26/2023

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 582	Continued From page 1	F 582		

§483.10(g)(17) The facility must--
(i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of-
(A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged;
(B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and
(ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this section.

§483.10(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate.
(i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible.
(ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change.
(iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any

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F 582	Continued From page 2 deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements. (iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility. (v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to provide the required Skilled Nursing Facility Advanced Beneficiary Notice (SNFABN) to 1 of 2 residents (R14) reviewed whose Medicare A coverage ended and remained in the facility. Findings include: R14's Centers for Medicare and Medicaid Services (CMS)-10123 dated 5/1/23, identified a Medicare last covered day (LCD) of 5/3/23. R14's undated Census Records form identified on 5/4/23, R14's payer source changed from Medicare Part A to "Private Pay," and R14 remained in the facility. R14's medical record lacked evidence a SNFABN was provided to explain the estimated cost per day or provide rationale of the extended care services or items to be furnished, reduced, or terminated.	F 582	1. How corrective action will be accomplished for those residents found to have been affected by the deficient practice. a. R14 has been discharged from the facility. 2. How the facility will identify other residents having the potential to be affected by the same deficient practice. a. Will complete audits of issuance of SNFABNs for all current residents who are private pay to determine gaps in service for other residents. 3. What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur. a. Education will be completed with the discharge planning team members to ensure understanding of the importance of issuing SNFABNs to patients when transitioning to private pay.	

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F 582	Continued From page 3 R14's progress note dated 5/1/23, identified the social worker (SW) had given R14 a Notice of Medicare Non-Coverage. The note identified R14 planned to discharge to home after her surgery. On 9/7/23 at 2:31 p.m., the SW reviewed R14's chart and identified R14 received the notice of non-coverage, and was planning to go home, but R14's surgery date was changed, therefore R14 remained in the facility. R14's status changed to private pay on of 5/4/23, and R14 did not receive a SNFABN, when they decided to remain in the facility. It was the facility process to make sure everyone received proper notice, to allow them to make an informed decision about discharging or remaining in the facility. On 9/8/23 at 8:40 a.m., the director of nursing (DON) stated it was her expectation that every resident received a SNFABN to notify them how much it would cost to stay in the facility as a private pay resident. The document allows residents and their families to make an informed decision. The facility policy Medicare Advanced Beneficiary and Medicare Non-Coverage, dated 9/22, identified the facility would issue a SNFABN to a resident or their representative in the event it was anticipated Medicare part A would not pay for an otherwise covered skilled service(s). The notification would inform residents that services may not be covered and of the resident's potential liability for payment of non-covered service(s).	F 582	4. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur. a. Audits of all residents receiving a SNFABN to ensure compliance will happen weekly x4 weeks, monthly x 2 months. Will review results with the QAPI team to make a recommendation for ongoing auditing. 5. The date that each deficiency will be corrected. a. 10/9/22	
F 756 SS=D	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review.	F 756		10/9/23

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F 756	Continued From page 4 §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the	F 756	1. How corrective action will be	

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F 756	Continued From page 5 facility failed for 1 of 5 residents (R159) reviewed for medications. Findings include: R159's admission Minimum Data Set (MDS) dated 7/4/23, identified memory problems and had no behaviors identified. R 159 utilized antipsychotic medications for seven days during the look back period. The antipsychotic identified it was used on a routine basis, there was no drug regimen review identified as completed and lacked and medication follow up. A diagnosis of insomnia was identified. R159's care plan revised on 9/6/23, identified R159 used Seroquel (an antipsychotic medication) and the facility would monitor for the inability to fall asleep/ stay asleep and for nocturnal restlessness. R159's Order Summary Reported dated 9/6/23, identified an order for Seroquel 50 milligrams (mg) via g-tube at bedtime for diagnosis pending. R159's Medication Administration Record (MAR) dated 9/7/23, identified the Seroquel was prescribed for insomnia. R159's pharmacy reviews from July 2023, through August 2023 identified the following: - 7/9/23 no irregularities - 8/12/23 no irregularities - 8/29/23 requested clarification of Amlodipine dose. Provider clarified dose. - 8/29/23 request to address PRN non-antipsychotic psychotropic medication Benadryl. A stop date was added for 9/11/23. During an interview on 9/8/23 at 8:38 a.m.,	F 756	accomplished for those residents found to have been affected by the deficient practice. a. R159 remains in the facility. Consultant Pharmacist completed a PMR for Seroquel with the diagnosis of insomnia for provider review and follow-up. 2. How the facility will identify other residents having the potential to be affected by the same deficient practice. a. Consultant Pharmacist team to complete a 100% audit of all patients on antipsychotics to ensure an approved diagnosis is in place and if not, generate PMR to provider to follow-up. 3. What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur. a. Director of Consulting at Thrifty White Pharmacy, will lead a consultant team education regarding increasing focus reviewing all antipsychotics for potentially inappropriate and/or unclear indications for use during the PMR and monthly PMR processes. 4. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur. a. Consultant Pharmacist or designee will conduct audits of all antipsychotics and associated diagnosis for use weekly x4 weeks, monthly x 2 months. Will review results with the QAPI team to make a recommendation for ongoing	

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F 756	Continued From page 6 director of nursing (DON) stated the medical providers prescribed medications so she could not say if it was appropriate for R159 to receive scheduled Seroquel for insomnia. During an interview on 9/8/23 at 10:01 a.m., consulting pharmacist (CP) stated Seroquel was an antipsychotic medication and insomnia was not an appropriate diagnosis for the use of Seroquel in the long-term setting. Indications for prescribing Seroquel included: as an adjunct to an antidepressant, bipolar, dementia with behaviors, or behaviors in conjunction with other diagnoses like a personality disorder. Seroquel was often used in the acute care setting to manage sleep but identified it was usually discontinued by the hospital provider at discharge or upon admission to a long-term facility. R159's Seroquel was not an appropriate dose for the treatment of insomnia. The CP stated their partner reviewed R159's admission orders not sure what happened. Typically the Seroquel would have been flagged to be discontinued and would flag the medication for review during the September reviews. R159 was at a greater risk for falls and Seroquel consumption by chemical design could result in changes to the brain and mood. The facility Medication Regimen Reviews policy dated May 2019, identified a medication review would be conducted by a pharmacist at the time of admit then monthly or as needed for all residents in the facility that received medication. The review included the identification of, notification to the provider, and resolution of medication irregularities. Actionable irregularities included but were not limited to: medication errors, excessive doses or doses without a	F 756	auditing. 5. The date that each deficiency will be corrected. a. 10/9/23	

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F 756	Continued From page 7 clinical indication, inadequate monitoring for side effects, duplicative therapies, and potentially adverse consequences of medications.	F 756		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and	F 758		10/9/23

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F 758	Continued From page 8 §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure an appropriate diagnosis to support ongoing use of an antipsychotic medication for 1 of 5 residents (R159) reviewed for medications. Findings include: R159's admission Minimum Data Set (MDS) dated 7/4/23, identified memory problems and had no behaviors identified. R 159 utilized antipsychotic medications for seven days during the look back period. The antipsychotic identified it was used on a routine basis, there was no drug regimen review identified as completed and lacked and medication follow up. A diagnosis of insomnia was identified. R159's care plan revised on 9/6/23, identified R159 used Seroquel (an antipsychotic medication) and the facility would monitor for the inability to fall asleep/ stay asleep and for nocturnal restlessness.	F 758	Added Nursing Education to 3a. ______ 1. How corrective action will be accomplished for those residents found to have been affected by the deficient practice. a. R159 remains in the facility. Consultant Pharmacist completed a PMR for Seroquel with the diagnosis of insomnia for provider review and follow-up. 2. How the facility will identify other residents having the potential to be affected by the same deficient practice. a. Consultant Pharmacist team to complete a 100% audit of all patients on antipsychotics to ensure an approved diagnosis is in place and if not, generate PMR to provider to follow-up. 3. What measures will be put into place, or systemic changes made, to ensure that	

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F 758

Continued From page 9

R159's Order Summary Reported dated 9/6/23, identified an order for Seroquel 50 milligrams (mg) via g-tube at bedtime for diagnosis pending. R159's Medication Administration Record (MAR) dated 9/7/23, identified the Seroquel was prescribed for insomnia.

R159's pharmacy reviews from July 2023, through August 2023, failed to identify a need to review an insomnia diagnosis for the use of antipsychotic medications.

During an interview on 9/8/23 at 8:38 a.m., director of nursing (DON) stated the medical providers prescribed medications so she could not say if it was appropriate for R159 to receive scheduled Seroquel for insomnia.

During an interview on 9/8/23 at 10:01 a.m., consulting pharmacist (CP) stated Seroquel was an antipsychotic medication and insomnia was not an appropriate diagnosis for the use of Seroquel in the long-term setting. Indications for prescribing Seroquel included: as an adjunct to an antidepressant, bipolar, dementia with behaviors, or behaviors in conjunction with other diagnoses like a personality disorder. Seroquel was often used in the acute care setting to manage sleep but identified it was usually discontinued by the hospital provider at discharge or upon admission to a long-term facility. R159's Seroquel was not an appropriate dose for the treatment of insomnia.

During an interview on 9/8/23 at 11:55 a.m., nurse practitioner (NP)-A stated NP-A was responsible for the management of R159's medication while he resided at the facility. R159 received Seroquel

F 758

the deficient practice will not recur.
a. Director of Consulting at Thrifty White Pharmacy, will lead a consultant team AND NURSING education regarding increasing focus reviewing all antipsychotics for potentially inappropriate and/or unclear indications for use during the PMR and monthly PMR processes.

4. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
a. Consultant Pharmacist or designee will conduct audits of all antipsychotics and associated diagnosis for use weekly x4 weeks, monthly x 2 months. Will review results with the QAPI team to make a recommendation for ongoing auditing.

5. The date that each deficiency will be corrected.
a. 10/9/23

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F 758	Continued From page 10 in the hospital and the order continued at the facility. R159's indication for Seroquel was insomnia and explained Seroquel was used off label to treat insomnia. R159's medical record lacked a medical provider's assessment related to Seroquel used for insomnia following admission to the facility. The facility Antipsychotic Medication Use policy dated July 2022, indicated residents would not receive medications that were not clinically indicated to treat a specific condition. The policy included a list from the Diagnostic and Statistical manual of Mental Disorders which provided conditions and diagnoses for which antipsychotic medications would be prescribed to treat a resident. Insomnia was not a listed indication for Seroquel. Antipsychotic medications would not be used if the only symptoms are one or more of the following: a. wandering; b. poor self-care; c restlessness; d. impaired memory; e. mild anxiety; f. insomnia; g. inattention or indifference to surrounding; h. sadness or crying alone that is not related to depression or other psychiatric disorders; fidgeting; j. nervousness; or k. uncooperativeness. A physician would either change or stop problematic doses or medications or document why the benefit of continuing a medication outweighed the risk of suspected or confirmed adverse consequences.	F 758		
F 805 SS=D	Food in Form to Meet Individual Needs CFR(s): 483.60(d)(3) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(3) Food prepared in a form designed	F 805		10/9/23

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F 805	Continued From page 11 to meet individual needs. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to cut food in bite size pieces as directed for 1 of 1 resident (R2) reviewed nutrition. Findings include: R2's admission Minimum Data Set (MDS) assessment dated 7/19/23, indicated R2 was severely cognitively impaired and had difficulty with swallowing. R2's undated Admission Record, included diagnoses of dementia, hemiplegia, and hemiparesis (paralysis and/or weakness on one side of the body) following a stroke affecting the right dominant side. R2's care plan dated 7/13/23, identified R2 had a self-care deficit and required assistance with eating. The interventions indicated R2 required set up and assistance for meals and staff were directed to cut up food. R2 had a swallowing problem secondary to cerebral infarction. Interventions included upright at 90 degrees with food/fluids, cut up foods, monitor for shortness of breath, choking, labored respirations, and lung congestion. Staff were directed to monitor for pocketing of food, choking, coughing, drooling, or holding food in mouth. R2 would refuse to eat and appeared concerned during meals. R2's orders dated 9/5/23, identified swallow precautions and the need to be upright 90 degrees for meals with food cut up. Staff were directed to report signs and symptoms of dysphagia (difficulty swallowing foods or liquids) or respiratory distress immediately every shift. In	F 805	Changed overall focus of patients from hospice to all patients with modified diets and/or swallow precautions. ____________________ 1. How corrective action will be accomplished for those residents found to have been affected by the deficient practice. a. R2 remains in the facility. Orders have been reviewed by nursing and Hospice team – orders for swallow precautions and cut up food no longer meet patient's current plan of care and have been removed. 2. How the facility will identify other residents having the potential to be affected by the same deficient practice. a. Will complete chart review of all current patients with modified diets to ensure order is accurate and being followed. 3. What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur. a. Education will be completed with all clinical and culinary staff to remind them to review meal tickets and follow instructions printed – such as the need to cut up food etc. and to follow modified diets and any associated precautions as ordered. 4. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and	

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F 805	Continued From page 12 addition, R2 had orders dated 7/13/23, for a regular diet level 7-regular texture (regular diet), level 0-thin liquids with half portions. During observation on 9/5/23 at 5:30 p.m., R2 was in her bed with her food in front of her, not eating anything. During observation on 9/5/23 at 5:55 p.m., R2 remained in bed with food in front of her, not cut into bite size pieces, with no staff assisting her with eating. R2 was not feeding themselves. During observation on 9/6/23 at 11:48 a.m., R2 was seated in her bed, her food was in front of her. R2 was served baby carrots (not cut up), beef stroganoff, ice cream, and juice. There was a paper napkin covering some of the food on her plate. During observation on 9/6/23 at 12:13 p.m., nursing assistant (NA)-B entered R2's room and asked R2 why R2 covered her food. NA-B removed the napkin, but did not cut the food. During observation on 9/7/23 at 7:53 a.m., R2 was seated in bed eating oatmeal. She also had juice, a quiche, a hash brown patty, of which were not cut up. During observation on 9/7/23 at 8:07 a.m., R2 was alone in her room and was heard coughing from the hallway. No staff were present in the area. During observation on 9/7/23 at 8:11 a.m., R2 remained alone in her room as she continued to cough. R2 had drank all of her juice and eaten everything on her tray with the exception of the	F 805	will not recur. a. Audits of 100% of residents with modified diets and/or swallow precautions to ensure orders meet current plan of care will happen weekly x4 weeks, monthly x 2 months. Will review results with the QAPI team to make a recommendation for ongoing auditing. 5. The date that each deficiency will be corrected. a. 10/9/23	

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F 805	Continued From page 13	F 805		

crust from the quiche .

During observation on 9/8/23 at 7:55 a.m., R2 was seated in her chair drinking her juice and had finished her oatmeal. There was an omelet on her plate not cut into bite size pieces. Registered nurse (RN)-C verified the omelet was not cut up. RN-C asked R2 if she ate the sausage and R2 shook her head yes. RN-C picked up the meal ticket and verified the instructions, "1/2 portions, cut food into bite sized pieces."

R2's meal ticket dated 9/8/23, for the breakfast meal, identified R2 should receive half portions and was supposed to have her food cut into bite size pieces.

During an interview on 9/7/23 at 8:59 a.m., NA-C stated R2 was supposed to have her food cut into bite size pieces.

During an interview on 9/8/23 at 8:44 a.m., RN-C stated the kitchen staff was new and had been reminded to look at meal tickets and follow the instructions. Staff would not be able to monitor a resident for coughing, choking, or drooling if they were not present in the room while the resident was eating. R2 had a current order for swallow precautions and staff were expected to cut up R2's food to prevent possible choking.

During an interview on 9/8/23 at 9:16 a.m., the director of nursing (DON) verified staff would need to be present with a resident to monitor for choking, coughing, and/or drooling. Staff were expected to follow orders for swallow precautions.

The policy Dysphagia-Clinical Protocol dated 9/2017, identified the staff and the physician

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F 805	Continued From page 14 would identify individuals with a history of swallowing difficulties or related diagnoses such as dysphagia as well as individuals who had difficulty chewing or swallowing food.	F 805		
F 880 SS=D	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: §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	F 880		10/9/23

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F 880	Continued From page 15 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 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 and document review, the facility failed to ensure staff completed proper hand hygiene and glove use during personal cares for 1 of 4 residents (R159) reviewed for activities of daily living (ADL).	F 880	1. How corrective action will be accomplished for those residents found to have been affected by the deficient practice. a. R159 remains in facility. Education	

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F 880

Continued From page 16

Findings include:

R159's admission Minimum Data Set (MDS) dated 7/4/23, identified memory problems, and required assist of two for transfers and ADL's.

During an observation on 9/6/23 at 11:20 a.m., trained medication aide (TMA)-A and nursing assistant (NA)-A entered R159's room to perform cares. TMA-A moved R159's catheter drainage bag from the lift to the bed, then stopped and donned gloves and lowered R159's pants. NA-A with gloved hands cleansed R159's peri area, catheter insertion site. TMA-A and NA-A cleansed R159's buttocks area with the same gloves. NA-A with the contaminated gloves opened R159's bedside table to look for barrier cream. NA-A and TMA-A with the same contaminated gloves secured a clean brief on R159 and pulled up their pants. NA-A lowered the bed with a remote and boosted R159 up in bed, then positioned R159 with pillows under both feet and left hip and raised the head of the bed with the remote, with the same gloved hands.

- NA-A then removed their gloves, did not perform hand hygiene and then arranged R159's bed covers. TMA-A grabbed the dignity bag from R159's recliner, secured it onto the bed, and then placed R159's drainage bag into the dignity bag. TMA-A removed her gloves, sanitized her hands and left the room. NA-A lowered R159's bed to the lowest position and clipped R159's call light within reach. NA-A gathered R159's garbage bag and tied it off and un-muted R159's tv with the remote and angled the tv so R159 could see it. NA-A arranged R159's glasses case and cell phone on the bed side table and moved the table

F 880

will be provided for clinical team members regarding the importance of hand hygiene following handling of the foley catheter bag and all of the 5 moments for hand hygiene. Additionally, hand hygiene observations will be completed per the monitoring plan below.

2. How the facility will identify other residents having the potential to be affected by the same deficient practice.
a. Will complete audits of hand hygiene and glove use to determine gaps in practice that have the potential to affect other residents.

3. What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.
a. Education will be completed with clinical and therapy team members to ensure understanding of the importance of following the 5 Moments of Hand Hygiene.

4. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
a. Ten observations of hand hygiene and glove use compliance will happen weekly x4 weeks, monthly x 2 months. Will review results with the QAPI team to make a recommendation for ongoing auditing.

5. The date that each deficiency will be corrected.
a. 10/9/23

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F 880	Continued From page 17	F 880		

bedside. NA-A then sanitized their hands, picked up the garbage and exited the room.

During an interview on 9/6/23 at 11:35 a.m., NA-A confirmed they did not remove their gloves after performing peri care on R159. NA-A should have removed their gloves, sanitized hands, and then finished with cares. NA-A also should have sanitized their hands before they touched the resident or items in the room upon entrance. It was important to remove gloves and sanitize hands after touching something that was considered dirty because it prevented the spread of germs and cross contamination. NA-A planned to go back into R159's room and sanitize the items they touched. NA-A would have changed gloves and sanitized hands after touching something dirty, but they had been distracted when they could not find barrier cream, so it was missed.

During an interview on 9/6/23 at 11:42 a.m., TMA-A verified TMA-A had not changed their gloves after touching the catheter drainage bag and before they assisted with cares for R159. The catheter drainage bag could have had urine on the outside so it would be considered dirty. It would have been best practice to remove their gloves and sanitize their hands after they touched the foley bag.

During an interview on 9/8/23 at 9:54 a.m., director of nursing (DON) stated gloves should come off and hand hygiene should take place after performing peri care and before proceeding to clean cares and/or touching clean items. This practice was important to prevent the spread of infection and cross contamination of clean items. A catheter drainage bag would be considered a

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F 880	Continued From page 18 dirty item so staff should remove gloves and sanitize hands before touching clean surfaces or the resident. The facility Handwashing/Hand Hygiene policy dated August 2019, provided instruction on when staff should complete hand hygiene. The policy identified hand hygiene was to be completed before and after contact with residents, before and after handling medical devices or equipment, before moving from a contaminated body site to a clean body site during care, after contact with resident skin, and before and after glove use. The purpose of appropriate glove use and hand sanitization was to prevent the spread of infections.	F 880		

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
September 19, 2023

Administrator
Ecumen Lakeshore
4002 London Road
Duluth, MN 55804

Re: State Nursing Home Licensing Orders
Event ID: JBF611

Dear Administrator:

The above facility was surveyed on September 5, 2023 through September 8, 2023 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

To assist in complying with the correction order(s), a "suggested method of correction" has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the order within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html. The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute or rule after the statement, "This MN Requirement is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.

THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact:

Alex Warren, Unit Supervisor
Duluth District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
11 East Superior Street, Suite 290
Duluth, MN 55082
Email: Alex.Warren@state.mn.us
Mobile: 651-279-5375 Office: 218-302-6186

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.

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing
Minnesota Department of Health
Health Regulation Division
Telephone: (651) 201-4112
Email: Kamala.Fiske-Downing@state.mn.us

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER # 245215	MULTIPLE CONSTRUCTION A. BUILDING: ______ B. WING ______	DATE SURVEY COMPLETE: 9/8/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ECUMEN LAKESHORE	**4002 LONDON ROAD DULUTH, MN**

ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
F 641	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to accurately code the Minimum Data Set (MDS) for 1 of 1 resident (R55) reviewed for hospitalization. Findings include: R55's discharge MDS dated 8/19/23, specifically section A2100, identified R55 discharged to "03. Acute Hospital." R55's progress note from 8/19/23, identified R55 was discharged home in stable condition via family transport. R55's Discharge Summary - V2 dated 8/21/23, identified R55 discharged to home on 8/19/23. During interview on 9/7/23 at 10:03 a.m., registered nurse (RN)-A reviewed R55's progress notes and discharge MDS and stated, "03. Acute Hospital" was not accurate as R55 returned home. The errors can affect payment, but in this case should not, and the MDS would be modified to reflect the correct discharge status. MDS Completion and Submission Timeframes dated July 2017, states "The Assessment Coordinator or designee is responsible for ensuring that resident assessments are submitted to CMS' QIES Assessment Submission and Processing (ASAP) system in accordance with current federal and state guidelines." The Centers for Medicare and Medicaid Services (CMS) Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual dated 10/2019 identifies the rationale for documenting a residents' discharge status as, "the location to which the resident is being discharge at the time of discharge. Knowing the setting to which the individual was discharged helps to inform discharge planning". An accurate discharge assessment includes clinical items for quality monitoring as well as discharge tracking information.

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

The above isolated deficiencies pose no actual harm to the residents

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00594	A. BUILDING: ______ B. WING ______	C 09/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ECUMEN LAKESHORE	4002 LONDON ROAD DULUTH, MN 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) COMPLETE DATE
2 000	Initial Comments	2 000		

*****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 9/5/23 - 9/8/23, a licensing survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was not in compliance with the MN State Licensure and the following correction orders are issued. Please indicate in your electronic plan of correction you have reviewed these orders and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00594	A. BUILDING: ______ B. WING ______	C 09/08/2023

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ECUMEN LAKESHORE	4002 LONDON ROAD DULUTH, MN 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) COMPLETE DATE
2 000	Continued From page 1	2 000		

identify the date when they will be completed.

The following complaint was reviewed:
H52154967 (MN96271)

Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health.

PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00594	A. BUILDING: ______ B. WING ______	C 09/08/2023

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2 000	Continued From page 2 "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000		
2 550	MN Rule 4658.0400 Subp. 4 Comprehensive Resident Assessment; Review Subp. 4. Review of assessments. A nursing home must examine each resident at least quarterly and must revise the resident's comprehensive assessment to ensure the continued accuracy of the assessment. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to accurately code the Minimum Data Set (MDS) for 1 of 1 resident (R55) reviewed for hospitalization. Findings include: R55's discharge MDS dated 8/19/23, specifically section A2100, identified R55 discharged to "03. Acute Hospital." R55's progress note from 8/19/23, identified R55 was discharged home in stable condition via family transport. R55's Discharge Summary - V2 dated 8/21/23, identified R55 discharged to home on 8/19/23. During interview on 9/7/23 at 10:03 a.m., registered nurse (RN)-A reviewed R55's progress	2 550	Corrected.	10/9/23

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2 550	Continued From page 3	2 550		

Continued From page 3

notes and discharge MDS and stated, "03. Acute Hospital" was not accurate as R55 returned home. The errors can affect payment, but in this case should not, and the MDS would be modified to reflect the correct discharge status.

MDS Completion and Submission Timeframes dated July 2017, states "The Assessment Coordinator or designee is responsible for ensuring that resident assessments are submitted to CMS' QIES Assessment Submission and Processing (ASAP) system in accordance with current federal and state guidelines."

The Centers for Medicare and Medicaid Services (CMS) Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual dated 10/2019 identifies the rationale for documenting a residents' discharge status as, "the location to which the resident is being discharge at the time of discharge. Knowing the setting to which the individual was discharged helps to inform discharge planning". An accurate discharge assessment includes clinical items for quality monitoring as well as discharge tracking information.

SUGGESTED METHOD OF CORRECTION:
The director of nursing (DON) or designee could review and revise policies and procedures related to performing Minimum Data Set (MDS)assessments and the collection of required information. The DON or designee should educate staff to the policy or procedure changes and audit other residents medical records to determine accuracy of their assessments. Audits should be measurable and specific. The results of those audits should be taken to the QAPI committee to determine compliance or the need for further monitoring.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00594	A. BUILDING: ______ B. WING ______	C 09/08/2023

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2 550	Continued From page 4 TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 550		
21385	MN Rule 4658.0800 Subp. 3 Infection Control; Staff assistance Subp. 3. Staff assistance with infection control. Personnel must be assigned to assist with the infection control program, based on the needs of the residents and nursing home, to implement the policies and procedures of the infection control program. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure staff completed proper hand hygiene and glove use during personal cares for 1 of 4 residents (R159) reviewed for activities of daily living (ADL). Findings include: R159's admission Minimum Data Set (MDS) dated 7/4/23, identified memory problems, and required assist of two for transfers and ADL's. During an observation on 9/6/23 at 11:20 a.m., trained medication aide (TMA)-A and nursing assistant (NA)-A entered R159's room to perform cares. TMA-A moved R159's catheter drainage bag from the lift to the bed, then stopped and donned gloves and lowered R159's pants. NA-A with gloved hands cleansed R159's peri area, catheter insertion site. TMA-A and NA-A cleansed R159's buttocks area with the same gloves. NA-A with the contaminated gloves	21385	Corrected.	10/9/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00594	A. BUILDING: ____ B. WING ____	C 09/08/2023

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21385	Continued From page 5	21385		

opened R159's bedside table to look for barrier cream. NA-A and TMA-A with the same contaminated gloves secured a clean brief on R159 and pulled up their pants. NA-A lowered the bed with a remote and boosted R159 up in bed, then positioned R159 with pillows under both feet and left hip and raised the head of the bed with the remote, with the same gloved hands.

- NA-A then removed their gloves, did not perform hand hygiene and then arranged R159's bed covers. TMA-A grabbed the dignity bag from R159's recliner, secured it onto the bed, and then placed R159's drainage bag into the dignity bag. TMA-A removed her gloves, sanitized her hands and left the room. NA-A lowered R159's bed to the lowest position and clipped R159's call light within reach. NA-A gathered R159's garbage bag and tied it off and un-muted R159's tv with the remote and angled the tv so R159 could see it. NA-A arranged R159's glasses case and cell phone on the bed side table and moved the table bedside. NA-A then sanitized their hands, picked up the garbage and exited the room.

During an interview on 9/6/23 at 11:35 a.m., NA-A confirmed they did not remove their gloves after performing peri care on R159. NA-A should have removed their gloves, sanitized hands, and then finished with cares. NA-A also should have sanitized their hands before they touched the resident or items in the room upon entrance. It was important to remove gloves and sanitize hands after touching something that was considered dirty because it prevented the spread of germs and cross contamination. NA-A planned to go back into R159's room and sanitize the items they touched. NA-A would have changed gloves and sanitized hands after touching something dirty, but they had been distracted

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ECUMEN LAKESHORE	4002 LONDON ROAD DULUTH, MN 55804

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21385	Continued From page 6	21385		

when they could not find barrier cream, so it was missed.

During an interview on 9/6/23 at 11:42 a.m., TMA-A verified TMA-A had not changed their gloves after touching the catheter drainage bag and before they assisted with cares for R159. The catheter drainage bag could have had urine on the outside so it would be considered dirty. It would have been best practice to remove their gloves and sanitize their hands after they touched the foley bag.

During an interview on 9/8/23 at 9:54 a.m., director of nursing (DON) stated gloves should come off and hand hygiene should take place after performing peri care and before proceeding to clean cares and/or touching clean items. This practice was important to prevent the spread of infection and cross contamination of clean items. A catheter drainage bag would be considered a dirty item so staff should remove gloves and sanitize hands before touching clean surfaces or the resident.

The facility Handwashing/Hand Hygiene policy dated August 2019, provided instruction on when staff should complete hand hygiene. The policy identified hand hygiene was to be completed before and after contact with residents, before and after handling medical devices or equipment, before moving from a contaminated body site to a clean body site during care, after contact with resident skin, and before and after glove use. The purpose of appropriate glove use and hand sanitization was to prevent the spread of infections.

SUGGESTED METHOD OF CORRECTION: The DON or designee should review/revise facility

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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21385	Continued From page 7 policies to ensure they contain all components of an infection control program to mitigate transmission of potential infections. The DON or designee could educate all staff on existing or revised policies and perform audits to ensure the policies are being followed. The results of those audits should be taken to Quality Assurance Performance Improvement committee to determine compliance and the need for further monitoring. Time Period for Correction: Twenty-one (21) days.	21385		
21530	MN Rule 4658.1310 A.B.C Drug Regimen Review A. The drug regimen of each resident must be reviewed at least monthly by a pharmacist currently licensed by the Board of Pharmacy. This review must be done in accordance with Appendix N of the State Operations Manual, Surveyor Procedures for Pharmaceutical Service Requirements in Long-Term Care, published by the Department of Health and Human Services, Health Care Financing Administration, April 1992. This standard is incorporated by reference. It is available through the Minitex interlibrary loan system. It is not subject to frequent change. B. The pharmacist must report any irregularities to the director of nursing services and the attending physician, and these reports must be acted upon by the time of the next physician visit, or sooner, if indicated by the pharmacist. For purposes of this part, "acted upon" means the acceptance or rejection of the report and the signing or initialing by the director of nursing services and the attending physician. C. If the attending physician does not concur with the pharmacist's recommendation, or does	21530		10/9/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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21530	Continued From page 8 not provide adequate justification, and the pharmacist believes the resident's quality of life is being adversely affected, the pharmacist must refer the matter to the medical director for review if the medical director is not the attending physician. If the medical director determines that the attending physician does not have adequate justification for the order and if the attending physician does not change the order, the matter must be referred for review to the quality assessment and assurance committee required by part 4658.0070. If the attending physician is the medical director, the consulting pharmacist must refer the matter directly to the quality assessment and assurance committee. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed for 1 of 5 residents (R159) reviewed for medications. Findings include: R159's admission Minimum Data Set (MDS) dated 7/4/23, identified memory problems and had no behaviors identified. R 159 utilized antipsychotic medications for seven days during the look back period. The antipsychotic identified it was used on a routine basis, there was no drug regimen review identified as completed and lacked and medication follow up. A diagnosis of insomnia was identified. R159's care plan revised on 9/6/23, identified R159 used Seroquel (an antipsychotic medication) and the facility would monitor for the inability to fall asleep/ stay asleep and for nocturnal restlessness.	21530	Corrected.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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21530	Continued From page 9	21530		

Continued From page 9

R159's Order Summary Reported dated 9/6/23, identified an order for Seroquel 50 milligrams (mg) via g-tube at bedtime for diagnosis pending. R159's Medication Administration Record (MAR) dated 9/7/23, identified the Seroquel was prescribed for insomnia.

R159's pharmacy reviews from July 2023, through August 2023 identified the following:
- 7/9/23 no irregularities
- 8/12/23 no irregularities
- 8/29/23 requested clarification of Amlodipine dose. Provider clarified dose.
- 8/29/23 request to address PRN non-antipsychotic psychotropic medication Benadryl. A stop date was added for 9/11/23.

During an interview on 9/8/23 at 8:38 a.m., director of nursing (DON) stated the medical providers prescribed medications so she could not say if it was appropriate for R159 to receive scheduled Seroquel for insomnia.

During an interview on 9/8/23 at 10:01 a.m., consulting pharmacist (CP) stated Seroquel was an antipsychotic medication and insomnia was not an appropriate diagnosis for the use of Seroquel in the long-term setting. Indications for prescribing Seroquel included: as an adjunct to an antidepressant, bipolar, dementia with behaviors, or behaviors in conjunction with other diagnoses like a personality disorder. Seroquel was often used in the acute care setting to manage sleep but identified it was usually discontinued by the hospital provider at discharge or upon admission to a long-term facility. R159's Seroquel was not an appropriate dose for the treatment of insomnia. The CP stated their partner reviewed R159's admission orders not

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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21530	Continued From page 10	21530		

sure what happened. Typically the Seroquel would have been flagged to be discontinued and would flag the medication for review during the September reviews. R159 was at a greater risk for falls and Seroquel consumption by chemical design could result in changes to the brain and mood.

The facility Medication Regimen Reviews policy dated May 2019, identified a medication review would be conducted by a pharmacist at the time of admit then monthly or as needed for all residents in the facility that received medication. The review included the identification of, notification to the provider, and resolution of medication irregularities. Actionable irregularities included but were not limited to: medication errors, excessive doses or doses without a clinical indication, inadequate monitoring for side effects, duplicative therapies, and potentially adverse consequences of medications.

SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review and revise policies and procedures for pharmacy reviews and irregularities. The DON or designee could develop a system to educate staff and develop a monitoring system to ensure pharmacy reviews are timely and irregularities are being acted upon. The quality assurance committee could monitor these measures to ensure compliance.

TIME PERIOD FOR CORRECTION: Twenty One (21) days

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245215	A. BUILDING **02 - NEW REPLACEMENT BLDG** B. WING ______	**09/05/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ECUMEN LAKESHORE	**4002 LONDON ROAD** **DULUTH, MN 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
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 09/05/2023. 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.	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		09/28/2023

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245215	A. BUILDING **02 - NEW REPLACEMENT BLDG** B. WING ____________	**09/05/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ECUMEN LAKESHORE	**4002 LONDON ROAD** **DULUTH, MN 55804**

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K 000	Continued From page 1	K 000		

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.

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.

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K 000	Continued From page 2 The requirements at 42 CFR, Subpart 483.70(a), are NOT MET as evidenced by:	K 000		
K 211 SS=D	Means of Egress - General CFR(s): NFPA 101 Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain a clear path of egress system per NFPA 101 (2012 edition), Life Safety Code, sections 19.2.1 and 7.1.10.1. This deficient finding could have an isolated impact on the residents within the facility. Findings include: On 09/05/2023, between 11:30am and 2:30pm, it was revealed by observation that there was medical equipment in the egress corridor which was removed at the time of discovery. An interview with Maintenance Director verified these deficient findings at the time of discovery.	K 211	1) Medical equipment in the corridor was removed and brought to the proper storage location. 2) Signage was put up stating that this area was not to be used as storage. 3) Monthly task was added to our computerized maintenance management system to inspect and clear corridors. Audits will be conducted daily for the first 2 weeks, weekly for one month, quarterly until no items are found. Will review results with the QAPI team to make a recommendation for ongoing auditing. 4) All delinquent tasks in computerized maintenance management system will alert ED and Corporate Team who will monitor deficient tasks. 5) Facilities Manager will be responsible. Will review results with the QAPI team to make a recommendation for ongoing auditing. 6) 10/1/2023	10/1/23
K 321	Hazardous Areas - Enclosure	K 321		9/25/23

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K 321 SS=D	Continued From page 3 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 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 REQUIREMENT 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 an isolated impact on the residents within the facility.	K 321	1) Storage door adjusted to close completely as designed. 2) Weekly checks for first 4 weeks, then monthly, then quarterly until no doors are found. 3) Computerized maintenance	

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K 321	Continued From page 4 Findings include: On 09/05/2023, between 11:30am and 2:30pm, it was revealed by observation that storage room in the second floor D pod did not close and latch. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 321	management system task was created to ensure ongoing compliance. 7) Maintenance team and Facilities Manager be responsible for the overall compliance. Will review results with the QAPI team to make a recommendation for ongoing auditing. 4) 9/25/23	
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: 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,	K 353	1) Documentation was found and shows inspection was completed on 4/27/2020 prior to Facilities Manager employment with Lakeshore. A copy will be emailed to	10/6/23

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K 353	Continued From page 5 and 4.6.12, 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 a widespread impact on the residents within the facility. Findings include: 1) On 09/05/2023, between 11:30am and 2:30pm, it was revealed by a review of available documentation the facility failed to perform the 5 Year sprinkler system evaluation / testing. 2) On 09/05/2023, between 11:30am and 2:30pm, it was revealed by observation that the facility Failed to insure that one of the sprinkler heads in the kitchen freezer was in operational order. 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 09/05/2023, between 11:30am and 2:30pm, 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 storage	K 353	the State Fire Marshal. 2) Computerized maintenance management system task was created to ensure compliance. 3) Facilities Manager will be responsible for compliance. 4) 9/25/23 Sprinkler head in freezer was in operational order- 1) Hired contractor to preform replacement of all 4 dry sprinkler heads in freezer/walk in cooler. 2) Computerized maintenance management system task was created to preform monthly inspection. 3) Facilities Manager will be responsible for compliance. 4) 10/6/2023 Storage rack in kitchen storage area with materials within 18 of sprinkler head 1) Removal and relocation of items on top shelves of storage rack Marked line made across the wall with signage stating no storage. 2) Provide education to all team members who use the storage racks. 3) Daily checks for the first 2 weeks, weekly for a month, quarterly until no items are found. 4) Culinary service director will be responsible for compliance. Will review results with the QAPI team to make a recommendation for ongoing auditing. 5) 10-1-23	

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K 353	Continued From page 6 room. An interview with Maintenance Director verified these deficient findings at the time of discovery.	K 353		
K 521 SS=F	HVAC CFR(s): NFPA 101 HVAC Heating, ventilation, and air conditioning shall comply with 9.2 and shall be installed in accordance with the manufacturer's specifications. 18.5.2.1, 19.5.2.1, 9.2 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to inspect fire dampers per NFPA 101 (2012 edition), Life Safety Code, section 8.5.5.4.2, and NFPA 105 (2010 edition), Standard for Smoke Door Assemblies and Other Opening Protectives, section 6.5.2, 6.5.11, and 6.5.12. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 09/05/2023, between 11:30am and 2:30pm, it was revealed by a review of available documentation that the facility could not provide a fire damper inspection report. An interview with Maintenance Director verified these deficient findings at the time of discovery.	K 521	1) Hire contractor to inspect Fire dampers in facility. 2) Computerized maintenance management system task was created ensure compliance with regulations. 3) Facilities Manager will be responsible for compliance. 4) 10/6/2023	10/6/23

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K 712 SS=D	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 an isolated impact on the residents within the facility. Findings include: On 09/05/2023, between 11:30am and 2:30pm, it was revealed by a review of available documentation that fire drills were not completed: third shift missing second quarter (October - December) drill completely. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 712	1) Organize Fire drills in Life safety book to ensure proper times for Fire drills. 2) Facilities manager will assign time and date of fire drills to ensure proper timing and shift cadence. And verify completion of all necessary documentation with initials on bottom of page 3) Computerized maintenance management system task was updated to reflect cadence. 4) Facilities Manager will be responsible for compliance. 5) 9/25/2023	9/25/23
K 761 SS=F	Maintenance, Inspection & Testing - Doors CFR(s): NFPA 101 Maintenance, Inspection & Testing - Doors	K 761		9/30/23

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K 761	Continued From page 8 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: On 09/05/2023, between 11:30am and 2:30pm, it was revealed by review of available documentation the required annual door inspection documentation was not available at the time of the survey. An interview with the Maintenance Director verified these deficient findings at the time of discovery.	K 761	1) Complete annual fire door inspection of facility 2) Created computerized maintenance management system task to perform an annual door inspection. 3) Facilities Manager will be responsible for compliance. 4) Paperwork was found 9-18-23 New audit completed by 9-30-23	