Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
June 18, 2024

Administrator
Ecumen Lakeshore
4002 London Road
Duluth, MN 55804

RE: CCN: 245215
Cycle Start Date: June 13, 2024

Dear Administrator:

On June 13, 2024, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

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

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

DEPARTMENT CONTACT

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

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

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 September 13, 2024 (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 December 13, 2024 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

INFORMAL DISPUTE RESOLUTION (IDR) / INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

In accordance with 42 CFR 488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to:

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

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

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

Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

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

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

Feel free to contact me if you have questions.

Sincerely,

Joanne Simon, Compliance Analyst
Minnesota Department of Health
Health Regulation Division
Telephone: 651-201-4161
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 06/13/2024

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 6/10/24 through 6/13/24, a survey for compliance with Appendix Z, Emergency Preparedness Requirements, §483.73 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 6/10/24 through 6/13/24, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were reviewed with NO deficiencies cited: H52154363C(MN00100457). The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulations has been attained.	F 000		
F 812	Food Procurement,Store/Prepare/Serve-Sanitary	F 812		6/25/24

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

Electronically Signed | 06/26/2024

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 812 SS=F	Continued From page 1 CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility failed to ensure dishwasher temperatures were maintained or implement other strategies to effectively sanitize dishware and utensils to reduce the risk of foodborne illness. This had potential to affect 56 residents residing in the nursing home along with staff and visitors who consume meals from the main production kitchen. Findings include: During observation on 6/13/24 at 8:43 a.m., culinary aide (CA)-A was washing morning dishes. The dishwasher monitoring system was flashing red and showed a low rinse temperature	F 812	Plan Of Correction June 21, 2024 Culinary POC report created by Wade Schadewald Corrective Action F812 Ecolab is in the process of ordering parts and fixing the dishwashing equipment. Food Services Director implemented a three-sink wash/rinse process on 6/13/2024 to ensure dishes are being properly sanitized. Food Services Director purchased	

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F 812	Continued From page 2 at 140 degrees Fahrenheit (F). The thermometer on the dishwasher also indicated 140 degrees. CA-A continued to insert dirty dishes in to the dishwasher. Review of the facilities dishwasher temperature log from 6/1/24 to 6/13/24, identified rinse temperatures that ranged from 145 to 155 degrees F. During an interview on 6/13/24 at 8:45 a.m., CA-A-stated the dishwasher temps had been below 180 degrees F since at least the beginning of June and Ecolab was aware and was going to fix the broken part. The food services director was aware. During an interview on 6/13/24 at 9:03 a.m., food services director (FSD) stated the dishwasher was a high temperature dishwasher which sanitized dishes with high heat and not chemicals. The FSD stated the rinse cycle temperatures had to be at least 180 degrees F to sanitize dishes appropriately. The booster was not working and to his knowledge, the booster had been broken for since at least the first of this month. FSD was unaware of any changes being made to the dishwashing process since the booster had broken stating, "everything stayed the same" regarding the process for cleaning and sanitizing the dishes used by the residents. FSD stated the dishes were still getting sanitized and safe to use even though the temperature was below 180 degrees. During an observation on 6/13/24 at 9:08 a.m., FSD performed a litmus test on the dishwasher which indicated the rinse cycle was not reaching160 degrees. He then utilized a	F 812	sanitizing agent that can be used in the event the dish machine fails to reach proper sanitizing temperature in the future. On June 18th at 9:30 am, Ecumen's Corporate Dietitian Manager, Toni Swanson provided in-service training to each team member who is responsible for washing dishes and food storage. This included the following: 1. Understanding the dish machine policies, operations, and procedures. 2. Understanding what to do if the dish machine is not working properly. 3. Understanding the importance of refrigeration cleanliness and sanitation. 4. Understanding the procedure of checking and recording temperatures on appliance units and making sure food items stored in refrigerator units are clearly labeled and dated appropriately. These mandatory trainings and policy reviews are designed to educate culinary team members on the proper standard operating procedures of a). the dish machine; b). ware washing; c). food storage; and to help ensure our facility implements practices and appropriate food safety requirements administered by Ecumen and the State of Minnesota. Also included was the plan of action if/when dish machine does not reach proper temperature or sanitary conditions are not maintained in any of our equipment or food storage and handling areas.	

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F 812	Continued From page 3 thermometer and stated the "core" was only reading 155 degrees at that time. During an interview on 6/13/24 at 9:22 a.m. the infection preventionist (IP) stated if dishes are not washed and sanitized at the appropriate temperature there was an increased risk of contamination and an increased risk anybody eating out of the kitchen becoming ill. A facility policy for dish cleaning was requested but not provided.	F 812	The Culinary Director, or the Person in Charge, will conduct an audit process to ensure proper ware washing and food storage policies are being practiced and adhered to. This kitchen audit process will be verified daily, weekly, monthly and quarterly as follows: a. Recording and documenting of POC policy and procedures data 3 times weekly for the first 4 weeks. b. Recording and documenting POC policy and procedures data 1 time weekly for one month. c. Recording and documenting of POC policy and procedures data 1 time per month for 3 months until discontinued through Ecumen's Quality Assurance Process Improvement program (QAPI). Date of Corrections June 25th, 2024	

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K 000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety recertification survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 06/11/2024. At the time of this survey, Ecumen Lakeshore was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: IF PARTICIPATING IN THE E-POC PROCESS, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED.	K 000		

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

Electronically Signed | 06/26/2024

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K 000	Continued From page 1 Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR By email to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A detailed description of the corrective action taken or planned to correct the deficiency. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. 4. Identify who is responsible for the corrective actions and monitoring of compliance. 5. The actual or proposed date for completion of the remedy. Ecumen Lakeshore Inc. is a two-story building of type II(222) construction that was built in 2004-2005. The building is fully sprinklered and there is supervised smoke detection located in the corridors, space open to corridor and in resident rooms. The facility has a capacity of 60 beds and had a census of 55 at the time of the survey.	K 000		

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K 000	Continued From page 2	K 000		
K 321 SS=F	The requirements at 42 CFR, Subpart 483.70(a), are NOT MET as evidenced by: Hazardous Areas - Enclosure CFR(s): NFPA 101 Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) This REQUIREMENT is not met as evidenced by:	K 321		6/25/24

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K 321	Continued From page 3 Based on observation and staff interview, the facility failed to maintain their smoke barrier per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.7.3, 8.5.6.5 and 8.5.6.2. These deficient findings could have a widespread impact on the residents within the facility. Findings include: On 06/11/2024, it was revealed by observation that there was a penetration running from one smoke compartment to another above doors in the following areas: 1) at 11:53am, pipe running through back wall of Electrical Room on Low level. 2) at 12:16pm, above ceiling in second floor Therapy room. 3) at 12:33pm, in the first floor elevator entrance. 4) at 12:37pm, above ceiling in first floor dinning room. An interview with the Director of Maintenance verified these deficient findings at the time of discovery.	K 321	K321 1.) On 6/12/2024 we installed 3m Fire barrier putty stix in red in all locations described below: deficient pictures are on the right-side Corrections are on the left a) at pipe running through back wall of Electrical Room on Low level. b) at above ceiling in second floor Therapy room. c) at the first-floor elevator entrance. d) at above ceiling in first floor dining room. 2.) All work performed above ceiling tiles will need an Above Ceiling Permit moving forward with pictures of before and after from vendors before work is considered completed. The maintenance team also did a read and sign about any work above the ceiling tile. 3.) New Above Ceiling Permit policy and checks through our computerized maintenance management system once a week for the 1st month, then monthly checks for the following 3 months, followed by quarterly checks until discontinuation through QAPI. 4.) Facilities Manager to do inspections of work completed QAPI to inspect any late	

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K 321	Continued From page 4	K 321	tasks in our computerized maintenance management system. 5.) 6/12/2024 penetrations were filled 6/20/2024 Policy and task created and implemented.	
K 353 SS=E	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain spacing between storage and the sprinkler system per NFPA 101 (2012 edition), Life Safety Code, Section 9.7.5, NFPA 25 (2011 edition), Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, Section 5.2.1.2, and NFPA 13 (2010	K 353	K353 1.) Removal of items on top of storage rack and sign made and placed so no items are placed back there. 2.) Signage created and placed on top of	6/25/24

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K 353	Continued From page 5 edition), Standard for the Installation of Sprinkler Systems, Sections 8.6.5.3.2 and 8.15.9. These deficient findings could a patterned impact on the residents within the facility. Findings include: On 06/11/2024, at 12:08pm, it was revealed by observation that storage materials had been placed on a storage rack, bringing the storage materials within the required 18 inch clearance area under the sprinkler heads. These obstructions were found in Therapy Kitchen. An interview with the Director of Maintenance verified these deficient findings at the time of discovery.	K 353	storage rack, and wall. Maintenance to audit storage spaces using our computerized maintenance management system 3.) Once a week checks in Facility for the 1st month, then monthly checks for following 3 months, followed by quarterly checks until discontinued through QAPI. 4.) Facilities Manager to do inspections of work completed QAPI to inspect any late tasks in our computerized maintenance management system. 5.) 6/13/2024 Items were removed, and signs placed and lines created	
K 363 SS=D	Corridor - Doors CFR(s): NFPA 101 Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided	K 363		6/25/24

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	245215	A. BUILDING **02 - NEW REPLACEMENT BLDG** B. WING _____	**06/11/2024**

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K 363	Continued From page 6 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 window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain corridor doors per NFPA 101 (2012 edition), Life Safety Code, section 19.3.6.3.5. This deficient finding could have an isolated impact on the residents within the facility. Findings include: On 06/11/2024, at 12:28pm, it was revealed by observation that the Director of Nursing Office door was using a hold open device that is not attached to the fire alarm system and in so doing defeats the self-closing device. An interview with the Director of Maintenance verified these deficient findings at the time of discovery.	K 363	K363 1.) Removal of non-compliant door holder on a door. 2.) Any requests for modifications to the offices must be approved by the Facilities Manager. 3.) Once a week Door audits for the 1st month, then monthly checks for the following 3 months, followed by quarterly checks until discontinued through QAPI. 4.) Facilities Manager to do inspections QAPI to inspect any late tasks in our computerized maintenance management	

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K 363	Continued From page 7	K 363	system until discontinued 5.) Holder was removed 6/21/2024	
K 541 SS=F	Rubbish Chutes, Incinerators, and Laundry Chu CFR(s): NFPA 101 Rubbish Chutes, Incinerators, and Laundry Chutes 2012 EXISTING (1) Any existing linen and trash chute, including pneumatic rubbish and linen systems, that opens directly onto any corridor shall be sealed by fire resistive construction to prevent further use or shall be provided with a fire door assembly having a fire protection rating of 1-hour. All new chutes shall comply with 9.5. (2) Any rubbish chute or linen chute, including pneumatic rubbish and linen systems, shall be provided with automatic extinguishing protection in accordance with 9.7. (3) Any trash chute shall discharge into a trash collection room used for no other purpose and protected in accordance with 8.4. (Existing laundry chutes permitted to discharge into same room are protected by automatic sprinklers in accordance with 19.3.5.9 or 19.3.5.7.) (4) Existing fuel-fed incinerators shall be sealed by fire resistive construction to prevent further use. 19.5.4, 9.5, 8.4, NFPA 82 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to secure the laundry chute door per NFPA 101 (2012 edition), Life Safety Code section 19.5.4.1. These deficient findings could have a widespread impact on the residents within the facility. On 06/11/2024, it was revealed by observation that	K 541	K541 1.) Replacement of SUSPA Gas Spring Strut in both 1st and 2nd floor chute rooms 2.) A task created in our Computerized Maintenance Management System to preform checks on all chute doors	6/25/24

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K 541	Continued From page 8 the laundry chute door located on the Lake View hallway was missing self-closing device and/or a device to secure chute door in the closed position in the following areas; 1) at 12:28pm, in the trash room on the second floor. 2) at 12:51pm, in the trash room on the first floor. An interview with the Director of Maintenance verified these deficient findings at the time of discovery.	K 541	3.) Once a week Chute audits for the 1st month, then monthly checks for following 3 months, followed by quarterly checks until discontinued through QAPI. 4.) Facilities Manager to do inspections QAPI to inspect any late tasks in our computerized maintenance management system until discontinued 5.) Gas Struts were replaced on 6/20/2024	
K 761 SS=F	Maintenance, Inspection & Testing - Doors CFR(s): NFPA 101 Maintenance, Inspection & Testing - Doors Fire doors assemblies are inspected and tested annually in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives. Non-rated doors, including corridor doors to patient rooms and smoke barrier doors, are routinely inspected as part of the facility maintenance program. Individuals performing the door inspections and testing possess knowledge, training or experience that demonstrates ability. Written records of inspection and testing are maintained and are available for review. 19.7.6, 8.3.3.1 (LSC) 5.2, 5.2.3 (2010 NFPA 80) This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to inspect fire doors per NFPA 101 (2012 edition), Life Safety Code section 8.3.3.1, and NFPA 80 (2010 edition), Standard for Fire Doors and Other Opening Protectives, section 5.2.1. This deficient finding	K 761	K761 1.) Location of completed Annual Door inspection 10/8/2023 2.) Record to be kept with Life Safety book	6/25/24

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K 761	Continued From page 9 could have a widespread impact on the residents within the facility. Findings include: On 06/11/2024, at 11:49am, it was revealed by review of available documentation the required annual door inspection documentation was not available at the time of the survey. An interview with the Director of Maintenance verified these deficient findings at the time of discovery.	K 761	so that it can be readily available for future inspections 3.) A task was created in our Computerized maintenance management system. Next inspection to be performed in September 2024 results to be brought to QAPI to be discussed to ensure compliance 4.) Facilities Manager to do inspections QAPI to inspect any late tasks in our computerized maintenance management system until discontinued 5.) log was found and relocated on 6/18/2024	
K 920 SS=F	Electrical Equipment - Power Cords and Extens CFR(s): NFPA 101 Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a	K 920		6/25/24

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K 920	Continued From page 10 structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain the usage of electrical adaptive devices per NFPA 99 (2012 edition), Health Care Facilities Code, sections 10.5.2.3.1 and 10.2.4.2.1, NFPA 70, (2011 edition), National Electrical Code, sections 400-8, and UL 1363. This deficient finding could have an isolated impact on the residents within the facility. Findings include: On 06/11/2024, it was revealed by observation that there were several electrical appliances plugged into a power strip in the following areas; 1) at 12:05pm, microwave and refrigerator plugged into power-strip in Rehab. Break Room. 2) at 12:25pm, appliances plugged into power strip in the Admissions Office on second floor. 3) at 12:29pm, microwave and refrigerator plugged into power-strip in the Director of Nursing Office. 4) at 12::47pm, appliances plugged into power strip in the MDS Coordinators Office. 5) at 12:49pm, appliances plugged into power strip in the brake-room on first floor. An interview with the Director of Maintenance verified these deficient findings at the time of discovery.	K 920	K920 1.) All equipment was removed from power strips and directly plugged into the wall outlet Electrician called to verify that circuits were not over drawn. a) Microwave and refrigerator plugged into Outlet in Rehab. Break Room. b) Appliances plugged into the Outlet in the Admissions Office on the second floor. c) Refrigerator plugged into the Outlet in the Director of Nursing Office. d) Refrigerator plugged into the Outlet in the MDS Coordinators Office. e) Refrigerator plugged into the Outlet in the break-room on first floor 2.) All new electrical equipment must be evaluated and approved by the Maintenance Department before being commissioned for use in the facility. This process ensures adherence to safety protocols, compatibility with existing infrastructure, and compliance with operational standards..	

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K 920	Continued From page 11	K 920	3.) Once a week office electrical audits for the 1st month, then monthly checks for the following 3 months, followed by quarterly checks until discontinued through QAPI. 4.) Facilities Manager to do inspections QAPI to inspect any late tasks in our computerized maintenance management system until discontinued 5.) Compliance and inspection of all outlets/appliances completed 6/23/2024	