



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
May 22, 2025

Administrator
Lifecare Greenbush Manor
19120 200th Street
Greenbush, MN 56726

RE: CCN: 245616
Cycle Start Date: May 14, 2025

Dear Administrator:

On May 14, 2025, 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 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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

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

If substantial compliance with the regulations is not verified by August 14, 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 November 14, 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>

Lifecare Greenbush Manor

May 22, 2025

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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.

Feel free to contact me if you have questions.

Sincerely,

A handwritten signature in black ink that reads "Kamala Fiske-Downing". The signature is written in a cursive, flowing style.

Kamala Fiske-Downing
Compliance Analyst | Federal Enforcement
Health Regulation Division
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Office: 651-201-4112

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245616	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/14/2025
NAME OF PROVIDER OR SUPPLIER LIFECARE GREENBUSH MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 19120 200TH STREET GREENBUSH, MN 56726		
(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 5/12/25 through 5/14/25., a survey for compliance with §483.73, Appendix Z, Emergency Preparedness Requirements for Long Term Care Facilities 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 5/12/25 through 5/14/25, a standard recertification survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with the requirements at 42 CFR Part 483, Subpart B, Requirements for Long Term Care Facilities. Your 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, the facility must acknowledge receipt of the electronic documents.	F 000			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		05/22/2025

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.

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

F5616019

PRINTED: 05/30/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245616		(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - GREENBUSH MANOR B. WING _____		(X3) DATE SURVEY COMPLETED 05/13/2025	
NAME OF PROVIDER OR SUPPLIER LIFECARE GREENBUSH MANOR				STREET ADDRESS, CITY, STATE, ZIP CODE 19120 200TH STREET GREENBUSH, MN 56726			
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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 05/13/2025. At the time of this survey, Lifecare Greenbush Manor 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		05/29/2025

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 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. LifeCare Greenbush Manor was built in 2010, is a 1-story building without a basement and was determined to be Type V(111) construction, A clinic and an assisted living building are attached and separated with 2-hour fire barriers between the Manor and the clinic, and the Manor and the assisted living building. The facility is divided into 4 smoke compartments with 1-hour and 2-hour fire barriers. The facility is fully protected with an automatic sprinkler system	K 000			

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

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K 000	Continued From page 2 installed in accordance with NFPA 13 The Standard for the Installation of Sprinkler Systems 1999 edition. The facility has a fire alarm system which includes corridor smoke detection throughout and in all common areas, installed in accordance with NFPA 72 "The National Fire Alarm Code" 1999 edition. All sleeping rooms have smoke detection and hazardous areas have automatic fire detection.. The fire alarm system is monitored for automatic fire department notification. The facility has a capacity of 40 beds and had a census of 37 at the time of the survey.	K 000			
K 324 SS=D	The requirements at 42 CFR, Subpart 483.70(a), are NOT MET as evidenced by: Cooking Facilities CFR(s): NFPA 101 Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96	K 324			5/13/25

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K 324	Continued From page 3 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to install the kitchen hood extinguishing system in accordance with NFPA 101 (2012 edition), The Life Safety Code, section 19.3.2.5, 19.3.2.5.1, 19.3.2.5.2*, 9.2.5, NFPA 96 (2011 edition) Ventilation Control and Fire Protection of Commercial Cooking Operations, section 12.1.2.3 and 12.1.2.3.1. This deficient finding could have an isolated impact on the residents within the facility. The findings include: On 05/13/2025, at 1:04pm, it was revealed that the wheeled, gas-fired stove and griddle located on the cooking line in the kitchen was not provided with an approved method of attachment and/or an alignment mark to ensure the appliances was returned to an approved design location after it had been moved for maintenance and cleaning. Both the attachment device and alignment mark are required for each gas operated and deep fat fryer cooking device. An interview with the Maintenance Director verified this deficient finding at the time of discovery.			K 324	1. Detailed description of the corrective action taken or planned to correct the deficiency. a. Maintenance supervisor reattached the cable to the stove that is anchored to the wall behind the gas stove. Placed permanent markings on the floor around the front casters of the gas stove. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. a. Placed permanent markings on the floor around the front casters of the gas stove. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. a. Director of maintenance or designee will monitor compliance by adding to quarterly preventative maintenance checks. 4. Identify who is responsible for the corrective actions and monitoring of compliance. a. Director of maintenance or designee with monitor compliance.		

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K 346 K 346 SS=D	Continued From page 4 Fire Alarm System - Out of Service CFR(s): NFPA 101 Fire Alarm - Out of Service Where required fire alarm system is out of services for more than 4 hours in a 24-hour period, the authority having jurisdiction shall be notified, and the building shall be evacuated or an approved fire watch shall be provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service. 9.6.1.6 This REQUIREMENT is not met as evidenced by: Based on a review of the available documentation and staff interview, the facility failed to implement a fire evacuation plan per NFPA 101 (2012 edition), Life Safety Code, section 9.6.1.6. This deficient finding could have an isolated impact on the residents within the facility. Findings include: On 05/13/2025 at 10:15am, it was revealed by a review of available documentation that the facility could not provide a copy of an Out of Service Policy indicating that the facility would contact the State Fire Marshals Office (Authority having jurisdiction) in the event on a fire alarm outage lasting longer than four (4) hours in a 24-hour period. Names and numbers for AHJ is required to be listed in policy. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 346 K 346			5/28/25
K 353 SS=D	Sprinkler System - Maintenance and Testing	K 353			5/28/25

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K 353	Continued From page 5 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 observation and staff interview, the facility failed to maintain the automatic fire sprinkler system per NFPA 101 (2012 edition), Life Safety Code, section 9.7.5, and NFPA 25 (2011 edition), the Standard for the Inspection, Testing, and Maintenance of Water Based Fire Protection Systems, section 5.4.1.4, and 5.4.1.4.2. This deficient finding could have an isolated impact on the residents within the facility. Findings include: On 05/13/2025, at 1:17pm, it was revealed by observation that there were unsecured fire sprinkler heads that were not protected from being damaged, stored loosely within the spare			K 353	1. Detailed description of the corrective action taken or planned to correct the deficiency. a. Maintenance supervisor mounted an additional storage box for sprinkler heads and tools on the wall near the riser. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. a. Maintenance supervisor or designee will monitor storage boxes quarterly. Audit results will be added to review at QAPI by the committee. 3. Indicate how the facility plans to monitor future performance to ensure		

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K 353	Continued From page 6 sprinkler head boxes located by the fire sprinkler riser in the kitchen dry storage room. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 353	solutions are sustained. a. Director of maintenance or designee will monitor compliance by adding to quarterly safety checks. 4. Identify who is responsible for the corrective actions and monitoring of compliance. a. Director of maintenance or designee with monitor compliance.	5/28/25	
K 354 SS=D	Sprinkler System - Out of Service CFR(s): NFPA 101 Sprinkler System - Out of Service Where the sprinkler system is impaired, the extent and duration of the impairment has been determined, areas or buildings involved are inspected and risks are determined, recommendations are submitted to management or designated representative, and the fire department and other authorities having jurisdiction have been notified. Where the sprinkler system is out of service for more than 10 hours in a 24-hour period, the building or portion of the building affected are evacuated or an approved fire watch is provided until the sprinkler system has been returned to service. 18.3.5.1, 19.3.5.1, 9.7.5, 15.5.2 (NFPA 25) This REQUIREMENT is not met as evidenced by: Based on document review and staff interview, the facility did not properly implement a fire watch protocol for when the fire alarm system is out of service for more than 10 hours in a 24-hour period, according to NFPA 101 2012 edition, Life Safety Code, section 19.3.5.1, 9.7.5, and NFPA 25 2017 edition, Installation, Test and Maintenance of Water Based System, section 15.5.2. This deficient finding could have an	K 354	1. Detailed description of the corrective action taken or planned to correct the deficiency. a. Sprinkler system-out of service policy was updated with the appropriate contact information. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur.		

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K 354	Continued From page 7 isolated impact on the residents within the facility. Findings include: On 05/13/2025 at 10:19am, it was revealed by documentation review that the facility failed to provide an out of service policy that indicated that the facility would contact the State Fire Marshals Office (Authority having jurisdiction) in the event on a fire sprinkler system outage lasting longer than ten (10) hours in a 24-hour period. Names and numbers for AHJ is required to be listed in policy. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 354	a. Review policy annually or more to ensure policy is current. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. a. Director of maintenance or designee will update policy annually or with changes as needed. 4. Identify who is responsible for the corrective actions and monitoring of compliance. a. Director of maintenance or designee with monitor compliance.		
K 355 SS=D	Portable Fire Extinguishers CFR(s): NFPA 101 Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain access to portable fire extinguishers per NFPA 101 (2012 edition), Life Safety Code, section 9.7.4.1, and NFPA 10 (2010 edition), Standard for Portable Fire Extinguishers, section 7.3.1.1.1. This deficient finding could have an isolated impact on the residents within the facility. Findings include:	K 355	1. Detailed description of the corrective action taken or planned to correct the deficiency. a. The vendor for the fire extinguishers sent the service list with the correct dates on 5/15/25. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. a. The maintenance supervisor or		5/15/25

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K 355	Continued From page 8 On 05/13/2025 at 10:39am it was revealed by documentation review that the fire extinguishers annual inspection documentation could not be provided. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 355	designee will ensure annual inspection documentation is received after each inspection is completed by the vendor. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. a. Director of maintenance or designee will add to calendar to annually to obtain report from vendor to have readily available in maintenance office. 4. Identify who is responsible for the corrective actions and monitoring of compliance. a. Director of maintenance or designee will monitor compliance.		
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,	K 372	1. Detailed description of the corrective action taken or planned to correct the deficiency.		5/13/25

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K 372	Continued From page 9 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 05/13/2025 at 11:46am, it was revealed by observation that there was a penetration running two (2) hour fire wall located between skilled nursing facility and attached assisted living facility. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 372	a. Penetrations were filled with the appropriate fire rated putty, Metacaulk FRS, 60 stc rating on 5/13/25. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. a. Maintenance supervisor or designee will complete audits weekly X 12 weeks throughout the facility to monitor for penetrations in smoke barriers. b. These findings will be reported to QAPI committee quarterly. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. a. Director of maintenance or designee will monitor compliance by adding to quarterly preventative maintenance checks. b. These findings will be reported to QAPI committee quarterly. 4. Identify who is responsible for the corrective actions and monitoring of compliance. a. Director of maintenance or designee will monitor compliance.		
K 511 SS=E	Utilities - Gas and Electric CFR(s): NFPA 101 Utilities - Gas and Electric Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NFPA 70, National Electric Code. Existing installations can continue in service provided no hazard to life. 18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2	K 511			6/6/25

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K 511	Continued From page 10 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain plant gas and electric utilities per NFPA 101 (2012 edition), Life Safety Code, sections 9.1.1 and 9.2.2, and NFPA 54 (2012 edition), National Fuel Gas Code, section 10.4.4.2. This deficient finding could have a patterned impact on the residents within the facility. Findings include: On 05/13/2025 at 12:27pm, observation revealed that combustible materials had fallen around dryer exhaust ductwork in the following laundry rooms: 1) Rosewood laundry room 2) Edgewood laundry room these items located on the heated dryer exhaust could lead to a hazardous situation. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 511	1. Detailed description of the corrective action taken or planned to correct the deficiency. a. The combustible material was removed on 5/14/25. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. a. Purchased laundry guards to place on top of machines to ensure combustible materials do not fall behind the machines onto the dryer exhaust duct work. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. a. Director of maintenance or designee will complete audits weekly X 12 weeks and report findings to QAPI committee. 4. Identify who is responsible for the corrective actions and monitoring of compliance. a. Director of maintenance or designee will monitor compliance.		
K 521 SS=D	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	K 521		5/28/25	

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K 521	Continued From page 11 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 an isolated impact on the residents within the facility. Findings include: On 05/13/2025 at 10:26am, it was revealed by a review of available documentation that the facility could not provide a fire damper inspection report with a readable date. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 521	1. Detailed description of the corrective action taken or planned to correct the deficiency. a. Maintenance supervisor contacted the vendor and requested having a separate damper testing form from the sensitivity reports. Also requested reports to be completely filled out and dated appropriately. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. a. Director of maintenance or designee will add to calendar to annually to obtain report from vendor to have readily available in maintenance office. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. a. Director of maintenance or designee will monitor compliance by adding it to calendar to be completed annually. 4. Identify who is responsible for the corrective actions and monitoring of compliance. a. Director of maintenance or designee will monitor compliance.		
K 712 SS=F	Fire Drills CFR(s): NFPA 101	K 712			5/29/25

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K 712	Continued From page 12 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 05/13/2025 at 10:07am, it was revealed by a review of available documentation that fire drills did not meet the varying time requirement: second shift 11/30/24 at 1615, 02/26/25 at 1645, and 05/30/24 at 1713. The for-mentioned drills do not meet the intent of vering times. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 712	1. Detailed description of the corrective action taken or planned to correct the deficiency. a. Maintenance supervisor will vary the time requirements of 2 hours between drills according to shift completing drills. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. a. Director of maintenance or designee will verify time of last fire drill completed to ensure there is at least a 2 hour minimum difference of time. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. a. Director of maintenance or designee will report all fire drills and times to QAPI committee. 4. Identify who is responsible for the corrective actions and monitoring of compliance. a. Director of maintenance or designee will monitor compliance.		

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K 920 K 920 SS=D	Continued From page 13 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) assemblies that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 This 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:	K 920 K 920	1. Detailed description of the corrective action taken or planned to correct the deficiency. a. Maintenance supervisor removed power strip from service in the maintenance shop on 5/13/25. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. a. Director of maintenance or designee	5/13/25	

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K 920	Continued From page 14 On 05/13/2025 at 1:34pm, it was revealed by observation that there were several electrical appliances plugged power-strips, multi-plug adapters and/or extension cords in the maintenance office. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 920	will audit random areas of facility for use of power strips and/or extension cords weekly X 12 weeks and report to QAPI committee. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. a. Director of maintenance or designee will audit random areas of facility for use of power strips and/or extension cords weekly X 12 weeks and report to QAPI committee. 4. Identify who is responsible for the corrective actions and monitoring of compliance. a. Director of maintenance or designee will monitor compliance.		