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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: VULM

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00594

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245215**
2.STATE VENDOR OR MEDICAID NO.
(L2) **001043000**

3. NAME AND ADDRESS OF FACILITY
(L3) **ECUMEN LAKESHORE**
(L4) **4002 LONDON ROAD**
(L5) **DULUTH, MN** (L6) **55804**

4. TYPE OF ACTION: **7** (L8)
1. Initial **2. Recertification**
3. Termination **4. CHOW**
5. Validation **6. Complaint**
7. On-Site Visit **9. Other**
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **06/29/2021** (L34)

8. ACCREDITATION STATUS: ___ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

01 Hospital	**05 HHA**	**09 ESRD**	**13 PTIP**	**22 CLIA**
02 SNF/NF/Dual	**06 PRTF**	**10 NF**	**14 CORF**	
03 SNF/NF/Distinct	**07 X-Ray**	**11 ICF/IID**	**15 ASC**	
04 SNF	**08 OPT/SP**	**12 RHC**	**16 HOSPICE**	

FISCAL YEAR ENDING DATE: (L35)
06/30

11. .LTC PERIOD OF CERTIFICATION
From (a) :
To (b) :

12.Total Facility Beds **60** (L18)
13.Total Certified Beds **60** (L17)

10.THE FACILITY IS CERTIFIED AS:
X A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC

B. Not in Compliance with Program Requirements and/or Applied Waivers:

And/Or Approved Waivers Of The Following Requirements:
___ 2. Technical Personnel ___ 6. Scope of Services Limit
___ 3. 24 Hour RN ___ 7. Medical Director
___ 4. 7-Day RN (Rural SNF) ___ 8. Patient Room Size
___ 5. Life Safety Code ___ 9. Beds/Room

* Code: **A** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	60			
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS
1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):

See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Teresa Ament, Unit Supervisor 06/30/2021 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Joanne Simon, Enforcement Specialist 06/30/2021 (L20)

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY
X 1. Facility is Eligible to Participate
___ 2. Facility is not Eligible
(L21)

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

21. 1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :

22. ORIGINAL DATE OF PARTICIPATION
07/01/1977
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions:
(L44)
B. Rescind Suspension Date:
(L45)

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal
INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
06/02/2021
(L33)

DETERMINATION APPROVAL

C&T REMARKS - CMS 1539 FORM **STATE AGENCY REMARKS**

Ecumen Lake Shore CCN: 24-5215

Documentation supporting your request for a waiver of the following life safety code (LSC) deficiency:

K 363 Corridor - Doors - NFPA 101 Bld 2

The facility's request has been forwarded to the CMS Region V Office for their review and determination.

Approval of the waiver has been recommended.

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
June 30, 2021

CMS Certification Number (CCN): 245215

Administrator
Ecumen Lakeshore
4002 London Road
Duluth, MN 55804

Dear Administrator:

The Minnesota Department of Health assists the Centers for Medicare and Medicaid Services (CMS) by surveying skilled nursing facilities and nursing facilities to determine whether they meet the requirements for participation. To participate as a skilled nursing facility in the Medicare program or as a nursing facility in the Medicaid program, a provider must be in substantial compliance with each of the requirements established by the Secretary of Health and Human Services found in 42 CFR part 483, Subpart B.

Based upon your facility being in substantial compliance, we are recommending to CMS that your facility be recertified for participation in the Medicare and Medicaid program.

Effective June 21, 2021 the above facility is certified for:

60 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 60 skilled nursing facility beds.

Your request for waiver of F363 has been recommended based on the submitted documentation. You will receive notification from CMS only if they do not concur with our recommendation.

If you are not in compliance with the above requirements at the time of your next survey, you will be required to submit a Plan of Correction for these deficiency(ies) or renew your request for waiver in order to continue your participation in the Medicare and Medicaid Program.

You should advise our office of any changes in staffing, services, or organization, which might affect your certification status. If, at the time of your next survey, we find your facility to not be in substantial compliance your Medicare and/or Medicaid provider agreement may be subject to non-renewal or termination.

Please contact me if you have any questions.

Sincerely,

Joanne Simon, Enforcement Specialist
Minnesota Department of Health
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

Electronically delivered

June 30, 2021

Administrator
Ecumen Lakeshore
4002 London Road
Duluth, MN 55804

RE: CCN: 245215
Cycle Start Date: April 15, 2021

Dear Administrator:

On May 21, 2021, Center for Medicare & Medicaid Services (CMS) forwarded the results of the Federal Monitoring Survey (FMS) to you and informed you that your facility was not in substantial compliance with the applicable Federal requirements for nursing homes participating in the Medicare and Medicaid programs and imposed enforcement remedies.

On June 29, 2021, the Minnesota Department of Health, completed a revisit and on June 4, 2021 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance. Based on our visit, we have determine:

As authorized by CMS the remedies of:

- Discretionary denial of payment for new Medicare and Medicaid admissions effective June 21, 2021 be discontinued as of June 21, 2021. (42 CFR 488.417 (b))

- Civil money penalty (42 CFR 488.430 through 488.444). CMS notified you of this rememdy on May 21, 2021.

However, as we notified you in our letter of April 29, 2021, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from June 21, 2021.

Your request for a continuing waiver involving the deficiency(ies) cited under F-363 at the time of the April 15, 2021 standard survey has been forwarded to CMS for their review and determination. Your facility's compliance is based on pending CMS approval of your request for waiver.

Feel free to contact me if you have questions.

Sincerely,

Joanne Simon, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: VULM

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Facility ID: 00594

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3. NAME AND ADDRESS OF FACILITY
(L3) **ECUMEN LAKESHORE**
(L4) **4002 LONDON ROAD**
(L5) **DULUTH, MN** (L6) **55804**

4. TYPE OF ACTION: **2** (L8)
1. Initial **2. Recertification**
3. Termination **4. CHOW**
5. Validation **6. Complaint**
7. On-Site Visit **9. Other**
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **04/15/2021** (L34)

8. ACCREDITATION STATUS: __ (L10)
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2 AOA 3 Other

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02 SNF/NF/Dual	**06 PRTF**	**10 NF**	**14 CORF**	
03 SNF/NF/Distinct	**07 X-Ray**	**11 ICF/IID**	**15 ASC**	
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FISCAL YEAR ENDING DATE: (L35)
06/30

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___1. Acceptable POC
X B. Not in Compliance with Program Requirements and/or Applied Waivers:

And/Or Approved Waivers Of The Following Requirements:
___ 2. Technical Personnel
___ 3. 24 Hour RN
___ 4. 7-Day RN (Rural SNF)
___ 5. Life Safety Code
___ 6. Scope of Services Limit
___ 7. Medical Director
___ 8. Patient Room Size
___ 9. Beds/Room

* Code: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	60			
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS
1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):

See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Kimberly Settergren, HFE - NE II 05/25/2021 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Joanne Simon, Enforcement Specialist 05/28/2021 (L20)

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY
X 1. Facility is Eligible to Participate
____ 2. Facility is not Eligible
(L21)

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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3. Both of the Above :

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07/01/1977
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions:
(L44)
B. Rescind Suspension Date:
(L45)

26. TERMINATION ACTION: (L30)

VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal

INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

Electronically delivered
April 29, 2021

Administrator
Ecumen Lakeshore
4002 London Road
Duluth, MN 55804

RE: CCN: 245215
Cycle Start Date: April 15, 2021

Dear Administrator:

On April 15, 2021, 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" tag) and emergency preparedness deficiencies (those preceded by an "E" tag), i.e., the plan of correction should be directed to:

Terri Ament, Unit Supervisor
Duluth District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Duluth Technology Village
11 East Superior Street, Suite 290
Duluth, Minnesota 55802-2007
Email: teresa.ament@state.mn.us
Office: (218) 302-6151 Mobile: (218) 766-2720

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 July 15, 2021 (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 October 15, 2021 (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:

William Abderhalden, Fire Safety Supervisor
Deputy State Fire Marshal
Health Care/Corrections Supervisor – Interim
Minnesota Department of Public Safety
445 Minnesota Street, Suite 145
St. Paul, MN 55101-5145
Cell: (507) 361-6204
Email: william.abderhalden@state.mn.us
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Joanne Simon, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

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 04/15/2021

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 4/12/21, through 4/15/21, 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 4/12/21, through 4/15/21, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was found to be NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were found to be UNSUBSTANTIATED: H5215056C (MN7023) H5215057C (MN70791) H5215058C (MN71220) H5215059C (MN71474) H5215061C (MN71739) The following complaint was found to be UNSUBSTANTIATED, however a related deficiency was cited. H5215060C (MN45099). The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		05/07/2021

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 _____ B. WING _____	C 04/15/2021

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
F 000	Continued From page 1 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 substantial compliance with the regulations has been attained.	F 000		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure timely repositioning to prevent pressure ulcers for 1 of 2 residents (R27) reviewed for pressure ulcers. R27's admission Minimum Data Set (MDS) dated 3/29/21 indicated R27 was cognitively impaired and required assist of one or two staff for all activities of daily living (ADLs) including transferring, and toileting. and did not ambulate.	F 686	1. How corrective action will be accomplished for those residents found to have been affected by the deficient practice. a. Addressed the concern with the team member who failed to perform repositioning on Friday, April 30, 2021 with corrective action planning pending union representation. 2. How the facility will identify other	5/30/21

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 04/15/2021

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
F 686	Continued From page 2 R27's diagnoses included multiple sclerosis (MS), neurogenic bladder, cerebrovascular accident (CVA) and hemiparesis (weakness or paralysis on one side of the body). R27's Braden Scale Assessment (to assess risk for pressure ulcers) dated 4/9/21 indicated R27 had limitations in sensory perception, was chair-bound, had limited mobility and was at moderate risk for pressure ulcers. Interventions included frequent repositioning and toileting program. R27's care plan directed one to two staff to offload (remove pressure from a body part) for at least one minute, and turn and reposition every two hours. On 4/14/21, from 8:46 a.m. through 12:14 p.m. R27 was continuously observed. R27 remained seated in her recliner. No staff offered toileting or repositioning to R27 for 3 and 28 minutes. -At 10:30 a.m. physical therapy assistant (PTA)-D enter R27's room, and completed leg exercises while R27 was seated in her recliner. R27 was not observed to stand or change positions during therapy session. At 10:55 a.m. PTA-D was interviewed and stated she completed lower extremity exercises including hip, knee and ankle range of motion with R27, but did not offer or assist R27 to change positions. -At 11:42 a.m. nursing assistant (NA)-A was interviewed and stated staff were to assist R27 with repositioning every two hours and as needed. NA-A stated he had not offered to reposition or toilet R27 because he didn't have the time.	F 686	residents having the potential to be affected by the same deficient practice. . Will complete audits of repositioning documentation for all current residents who receive assistance with repositioning to determine gaps in service for other residents by 5/30/21. 3. What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur. . Education will be completed with all nursing and therapy team members to ensure understanding of the importance of following the plan of care for all repositioning needs. Any team members who do not receive this education by 5/30/21, will not work until the education has been completed. 4. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur. . Audits of 10% of residents who receive assistance with repositioning for documentation compliance will happen weekly x4 weeks, monthly x 2 months. Will review results with the QAPI team to make a recommendation for ongoing auditing. a. Will complete observational audits for 2 random residents who receive assistance with repositioning weekly x 4 weeks then monthly x2 months. Will review results with the QAPI team to make a recommendation for ongoing auditing.	

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
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
F 686	Continued From page 3 -At 12:14 p.m. NA-A assisted R27 into the bathroom. On 4/15/21, at 3:10 p.m. registered nurse (RN)-D was interviewed and stated R27 should be offered repositioning every two hours and as needed. RN-D stated it was not appropriate to wait three or more hours to toilet or reposition R27. -At 3:28 p.m. RN-E was interviewed and stated repositioning was primarily a NA task, but all staff assist with turning and repositioning residents. RN-E stated R27 should be checked every hour and it was not appropriate to wait three or more hours to be offered. The facility Repositioning policy revised 5/13, directed the purpose was to provide guidelines for the evaluation of residents repositioning needs, to aide in the development of an individualized care plan for repositioning, to promote comfort for all bed or chair-bound residents, and to prevent skin breakdown, promote circulation and provide pressure relief for residents.	F 686		
F 730 SS=D	Nurse Aide Peform Review-12 hr/yr In-Service CFR(s): 483.35(d)(7) §483.35(d)(7) Regular in-service education. The facility must complete a performance review of every nurse aide at least once every 12 months, and must provide regular in-service education based on the outcome of these reviews. In-service training must comply with the requirements of §483.95(g). This REQUIREMENT is not met as evidenced by:	F 730		5/30/21

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	245215	A. BUILDING _____ B. WING _____	C 04/15/2021

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F 730	Continued From page 4 Based on interview and document review, the facility failed to ensure the 12 hours of required inservice education was completed for 2 of 7 nursing assistants (NA-B, NA-C) whose personnel files were reviewed. Findings include: A staffing list undated, indicated nursing assistant (NA)-B was hired on 5/26/16. NA-B's Relias (computer module) training transcript dated 4/1/20, through 3/18/21, indicated NA-B had 2.7 hours of training, rather than the required 12 hours. A staffing list undated, indicated NA-C was hired on 5/22/00. NA-C's Relias training transcript dated 4/1/20, through 3/18/21, indicated NA-C had 3.7 hours of training, rather than the required 12 hours. On 4/15/21, at 3:00 p.m. the director of nursing (DON) and registered nurse (RN)-A were interviewed. The DON verified NA-B and NA-C did had not received the 12 hours of required training in 2020. The facility policy In-Service Training Program, Nurse Aide dated 12/20, directed all nurse aides would receive no less than 12 hours of inservice training per employment year.	F 730	1. How corrective action will be accomplished for those residents found to have been affected by the deficient practice. a. No specific residents were cited as it relates to this deficiency. b. For the team members specifically affected, Relias education assignments were audited and the team members were directed to complete the required education by 5/30/21. 2. How the facility will identify other residents having the potential to be affected by the same deficient practice. . No specific residents were cited as it relates to this deficiency. a. All TMA and CNAs' Relias education assignments were audited, any TMAs or CNAs found to have not met the 12 hour minimum education hours, were directed to complete the required education by 5/30/21. 3. What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur. . On April 22, 2021, an annual education training path was assigned to all CNAs and TMAs in Relias. Completion of the assigned training path and associated learning modules will result in a total of 14.5 hours of education to be completed by December 31, 2021. a. In addition to the annual training paths noted above, all CNAs and TMAs have also been assigned 3 Hours of VA Reporting and Dementia education for immediate completion by 5/30/21. b. Department leaders will complete monthly audits on CNA and TMA progress	

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F 730	Continued From page 5	F 730	towards education completion to ensure it is completed in a timely manner. 4. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur. . Annual education needs assessments and planning meetings will be held each Fall to determine the annual training path content to be assigned in January/February of the following year. a. These annual training paths auto-release 1-2 modules each month and provide email notification reminders to employees for completion. b. Department leaders will run monthly completion reports to assess team members' progress towards completion and follow-up with any team member that is out of compliance and determine a plan to get the team member into compliance in a timely manner.	
F 755 SS=F	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and	F 755		5/30/21

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F 755	Continued From page 6 biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure the emergency kits were tracked to prevent potential theft and diversion of medications. This had the potential to affect all 45 residents residing in the facility. Findings include: On 4/14/21, at 1:52 p.m. a tour of the medication storage room on the first floor was conducted with registered nurse (RN)-C. The emergency medication kit (e-kit) was in a locked cupboard and had a green plastic numbered security lock. RN-C stated two nurses signed out medications from this e-kit when a medication was ordered and the pharmacy was closed. -at 2:38 p.m. RN-D was interviewed. RN-D stated the e-kit contained narcotic medications. RN-D	F 755	1. How corrective action will be accomplished for those residents found to have been affected by the deficient practice. a. No specific residents were cited in this deficiency. 2. How the facility will identify other residents having the potential to be affected by the same deficient practice. . No residents were affected by the narcotic accounting practices of the facility. But all residents have the potential to be impacted by deficient practices in narcotic accounting. 3. What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur. . On April 22, 2021 - April 30, 2021 all nurses and TMAs were educated via	

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F 755	Continued From page 7 stated staff do not verify the plastic lock number on a routine basis. RN-D stated two nurses go into the cupboard where the e-kit was located when a medication was needed, they would remove the emergency medication from the e-kit, and both nurses signed out the medication. RN-D continued to state the nurses then replaced the lock with a lock from inside the e-kit, recorded the number on the lock, filled out a slip of paper with a carbon copy, and faxed the sheet to the pharmacy of what medication was removed. RN-D verified they only time they went into the e-kit was when they needed an emergency narcotic. A list taped to the top of the e-kit indicated the e-kit contained the following medications: hydrocodone/APAP 5/325 (a narcotic pain medication containing 5 milligrams [mg] of hydrocodone and 325 mg of acetaminophen [a non-narcotic pain medication]) six tablets hydrocodone/APAP 7.5/325 six tablets hydrocodone/APAP 10/325 six tablets morphine sulfate suppository 5 mg (a narcotic pain medication given rectally) six suppositories oxycodone tablet 5 mg (a narcotic pain medication) six tablets morphine sulfate concentrate solution 20 mg/milliliter (ml) 15 ml (a liquid narcotic pain medication) three morphine sulfate injection 10 mg/ml (a narcotic pain medication given by injection) two hydromorphone tablet 2 mg (a narcotic pain medication) six tablets lorazepam tablet 0.5 mg (a controlled substance used to treat anxiety) six tablets -at 2:52 p.m. the medication room on the second	F 755	email and in shift huddles of the expectation that the Narcotic eKits must be logged at every change of shift by two authorized medication passers. a. To further support this new practice, laminated communication signs were placed on the medication carts, in the controlled substance logs, reminding team members that the Narcotic eKits must be logged every shift by two authorized medication passers. 4. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur. . Nursing leadership conducting daily audits M-F x 4 weeks to ensure compliance with direct follow-up and education to the team members if the Narcotic eKit was not logged. a. Review of Narcotic eKit log added to the monthly controlled substance audit form to provide ongoing monitoring. b. Inclusion of Narcotic eKit log into the TMA and Nurse Orientation Checklists to ensure proper orientation for new team members.	

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F 755	Continued From page 8 floor was toured with licensed practical nurse (LPN)-A. LPN-A verified they do not ensure the e-kit plastic lock is intact on a routine basis. LPN-A stated they do not verify and record the numbers on the e-kit lock on a regular basis. LPN-A stated the e-kit was only checked when medications were removed and signed out by two nurses. On 4/15/21, at 1:54 p.m. the consultant pharmacist was interviewed. The consultant pharmacist stated the off-going nurse and the on-coming nurse at each shift change should verify the e-kit was present, and they should verify and record the lock was intact and the lock number is the same. -at 3:13 p.m. the director of nursing (DON) verified tracking of e-kit lock should be completed at every shift change to prevent diversion. The facility policy Controlled Medication Storage revised 1/20, directed at each shift change, or per facility policy, a physical inventory of all controlled medications is conducted by two authorized med passers. A controlled medication accountability record is prepared by the facility for all Schedule II medications regardless if routine or PRN. If a schedule III, IV, V medication is not supplied in a unit dose automatic exchange system, the facility must implement an accountability record system. The policy lacked direction for tracking the emergency medication kit tags every shift.	F 755		
F 943 SS=E	Abuse, Neglect, and Exploitation Training CFR(s): 483.95(c)(1)-(3) §483.95(c) Abuse, neglect, and exploitation. In addition to the freedom from abuse, neglect,	F 943		5/30/21

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F 943	Continued From page 9 and exploitation requirements in § 483.12, facilities must also provide training to their staff that at a minimum educates staff on- §483.95(c)(1) Activities that constitute abuse, neglect, exploitation, and misappropriation of resident property as set forth at § 483.12. §483.95(c)(2) Procedures for reporting incidents of abuse, neglect, exploitation, or the misappropriation of resident property §483.95(c)(3) Dementia management and resident abuse prevention. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure 7 staff (RN-B, LPN-A, NA-D, NA-E, SW-A, A-A, NA-E, and NA-C) received annual training for vulnerable adult (VA) abuse prevention and reporting. Findings include: Review of the facility abuse training records indicated: -Registered nurse (RN)-B was hired on 7/2/19, and completed only one of the Abuse and Neglect module in 2020. - Licensed practical nurse (LPN)-A was hired on 8/13/19, and did not complete either of the abuse modules in 2020. -Nursing assistant (NA)-D was hired on 10/15/19, and did not complete either of the abuse modules in 2020. -NA-E was hired on 1/22/90, and did not complete either of the abuse modules in 2020. -Social worker (SW)-A was hired on 9/20/81, and did not complete either of the abuse modules in	F 943	1. How corrective action will be accomplished for those residents found to have been affected by the deficient practice. a. No residents were cited in this area of deficiency. 2. How the facility will identify other residents having the potential to be affected by the same deficient practice. . All residents have the potential to be affected by the lack of training on abuse prevention and dementia care. 3. What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur. . On April 22, 2021, all team members working in the Fountains were assigned 3 hours of VA reporting and Dementia education in Relias. Modules included: i. Recognizing, Reporting, and Preventing Abuse 0.5hrs 1. Course Objectives: All healthcare workers are responsible for ensuring the	

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F 943	Continued From page 10 2020. -Activities (A)-A was hired on 11/12/13, and did not complete either of the abuse modules in 2020. -NA-E was hired on 1/22/90, and did not complete either of the abuse modules in 2020. -NA-C was hired on 5/22/00, did not complete either of the abuse modules in 2020. -at 3:00 p.m. the DON and RN-A were interviewed. The DON verified the staff listed above did not complete both Relias (computer module) modules for abuse in 2020. The DON stated in 2019 the facility transitioned to the Relias computer training program, and shortly after the transition they lost the staff development position. The DON stated no one realized the abuse education modules were not assigned to staff. An assumption was made that the modules would automatically be assigned to all staff. The DON verified annual training on abuse was a requirement for staff. -at 4:15 p.m. SW-A was interviewed. SW-A verified she should have had annual abuse training in 2020. SW-A stated she waits for modules to show up in the computer program, and then she completes the training modules. SW-A stated she did not notice abuse modules were not assigned in 2020. The facility Abuse Prevention Plan For Minnesota Skilled Nursing Facilities dated 3/14/18, directed the facility would have a training program that covers all new and existing staff; individuals providing services under a contractual arrangement; and volunteers. All such employees, independent contractors, and volunteers will be trained during orientation to the	F 943	safety of those in their care. This includes protecting them from abuse. Unfortunately, incidents of abuse and neglect are all too common in healthcare, often going unrecognized and unreported. This is why it is critical for all employees to be able to recognize potential abuse and know how to respond, including how to report abuse. The goal of this course is to provide direct care professionals in post-acute care with knowledge of preventing, recognizing, and reporting abuse. ii. Dementia Care: Normal Aging vs. Dementia/Alzheimers 0.5hrs 1. Course Objectives: Normal aging is not a disease and does not always result in dementia. Therefore, when caring for older adults, healthcare workers need to be able to determine what is normal aging and what is dementia. In this course, the learner will learn about the differences between normal aging and dementia as well as the various stages of Alzheimer's disease. iii. Dementia Care: CMS Hand in Hand Module 1: Understanding the World of Dementia: The Person and Disease 1.0hr 1. Course Objectives: This training focuses on caring for residents with dementia and on preventing abuse. CMS, supported by a team of training developers and subject matter experts, created this training to address the need for nurse aides' in-service training on these important topics. The mission of the Hand in Hand training is to provide nursing homes with a high-quality training program that emphasizes	

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F 943	Continued From page 11 facility, and at least annually thereafter, on the abuse prohibition practices.	F 943	person-centered care in the care of persons with dementia and the prevention of abuse. iv. Awakenings: Communication for Caregivers 1.0hr 1. Course Objectives: Explore ways to improve communication with the person living with dementia. Discuss non-verbal body language and its importance in communicating with a person with dementia. Demonstrate the principles of Improv and communicating with a person with dementia. a. All team members to have this education completed by May 30, 2021 or they will not be allowed to work until completed. 4. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur. . Department leaders will complete monthly audits on all team members' progress towards education completion to ensure it is completed in a timely manner. a. Department leaders to coordinate education days for team members and/or rotation of team members each shift to complete education, as staffing allows. b. Abuse, Neglect and Exploitation Training, as well as, Dementia training were incorporated into all team member's annual training paths that were also assigned on April 22, 2021 with completion due by December 31, 2021.	

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
April 29, 2021

Administrator
Ecumen Lakeshore
4002 London Road
Duluth, MN 55804

Re: State Nursing Home Licensing Orders
Event ID: VULM11

Dear Administrator:

The above facility was surveyed on April 12, 2021 through April 15, 2021 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:

Terri Ament, Unit Supervisor
Duluth District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Duluth Technology Village
11 East Superior Street, Suite 290
Duluth, Minnesota 55802-2007
Email: teresa.ament@state.mn.us
Office: (218) 302-6151 Mobile: (218) 766-2720

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 note it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

Please feel free to call me with any questions.

Sincerely,

Joanne Simon, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

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	00594	A. BUILDING: _____ B. WING _____	C 04/15/2021

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 4/12/21, through 4/15/21, a licensing survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was found 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	2 000		

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ECUMEN LAKESHORE	4002 LONDON ROAD DULUTH, MN 55804

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2 000	Continued From page 1 these orders, and identify the date when they will be completed. 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 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm 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, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY.	2 000		

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 04/15/2021

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2 000	Continued From page 2 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		
2 285	MN Rule 4658.0100 Subp. 2 Employee Orientation and In-Service Education Subp. 2. In-service education. A nursing home must provide in-service education. The in-service education must be sufficient to ensure the continuing competence of employees, must address areas identified by the quality assessment and assurance committee, and must address the special needs of residents as determined by the nursing home staff. A nursing home must provide an in-service training program in rehabilitation for all nursing personnel to promote ambulation; aid in activities of daily living; assist in activities, self-help, maintenance of range of motion, and proper chair and bed positioning; and in the prevention or reduction of incontinence. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure the 12 hours of required inservice education was completed for 2 of 7 nursing assistants (NA-B, NA-C) whose personnel files were reviewed. This had the potential to affect all 45 residents residing in the facility. Findings include: A staffing list undated, indicated nursing assistant (NA)-B was hired on 5/26/16.	2 285	corrected	5/30/21

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2 285	Continued From page 3 NA-B's Relias (computer module) training transcript dated 4/1/20, through 3/18/21, indicated NA-B had 2.7 hours of training, rather than the required 12 hours. A staffing list undated, indicated NA-C was hired on 5/22/00. NA-C's Relias training transcript dated 4/1/20, through 3/18/21, indicated NA-C had 3.7 hours of training, rather than the required 12 hours. On 4/15/21, at 3:00 p.m. the director of nursing (DON) and registered nurse (RN)-A were interviewed. The DON verified NA-B and NA-C did had not received the 12 hours of required training in 2020. The facility policy In-Service Training Program, Nurse Aide dated 12/20, directed all nurse aides would receive no less than 12 hours of inservice training per employment year. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could develop, review, and/or revise policies and procedures related to nursing assistant training requirements. The DON or designee could educate all appropriate staff on the policies and procedures. The DON or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 285		
2 302	MN State Statute 144.6503 Alzheimer's disease or related disorder train	2 302		5/30/21

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2 302	Continued From page 4 ALZHEIMER'S DISEASE OR RELATED DISORDER TRAINING: MN St. Statute 144.6503 (a) If a nursing facility serves persons with Alzheimer's disease or related disorders, whether in a segregated or general unit, the facility's direct care staff and their supervisors must be trained in dementia care. (b) Areas of required training include: (1) an explanation of Alzheimer's disease and related disorders; (2) assistance with activities of daily living; (3) problem solving with challenging behaviors; and (4) communication skills. (c) The facility shall provide to consumers in written or electronic form a description of the training program, the categories of employees trained, the frequency of training, and the basic topics covered. (d) The facility shall document compliance with this section. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure 5 staff (NA-B, NA-C, SW, and PTA) received annual training that included all required components of Alzheimer's/dementia care. This had the potential to affect all 3 residents currently residing in the facility with a diagnosis of Alzheimer's or dementia. Findings include:	2 302	corrected	

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2 302	Continued From page 5 Minnesota state statute 144.6503 for Alzheimer's disease or related disorder training, directed areas of required training for direct care staff and their supervisors included: -an explanation of Alzheimer's disease and related disorders -assistance with activities of daily living -problem solving with challenging behaviors -communication skills A review of the facility abuse training records indicated: -Nursing assistant (NA)-B was hired on 5/26/16, and had not completed any of the four required components of Alzheimer's training in the past year. -NA-C was hired on 5/22/00, and had not completed any of the four required components of Alzheimer's training in the past year. -Social worker (SW)-A was hired on 9/20/81, and had not completed any of the four required components of Alzheimer's training in the past year. -Physical therapy aide (PTA) was hired on 3/8/17, and had not completed the components of Alzheimer's training including explanation of Alzheimer's disease and related disorders, assistance with activities of daily living, and problem solving with challenging behaviors in the past year. On 4/15/21, at 3:00 p.m. the DON stated in 2019 the facility transitioned to the Relias computer training program, and shortly after the transition they lost the staff development position. The DON stated no one realized training modules were not assigned to staff. An assumption was made that the modules would automatically be assigned to all staff. The DON provided the document from the admission packet that ensured consumers	2 302		

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2 302	Continued From page 6 that staff received appropriate training on dementia care that included the following courses: -Promoting independence for persons with dementia -family issues with dementia -dementia behavior management -communicating with persons with dementia -awakenings-an Ecumen designed and created Dementia program On 4/15/21, at 4:15 p.m. SW-A verified she should have had annual training in 2020. SW-A stated she waited for modules to show up in the computer program, and then she completed the training modules. The facility Abuse Prevention Plan for Minnesota Skilled Nursing Facilities dated 3/14/18, directed all employees, independent contractors, and volunteers would be trained during orientation to the facility, and at least annually thereafter, on dementia management. The facility Dementia-Clinical Protocol dated 11/18, directed nursing assistants to receive initial training in the care of residents with dementia and related behaviors and annually thereafter. The facility policy and procedure for Nurse Aide Qualifications and Training Requirements revised 5/19, directed nursing assistants to receive the following training prior to direct contact with residents, including the following areas regarding the care of cognitively impaired residents: (1) Techniques for addressing the unique needs and behaviors of individuals with dementia (Alzheimer's and others); (2) Communicating with cognitively impaired residents;	2 302		

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2 302	Continued From page 7 (3) Understanding the behavior of cognitively impaired residents; (4) Appropriate responses to the behavior of cognitively impaired residents; and (5) Methods of reducing the effects of cognitive impairments. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could develop, review, and/or revise policies and procedures related to staff training pertaining to Alzheimer's and dementia. The DON or designee could educate all appropriate staff on the policies and procedures. The DON or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 302		
2 900	MN Rule 4658.0525 Subp. 3 Rehab - Pressure Ulcers Subp. 3. Pressure sores. Based on the comprehensive resident assessment, the director of nursing services must coordinate the development of a nursing care plan which provides that: A. a resident who enters the nursing home without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates, and a physician authenticates, that they were unavoidable; and	2 900		5/30/21

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2 900	Continued From page 8 B. a resident who has pressure sores receives necessary treatment and services to promote healing, prevent infection, and prevent new sores from developing. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure timely repositioning to prevent pressure ulcers for 1 of 2 residents (R27) reviewed for pressure ulcers. R27's admission Minimum Data Set (MDS) dated 3/29/21 indicated R27 was cognitively impaired and required assist of one or two staff for all activities of daily living (ADLs) including transferring, and toileting. and did not ambulate. R27's diagnoses included multiple sclerosis (MS), neurogenic bladder, cerebrovascular accident (CVA) and hemiparesis (weakness or paralysis on one side of the body). R27's Braden Scale Assessment (to assess risk for pressure ulcers) dated 4/9/21 indicated R27 had limitations in sensory perception, was chair-bound, had limited mobility and was at moderate risk for pressure ulcers. Interventions included frequent repositioning and toileting program. R27's care plan directed one to two staff to offload (remove pressure from a body part) for at least one minute, and turn and reposition every two hours. On 4/14/21, from 8:46 a.m. through 12:14 p.m. R27 was continuously observed. R27 remained seated in her recliner. No staff offered toileting or repositioning to R27 for 3 and 28 minutes.	2 900	corrected	

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2 900	Continued From page 9 -at 10:30 a.m. physical therapy assistant (PTA)-D enter R27's room, and completed leg exercises while R27 was seated in her recliner. R27 was not observed to stand or change positions during therapy session. At 10:55 a.m. PTA-D was interviewed and stated she completed lower extremity exercises including hip, knee and ankle range of motion with R27, but did not offer or assist R27 to change positions. -At 11:42 a.m. nursing assistant (NA)-A was interviewed and stated staff were to assist R27 with repositioning every two hours and as needed. NA-A stated he had not offered to reposition or toilet R27 because he didn't have the time. -At 12:14 p.m. NA-A assisted R27 into the bathroom. On 4/15/21, at 3:10 p.m. registered nurse (RN)-D was interviewed and stated R27 should be offered repositioning every two hours and as needed. RN-D stated it was not appropriate to wait three or more hours to toilet or reposition R27. -At 3:28 p.m. RN-E was interviewed and stated repositioning was primarily a NA task, but all staff assist with turning and repositioning residents. RN-E stated R27 should be checked every hour and it was not appropriate to wait three or more hours to be offered. The facility Repositioning policy revised date 5/13, directed the purpose was to provide guidelines for the evaluation of residents repositioning needs, to aide in the development of an individualized care plan for repositioning, to	2 900		

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2 900	Continued From page 10 promote comfort for all bed or chair-bound residents, and to prevent skin breakdown, promote circulation and provide pressure relief for residents. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could develop, review, and/or revise policies and procedures related to prevention of pressure ulcer development or worsening of pressure ulcers. The DON or designee could educate all appropriate staff on the policies and procedures. The DON or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 900		
21610	MN Rule 4658.1340 Subp. 1 Medicine Cabinet and Preparation Area;Storage Subpart 1. Storage of drugs. A nursing home must store all drugs in locked compartments under proper temperature controls, and permit only authorized nursing personnel to have access to the keys. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure the emergency kits were tracked to prevent potential theft and diversion of medications. This had the potential to affect all 45 residents residing in the facility. Findings include: On 4/14/21, at 1:52 p.m. a tour of the medication	21610	corrected	5/30/21

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21610	Continued From page 11	21610		

storage room on the first floor was conducted with registered nurse (RN)-C. The emergency medication kit (e-kit) was in a locked cupboard and had a green plastic numbered security lock. RN-C stated two nurses signed out medications from this e-kit when a medication was ordered and the pharmacy was closed.

-at 2:38 p.m. RN-D was interviewed. RN-D stated the e-kit contained narcotic medications. RN-D stated staff do not verify the plastic lock number on a routine basis. RN-D stated two nurses go into the cupboard where the e-kit was located when a medication was needed, they would remove the emergency medication from the e-kit, and both nurses signed out the medication. RN-D continued to state the nurses then replaced the lock with a lock from inside the e-kit, recorded the number on the lock, filled out a slip of paper with a carbon copy, and faxed the sheet to the pharmacy of what medication was removed. RN-D verified they only time they went into the e-kit was when they needed an emergency narcotic.

A list taped to the top of the e-kit indicated the e-kit contained the following medications:

hydrocodone/APAP 5/325 (a narcotic pain medication containing 5 milligrams [mg] of hydrocodone and 325 mg of acetaminophen [a non-narcotic pain medication]) six tablets
hydrocodone/APAP 7.5/325 six tablets
hydrocodone/APAP 10/325 six tablets
morphine sulfate suppository 5 mg (a narcotic pain medication given rectally) six suppositories
oxycodone tablet 5 mg (a narcotic pain medication) six tablets
morphine sulfate concentrate solution 20 mg/milliliter (ml) 15 ml (a liquid narcotic pain

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21610	Continued From page 12	21610		

medication) three
morphine sulfate injection 10 mg/ml (a narcotic pain medication given by injection) two
hydromorphone tablet 2 mg (a narcotic pain medication) six tablets
lorazepam tablet 0.5 mg (a controlled substance used to treat anxiety) six tablets

-at 2:52 p.m. the medication room on the second floor was toured with licensed practical nurse (LPN)-A. LPN-A verified they do not ensure the e-kit plastic lock is intact on a routine basis. LPN-A stated they do not verify and record the numbers on the e-kit lock on a regular basis. LPN-A stated the e-kit was only checked when medications were removed and signed out by two nurses.

On 4/15/21, at 1:54 p.m. the consultant pharmacist was interviewed. The consultant pharmacist stated the off-going nurse and the on-coming nurse at each shift change should verify the e-kit was present, and they should verify and record the lock was intact and the lock number is the same.

-at 3:13 p.m. the director of nursing (DON) verified tracking of e-kit lock should be completed at every shift change to prevent diversion.

The facility policy Controlled Medication Storage revised 1/20, directed at each shift change, or per facility policy, a physical inventory of all controlled medications is conducted by two authorized med passers. A controlled medication accountability record is prepared by the facility for all Schedule II medications regardless if routine or PRN. If a schedule III, IV, V medication is not supplied in a unit dose automatic exchange system, the facility must implement an accountability record system.

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21610	Continued From page 13 The policy lacked direction for tracking the emergency medication kit tags every shift. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could develop, review, and/or revise policies and procedures related to medication storage and monitoring of controlled medications to prevent diversion. The DON or designee could educate all appropriate staff on the policies and procedures. The DON or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21610		

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	245215	A. BUILDING **02 - NEW REPLACEMENT BLDG** B. WING _____	**04/13/2021**

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K 000	INITIAL COMMENTS FIRE SAFETY A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey, Lakeshore Inc. 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) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. 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 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. IF OPTING TO USE AN EPOC A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K TAGS) TO: HEALTH CARE FIRE INSPECTIONS STATE FIRE MARSHAL DIVISION	K 000		

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

Electronically Signed | 05/07/2021

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 1 445 MINNESOTA STREET, SUITE 145 ST. PAUL, MN 55101-5145, or By e-mail 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. 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 60 certified beds and at the time of the inspection the census was 40. The requirements of 42 CFR Subpart 483.70(a) are NOT MET.	K 000		

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	245215	A. BUILDING **02 - NEW REPLACEMENT BLDG** B. WING _____	**04/13/2021**

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K 345	Continued From page 2	K 345		
K 345 SS=F	Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This REQUIREMENT is not met as evidenced by: Based on documentation review and staff interview, the facility has not maintained the fire alarm system testing and maintenance documentation in accordance with NFPA 101 (2012 edition), Life Safety Code, sections 9.6.1.3 and 9.6.1.5, and NFPA 72 National Fire Alarm Code 2010 edition, section 14.3.1 and 14.4.5. This deficient practice could affect 60 of 60 residents. Findings include: 1. On 04/13/2021, at 12:50 p.m., during the review of all available fire alarm maintenance and testing documentation for the last 12 months, and an interview with the Maintenance Supervisor it was revealed that the facility did not conduct a semi-annual visual inspection of the fire alarm initiating devices. 2. On 04/13/2021, at 12:55 p.m., during the review of all available fire alarm maintenance and testing documentation for the last 12 months, and an interview with the Maintenance Supervisor it was revealed that the facility did not conduct an	K 345	1. The documentation for the annual inspection that occurred on 12/10/20 was located. The last annual inspection occurred on 4/28/21. A semi-annual visual inspection is scheduled for 10/28/21. 2. A preventative maintenance task will be recurring to happen within 6 months of each inspection. Missed tasks will be reported to the Executive Director and Regional Director of Operations. 3. Future performance will be monitored by Executive Director review of preventative maintenance program results. 4. Environmental Services Director 5. 5/7/21	5/7/21

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K 345	Continued From page 3 annual inspection of the fire alarm system within 12 months of the last annual test/inspection. The last annual fire alarm test was conducted on 03/28/2020. This deficient condition was verified by the Maintenance Supervisor.	K 345		
K 363 SS=F	Corridor - Doors CFR(s): NFPA 101 Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire	K 363		5/7/21

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K 363	Continued From page 4 window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility had multiple corridor doors that did not meet the requirements of NFPA 101 "The Life Safety Code" 2012 edition (LSC) section 19.3.6.3. This deficient practice could affect 60 of 60 residents. Findings include: On 04/13/2021 at 2:25 p.m., observation revealed that the lower level physical therapy area was open to the corridor and that there are two sets of closets with bi-fold doors that were located in the walls around the physical therapy room. Because the physical therapy area is open to the corridor the walls around the physical therapy area must meet the requirements for corridor walls. The doors to the two closets were bi-fold doors that were not automatically positively latching and there was a 1/2" gap at the top of the doors. The doors were not constructed to limit the transfer of smoke and do not meet the requirements for corridor doors. This deficient condition was verified by the Maintenance Supervisor.	K 363	An annual/continuing waiver is being requested for K363. A. Compliance with this provision will cause an unreasonable hardship because: 1. NFPA 101(00), Sec. 4.6.3 allows the authority having jurisdiction to modify the requirements of the Code for existing buildings in cases where their application would be impractical. Ecumen Lakeshore feels that it would be impractical to install positive latching doors on the 2 sets of closets with bi-fold doors located in the walls around the physical therapy room as they would restrict access to and interfere with exiting from treatment room #4; In addition, access to and egress from the treatment space located at the southeast corner of the therapy area would be restricted. Ecumen Lakeshore. specializes in the housing and rehabilitation of persons in various stages of recovery from surgery (e.g. hip and knee replacements). Many of these persons use wheelchairs, walkers, canes and/or crutches as they progress through their recovery process. To maintain easy	

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K 363	Continued From page 5	K 363	access to the PT spaces, as well as to reduce the potential for injury, these areas were intentionally designed to be as open and barrier free (e.g. doors) as possible. 2. Ecumen Lakeshore feels that the correction of this deficiency would cause the need for disproportionate effort, expense and disruption of services with little or no increase in life safety. The facility feels that the physical arrangement of the lower level is very similar to that allowed by the Code for suites, based on the following: a. There are no sleeping rooms on the lower level. b. The lower level is roughly 8,750 ft2 in size, which is less than the 10,000 ft2 allowed by NFPA 101(00), Sec. 18.2.5.7 for non sleeping suites. The smoke zone in which the PT/OT spaces are located is roughly 6,070 ft2 in size. c. There are two exits from the PT/OT space to meet the requirements of NFPA 101(00), Sec. 18.2.5.3. One of these exits discharges directly to the exterior at grade level. d. The north closet is 22.5 ft2 in size and the south closet is 21 ft2 in size. As such the closets meet the requirements in Exception No. 1 to NFPA 101(00), Sec. 18.3.6.1 for spaces allowed to be open to the corridor. Both of the closets are fully sprinklered and the space into which they open is protected by automatic smoke detection. B. There will be no adverse effect on the safety of building occupants because: 1. The lower level is only occupied between the hours of 7:00 AM to 5:00 PM.	

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K 363	Continued From page 6	K 363	2. There are a maximum of 18 residents on the lower level at any time. Sufficient staff are present to maintain a staffing ratio of at least one (1) staff person for each two (2) residents using PT services. 3. Based on review of building construction drawings and discussion with the facility architect, it has been confirmed that the lower level is subdivided into two separate smoke compartments. 4. The building is protected throughout by a complete supervised automatic fire sprinkler system installed in accordance with NFPA 13. 5. Automatic smoke detection, interconnected with the building's addressable fire alarm system, is present in the corridors and PT space on the lower level. 6. The building fire alarm system is monitored to provide automatic notification to the Duluth Fire Department, which is a full-time department. 7. Ecumen Lakeshore is a smoke-free facility and signs to that effect are prominently displayed at all major entrances to the building.	
K 372 SS=D	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	K 372		5/7/21

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K 372	Continued From page 7 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 1 of 3 smoke barrier walls in accordance with the requirements of NFPA 101 "The Life Safety Code" 2012 edition sections 19.3.7.3 and 8.5.6. This deficient practice could affect 20 of 60 residents. Findings include: On 04/13/2021 at 1:06 p.m., observations revealed that there is a 1 inch opening around wires that are passing through the smoke barrier wall above the ceiling tile over cross-corridor doors located the smoke barrier by the resident room 140. This deficient condition was verified by the Maintenance Supervisor.	K 372	1. Area identified was corrected with 3m Fire Barrier Moldable Putty. 2. To ensure vulnerabilities of smoke barriers does not occur in the future, Ecumen Lakeshore has administered two processes. 3. Assigned a TELs maintenance task “Visually inspect all walls in or near these areas for damage and holes” Set on a 3 month cycle. Next due 07/2021. If a task is not completed or is late, Regional Director, Executive Director, and EvS Director will be alerted. Additionally, when vendors/contractors are to work in areas where potential smoke barriers may be affected, the EvS Director and lead contractor will sign off on the FIRE AND SMOKE BARRIER PENETRATION POLICY 4. Environmental Services Director 5. 4/13/21	
K 712 SS=F	Fire Drills CFR(s): NFPA 101 Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar	K 712		5/7/21

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K 712	Continued From page 8 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 documentation review and staff interview, it was determined that the facility failed to conduct 7 of 12 fire drills in accordance with the NFPA 101 "The Life Safety Code" 2012 edition, sections 19.7.1.2 and 19.7.1.6, during the last 12 months. This deficient practice could affect 60 of 60 residents. Findings include: On 04/14/2021, at 11:10 a.m., during the review of all available fire drill documentation and interview with the Maintenance Supervisor the following deficient conditions were found: 1. The facility failed to vary the times of the evening shift fire drills by conducting 3 fire drills in the 2 p.m. hour. 2. The facility failed to vary the times of the night shift fire drills by conducting 3 fire drills in the 11 p.m. hour. 3. The facility failed to conduct an evening fire drill in the 4th quarter within the last 12 month period. This deficient condition was verified by the Maintenance Supervisor.	K 712	1. Environmental Services Director reviewed NFPA 101 Life Safety Code 2012 edition, Section 19. 7 . 1 . 2 and Section 19. 7.1.6 2. Environmental Services Director will incorporate new knowledge related to varying times of fire drills into the future fire drill schedule. 3. Environmental Services Director will report Quarterly Fire Drill times and results to QAPI for six months or until the audit is reviewed and discontinued by QAPI. 4. Environmental Services Director, QAPI Committee 5. 5/6/21	

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K 761 SS=F	Maintenance, Inspection & Testing - Doors CFR(s): NFPA 101 Maintenance, Inspection & Testing - Doors Fire doors assemblies are inspected and tested annually in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives. Non-rated doors, including corridor doors to patient rooms and smoke barrier doors, are routinely inspected as part of the facility maintenance program. Individuals performing the door inspections and testing possess knowledge, training or experience that demonstrates ability. Written records of inspection and testing are maintained and are available for review. 19.7.6, 8.3.3.1 (LSC) 5.2, 5.2.3 (2010 NFPA 80) This REQUIREMENT is not met as evidenced by: Based on documentation review and staff interview, the facility did not complete the annual fire door inspections in accordance with the requirements of NFPA 101 "The Life Safety Code" 2012 edition sections 8.3.3.1, 19.7.6 and the NFPA 80 Standard for Fire Doors and Other Opening Protectives 2010 edition sections 5.2.1. This deficient practice could affect the safety of 60 of 60 residents. Findings include: On 04/13/2021, at 11:45 a.m., during the review of all available fire door test and inspection documentation and an interview with the Maintenance Supervisor, that at the time of the inspection the facility could not provide documentation verifying that the fire door inspection had been completed within 12 months of the last annual fire door inspection that was	K 761	1. Documentation was located and the most recent inspection of the fire doors was completed on 1/12/21. 2. Documentation was converted to electronic format to help ensure storage and access. 3. Once completed the document is added to the preventative maintenance system and to the fire book. 4. Environmental Services Director 5. 5/7/21	5/7/21

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K 761	Continued From page 10 conducted on 03/16/2020. This deficient condition was verified by the Maintenance Supervisor.	K 761		
K 914 SS=F	Electrical Systems - Maintenance and Testing CFR(s): NFPA 101 Electrical Systems - Maintenance and Testing Hospital-grade receptacles at patient bed locations and where deep sedation or general anesthesia is administered, are tested after initial installation, replacement or servicing. Additional testing is performed at intervals defined by documented performance data. Receptacles not listed as hospital-grade at these locations are tested at intervals not exceeding 12 months. Line isolation monitors (LIM), if installed, are tested at intervals of less than or equal to 1 month by actuating the LIM test switch per 6.3.2.6.3.6, which activates both visual and audible alarm. For LIM circuits with automated self-testing, this manual test is performed at intervals less than or equal to 12 months. LIM circuits are tested per 6.3.3.3.2 after any repair or renovation to the electric distribution system. Records are maintained of required tests and associated repairs or modifications, containing date, room or area tested, and results. 6.3.4 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on staff interview and a review of the available fire drill documentation, that the electrical testing and maintenance was not maintained in accordance with NFPA 99 Standards for Health Care Facilities 2012 edition, section 6.3.4. This deficient practice could affect	K 914	1. Electrical outlet testing began on 3/15/21 and completed 5/6/21. 2. Schedule electrical outlet testing to be completed within 12 months from the last testing start date of 3/15/21. a. Annual outlet test to be completed in	5/7/21

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K 914	Continued From page 11 the safety of 60 of 60 residents. Findings include: On 04/13/2021, at 12:00, during a records review and an interview with the Maintenance Supervisor, the facility could not provide any documentation for the current completion of the annual electrical outlet inspection and testing for the electrical outlets located in the resident rooms located throughout the facility. The last annual electrical outlet inspection was completed on 03/20/2020. This deficient condition was verified by the Maintenance Supervisor.	K 914	2022, TELs maintenance task is set to be completed for all rooms by 3/14/2022 to stay in compliance with all outlets tested within a 12 month time frame. b. Once the annual test is completed, EvS Director is to schedule the annual test(TELs) to be completed on or before the date of the first outlet being tested for the current year's test. 3. TELs task is automatically set on an 11 month cycle, but can be adjusted by authorized users if the completion date will fall out of the 12 month range. If a task is not completed or is late, Regional Director, Executive Director, and EvS Director will be alerted. 4. EvS Director, Executive Director 5. Completed on 5/6/21	