#### DEPARTMENT OF HEALTH AND HUMAN SERVICES

#### **CENTERS FOR MEDICARE & MEDICAID SERVICES**

	CARE/MEDICAID CERTIFICATION A		ID: 679B Facility ID: 00917					
1. MEDICARE/MEDICAID PROVIDER NO. (L1) 245376 2.STATE VENDOR OR MEDICAID NO. (L2) 766119300	<ul> <li>3. NAME AND ADDRESS OF FACILITY</li> <li>(L3) ZUMBROTA CARE CENTER</li> <li>(L4) 433 MILL STREET</li> <li>(L5) ZUMBROTA, MN</li> </ul>	(L6) 55992	4. TYPE OF ACTION:     7 (L8)       1. Initial     2. Recertification       3. Termination     4. CHOW       5. Validation     6. Complaint       7. On-Site Visit     9. Other					
<ol> <li>5. EFFECTIVE DATE CHANGE OF OWNERSHIP</li> <li>(L9) 12/17/2003</li> </ol>	7. PROVIDER/SUPPLIER CATEGORY       01 Hospital     05 HHA     09 ESRD	<u>02</u> (L7) 13 PTIP 22 CLIA	8. Full Survey After Complaint					
6. DATE OF SURVEY     09/15/2018     (L34)       8. ACCREDITATION STATUS:	02 SNF/NF/Dual     06 PRTF     10 NF       03 SNF/NF/Distinct     07 X-Ray     11 ICF/IID       04 SNF     08 OPT/SP     12 RHC	14 CORF 15 ASC 16 HOSPICE	FISCAL YEAR ENDING DATE: (L35) 09/30					
11LTC PERIOD OF CERTIFICATION From (a): To (b):	10.THE FACILITY IS CERTIFIED AS: X A. In Compliance With Program Requirements Compliance Based On:	And/Or Approved Waivers Of The 2. Technical Personnel 3. 24 Hour RN	Following Requirements: 6. Scope of Services Limit 7. Medical Director					
12.Total Facility Beds     50 (L18)       13.Total Certified Beds     50 (L17)	<ul><li>1. Acceptable POC</li><li>B. Not in Compliance with Program Requirements and/or Applied Waivers:</li></ul>	4. 7-Day RN (Rural SNF) 5. Life Safety Code * Code: A	8. Patient Room Size 9. Beds/Room (L12)					
14. LTC CERTIFIED BED BREAKDOWN 18 SNF 18/19 SNF 19 SNF 50	ICF IID (L42) (L43)	15. FACILITY MEETS 1861 (e) (1) or 1861 (j) (1):	(L15)					
(L37) (L38) (L39) 16. STATE SURVEY AGENCY REMARKS (IF APPLICABL	6. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):							
17. SURVEYOR SIGNATURE	Date:	18. STATE SURVEY AGENCY A	PPROVAL Date:					
Gary Nederhoff, Unit Supervisor	10/04/2018 (L19)	Douglas Larson, Enfo	prcement Specialist 10/04/2018					
PART II - TO B	E COMPLETED BY HCFA REGIONAL	L OFFICE OR SINGLE STA						
<ul> <li>19. DETERMINATION OF ELIGIBILITY</li> <li><u>X</u> 1. Facility is Eligible to Participate</li> <li><u>2</u>. Facility is not Eligible (L21)</li> </ul>	20. COMPLIANCE WITH CIVIL RIGHTS ACT:	<ol> <li>Statement of Financial Solvency (HCFA-2572)</li> <li>Ownership/Control Interest Disclosure Stmt (HCFA-1513)</li> <li>Both of the Above :</li> </ol>						
22. ORIGINAL DATE 23. LTC AGREEN	MENT 24. LTC AGREEMENT	26. TERMINATION ACTION:	(L30)					
OF PARTICIPATION BEGINNING 12/01/1986	DATE ENDING DATE	VOLUNTARY         00           01-Merger, Closure         0	INVOLUNTARY 05-Fail to Meet Health/Safety					
(L24) (L41)	(L25)	02-Dissatisfaction W/ Reimbursemen	nt 06-Fail to Meet Agreement					
25. LTC EXTENSION DATE: 27. ALTERNATI A. Suspensio	VE SANCTIONS n of Admissions: (L44)	03-Risk of Involuntary Termination 04-Other Reason for Withdrawal	<u>OTHER</u> 07-Provider Status Change 00-Active					
(L27) B. Rescind Su	spension Date: (L45)							
28. TERMINATION DATE: 22	9. INTERMEDIARY/CARRIER NO.	30. REMARKS						
	00220							
(L28)	(L31)							
31. RO RECEIPT OF CMS-1539 33	2. DETERMINATION OF APPROVAL DATE							
(L32)	<b>09/19/2018</b> (L33)	DETERMINATION APPRO	OVAL					



Protecting, Maintaining and Improvingthe Health of All Minnesotans

Electronically delivered

CMS Certification Number (CCN): 245376

October 4, 2018

Administrator Zumbrota Care Center 433 Mill Street Zumbrota, MN 55992

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 September 10, 2018 the above facility is certified for:

50 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 50 skilled nursing facility beds.

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 Medicaid provider agreement may be subject to non-renewal or termination.

Please contact me if you have any questions.

Sincerely,

Durine Stapson

Douglas Larson, Enforcement Specialist



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

October 4, 2018

Administrator Zumbrota Care Center 433 Mill Street Zumbrota, MN 55992

RE: Project Number S5376028

Dear Administrator:

On August 20, 2018, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for, a standard survey, completed on August 2, 2018. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required.

On September 15, 2018, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on October 3, 2018 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on August 2, 2018. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of September 10, 2018. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on August 2, 2018, effective September 24, 2018 and therefore remedies outlined in our letter to you dated August 20, 2018, will not be imposed.

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.

Feel free to contact me if you have questions.

Sincerely,

Dourses Stapson

Douglas Larson, Enforcement Specialist Minnesota Department of Health Licensing and Certification Program

DEPARTMENT OF HEALTH AND HUMAN SERVICES **CENTERS FOR MEDICARE & MEDICAID SERVICES** MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL ID: 679B PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY Facility ID: 00917 1. MEDICARE/MEDICAID PROVIDER NO. 3. NAME AND ADDRESS OF FACILITY 4. TYPE OF ACTION: 2 (L8) (L3) ZUMBROTA CARE CENTER (L1) 245376 1. Initial 2. Recertification 2.STATE VENDOR OR MEDICAID NO. (L4) 433 MILL STREET 3. Termination 4. CHOW 766119300 (L5) ZUMBROTA, MN (L6) 55992 (L2) 5. Validation 6. Complaint 7. On-Site Visit 9. Other 5. EFFECTIVE DATE CHANGE OF OWNERSHIP 7. PROVIDER/SUPPLIER CATEGORY 02 (L7) 8. Full Survey After Complaint (L9) 12/17/2003 01 Hospital 05 HHA 09 ESRD **13 PTIP** 22 CLIA 08/02/2018 02 SNF/NF/Dual 06 PRTF 6. DATE OF SURVEY (L34) 10 NF 14 CORF FISCAL YEAR ENDING DATE: (1.35)8. ACCREDITATION STATUS: (L10) 03 SNF/NF/Distinct 07 X-Ray 11 ICF/IID 15 ASC 09/300 Unaccredited 1 TJC 04 SNF 08 OPT/SP 12 RHC 16 HOSPICE 2 AOA3 Other 11. .LTC PERIOD OF CERTIFICATION 10. THE FACILITY IS CERTIFIED AS: From (a): A In Compliance With And/Or Approved Waivers Of The Following Requirements: 2. Technical Personnel 6. Scope of Services Limit To (h). Program Requirements Compliance Based On: 3. 24 Hour RN 7. Medical Director 8. Patient Room Size 4. 7-Day RN (Rural SNF) 1. Acceptable POC 12. Total Facility Beds 50 (L18) 5. Life Safety Code \_\_\_\_ 9. Beds/Room 13. Total Certified Beds 50 (L17) X B. Not in Compliance with Program (L12) Requirements and/or Applied Waivers: \* Code B\* 14. LTC CERTIFIED BED BREAKDOWN 15. FACILITY MEETS (L15) 18 SNF 18/19 SNF ICF IID 19 SNF 1861 (e) (1) or 1861 (j) (1): 50 (L38) (1.39)(1.42)(1.43)(L37) 16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE): An FSES survey was completed and the facility received a passing score. Refer to enclosed FSES for additional information. 17. SURVEYOR SIGNATURE Date : 18. STATE SURVEY AGENCY APPROVAL Date: Danette Bakken, HFE II 09/10/2018 Kamala Fiske-Downing, Enforcement Specialist 09/14/2018 (L19) (L20) PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY 19. DETERMINATION OF ELIGIBILITY 20. COMPLIANCE WITH CIVIL 1. Statement of Financial Solvency (HCFA-2572) 21. Ownership/Control Interest Disclosure Stmt (HCFA-1513) RIGHTS ACT: 2 1. Facility is Eligible to Participate 3. Both of the Above : Facility is not Eligible (L21) 22. ORIGINAL DATE 24. LTC AGREEMENT 26. TERMINATION ACTION: 23. LTC AGREEMENT (L30) 00 BEGINNING DATE ENDING DATE OF PARTICIPATION VOLUNTARY INVOLUNTARY 12/01/1986 01-Merger, Closure 05-Fail to Meet Health/Safety 02-Dissatisfaction W/ Reimbursement 06-Fail to Meet Agreement (L24) (L41) (L25) 03-Risk of Involuntary Termination 25. LTC EXTENSION DATE: 27. ALTERNATIVE SANCTIONS OTHER 04-Other Reason for Withdrawal 07-Provider Status Change A. Suspension of Admissions: 00-Active (L44) (L27) B. Rescind Suspension Date: (1.45)28. TERMINATION DATE: 29. INTERMEDIARY/CARRIER NO. 30. REMARKS 00220 (L28) (L31) 32. DETERMINATION OF APPROVAL DATE 31 RO RECEIPT OF CMS-1539 (L32) (L33) DETERMINATION APPROVAL



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered August 20, 2018

Ms. Krista Siddiqui, Administrator Zumbrota Care Center 433 Mill Street Zumbrota, MN 55992

RE: Project Number S5376028

Dear Ms. Siddiqui:

On August 2, 2018, a standard 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 constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), as evidenced by the attached CMS-2567 whereby corrections are required.

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.

This letter provides important information regarding your response to these deficiencies and addresses the following issues:

<u>Opportunity to Correct</u> - the facility is allowed an opportunity to correct identified deficiencies before remedies are imposed;

<u>Electronic Plan of Correction</u> - when a plan of correction will be due and the information to be contained in that document;

<u>Remedies</u> - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS) if substantial compliance is not attained at the time of a revisit;

<u>Potential Consequences</u> - the consequences of not attaining substantial compliance 3 and 6 months after the survey date; and

# <u>Informal Dispute Resolution</u> - your right to request an informal reconsideration to dispute the attached deficiencies.

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.

## 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:

Gary Nederhoff, Unit Supervisor Rochester Survey Team Licensing and Certification Program Health Regulation Division Minnesota Department of Health 18 Wood Lake Drive Southeast Rochester, Minnesota 55904-5506 Email: gary.nederhoff@state.mn.us Phone: (507) 206-2731 Fax: (507) 206-2711

## **OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES**

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by September 11, 2018, the Department of Health will impose the following remedy:

• State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by September 11, 2018 the following remedy will be imposed:

• Per instance civil money penalty. (42 CFR 488.430 through 488.444)

## ELECTRONIC PLAN OF CORRECTION (ePoC)

An ePoC for the deficiencies must be submitted within **ten calendar days** of your receipt of this letter. Your ePoC must:

- Address how corrective action will be accomplished for those residents found to have

been affected by the deficient practice;

- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;
- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;
- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;
- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,
- Submit electronically to acknowledge your receipt of the electronic 2567, your review and your ePoC submission.

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:

- Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));
- Per day civil money penalty (42 CFR 488.430 through 488.444).

Failure to submit an acceptable ePoC could also result in the termination of your facility's Medicare and/or Medicaid agreement.

### PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC 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. 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, 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. A Post Certification Revisit (PCR) will occur after the date you identified that compliance was achieved in your plan of correction.

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.

### Original deficiencies not corrected

If your facility has not achieved substantial compliance, we will impose the remedies described above. If the level of noncompliance worsened to a point where a higher category of remedy may be imposed, we will recommend to the CMS Region V Office that those other remedies be imposed.

### Original deficiencies not corrected and new deficiencies found during the revisit

If new deficiencies are identified at the time of the revisit, those deficiencies may be disputed through the informal dispute resolution process. However, the remedies specified in this letter will be imposed for original deficiencies not corrected. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed.

### Original deficiencies corrected but new deficiencies found during the revisit

If new deficiencies are found at the revisit, the remedies specified in this letter will be imposed. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed. You will be provided the required notice before the imposition of a new remedy or informed if another date will be set for the imposition of these remedies.

# 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 November 2, 2018 (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). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the

result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by February 2, 2019 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. 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.

### INFORMAL DISPUTE RESOLUTION

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: <u>http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc\_idr.cfm</u>

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: <u>http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm</u>

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:

Mr. Tom Linhoff, Fire Safety Supervisor Health Care Fire Inspections Minnesota Department of Public Safety State Fire Marshal Division 445 Minnesota Street, Suite 145 St. Paul, Minnesota 55101-5145

> Email: tom.linhoff@state.mn.us Telephone: (651) 430-3012 Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Kumala Fiske Downing

Kamala Fiske-Downing Licensing and Certification Program Minnesota Department of Health P.O. Box 64900 St. Paul, MN 55164-0900 Telephone: (651) 201-4112 Fax: (651) 215-9697 Email: <u>Kamala.Fiske-Downing@state.mn.us</u>

cc: Licensing and Certification File

DEPARTMENT OF HEALTH AND HUMAN SERVICES							APPROVED
CENTER	RS FOR MEDICARE	& MEDICAID SERVICES	-		C	MB NO	<u>. 0938-0391</u>
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '				E SURVEY IPLETED
		245376	B. WING			08/	/02/2018
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	<u>.</u>	
ZUMBRO	OTA CARE CENTER				133 MILL STREET ZUMBROTA, MN 55992		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)	) BE	(X5) COMPLETION DATE
E 000	Initial Comments		EC	000			
E 041 SS=C	Preparedness Required July 30, 31, August recertification surverse compliance with the Preparedness Required Hospital CAH and L	Appendix Z Emergency uirements, was conducted on 1 & 2, 2018, during a ey. The facility is NOT in e Appendix Z Emergency uirements. TC Emergency Power	EC	)41			8/24/18
	hospital must imple power systems bas forth in paragraph ( policies and proced	standby power systems. The ment emergency and standby ed on the emergency plan set a) of this section and in the lures plan set forth in ) and (ii) of this section.					
	[LTC facility and the emergency and sta	25(e) standby power systems. The e CAH] must implement ndby power systems based on n set forth in paragraph (a) of					
	Emergency general must be located in a requirements found Code (NFPA 99 and Amendments TIA 1 12-5, and TIA 12-6) and Tentative Interi 12-2, TIA 12-3, and	2-2, TIA 12-3, TIA 12-4, TIA , Life Safety Code (NFPA 101 m Amendments TIA 12-1, TIA TIA 12-4), and NFPA 110, rre is built or when an existing					
		73(e)(2), §485.625(e)(2) tor inspection and testing. The					
	Y DIRECTOR'S OR PROVID	DER/SUPPLIER REPRESENTATIVE'S SIGN	NATURE		TITLE		(X6) DATE 08/29/2018

**Electronically Signed** 

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.

PRINTED: 08/30/2018

		AND HUMAN SERVICES				FORM	: 08/30/2018 APPROVED . 0938-0391
STATEMENT	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		CONSTRUCTION	(X3) DATI	E SURVEY IPLETED
		245376	B. WING	;		08/	02/2018
NAME OF I	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
ZUMBRO	OTA CARE CENTER				433 MILL STREET ZUMBROTA, MN 55992		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRON DEFICIENCY)	D BE	(X5) COMPLETION DATE
E 041	[hospital, CAH and the emergency pow and maintenance re Health Care Facilities Safety Code. 482.15(e)(3), §483. Emergency general LTC facilities] that n to power emergenc for how it will keep of operational during t evacuates. *[For hospitals at §4 and CAHs §485.629 The standards inco section are approver reference by the Dir Federal Register in 552(a) and 1 CFR p material from the so inspect a copy at th Center, 7500 Secur or at the National At Administration (NAF availability of this m 202-741-6030, or gu http://www.archives _federal_regulation If any changes in th incorporated by refe document in the Fe the changes.	LTC facility] must implement ver system inspection, testing, equirements found in the es Code, NFPA 110, and Life .73(e)(3), §485.625(e)(3) tor fuel. [Hospitals, CAHs and maintain an onsite fuel source cy generators must have a plan emergency power systems the emergency, unless it 482.15(h), LTC at §483.73(g), 5(g):] orporated by reference in this ed for incorporation by rector of the Office of the accordance with 5 U.S.C. part 51. You may obtain the ources listed below. You may be CMS Information Resource rity Boulevard, Baltimore, MD rchives and Records RA). For information on the naterial at NARA, call to to: s.gov/federal_register/code_of is/ibr_locations.html. his edition of the Code are erence, CMS will publish a ederal Register to announce otection Association, 1	E	041			

FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING 245376 B. WING 08/02/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **433 MILL STREET ZUMBROTA CARE CENTER** ZUMBROTA, MN 55992 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION ID (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PRÉFIX** PREFIX (EACH CORRECTIVE ACTION SHOULD BE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) E 041 Continued From page 2 E 041 (i) NFPA 99, Health Care Facilities Code, 2012 edition, issued August 11, 2011. (ii) Technical interim amendment (TIA) 12-2 to NFPA 99, issued August 11, 2011. (iii) TIA 12-3 to NFPA 99, issued August 9, 2012. (iv) TIA 12-4 to NFPA 99, issued March 7, 2013. (v) TIA 12-5 to NFPA 99, issued August 1, 2013. (vi) TIA 12-6 to NFPA 99, issued March 3, 2014. (vii) NFPA 101, Life Safety Code, 2012 edition, issued August 11, 2011. (viii) TIA 12-1 to NFPA 101, issued August 11, 2011. (ix) TIA 12-2 to NFPA 101, issued October 30, 2012. (x) TIA 12-3 to NFPA 101, issued October 22, 2013. (xi) TIA 12-4 to NFPA 101, issued October 22, 2013. (xiii) NFPA 110, Standard for Emergency and Standby Power Systems, 2010 edition, including TIAs to chapter 7, issued August 6, 2009. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the An emergency stop push-button control facility did not provide an essential electrical was installed on the outside of the system in accordance with NFPA 99 (2012) generator on 8/24/2018. Health Care Facilities Code and NFPA 110 (2010) Standard for Emergency and Standby Power Systems. This had the potential to affect all residents residing in the facility. Findings include: On facility tour between 9:00 a.m. and 12:00 p.m. on 8/2/18, observations and staff interview revealed the following: Observation during the inspection revealed there is no emergency stop button for the generator -

FORM CMS-2567(02-99) Previous Versions Obsolete

DEPARTMENT OF HEALTH AND HUMAN SERVICES

If continuation sheet Page 3 of 37

PRINTED: 08/30/2018

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	08/30/2018 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '			X3) DATE	E SURVEY PLETED
		245376	B. WING			08/0	02/2018
NAME OF F	PROVIDER OR SUPPLIER			ST	IREET ADDRESS, CITY, STATE, ZIP CODE		
ZUMBRC	TA CARE CENTER				33 MILL STREET UMBROTA, MN 55992		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
E 041	-or- inside the facilit This deficient practi	de of the generator enclosure	EC	)41			
F 000	2018, a standard su facility by the Minne	2018 and August 1 and 2, urvey was completed at your sota Department of Health to	F (	000			
	requirements of 42 Requirements for L The plan of correcti allegation of compli enrolled in the elect (ePOC), a signatur	cility was in compliance with CFR Part 483, Subpart B, and ong Term Care Facilities. on will serve as your facility's ance. Since your facility is ronic Plan of Correction e is not required at the bottom he CMS-2567 form.					
	revisit of your facilit validate that substa regulations has bee your verification.	acceptable ePOC an on-site y may be conducted to ntial compliance with the en attained in accordance with for Dependent Residents 2)	F 6	677			9/10/18
	out activities of daily services to maintair personal and oral h This REQUIREMEN by:	ident who is unable to carry y living receives the necessary n good nutrition, grooming, and ygiene; NT is not met as evidenced ion, interview and record			R#14's nails were trimmed and clea	ined.	

Facility ID: 00917

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		<u>&amp; MEDICAID SERVICES</u> (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTI	PLE CONSTRUCTION		<u>. 0938-039</u> E SURVEY
AND PLAN C	F CORRECTION	IDENTIFICATION NUMBER:		G	COM	IPLETED
		245376	B. WING		08/	02/2018
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CC	DE	
ZUMBRO	TA CARE CENTER			433 MILL STREET ZUMBROTA, MN 55992		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE
F 677	review the facility failed to ensure nail care was provided to 2 of 2 residents (R14, R42) reviewed for activities of daily living (ADL's) and whom was dependent on staff for care.		F 67	7 R#42's nails were trimmed a	nd cleaned.	
				All residents have plans of ca be followed. All residents tha dependent upon staff for nail reviewed and will have nails	at are care will be	
R14's admit type 2 pulme R14's asses intact exter Care perso and 0 provid Unda identi on M Unda R14 t Durin 12:30 dress finge finge really	Findings include: R14's resident face	e sheet identified a current		and/or cleaned as needed. All Nursing staff were re-edu policy for nail care and the ne	cated on the	
	type 2 diabetes me	2/22/16, and a diagnosis of Ilitus, chronic obstructive (COPD), and anxiety disorder.		the plan of care. Random observational audits will be completed by the DOI 3x's/week for 4 weeks, then	V/designee	
	assessment dated intact cognition and	nimum Data Set (MDS) an 5/18/18, identified R14 to have d required one person th personal hygiene.		monthly thereafter to ensure compliance. Audit results wi to the QAPI committee for re further recommendations	ongoing Il be brought	
	person assist with and COPD, with an	5/18, identified R14 needs one nail care related to diabetes a approach to have nurse to ith bathing as needed.				
	identified R14 (by r on Monday am. Undated, nursing a	cument, "Bath Schedule," oom number) will get a bath ssistant care guide identified				
	During observation 12:30 p.m. R14 is s dressed and is note fingernails. R14 st fingernails, "They o really could be clear	and bath on Mondays. and interview on 7/30/18, at sitting up in her wheelchair well ed to have untrimmed, jagged ated, in regards to her could use a trimming, they aned." They tell me that only a n because I am diabetic.				
	During observation 12:43 p.m. R14 is s	and interview on 7/31/18, at sitting in her wheelchair in her ne is waiting for her son to				

		AND HUMAN SERVICES				FORM	08/30/2018 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '			(X3) DAT	E SURVEY PLETED
		245376	B. WING			08/	02/2018
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
ZUMBRC	TA CARE CENTER				133 MILL STREET ZUMBROTA, MN 55992		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 677	remain untrimmed a During observation 9:45 a.m. R14 is lyin one had clipped her her fingernails and though don't they, a observed to have a of the untrimmed fir fingernail is jagged. During interview on medication aide (TM get their nails clippe aides do it unless th the nurse has to do R14's is diabetic, na receives her baths of During interview on practical nurse (LPI have brown substant and that there are s be clipped. Further R14's because she should be doing it of around to clip the re- just haven't had tim During interview on director of nursing ( residents need to here)	he dentist. R14's fingernails and jagged. and interview on 8/01/18, at ng in her bed and verified no r fingernails yet. R14 looks at stated, "They sure need it and they are kind of dirty." R14 dark substance under some ngernails, and the left middle 8/1/18, at 9:53 a.m. trained WA)-A verified the residents ed on their bath days, the ne resident is diabetic, then o it . TMA-A further verified ails are untrimmed and on Mondays. 8/1/18, at 9:55 a.m. licensed N)-A- verified R14's fingernails nce underneath some of them some jagged nails that need to r verified a nurse needs to clip is diabetic and stated, they on her bath days, "I used to go esident's nails, but honestly I	F	577			
		sheet identified a current 3/21/18, and a diagnosis of					

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		AND HUMAN SERVICES				FORM	08/30/2018 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ´		E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245376	B. WING			08/	02/2018
NAME OF I	PROVIDER OR SUPPLIER		•		TREET ADDRESS, CITY, STATE, ZIP CODE		
ZUMBRO	DTA CARE CENTER				33 MILL STREET ZUMBROTA, MN 55992		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 677	type 2 diabetes mel and hemiplegia (pa body), following a c R42's quarterly min 7/5/18, identified R4 required one person personal hygiene. Care plan dated 5/7 one person assist fin nail care related to Undated facility doc identified R42 (by ro on Thursday am. Undated, nursing at R42 to be diabetic at During observation is noted to have lon her right hand. A da noted under all of h contracted and una During observation is sitting up to the ta feeding self, eating continues to have lon hails with brown-lood fingernails. During observation 10:02 a.m. R42 is ly remain unclipped w underneath the right verified she gets he stated, "I do want m	Ilitus with diabetic neuropathy ralysis of one side of the erebral infarct (stroke). himum data set (MDS) dated 42 to have intact cognition and n extensive assist with 7/18, identified R42 needed rom licensed staff weekly with	F	577			

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		AND HUMAN SERVICES				FORM	08/30/2018 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ´		E CONSTRUCTION	(X3) DATE	E SURVEY IPLETED
		245376	B. WING			08/	02/2018
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
ZUMBRC	OTA CARE CENTER				33 MILL STREET UMBROTA, MN 55992		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 677 F 684 SS=D	supposed to clip my Nursing assistant (f out R42's left hand nails are long untrin substance on top of During interview on stated R42's fingerr substance underne that they are long a cleaned. NA-A furth can do [R42's] nails During interview on registered nurse (R are long, and have nails, and stated, "T During interview on director of nursing ( residents need to h licensed nurse, and be getting nail care days. Facility document, I indicated residents on hands and feet of needed between bas special instructions nails as ordered. N refuses notify nurse Quality of Care CFR(s): 483.25 § 483.25 Quality of	y nails on my bath day. NA)-A was trying to straighten to see the fingernails, and mmed with unknown brown f some of the nails. 8/1/18, at 10:06 a.m. NA-A nails all have dark brown eath the pink painted nails and ind need to be clipped and her stated, "Only the nurse s, she is diabetic." 8/1/18, at 10:08 a.m. N)-B verified R42's fingernails brown debris underneath the They need to be cleaned." 8/1/18, at 10:12 a.m. interim (IDON) verified diabetic have their nails trimmed by a d further verified they should at least weekly on their bath Nail Care, dated 11/20/17, will be provided with nail care on bath day as needed and as aths. Check care plan for . If diabetic, clean and file Nurse to trim nails. If resident e and re-approach.	F 6		DEFICIENCY)		9/10/18
	§ 483.25 Quality of Quality of care is a	care fundamental principle that nent and care provided to					

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TATEMENT	OF DEFICIENCIES	& MEDICAID SERVICES	(X2) MULT	IPLE CONSTRUCTION		0938-039 E SURVEY	
	OF CORRECTION	IDENTIFICATION NUMBER:		NG		PLETED	
		245376	B. WING _		08/	08/02/2018	
NAME OF I	PROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP	CODE		
ZUMBRO	OTA CARE CENTER			433 MILL STREET ZUMBROTA, MN 55992			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETIO DATE	
F 684	Continued From pa	ge 8	F 68	34			
	· ·	ased on the comprehensive					
		sident, the facility must ensure					
	that residents recei	ve treatment and care in					
		ofessional standards of					
		ehensive person-centered					
	care plan, and the	residents' choices.					
	by:	NT is not met as evidenced					
		tion, interview and document		R#14 arterial ulcer to top	of 4th diait I eft		
r e ii		ailed to adequately monitor		foot and arterial ulcer to L			
		tions to promote intact skin		were measured.	0		
		g of two non-pressure wounds		R#43's care plan was upd			
		l of 1 resident (R14) also failed		interventions for head/neo			
	for 1 of 1 resident (	nt regarding head positioning R43).		request for OT to screen f positioning was submitted All residents with skin ulce	8-17-18		
	Findings include:			their wounds measured an on weekly. All residents w	nd documented vith positioning		
		imum Data Set (MDS) an		needs of the head/neck w			
		5/18/18, identified R14 with an		to ensure interventions we	•		
		2/22/16, had intact cognition, staff for activities of daily living		address positioning needs All licensed nurses were r			
		dentified R14 had medical		the Skin Ulcer protocol as			
		cluded diabetes mellitus		monitoring and measuring			
		ated blood sugars), diabetic		the need to implement wri			
		ges nerves in your legs and		recommendations.			
		al vascular disease (circulatory		Random chart audits will t			
		arrowed arteries reduce blood		the DON/designee 3x's/w			
	flow to your limbs).			and then 2 audits monthly ensure wounds are measure			
	R14's progress not	e dated, 2/24/18, revealed an		Random chart audits will t			
		left top 4th toe with a		the DON/designee 3x's/w			
	measurement of 1.	2 centimeters (cm) x 1.2 cm.		and then 2 audits monthly	thereafter to		
		coming progress notes, wound		ensure therapy recommer			
		again until 7/31/18, revealing a		implemented for wheelcha			
	measurement of 0.	/ cm x υ.8 cm.		Audit results will be broug committee for review and			
	R14's progress not	e dated, 2/16/18, revealed an		recommendations.			
		- $        -$		i sesti mondutorio.			

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		AND HUMAN SERVICES				FORM	08/30/2018 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245376	B. WING			08/	02/2018
NAME OF	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
ZUMBRO	DTA CARE CENTER				33 MILL STREET UMBROTA, MN 55992		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 684	"punched out" appe 2/10/18, a partial th present upon removies with no measureme R14's progress note wound measureme eschar tissue type. progress notes, wou until 7/31/18, after size measurement 2.0 x R14's Wound Care revealed R14 was e on 2/1/18, and was management. Reve continue the use of iodosorb/solosite to (Solosite is a hydro preservatives). R14's signed physic revealed left lateral with normal saline, mixture to ulcer bas with dry soft gauze R14's onsite Podiat identified to continue dressings to left to eschar and reduce worsen, again record	earance. Further revealed on nickness open area was val of (R14's) grippy socks, ents documented. e dated 2/17/18, left great toe ent was 2 cm x 3.5 cm x 0.1 cm e dated 2/24/18, left great toe ent was 2 cm x 3.5 cm. 100 % Upon review of further und was not measured again surveyor asking for the c 3.5 cm. e physician visit dated 3/9/18, evaluated by vascular surgery to continue with conservative ealed a recommendation to	F 6	84			

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		AND HUMAN SERVICES				FORM	08/30/2018 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245376	B. WING			08/	02/2018
NAME OF F	PROVIDER OR SUPPLIER		•	S	TREET ADDRESS, CITY, STATE, ZIP CODE	-	
ZUMBRO	TA CARE CENTER				33 MILL STREET 2UMBROTA, MN 55992		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 684	Continued From pa extremities.	ge 10	F6	84			
	revealed an exam of plan: bandaging int 4th digit at this time practitioner, recom	for visit note dated 7/10/18, of lower extremities, with a act to left foot great toe and e, managed by facility nurse mend heel cushions to both and diabetic foot education					
	revealed, "We will o	ogress notes dated 7/23/18, continue with wound care and ar surgery as needed."					
	be at risk for impair by history of diabeti goal was identified symptoms of infect inspect skin weekly	iated 9/8/17, identified R14 to ed skin integrity as evidenced c neuropathic foot ulcers. A for ulcers to heal without ion. Interventions to include; r, observe skin daily and ss of treatment and report to					
	stated, "I have som foot and they are no has been 6 months	7/30/18, at 12:59 p.m. R14 e sores on my toes on my left ot getting any better, I bet it ." They are putting some kind ad they change the dressing					
	sitting up in her whe dressed, wearing w (shoes that reduce the forefoot, which	on 7/31/18, at 12:43 p.m. eelchair in her room, well hite socks and Darco shoes, weight-bearing pressure on promotes faster healing when ulcerations are present).					
		a.m. licensed practical nurse had already did R14's					

Facility ID: 00917

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		AND HUMAN SERVICES				FORM	08/30/2018 APPROVED 0938-0391
STATEMENT OF DEFICIE AND PLAN OF CORRECT	INCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ·		E CONSTRUCTION	(X3) DAT	E SURVEY IPLETED
		245376	B. WING			08/	02/2018
NAME OF PROVIDER C	OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
ZUMBROTA CARE	CENTER				33 MILL STREET 2UMBROTA, MN 55992		
PREFIX (EAC	H DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)	) BE	(X5) COMPLETION DATE
dressing that R14 measure February a wound guess if better id On 8/1/1 verified I being me guess if basis it v is getting During a 8:36 a.m to do wo toe. RN- measure cm x 3.5 0.7 cm x On 8/2/1 verified I declined have not 2018. R be meas progress order in of our we On 8/2/1	I's wounds ed since the y 2018. Whi I was gettin we measure a if they a 8, at 1:09 p R14's wour easured on we measure yould be eas g better. In observat n. registered bund care o C measure ements; Lei c m and le c 0.6 cm. 8, at 9:09 a the length of by 0.6 cm, the length of Sured once sion of the on Tuesday ounds once a (IDON), vel a All wounds	her left foot. LPN-A verified on her left foot had not ey were identified back in hen asked how they monitor if ig better LPN-A stated, "I red it weekly we would have a re getting better or not." o.m. registered nurse (RN)-B, hds on her left foot were not a regular basis, and stated, I red the wounds on a regular asier for us to tell if the wound ion and interview on 8/2/18, at d nurse (RN)-C was observed in left great toe and left fourth ed both toes with the following ft great toe measurement: 2.6 ft 4th toe measurement was a.m. registered nurse (RN)-C of the wound on the great toe , and that wounds for R14 itored weekly since February I, I think these wounds should a week so we can see the wound, in fact I just put that y, we should be measuring all	F	584			

Facility ID: 00917

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		AND HUMAN SERVICES				FORM	: 08/30/2018 APPROVED . 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DAT	E SURVEY IPLETED
		245376	B. WING	i		08/02/2018	
NAME OF F	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
ZUMBRO	DTA CARE CENTER				433 MILL STREET ZUMBROTA, MN 55992		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 684	Continued From pa	ige 12	F(	584			
	not find any docume wounds on R14's le other than she had Facility document, S 11/1/15, identified re pressure ulcers or of clinically unavoidab services will be pro- monitor progress of revealed, assessme concerns, and wour weekly at a minimu measurements in c depth, and the pres- tunneling. If not she	a.m. IDON stated she could entation saying the two eff foot were unavoidable, peripheral vascular disease. Skin Ulcer Protocol, updated esidents will not develop other skin ulcers unless ole. And appropriate care and vided to prevent, treat and f all healing ulcers. Page 6, ent and monitoring of skin nd round documentation im the size of the wound, centimeters in length, width and sence of any undermining or owing improvement in last 2-4 ctor should be contacted for ers.					
	assessment, dated one assist with bed	imum Data Set (MDS) an 7/6/18, identified R43 required mobility, total assist for noses of dementia and severe nt.					
	related to diagnosis process and kyphos of the upper (thorac hunchback appears to independently an encourage to get ou monitor for changes motion (PROM) to I splint/brace to lowe	plan included impaired mobility s of advanced dementia sis (an exaggerated curvature cic) spine that creates a ance) as evidenced by inability nbulate. Approaches included ut of bed three times per day, s in abilities, passive range of lower extremities and er extremities twice daily. motion (ROM), at risk for					

Facility ID: 00917

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		AND HUMAN SERVICES				FORM	08/30/2018 APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245376	B. WING			08/0	02/2018
NAME OF F	PROVIDER OR SUPPLIER	•			TREET ADDRESS, CITY, STATE, ZIP CODE		
ZUMBRO	DTA CARE CENTER				33 MILL STREET 2UMBROTA, MN 55992		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 684	contractures related dementia. Approacl bilateral AFO's (ank extremities twice da care plan lacked int positioning. R43 was observed seated upright in a positioning chair) in hanging straight do p.m., R43 was seat her room. R43's he in front of her. Whe lifted her head up to R43 was observed seated in a Broda of her room. R43's he in front of her. R43 able to lift her head she was done, look straight in front of h R43 was observed seated upright in a room. R43's head y front of her. On 8/1/18, at 7:16 a stated R43's head p down in front of her had worked at the f stated R43 was on working here until r ago. When asked if therapy for head pot think residents can	d to osteoarthritis and hes included staff will place kle-foot orthosis) to lower aily when up in chair. R43's terventions for head/neck on 7/30/18, at 1:11 p.m., Broda chair (tilt-in-space on her room. R43's head was own in front of her. At 6:22 ted upright in a Broda chair in ead was hanging straight down en surveyor spoke to R43, R43 o speak to surveyor. on 7/31/18, at 12:48 p.m., chair, in an upright position, in ead was hanging straight down lifted her head up (but was not I fully straight up) and when sing up her head hung down	F	584			

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		I AND HUMAN SERVICES E & MEDICAID SERVICES				FORM	08/30/2018 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l` í		E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245376	B. WING			08/	02/2018
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
ZUMBRO	DTA CARE CENTER				33 MILL STREET 2UMBROTA, MN 55992		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 684	department work w	ith R43.	F6	684			
	(OT)-E stated R43 therapy (OT) in Oct her head. When as head positioning, O were applied on wh top of bed to allow a being in chair all da	a.m., occupational therapist had received occupational tober 2017, for positioning of sked what was done for R43's DT-E stated lateral supports neelchair and routine resting on stretching of neck, versus ay. OT-E stated a brace for I upright was not tried, when nerapy.					
	provided by OT-E r sitting in wheelchair pressure relief. Wh needed for better h needed to lift head strengthen neck mu	endations, dated 10/19/17, read, alternate in bed with r to allow for comfort and ten sitting in chair tilt back as lead/neck positioning. Cue as during activities/mealtime to uscles for better positioning. eked the OT recommendations g.					
	nursing (IDON) stat kyphosis. IDON cor straight down. Whe regarding R43's he was on hospice unt	p.m., the interim director of ted R43 had extreme nfirmed R43's head hung en queried what had been done ad position, IDON stated R43 til recently. We have not done <i>t</i> thing like that, R43's head ong term.					
	would have expected to be on R43's care	p.m., the IDON stated she ed the OT recommendations e plan, communicated to the and placed on the care guide istants.					
	A policy for position	ning was requested, but not					

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ATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	IPLE CONSTRUCTION	(X3) DAT	E SURVEY	
	F CORRECTION	IDENTIFICATION NUMBER:		IG		IPLETED	
		245376	B. WING _		08/02/2018		
IAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
UMBRC	DTA CARE CENTER			433 MILL STREET ZUMBROTA, MN 55992			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETIO DATE	
F 684	Continued From pa provided.	ge 15	F 68	34			
F 688 SS=D	•	ecrease in ROM/Mobility 1)-(3)	F 68	38		9/10/18	
	resident who enters range of motion doe range of motion unl	acility must ensure that a the facility without limited es not experience reduction in ess the resident's clinical ates that a reduction in range					
	motion receives ap services to increase	ident with limited range of propriate treatment and e range of motion and/or to rease in range of motion.					
	receives appropriat assistance to maint the maximum pract reduction in mobility	ident with limited mobility e services, equipment, and ain or improve mobility with icable independence unless a y is demonstrably unavoidable. NT is not met as evidenced					
	Based on observat review, the facility fa maintain range of n	ion, interview and record ailed to provide services to notion (ROM) of upper 1 resident (R42) reviewed for		R#42 PROM program was add care plan and NAR assignmen staff caring for R42 were re-ed the plan. R#42 was referred ba for splinting needs, R#42's card be updated as needed based of	t sheet and ucated on ack to OT e plan will		
	face sheet included side of the body),	oses according to the undated : Hemiplegia (paralysis of one following cerebral infarct ft dominant side, and Major er.		assessment. Residents that require ROM for extremities will be reviewed to ROM program/needs are on th plan. Staff responsible for care planr programs, including splinting no re-educated on the process of	r upper ensure e care ning ROM eeds were		

Event ID:679B11

Facility ID: 00917

If continuation sheet Page 16 of 37

STATEMEN	F OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTI	IPLE CONSTRUCTION	(X3) DAT	<u>. 0938-039</u> E SURVEY
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN	NG	CON	IPLETED
		245376	B. WING		08/	02/2018
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	DDE	
ZUMBRO	DTA CARE CENTER			433 MILL STREET ZUMBROTA, MN 55992		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE
F 688	R42's Prospective I day, Minimum Data dated 7/5/18, indica required extensive activities of daily liv a functional limitation side in the upper and R42's care plan, day mobility related to one evidenced by inability to remain free of con- identified R42 requing (PROM) to lower ex- hand/forearm splint taken off at bedtime PROM to the upper R42's current, undar sheet, indicated star- splint on left hand/f bedtime. PROM with Review of the occur Discharge Summan needs: requires data hygiene program for to maintain joint mo- and skin integrity is with no questions, si with the range of mi- R42's undated, Sel for Shoulders, Arm- indicated staff to do fingers to do thunk- to open fingers as to to open fingers as to	Payment System (PPS) 90 a Set (MDS) an assessment ated intact cognition and assistance of staff with ing (ADLs). Further identified on in range of motion to one nd lower extremity. Ated 5/7/18, identified impaired diagnosis of hemiplegia as ity to ambulate. R42's goal is ontractures. The care plan also ired passive range of motion extremities and the use of a left t to be put on in the am and e. (Care plan did not identify r extremities). Ated, resident assignment aff were to remember to place orearm on in the am and off at as not identified as a task. pational therapy (OT) ry dated 7/13/18, included R42 ily range of motion and or left upper extremity in order obility, prevent contractures uses. Staff training completed staff reports feeling confident	F 68	planning therapy recommen Random chart audits will be the DON/designee 3x's/wee and then 2 audits monthly th ensure therapy recommenda implemented for ROM needs results will be brought to the committee for review and fur recommendations.	complete by k for 4 weeks ereafter to ations are s. Audit QAPI	

		AND HUMAN SERVICES				FORM	: 08/30/2018 APPROVED . 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ´		PLE CONSTRUCTION	(X3) DAT	E SURVEY IPLETED
		245376	B. WING	. <u> </u>		08/	02/2018
NAME OF F	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
ZUMBRC	OTA CARE CENTER				433 MILL STREET ZUMBROTA, MN 55992		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 688	Continued From par check after stretchin During observation left hand is noted to open her hand whe grips noted on left h don't ever use a spl motion to my left ar exercises. During observation is sitting in her where dining room and is in hand splint. During observation is lying down in her assistant (NA)-A triat fingers to see her fi ouch, [curse words] she was sorry and I leave them alone! be wearing a splint During interview on assistant (NA)-D sta sheet R42 is suppo hand, if there was ra would be on our can verified she did not NA-D could not find During observation 12:59 p.m. R42 was dressed, no splint in R42's left hand was her thumb tucked b	nge 17 ng and apply lotion to hands. 7/30/18, at 5:59 p.m. R42's o be contracted, and unable to in asked. No splints or palm hand/forearm. R42 stated, "I lint. No one does range of im unless I go to those on 7/31/18, at 12:23 p.m. R42 elchair up to the table in the noted to not be wearing a on 8/1/18, at 10:02 a.m. R42 bed on her back. Nursing ed to straighten out R42's left ingernails, R42 stated, "Ouch, I that hurts!" NA-A told R42 R42 stated, Oh my fingers hurt Resident was not observed to on her left hand. 8/2/18, at 12:55 p.m. nursing ated, according to our care bed to have a splint on her left range of motion to do for her it re sheet and it is not. NA-D do PROM for R42 today. 4 R42's splint in her room. and interview on 8/2/18, at s sitting in her wheelchair, well hoted to be on her left hand. in a closed fist position with behind her fingers. R42 when	1	588	DEFICIENCY)		
	dressed, no splint n R42's left hand was her thumb tucked b asked was unable t	noted to be on her left hand. s in a closed fist position with					

If continuation sheet Page 18 of 37

		AND HUMAN SERVICES				FORM	08/30/2018 APPROVED 0938-0391			
STATEMENT	OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ´		E CONSTRUCTION	(X3) DATE	E SURVEY PLETED			
		245376	B. WING			08/0	02/2018			
NAME OF F	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE							
ZUMBRO	DTA CARE CENTER				33 MILL STREET (UMBROTA, MN 55992					
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE			
F 688	Continued From par supposed to be weat contractures." I wa (LPN) for several yeat During interview on assistant (NA)-E veat splint, but can't remain it on. During interview on registered nurse (R wearing the splint to plan indicated. RN- to prevent contractur During interview on therapist (PT) reviee R42 was in occupan 7/11/18, and should to put be put on in the bedtime to help pre- verified she should hand and highly reconstruction During interview on director of nursing ( is discharged from recommendations to copies of the forms and make copies to communication boot	age 18 aring a splint to help prevent is a licensed practical nurse ears you know. 8/2/18, at 1:07 p.m. nursing erified R42 used to wear a nember that last time R42 had 8/2/18, at 1:08 p.m. N)-C verified R42 is not o her left hand like the care -C stated the splint would help ures. 8/2/18, at 1:16 p.m. physical ewed R42's record and verified tional therapy from 4/5/18, to d have a splint to her left hand the morning and remove at event contractures. PT further be getting PROM to her left commends it. 8/2/18, at 1:27 p.m. interim (IDON) stated when a resident therapy, they will give their to nursing. Nursing will make and give to the wing nurses	F	588						
	will be put on the re During interview on registered nurse (R contacted her on 7/ implementation of a	esident assignment sheet. 8/2/18, at 1:34 p.m. RN)-A verified therapy had								

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ID HUMAN SERVICES MEDICAID SERVICES				FORM	08/30/2018 APPROVED 0938-0391
) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
245376	B. WING			08/02/2018	
IENT OF DEFICIENCIES IST BE PRECEDED BY FULL DENTIFYING INFORMATION)	ID PREFI TAG		(EACH CORRECTIVE ACTION SHOULD	BE	(X5) COMPLETION DATE
19 "	F 6	688			
none on 8/2/18, at 2:21 p.m. (OT) stated, "I am shocked ag [R42's] range of motion, I D18, when I trained all of the told me they felt confident verified R42 should be e and PROM to her left OT stated, a result of not otion for the last two and a at could suffer from joint or positioning. This is normal for R42's left in as follows: fingers curled sponded, when I first R42) she did that, but when of motion every day, when I tion her thumb over her has been in that position, range of motion, a harmful d the splint should be worn. tive Nursing Program indicated passive range of t be care planned, nented in the medical ed with splint or brace es, manipulates, and cares de verbal cues, guidance, the resident to use it. hence, Catheter, UTI (3) ce. ility must ensure that ent of bladder and bowel on	F 6	\$90			9/10/18
	MEDICAID SERVICES PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245376 ENT OF DEFICIENCIES ST BE PRECEDED BY FULL DENTIFYING INFORMATION) 19 ' one on 8/2/18, at 2:21 p.m. (OT) stated, "I am shocked g [R42's] range of motion, I 18, when I trained all of the cold me they felt confident verified R42 should be e and PROM to her left OT stated, a result of not bit on for the last two and a t could suffer from joint or positioning. This is normal for R42's left n as follows: fingers curled sponded, when I first 42) she did that, but when f motion every day, when I ion her thumb over her has been in that position, range of motion, a harmful d the splint should be worn. tive Nursing Program ndicated passive range of be care planned, ented in the medical ed with splint or brace is, manipulates, and cares le verbal cues, guidance, the resident to use it. hence, Catheter, UTI 3) ce. lity must ensure that	MEDICAID SERVICES         PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:         245376         B. WING         245376         EENT OF DEFICIENCIES ST BE PRECEDED BY FULL DENTIFYING INFORMATION)         19         19         r         one on 8/2/18, at 2:21 p.m. (OT) stated, "I am shocked g [R42's] range of motion, I 18, when I trained all of the cold me they felt confident verified R42 should be e and PROM to her left OT stated, a result of not botion for the last two and a t could suffer from joint or positioning. This s normal for R42's left n as follows: fingers curled sponded, when I first 442) she did that, but when f motion every day, when I ion her thumb over her has been in that position, range of motion, a harmful d the splint should be worn.         tive Nursing Program ndicated passive range of be care planned, ented in the medical ed with splint or brace es, manipulates, and cares le verbal cues, guidance, the resident to use it. nence, Catheter, UTI 3)         ce. lity must ensure that ent of bladder and bowel on	MEDICAID SERVICES         ) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:       (X2) MULTIPL A. BUILDING         245376       B. WING	D HUMAN SERVICES OI MEDICAID SERVICES OI PROVIDENSUPPLIER/CLIA IDENTIFICATION NUMBER: 245376 B. WING 245376 B. WING 245376 B. WING 245376 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE 433 MILL STREET ZUMBROTA, MN 55992 ENT OF DEFICIENCIES ST BE PRECEDED BY FULL DENTIFYING INFORMATION) FREFX TAG TAG TAG F 688 ON ON ON 8/2/18, at 2:21 p.m. (CT) stated, "I am shocked g [R42's] range of motion, I 18, when I trained all of the old me they felt confident verified R42 should be a and PROM to her left OT stated, a result of not otion for the last two and a t could suffer from joint r positioning. This s normal for R42's left a s follows: fingers curled sponded, when I first 142) she did that, but when f motion every day, when I ion her thumb over her has been in that position, ange of motion, a harmful i the splint or brace s, manipulates, and caress te verbal cues, guidance, her resident to use it. tence, Catheter, UTI 3) se. Ity must ensure that int of bladder and bowed on	D HUMAN SERVICES FORM WEDICAID SERVICES OMBON. IDENTIFICATION NUMBER: 245376 0. WING

Facility ID: 00917

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		AND HUMAN SERVICES				FORMA	08/30/2018 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ´			X3) DATE	SURVEY
		245376	B. WING			08/02/2018	
NAME OF I	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
ZUMBRO	OTA CARE CENTER				33 MILL STREET UMBROTA, MN 55992		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)				(X5) COMPLETION DATE
F 690	maintain continence condition is or beco not possible to main §483.25(e)(2)For a incontinence, based comprehensive ass ensure that- (i) A resident who e indwelling catheter resident's clinical co catheterization was (ii) A resident who e indwelling catheter is assessed for rem as possible unless demonstrates that o and (iii) A resident who is receives appropriat prevent urinary trac continence to the e §483.25(e)(3) For a incontinence, based comprehensive ass ensure that a reside receives appropriat restore as much no possible. This REQUIREMEN by: Based on observat review, the facility fa-	e unless his or her clinical omes such that continence is ntain. resident with urinary d on the resident's sessment, the facility must is not catheterized unless the ondition demonstrates that necessary; enters the facility with an or subsequently receives one noval of the catheter as soon the resident's clinical condition catheterization is necessary; is incontinent of bladder the treatment and services to et infections and to restore extent possible.	F	690	R#14 MD was updated on recent catheter changes and new orders we obtained. All residents with catheters were rev to ensure physician orders are follow written. Licensed nursing staff were re-educa	iewed ved as	

Facility ID: 00917

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	OF DEFICIENCIES	<u>&amp; MEDICAID SERVICES</u> (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	PLE CONSTRUCTION		0938-039
	OF DEFICIENCIES OF CORRECTION	IDENTIFICATION NUMBER:		G		PLETED
		245376	B. WING			02/2018
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	DE	
ZUMBRO	OTA CARE CENTER			433 MILL STREET ZUMBROTA, MN 55992		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLETIO DATE
F 690	• • • • • • • • • • • • • • • • • • •	-	F 69			
	assessment dated admit date of 2/22/ dependent on staff	imum Data Set (MDS) an 5/18/18, identified R14 with an 16, had intact cognition, was for activities of daily living entified R14 to have an		on following physician orders size and on the need to notify physician when frequent cath are needed. Random chart and observation will be completed by the DON	r the eter changes onal audits	
	R14's face sheet pi following diagnoses	rinted 8/1/18, identified the s: retention of urine and urinary tract infections.		3x's/week for 4 weeks and th monthly thereafter to ensure orders are being followed as catheter size. Audit results w to the QAPI committee for re	en 2 audits physician it relates to rill be brought	
	physician on 4/19/1 catheter on the 17t	der Sheet dated and signed by 8 identified to change Foley h of every month, for retention ench, 10 milliliter (ml) balloon.		further recommendations.		
	indicated the use of	nscribed order, dated 7/8/18, f 18 French 30 ml balloon e changed the 5th of every by physician).				
	infection related to evidenced by Foley remain free from in catheter. Approach symptoms of infect appropriate hand h	tted 9/8/17, revealed risk of invasive procedure as catheter. Goal is resident will fection while having a Foley n is to monitor for signs and ion, report abnormal labs, use ygiene, use appropriate ist with pericare twice a day				
	(ETAR), dated 7/18 On 4/17/18, change every month with 1 7/8/18, change Fole every month with 1 treatments for eithe	eatment administration sheet d, identified 2 different orders: e Foley catheter on the 17th of 6 French 10 ml balloon. On ey catheter on the 17th of 8 French 30 ml balloon. No er order were documented for Review of August ETAR,				

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		AND HUMAN SERVICES				FORM	: 08/30/2018 APPROVED . 0938-0391			
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l` í			(X3) DATI	E SURVEY IPLETED			
		245376	B. WING	. <u> </u>		08/	02/2018			
NAME OF F	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE					
ZUMBRO	OTA CARE CENTER		433 MILL STREET ZUMBROTA, MN 55992							
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	) BE	(X5) COMPLETION DATE			
F 690	change. R14's progress note catheter changed a size of catheter use R14's progress note resident used call li Foley catheter in pla Deflated and reflate hour resident activa same statement of a moderate saturati catheter, 16 French R14's progress note (R14) alerted the st myself again." defla balloon, attempt to advance flush. Ord balloon. Changed p was soiled with urin order for monthly cl catheter change. R14's progress note was no longer pate around the lumen. with an 18 French 3 Moderate amount co output. Catheter is R14's progress note mursing assistant al with urine, catheter urine output. Attern	entation of Foley catheter e dated 6/17/18, at 7:38 a.m. is ordered. (Does not identify ed). e dated 6/6/18, at 2:12 a.m. ight "I feel myself getting wet." ace, urine in the tubing. ed balloon with 10 cc. Every ated the call light with the feeling wet in brief. Brief with ion of urine. Changed Foley n with 10 cc balloon. e dated 7/5/18, at 2:21 a.m. taff, "feel like I am wetting ated and re-inflated the flush unsuccessful unable to der calls for 16 French 10 cc per order instruction. Brief ne. Change the treatment hanges to reflect the Foley e dated 7/8/18, Foley catheter nt and was leaking urine 16 French catheter replaced 30 cc balloon Foley catheter. of sediment noted with initial	F	690						
		neter change with 18 French tolerated without incident. 900								

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		I AND HUMAN SERVICES E & MEDICAID SERVICES				FORM	08/30/2018 APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION	(X3) DATI	E SURVEY IPLETED
		245376	B. WING			08/	02/2018
NAME OF	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
ZUMBRO	OTA CARE CENTER				33 MILL STREET 2UMBROTA, MN 55992		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 690	ml output immediat noted on Foley cath have a leak. R14's progress note catheter leaking, s was low (just above the catheter to leak though continued to French 30 cc with r placed upper thigh and prevent pulling R14's progress note Foley catheter leak out further than rec and yellow/light yell tuning. Leg strap a catheter in place. L reported the Cathet Catheter changed v discomfort from res flowing from the tut documented). During interview on stated I have had a it had to be replace During interview on stated, I had to hav night, it just wasn't During observation 7:25 a.m. R14 is lyi night gown and nur assisting R14 with o	tely following the change, heter removed the balloon did e dated, 7/18/18, at 10:55 p.m. trap to hold catheter in place e the knee) possibly causing to Catheter was advanced to leak. Catheter changed 16 ho further issues. Strap was area to hold catheter in place of catheter. e dated 7/30/18, at 11:47 p.m. ing and tubing appeared to be commended. Tubing advanced low urine noted in catheter applied to upper thigh to hold later in the shift it was ter was leaking again. with no issues, c/o pain, sident. Yellow/light yellow urine be. (Size of catheter not n 7/30/18, at 12:47 p.m. R14 in catheter for a while now, and before it was supposed to. n 7/31/18, at 12:45 p.m. R14 re a new catheter put in last working right. and interview on 8/1/18, at ing in bed, dressed in facility sing assistant (NA)-B is catheter care. NA-B verified as is an 18 French catheter	F	690			

DEPART CENTE		PRINTED: 08/30/2018 FORM APPROVED OMB NO. 0938-0391							
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED			
		245376	B. WING	·			08/0	2/2018	
NAME OF I	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE				
ZUMBROTA CARE CENTER				433 MILL STREET ZUMBROTA, MN 55992					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			IX	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE		(X5) COMPLETION DATE	
F 690	Continued From page 24		F6	590					

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						0938-039	
TATEMENT OF DEFICIENCIES ND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ·	IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
245376			B. WING		08/02/2018		
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
ZUMBROTA CARE CENTER				433 MILL STREET ZUMBROTA, MN 55992			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	OULD BE COMPLETION		
F 711 SS=E	, , , , , , , , , , , , , , , , , , ,		F 7 <sup>,</sup>	11		9/10/18	
	§483.30(b) Physicia The physician mus						
	of care, including m	ew the resident's total program nedications and treatments, at by paragraph (c) of this					
	§483.30(b)(2) Write notes at each visit;	e, sign, and date progress and					
	exception of influer vaccines, which ma physician-approved assessment for cor	and date all orders with the iza and pneumococcal ay be administered per I facility policy after an intraindications. NT is not met as evidenced					
	Based on observative review, the facility for the facility for reviewed treatment routine visits for 16 R43, R45, R9, R10	tion, interview and document ailed to ensure the physician is and auxillary orders during of 16 residents (R17, R22, , R31, R40, R2, R6, R13, R14, ) reviewed for signed physician		<ul> <li>R 17, 22, 43, 45, 9, 10, 31, 40, 2, 14, 18, 20, and 42 physician orde including medication, treatments a auxiliary orders were reviewed an by the physician.</li> <li>All other residents' physician orde medication, treatments and auxilia orders were reviewed and signed</li> </ul>	rs and d signed rs for ary		
	diagnoses of Alzhe pulmonary embolis hypertension, nutrit disorder, combined	dated 8/1/18, included imer's disease, chronic m, obstructive sleep apnea, ional deficiency, anxiety l systolic and diastolic heart		physician. Nursing staff were re-educated or requirement of the physician to re resident's total plan of care, includ medication and treatment orders routine visits and to sign and date orders	the view the ing during all		
		der Sheet, signed by a titioner, dated 7/26/18,		Random chart audits will be comp the DON/designee 3x's/week for and then 2 audits monthly thereaf ensure ongoing compliance. Aud	4 weeks ter to		

Facility ID: 00917
		& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	IPI F	E CONSTRUCTION		0938-039 SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER:	. ,				PLETED
		245376	B. WING _			08/0	02/2018
NAME OF	PROVIDER OR SUPPLIER	·		ST	TREET ADDRESS, CITY, STATE, ZIP CODE		
ZUMBRO	DTA CARE CENTER				33 MILL STREET UMBROTA, MN 55992		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETIO DATE
F 711	Continued From pa	age 26	F 7'	11			
	included review of The order sheets la	medications and care plan. acked documentation of review s and auxiliary orders.			will be brought to the QAPI commit review and further recommendation		
	diagnoses of chron disease, chronic di atrial fibrillation, an	dated 8/1/18, included ic obstructive pulmonary astolic heart failure, chronic emia, malignant neoplasm of I deficiency and sleep apnea.					
	3:18 p.m., R22 stat	and interview, on 7/30/18, at ted he had a catheter in place. b bag was observed to be s wheelchair.					
	certified nurse practice review of medication	rder Sheet, signed by a ctitioner, dated 7/9/18, included ons and care plan. The order umentation of review of R22's ciliary orders.					
	diagnoses of chron	dated 8/1/18, included ic pain, kyphosis, peripheral osteoarthritis and dementia.					
	certified nurse practincluded review of The order sheets la	rder Sheet, signed by a stitioner, dated 6/21/18, medications and care plan. acked documentation of review s and auxiliary orders.					
	diagnoses of chron	dated 8/1/18, included ic pain, kyphosis, peripheral osteoarthritis and dementia.					
	physician, dated 7/ medications and ca	der Sheet, signed by the 10/18, included review of are plan. The order sheets ion of review of R45's					

		AND HUMAN SERVICES				FORM	08/30/2018 APPROVED 0938-0391		
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ´			(X3) DATI	E SURVEY PLETED		
		245376	B. WING			08/02/2018			
NAME OF F	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE						
ZUMBRC	TA CARE CENTER				33 MILL STREET 2UMBROTA, MN 55992				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE		
F 711	IDON stated Physic print out the medica he wanted to addre narrative notes. How related to R17, R22 include a review of The IDON stated shi included the same a every resident exce R9's Face sheet inc 11/3/17, with diagno non-pressure chrom insufficiency (periph and hypertension. R9's most recent sid dated 7/9/18, show R9's most recent nut from visit dated 7/9, medications orders noted to have order to left lower leg ulce However, no other of treatment, dietary, or reviewed and signe this visit. R10's face sheet inc 2/1/18, with diagnos disease, congestive hypertenstion. R10's most recent si	ckiliary orders. 17/31/18, at 12:09 p.m., the cian (P)-F preference was to ations for residents only and ass the treatments in his wever, the progress notes 2, R43, & R45, lacked to treatment and auxiliary orders. the would guess all residents and P-F was physician for ept one resident. dicated, R9 admitted on oses that included, nic ulcer of left calf, venous heral), atrial fib, heart failure agned ordered for medications ed medications only. urse practitioner progress note /18, indicated review of ., review of systems and was r to continue dressing changes er twice daily. documentation indicated or ancillary orders were ed by nurse practitioner during dicated, R10 admitted on ses that included stroke, heart e heart failure and signed ordered for	F	711					
		6/7/18, showed medications							

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		AND HUMAN SERVICES				FORM	08/30/2018 APPROVED 0938-0391	
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ´		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		245376	B. WING	i		08/	02/2018	
NAME OF F	PROVIDER OR SUPPLIER		•		TREET ADDRESS, CITY, STATE, ZIP CODE			
ZUMBRC	TA CARE CENTER				33 MILL STREET ZUMBROTA, MN 55992			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE	
F 711	Continued From pa only.	ge 28	F	711				
	note from visit date	nurse practitioner progress d 6/7/18, indicated review of and review of systems.						
	treatment, dietary, o	documentation indicated or ancillary orders were ed by nurse practitioner during						
	11/4/16, with diagno	dicated, R31 admitted on oses that include heart attack, g, urinary retention and hearing						
	R31's most recent s medications dated only.	signed ordered for 6/4/18, showed medications						
	note from visit date	nurse practitioner progress d 6/4/2018, indicated review of and review of systems.						
	treatment, dietary, o	documentation indicated or ancillary orders were ed by nurse practitioner during						
	12/29/17, with diagonal supranuclear opthat condition that cause vision, speech, move anxiety disorder, un	dicated, R40 admitted on noses that include progress Imoplegia (neurodegenerative es problems with balance, vement and swallowing), inary retention, major r and delusional disorder.						
	R40's most recent p visit dated 6/26/18,	physician's progress note from indicated review of						

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		AND HUMAN SERVICES				FORM	08/30/2018 APPROVED 0938-0391
STATEMEN	OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	ì í		E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245376	B. WING			08/	02/2018
NAME OF	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
ZUMBRO	DTA CARE CENTER				33 MILL STREET 2UMBROTA, MN 55992		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 711	medications orders was electronically s 6/26/18. However, no other of treatment, dietary, of reviewed and signe R2's Face Sheet, d diagnoses of deme disturbance, major disorder, presence insomnia. R2's Physician Orde physician, dated 7/2 medications and ca lacked documentati treatments and aux R6's Face Sheet, d diagnoses of diabet major depressive d giddiness, legal blin R6's Physician Orde physician, dated 7/7 medications and ca lacked documentati treatments and aux R13's Face Sheet, d diagnoses of type 2 major depressive d knee, cerebral infar side, and heart failu R13's Physician Orde physician, dated 6/7	and review of systems and igned by the physician on documentation indicated or ancillary orders were ed by physician during this visit. ated 8/1/18, included ntia with behavioral depressive disorder, anxiety of cardiac pacemaker, and er Sheet, signed by the 24/18, included review of are plan. The order sheets ion of review of R2's tiliary orders. ated 8/1/18, included tes mellitus, hypertension, isorder, anemia, dizziness and indness, and insomnia. er Sheet, signed by the 17/18, included review of are plan. The order sheets ion of review of R6's tiliary orders. dated 8/1/18, included 2 diabetes mellitus, obesity, isorder, contracture of the rct with hemiplegia of the right	F	711			

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DEPARTMENT OF HEALTH AND CENTERS FOR MEDICARE & M					FORM	08/30/2018 APPROVED 0938-0391
STATEMENT OF DEFICIENCIES (X1)	PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE	E SURVEY PLETED
	245376	B. WING			08/	02/2018
NAME OF PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
ZUMBROTA CARE CENTER				33 MILL STREET ZUMBROTA, MN 55992		
PREFIX (EACH DEFICIENCY MUST	NT OF DEFICIENCIES T BE PRECEDED BY FULL ENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	) BE	(X5) COMPLETION DATE
<ul> <li>neuropathy, urinary reterinsomnia, anxiety, morbifailure, presence of cardiasthma.</li> <li>R14's Physician Order Sphysician, dated 7/10/18 medications and care plalacked documentation of treatments and auxiliary catheter orders, when R catheter.</li> <li>R18's Face Sheet, dated diagnoses of anxiety dis constipation, gastritis, ar ulcer.</li> <li>R18's Physician Order Sphysician, dated 6/12/18 medications and care plalacked documentation of treatments and auxiliary catheter orders, when R catheter.</li> <li>R18's Physician Order Sphysician, dated 6/12/18 medications and care plalacked documentation of treatments and auxiliary R20's Face Sheet, dated diagnoses of type 2 diab chronic diastolic heart fafibrillation, phantom limb failure with hypoxia, dem and stage 3 kidney disea</li> <li>R20's Physician Order Sphysician Order Sphysician Context fafibrillation, phantom limb failure with hypoxia, dem and stage 3 kidney disea</li> </ul>	f review of R13's orders. d 8/1/18, included tes mellitus with diabetic ntion, pulmonary edema, id obesity, diastolic heart diac pacemaker, and Sheet, signed by the 3, included review of an. The order sheets of review of R14's orders, to include foley the utilized a foley d 8/1/18, included corder, low back pain, ind unstageable pressure Sheet, signed by a 3, included review of an. The order sheets of review of R18's orders. d 8/1/18, included betes mellitus, anemia, ailure, hypertension, atrial o pain, chronic respiratory inentia, insomnia, anemia,	F	711			

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		AND HUMAN SERVICES & MEDICAID SERVICES			FORM	08/30/2018 APPROVED 0938-0391		
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ´	IPLE CONSTRUCTION		E SURVEY IPLETED		
		245376	B. WING _		08/	02/2018		
NAME OF F	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE					
ZUMBRO	TA CARE CENTER			433 MILL STREET ZUMBROTA, MN 55992				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ( (EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETION DATE		
F 711	treatments and aux R42's Face Sheet, of diagnoses of toxic ef following a stroke of failure, cardiomega retention, major deg insomnia, chronic of seizures, sleep aph stage 5. R42's Physician Oro physician, dated 6/7 medications and cal lacked documentati treatments and aux During interview on registered nurse (R reason why our doc and just signs the m because he though? We have alerted him last page, so now th problem, we are go Facility policy, "Phys reviewed/amended regulated physician actual face to face of reviewing the reside including medicatio progress note which	<ul> <li>dated 8/1/18, included</li> <li>encephalopathy, hemiplegia</li> <li>n left side, congestive heart</li> <li>ly, hypertension, urinary</li> <li>pressive disorder, anemia,</li> <li>bstructive pulmonary disease,</li> <li>ea and chronic kidney disease</li> <li>der Sheet, signed by a</li> <li>19/18, included review of</li> <li>are plan. The order sheets</li> <li>ion of review of R42's</li> <li>iliary orders.</li> <li>8/1/18, at 1:09 p.m.</li> <li>N)-B said, "I can't tell a lie, the</li> <li>tor quit signing the treatments</li> <li>nd [medication] orders now, is</li> <li>the had to sign every page."</li> <li>m that he only has to sign the</li> <li>hat we are aware of this</li> <li>ing to fix that.</li> <li>sician visits"</li> <li>10/20/17, indicated each</li> <li>visit will minimally consist of</li> <li>contact with the resident,</li> <li>ents total plan of care,</li> <li>ns and treatments, writing a</li> <li>h is signed and dated as well</li> </ul>	F 71					
F 867 SS=F	as signing all new o QAPI/QAA Improve CFR(s): 483.75(g)(2	ment Activities	F 86	57		9/10/18		

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	OF DEFICIENCIES	& MEDICAID SERVICES	(X2) MEILTI	PLE CONSTRUCTION	OMB NO.	E SURVEY		
	OF CORRECTION	IDENTIFICATION NUMBER:		G		PLETED		
		245376	B. WING		08/0	02/2018		
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE				
ZUMBRO	OTA CARE CENTER			433 MILL STREET ZUMBROTA, MN 55992				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	ULD BE	(X5) COMPLETIO DATE		
F 867	•	-	F 86	7				
	§483.75(g) Quality	assessment and assurance.						
	§483.75(g)(2) The assurance committ	quality assessment and ee must:						
(ii) Dev action This R by: Based failed t Assura	action to correct ide	plement appropriate plans of entified quality deficiencies; NT is not met as evidenced						
	Based on interview	v and record review, the facility ad implement a Quality		The Administrator has commun with the Medical Team as well a				
	Assurance and Per	formance Improvement		staff and reeducated on the neo bringing any system change to	essity of			
				committee for review and appro This deficiency had the potentia				
			44 of 45 residents. To more completely address thi					
	Assurance and Performance Improvement (QAPI) plan to correct and identify quality deficiencies with identified areas for lack of physician review of treatment and auxiliary order for residents. This had the potential to affect 44 of		practice, a subject line will be a QAPI minutes to include propos	ed or				
		7/30/18, at 5:56 p.m., the nursing (IDON) reviewed R22's		suggested system changes by team or ZHS staff to be discuss conclusion of each quarterly QA	ed at the			
	Physician Order Sh	neet, dated 7/9/18, and verified review of medications and		meeting to address any improve changes in processes to ensure	ements or			
	care plan, and lack	ed review of treatment orders. will find out if the treatment		changes are made without the involvement of the medical tear	express			
		gned every 60 days. In lacked to include auxiliary		facility leadership.				
	IDON stated Physic print out the medica he wanted to addre	7/31/18, at 12:09 p.m., the cian (P)-F preference was to ations for residents only and ass the treatments in his wever, the progress notes						
	related to the visits, treatment and auxi	, lacked to include a review of liary orders. The IDON stated I residents included the same						

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		AND HUMAN SERVICES				FORM	08/30/2018 APPROVED 0938-0391		
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		E CONSTRUCTION	(X3) DATE	E SURVEY PLETED		
		245376	B. WING			08/	02/2018		
NAME OF F	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE						
ZUMBRO	TA CARE CENTER				33 MILL STREET UMBROTA, MN 55992				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE		
F 867	Continued From pa	ge 33	F 8	67					
	administrator stated physician was not re- the time of the inter- stated I was aware. medical director) int treatment and medi asked why he need admission. The ac- been signing for all residents up until M she would have exp communicated to he nursing and the inter- decision could be m accommodate P-F's During interview on administrator stated	8/2/18, at 3:09 p.m., the d she was not aware the eviewing treatment orders. At view registered nurse (RN)-C . Physician (P)-F (facility formed he wanted to sign all ication orders on admit and led to see these after general dministrator stated P-F had treatments orders on larch. The administrator stated bected the request of P-F to be erself, the assistant director of erim director of nursing, so a nade whether we could s request or not. 8/2/18, at 3:44 p.m., the d health unit coordinator was uest regarding the treatment							
F 880 SS=D	indicated Our QAPI systems that affect satisfaction, quality and quality of life fo our organization. Infection Preventior CFR(s): 483.80(a)( §483.80 Infection C The facility must es infection prevention designed to provide	PI) Plan, reviewed 10/23/17, I plan focus areas includes all resident and family of care and services provided, or persons living and working in h & Control 1)(2)(4)(e)(f)	F 8	80			9/10/18		

Facility ID: 00917

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		AND HUMAN SERVICES				FORM /	08/30/2018 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '			(X3) DATE	E SURVEY PLETED
		245376	B. WING			08/0	02/2018
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
ZUMBRO	OTA CARE CENTER				I33 MILL STREET ZUMBROTA, MN 55992		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 880	Continued From pa	ge 34	F٤	380			
	development and tr diseases and infect	ansmission of communicable tions.					
	program. The facility must es and control progran a minimum, the follo	C C					
	reporting, investigat and communicable staff, volunteers, vis providing services u arrangement based	l upon the facility assessment ng to §483.70(e) and following					
	procedures for the p but are not limited to (i) A system of surve possible communic infections before the persons in the facili (ii) When and to wh communicable dise reported; (iii) Standard and tra to be followed to pre (iv)When and how i resident; including to (A) The type and du depending upon the involved, and (B) A requirement th	eillance designed to identify sable diseases or ey can spread to other ity; nom possible incidents of ease or infections should be ansmission-based precautions event spread of infections; isolation should be used for a					

		AND HUMAN SERVICES & MEDICAID SERVICES			F	ORM A	08/30/2018 APPROVED 0938-0391	
STATEMEN	F OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /			3) DATE	SURVEY PLETED	
		245376	B. WING			08/0	2/2018	
NAME OF	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE					
ZUMBRO	DTA CARE CENTER				33 MILL STREET UMBROTA, MN 55992			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIZ TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)		(X5) COMPLETION DATE	
F 880	<ul> <li>(v) The circumstand must prohibit emploidisease or infected contact with resider contact will transmi (vi)The hand hygier by staff involved in §483.80(a)(4) A sys- identified under the corrective actions ta §483.80(e) Linens. Personnel must han transport linens so infection.</li> <li>§483.80(f) Annual r The facility will cond IPCP and update th This REQUIREMEN by: Based on observative review, the facility fis standards of practice providing peri cares was observed durin</li> <li>Findings include: During observation 7:16 a.m., nursing a gloves, cleansed R (urine) incontinent product down R43's shirt, to towards her and real</li> </ul>	ces under which the facility byees with a communicable skin lesions from direct the disease; and he procedures to be followed direct resident contact. Stem for recording incidents facility's IPCP and the aken by the facility. Adle, store, process, and as to prevent the spread of eview. duct an annual review of its heir program, as necessary. NT is not met as evidenced ion, interview and document ailed to ensure current ce for infection control when s for 1 of 1 resident (R3), who	F 8	880	Staff caring for R#43 were re-educate on proper handwashing. All residents must have cares provided that ensure current standards of pract for infection control are followed. All nursing staff were re-educated on proper handwashing after providing pericare. Random observational audits will be completed by the DON/designee 3x's/week for 4 weeks, then 2 audits monthly thereafter to ensure ongoing compliance. Audit results will be broug to the QAPI committee for review and further recommendations.	d tice ght		

Facility ID: 00917

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		I AND HUMAN SERVICES E & MEDICAID SERVICES				FORM	08/30/2018 APPROVED 0938-0391		
STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION		E SURVEY PLETED		
		245376	B. WING _			08/	02/2018		
NAME OF	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE						
ZUMBRO	OTA CARE CENTER				33 MILL STREET UMBROTA, MN 55992				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	¢	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE		
F 880	staff, put R43's lotic linens in a bag and R43's feet. The inter- walked into R43's r R43 into a Broda cl to wash my hands in NA-C after providin verified she had no washed hands afte On 8/1/18, at 1:21 p would expect glove washed after provid On 8/2/18, at 11:05 nursing stated she contaminated, staff before touching oth hygiene. The Hand Hygiene indicated Procedure hygiene: 2. Before a gloves.	on bottle away, placed dirty applied heel protectors to erim director of nursing (IDON) oom to assist with transferring hair. NA-C stated I am going now. During interview with og R43's morning care, NA-C t removed her gloves and r providing peri cares for R43.	F 88	80					

Facility ID: 00917

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		AND HUMAN SERVICES & MEDICAID SERVICES		F635	76024		FORM APPROV MB NO. 0938-03	ΈD
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONST		0	(X3) DATE SURVEY COMPLETED	
		245376	B. WING				08/02/2018	
NAME OF F	PROVIDER OR SUPPLIER			STREET A	DDRESS, CITY, STATE, 3	ZIP CODE		
ZUMBRC	OTA CARE CENTER				OTA, MN 55992			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG		PROVIDER'S PLAN OF (EACH CORRECTIVE AC ROSS-REFERENCED TO DEFICIEN	TION SHOULD	BE COMPLETI	ON
K 000	INITIAL COMMENT	ſS	КO	00				
	ALLEGATION OF O DEPARTMENT'S A SIGNATURE AT TH	OC WILL SERVE AS YOUR COMPLIANCE UPON THE CCEPTANCE. YOUR IE BOTTOM OF THE FIRST S-2567 WILL BE USED AS COMPLIANCE.						
a	ON-SITE REVISIT CONDUCTED TO V SUBSTANTIAL CO REGULATIONS HA	F AN ACCEPTABLE POC, AN OF YOUR FACILITY MAY BE VALIDATE THAT MPLIANCE WITH THE AS BEEN ATTAINED IN ITH YOUR VERIFICATION.						
iî.	Minnesota Departm Fire Marshal Divisio (Zumbrota Care Ce compliance with the in Medicare/Medica 483.70(a), Life Safe edition of National F	Survey was conducted by the nent of Public Safety - State on. At the time of this survey, enter) was found not in a requirements for participation hid at 42 CFR, Subpart ety from Fire, and the 2012 Fire Protection Association 01, Life Safety Code (LSC), Health Care.						
	PLEASE RETURN CORRECTION FOI DEFICIENCIES (K-TAGS) TO: Health Care Fire In:	R THE FIRE SAFETY			EP(			
	State Fire Marshal 445 Minnesota St., St Paul, MN 55101-	Division Suite 145						
	By email to: Marian.Whitney@st	tate.mn.us and						
		ER/SUPPLIER REPRESENTATIVE'S SIG	NATURE		TITLE		(X6) DATE 08/29/2	
	ically Signed	an asterisk (*) denotes a deficiency wh	ich the ins	titution mav	be excused from corre	cting providing		

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.

	the second second second second	AND HUMAN SERVICES & MEDICAID SERVICES				FORM	09/10/2018 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · ·		E CONSTRUCTION 01 - MAIN BUILDING 01		E SURVEY PLETED
		245376	B, WING			08/0	02/2018
NAME OF F	PROVIDER OR SUPPLIER	······································			TREET ADDRESS, CITY, STATE, ZIP CODE		
ZUMBRC	TA CARE CENTER				33 MILL STREET UMBROTA, MN 55992		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
K 000	Continued From pa Angela.Kappenmar	-	К 0	00			
		RRECTION FOR EACH T INCLUDE ALL OF THE DRMATION:					
	1. A description of v to correct the defici	vhat has been, or will be, done ency.					
	2. The actual, or pro	oposed, completion date.					
	prevent a reoccurre Zumbrota Care Ce building was constr original building was determined to be of with a partial basen constructed that wa II(000) construction In 2014 a 2-story a	r title of the person ection and monitoring to ence of the deficiency. enter is a 1-story building. The ucted at 3 different times. The s constructed in 1964 and was Type II(000) construction, nent. In 1968, an addition was is determined to be of Type , with no basement. ddition was constructed that be of Type II(000) construction					
	system. The facility full corridor smoke	ected by a full fire sprinkler has a fire alarm system with detection and spaces open to monitored for automatic fire tion.					
	The facility has a ca census of 44 at the	apacity of 50 beds and had a time of the survey.					
	NOT MET as evide Means of Egress - (	•	К 2	211			9/13/18
SS=F	CFR(s): NFPA 101						at Dago 2 of 5

Facility ID: 00917

If continuation sheet Page 2 of 5

Status         Construction			AND HUMAN SERVICES & MEDICAID SERVICES		FO	TED: 09/10/2018 DRM APPROVED NO. 0938-0391
NAME OF PROVIDER OR SUPPLIER     STREET ADDRESS, CITY, STATE, ZIP CODE       ZUMBROTA CARE CENTER     33 MILL STREET       CMIPER     UMBROTA MS 5592       CMIPER     EACH DEFICIENCIES       PROVIDER SPLANK MS 5592     PROVIDER SPLANK MS 5592       CMIPER     EACH DEFICIENCIES       PROVIDER SPLANK MS 5592     PROVIDER SPLANK MS 5592       CMIPER     EACH DEFICIENCIES       PROVIDER SPLANK MS 5592     PROVIDER SPLANK MS 5592       CMIPER     EACH DEFICIENCIES       PROVIDER SPLANK MS 5592     PROVIDER SPLANK MS 5592       COMMETOR     EACH DEFICIENCIES       PROVIDER SPLANK MS 5592     PROVIDER SPLANK MS 5592       COMMETOR     EACH DEFICIENCIES       PROVIDER SPLANK MS 5592     PROVIDER SPLANK MS 5592       COMMETOR     EACH DEFICIENCIES       PROVIDER SPLANK MS 5592     PROVIDER SPLANK MS 5592       COMMETOR     EACH DEFICIENCIES       FIGURATION     PROVIDER SPLANK MS 5592       K 211     Continued From page 2       K 211     Resolution for the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/2-1, 12, 21, 7, 1.10.1       This REQUIREMENT is not met as evidenced by:     The facility failed to comply with Life Safety Code (18.2.1, 19.2.1, 7, 1.10.1       This deficient practice could affect the safety of all (44) the residents, staff and visitors with	STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA		PLE CONSTRUCTION (X3)	DATE SURVEY
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	K 918		- Essential Electric Syste	K 91	8	8/24/18

If continuation sheet Page 3 of 5

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	09/10/2018 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 · ·		E CONSTRUCTION 01 - MAIN BUILDING 01	(X3) DATE	SURVEY PLETED
	П	245376	B, WING			08/0	02/2018
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
ZUMBRC	TA CARE CENTER				33 MILL STREET UMBROTA, MN 55992		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
	Continued From pa	ge 3	K	918			
SS=D	CFR(s): NFPA 101						
	Maintenance and Te The generator or of and associated equi- service within 10 se criterion is not met of process shall be pro- capability for the life Maintenance and te transfer switches ar with NFPA 110. Generator sets are under load 30 minut day intervals, and e months for 4 contin- under load condition simulated cold start transfer of all EES I competent personn stored energy powe accordance with NF circuit breakers are program for periodic components is esta manufacturer requir maintenance and te readily available. EE circuits are marked, separate from norm the possibility of dat source is a design of installations. 6.4.4, 6.5.4, 6.6.4 (N 111, 700.10 (NFPA) This REQUIREMEN by:	ther alternate power source ipment is capable of supplying conds. If the 10-second during the monthly test, a by ided to annually confirm this e safety and critical branches. esting of the generator and re performed in accordance inspected weekly, exercised tes 12 times a year in 20-40 xercised once every 36 uous hours. Scheduled test hs include a complete and automatic or manual oads, and are conducted by el. Maintenance and testing of er sources (Type 3 EES) are in FPA 111. Main and feeder inspected annually, and a cally exercising the blished according to rements. Written records of esting are maintained and ES electrical panels and , readily identifiable, and hal power circuits. Minimizing mage of the emergency power consideration for new NFPA 99), NFPA 110, NFPA 70) NT is not met as evidenced				0018	
		comply with Life Safety Code			In order to gain compliance with K	0918,	

Event ID: 679B21

Facility ID: 00917

If continuation sheet Page 4 of 5

		AND HUMAN SERVICES & MEDICAID SERVICES			- 13	FORM	09/10/2018 APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION 01 - MAIN BUILDING 01		E SURVEY PLETED
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NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
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K 918	Continued From pa	ge 4	ĸ	918			
		(NFPA 99), NFPA 110, NFPA			an emergency stop push-button con was installed on the outside of the generator on 8/24/2018.	ntrol	
		ice could affect the safety of all staff and visitors within the nt/ Facility.					
		veen 09:00 AM and 12:00 PM ervations and staff interview ng:					
	is no emergency st	the inspection revealed there op button for the generator - de of the generator enclosure ty					
		ice was confirmed by the e Director at the time of					
					<i>s</i>		1

Facility ID: 00917

If continuation sheet Page 5 of 5

# **Report of Consultant FSES Findings**

Zumbrota Care Center 433 Mill Street Zumbrota, MN 55992

Provider No. 245376

# Date of Survey: September 13, 2018

Prepared by: Robert L. Imholte, President *Fire Safety Resources, LLC* 16768 County Road 160 Cold Spring, MN 56320 320-685-8559 <u>RimholteFiresafe@aol.com</u>



16768 County Road 160 Cold Spring, MN 56320 (320) 685-8559 E-mail: RImholteFiresafe@aol.com

September 17, 2018

Ms. Lily Bartz Administrator Zumbrota Care Center 433 Mill Street Zumbrota, Minnesota 55992

RE: FSES at Zumbrota Care Center

Dear Ms. Bartz:

Enclosed please find the survey information relating to the fire safety evaluation of Zumbrota Care Center, 433 Mill Street in Zumbrota, MN conducted on 09/13/2018. This evaluation was conducted in accordance with the Fire Safety Evaluation System (FSES) specified in Chapter 4 of NFPA 101A(2013), *Guide on Alternative Approaches to Life Safety*.

As you're aware, the FSES is a rating system designed to evaluate the level of fire/life safety in health care facilities and serves as a method to demonstrate alternative compliance with the 2012 edition of the *Life Safety Code*<sup>\*</sup> (NFPA 101). An FSES was made necessary in this case because of a corridor obstruction (K211) deficiency cited during a state fire/life safety recertification survey conducted on 08/02/2018.

The following factors served as the basis for this evaluation:

- The original building and 1968 addition are one story in height and have a partial basement. For purposes of this FSES, the two occupied building levels were divided into four (4) separate smoke zones.
- The 2014 addition is two (2) stories in height and has no basement. For purposes of this FSES, each level was treated as a separate smoke zone. Because the building is on a sloping grade, both the upper and lower levels of the building have direct access to the exterior at grade level. In accordance with NFPA 101A(13), Sec. 4.5.3.2, therefore, each level was scored as a first floor zone for purposes of this FSES.
- For purposes of this FSES, it was assumed that the basement level of the original building does not involve resident housing, treatment or customary access.

Based on conditions found between 0815 hours and 1220 hours on 09/13/2018, all four parameters in Worksheet 4.7.9 of the FSES worksheets, ZONE FIRE SAFETY EQUIVALENCY EVALUATION, in all six (6) zones evaluated were found to have a score of zero or greater. *Fire Safety Resources* finds, therefore, that Zumbrota Care Center has achieved a passing FSES score.

Should you have any questions or need additional information, please don't hesitate to get back to me.

Wishing you a safe day!

Robert S. Indella

Robert L. Imholte President, Fire Safety Resources, LLC

Enclosures

#### FIRE SAFETY EVALUATION

Name of Facility: Zumbrota Care Center Address: 433 Mill Street, Zumbrota, MN 55992 Phone: 507-732-8400 Licensed capacity: 50 Census at time of survey: 43

Evaluator: Robert L. Imholte, President, Fire Safety Resources, LLC

What follows is a report on the findings of a fire safety evaluation of the above-named facility that was conducted during an on-site visit to the facility between 0815 hours and 1220 hours on 09/13/2018. This evaluation was conducted in accordance with the Fire Safety Evaluation System (FSES) specified in Chapter 4 of NFPA 101A(13), *Guide on Alternative Approaches to Life Safety*. Based on this evaluation, it was determined that Zumbrota Care Center has achieved a passing score on the FSES.

In addition to observations made and documentation review conducted during the 09/13/2018 on-site visit, the findings outlined herein are based on:

- Information provided by Ms. Lily Bartz, Administrator, and Mr. Ray Goranson, Director of Environmental Services; and
- A review of the Statement of Deficiencies (Form CMS-2567) from a fire/life safety recertification survey conducted on 08/02/2018.

#### **Initial Comments:**

Zumbrota Care Center was originally constructed in 1964 as a single-story building with a partial basement. In 1968 a one-story addition with no basement was added to the west of the original building. The original building and 1968 addition were determined to be constructed of masonry exterior bearing walls and a steel roof deck supported by steel bar joists. The roof/ceiling assembly is protected by a suspended-grid acoustical tile ceiling. Because no documentation was available certifying that the acoustical tile ceiling assembly carries a fire resistance rating of one hour or better, the building was assigned a Type II(000) construction type in accordance with NFPA 220(12), Sec. 4.3.1 and Table 4.1.1.

The facility's residents are not allowed in the basement of the original (1964) building. For purposes of this FSES, therefore, it was assumed that this level does not involve resident housing, treatment or customary access and it was scored accordingly in performing the FSES calculations.

At the northeast end of the original (1964) building, the nursing home is connected to a senior assisted living facility called Bridges of Zumbrota. Because Bridges of Zumbrota is not used for purposes of housing, treatment or customary access by the facility's residents and because it is separated from the nursing home by a 2-hourrated fire barrier, this building was not included in this evaluation.

In 2013, construction commenced on a new resident wing addition to the east side of the South Wing of the original (1964) building; the building was occupied in 2014. This addition, known as Mill River, is two (2) stories in height and has no basement. Because the building is on a sloping grade, both the upper and lower levels of the building have direct access to the exterior at grade level. In accordance with NFPA 101A(13), Sec. 4.5.3.2, therefore, each level was scored as a first floor zone for purposes of this FSES.

Based on observation, interview of the Environmental Services Director and review of the Code Summary attached to the building construction drawings, the 2014 addition was assigned a Type II(111) construction type – the building was determined to be constructed of masonry exterior bearing walls, a precast concrete plank floor assembly supported by steel I-beams with spray-on fireproofing, and a steel roof deck supported by steel bar joists. In accordance with NFPA 101(12), Sections 19.1.6.1 and 8.2.1.3, however, the building was assigned a Type II(000) construction type for purposes of this FSES, because it is not separated from the original (1964) building by a minimum 2-hour-rated fire barrier wall.

The Lower Level of the 2014 Addition was found to be a mixed-use occupancy – health care and educational. A preschool occupancy, located at the south end of the Lower Level, occupies approximately one-third of that level of the building. The preschool occupancy is not used for purposes of housing, treatment or customary access by the facility's residents. Based on observation, interview of the Environmental Services Director and review of building construction drawings, the health care and educational occupancies are separated from each other by construction having a fire resistance rating of at least 2 hours as specified in NFPA 101(12), Sec. 6.1.14.4 and Table 6.1.14.4.1(a). For purposes of this FSES, the preschool occupancy was treated as a separate occupancy as allowed by NFPA 101(12), Sec. 19.1.3.3 and, therefore, was not included in this evaluation.

The facility has an addressable manual fire alarm system, which is monitored for automatic fire department notification. In addition, automatic smoke detectors are provided for door release service at the smoke barrier doors and other doors allowed to be held open in accordance with NFPA 101(12), Sections 19.2.2.2.7 and 7.2.1.8.2. The 2014 resident wing addition has automatic smoke detection in the corridors and spaces open to corridors that is monitored for automatic fire department notification. In addition, the resident sleeping rooms in this addition are equipped with single station smoke alarms. Based on documentation review, the fire alarm system and smoke detectors are being inspected, tested and maintained in accordance with NFPA 72.

The facility is protected throughout by a supervised, wet-pipe automatic fire sprinkler system. Based on observation and interview of the Environmental Services Director, it was determined that the standard spray fire sprinklers in Zone 4 (Main Level West Wing) have been replaced with quick-response sprinklers to meet the requirements of NFPA 25(11), Sec. 5.3.1.1.1. As a result, all six (6) smoke zones in the facility are now protected with quick-response sprinklers. Based on documentation review, the fire sprinkler system is being inspected, tested and maintained in accordance with NFPA 25.

Based on observation, interview of the Environmental Services Director and review of the facility's smoke compartment drawings, the South Wing of the 1964 original building, with the exception of the South Wing dayroom space, is located in the same smoke compartment as the 2014 resident wing addition. For purposes of this FSES, therefore, the South Wing, with the exception of the South Wing dayroom space, was surveyed as part of the upper level of the 2014 addition.

For purposes of this FSES, therefore, the building was divided into six (6) separate smoke zones as follows:

Zone 1 – Original Building, Basement Level

- Zone 2 Main Level North Wing and Lobby Area
- Zone 3 Main Level South Wing Dayroom
- Zone 4 Main Level West Wing
- Zone 5 2014 Addition, Lower Level
- Zone 6 South Wing and 2014 Addition, Upper Level

This report is intended to serve as an explanation of the scores entered on Worksheets 4.7.2, 4.7.6 and 4.7.10 of the FSES worksheets for the facility as it was found on 09/13/2018. The score assigned to each item is noted in brackets ([]). It must be noted that numbers were rounded to the nearest tenth of a point and that measurements of over one-half inch were rounded to the nearest inch. To ensure that the FSES addresses the "worst-case scenario", the product of the multiplication in Worksheet 4.7.5 (i.e. value of "R") was rounded up to the nearest whole number. Code references are provided where appropriate. Codes referenced include the 2013 edition of NFPA 101A and the 2012 edition of the *Life Safety Code*<sup>®</sup> (NFPA 101).

With the exception of Worksheet 4.7.10, which applies to all zones, this narrative will address each of the facility's six (6) zones separately.

#### All Zones – WORKSHEET 4.7.10. FACILITY FIRE SAFETY REQUIREMENTS WORKSHEET

In accordance with NFPA 101A(13), Sec. 4.7.9, Step 9, only one copy of this worksheet is required to be filled out for each building. For convenience, however, this table was filled out on the worksheets for all zones evaluated. All items in Worksheet 4.7.10 could be checked 'Met' with the exception of Items B and L. Because Zumbrota Care Center is an existing facility and does not meet the definition of a high rise, Items B and L were checked 'Not Applicable'.

The remaining items in Worksheet 4.7.10 were identified as 'Met' based on the following:

• Building utilities and heating and air conditioning systems appeared to be in conformance with NFPA 101(12), Sec. 9.1 and 9.2.

**Surveyor Note:** A review of the Statement of Deficiencies from the 08/02/2018 fire/life safety recertification survey revealed that the facility was cited because no emergency stop button was provided for the emergency generator – either located outside the generator enclosure or inside the facility (see data tag K918). Based on interview, it was determined that what was thought by the Environmental Services Director to be an emergency stop button on the emergency generator remote annunciator panel located at the main nurse station was, in fact, not. Based on observation, interview of the Environmental Services Director and review of the facility's Plan of Correction submitted in response to the 08/02/2018 fire/life safety recertification survey, it was confirmed that an emergency stop button was installed outside the generator enclosure on 08/24/2018.

- No incinerator or space heaters were found.
- The facility's evacuation plan and fire drill records was reviewed and appeared to be in order.
- The facility's smoking regulations were reviewed and appeared to be in order. Zumbrota Care Center is a smoke-free facility.
- Documentation review showed all draperies, cubicle curtains, upholstered furniture, mattresses and decorations to be in accordance with NFPA 101(12), Sec. 19.7.5.
- Documentation was provided certifying that the plantscapes (e.g faux trees) installed in the facility's public spaces are either flame resistant when tested in accordance with NFPA 701 and/or carry a Class A (25 or less) flame spread rating.
- Portable fire extinguishers, EXIT signage and emergency lighting appeared to be provided in accordance with applicable requirements.

### Zone 1 – Original Building, Basement Level:

#### WORKSHEET 4.7.2. OCCUPANY RISK PARAMETER FACTORS

The facility's residents are not allowed in the basement of the original (1964) building. For purposes of this FSES, therefore, it was assumed that this level did not involve resident housing, treatment or customary access. The basement was found to house staff break rooms, laundry facilities, and mechanical and storage spaces. As a result, in accordance with instruction given in NFPA 101A(13), Sec. 4.3.2(4)a, only Item 3, Zone Location (L), of Worksheet 4.7.2 was addressed and the value of factor F in Worksheet 4.7.3, OCCUPANCY RISK FACTOR CALCULATION, was assigned a factor of 1.6 (i.e. the value assigned to basements in factor L of Worksheet 4.7.2).

### WORKSHEET 4.7.6. SAFETY PARAMETERS and SAFETY PARAMETER VALUES

- 1. Construction [Score: -2]:
- The building was assigned a Type II(000) construction type.
- Interior Finish (Corridors and Exits) [Score: +3]: Walls in corridors and exits were determined to be of masonry and plaster. Documentation was provided certifying that the acoustical ceiling tile carries a Class A (25 or less) flame spread rating.
- Interior Finish (Rooms) [Score: +3]:
   While most walls in rooms were determined to be of masonry and gypsum wallboard, wood paneling was found on some walls. Documentation was provided certifying that:
  - The wood paneling was treated with Flame Control Fire Retardant Coating 40-40A to achieve a Class A (25 or less) flame spread rating, and
  - The acoustical ceiling tile carries a Class A (25 or less) flame spread rating.
- Corridor Partitions/Walls [Score: 0]: Corridor walls were determined to be constructed of glazed masonry block and plaster, but terminate at the acoustical tile ceiling. For this reason, NFPA 101A(13), Sec. 4.6.4.2 requires that they be graded as "<½ hour".</li>
- Doors to Corridor [Score: +1]: Corridor doors in this zone were found to be of 1<sup>3</sup>/<sub>4</sub>-inch-thick solid wood construction mounted in metal frames.
- 6. Zone Dimensions [Score: +1]:
  - This zone measures approximately 94 feet in length and has no dead ends.
- 7. Vertical Openings [Score: 0]:

This score was assigned per Footnote e to this Worksheet – Parameter 1 is based on a Type II(000) construction type. Vertical openings were found to be enclosed with construction providing a minimum 1-hour fire resistance.

8. Hazardous Areas [Score: 0]:

No hazardous area deficiencies were found in this zone.

- 9. Smoke Control [Score: 0]: A smoke barrier serves this zone.
- 10. Emergency Movement Routes [Score: 0]:
- There are two remote exits from this zone.
- Manual Fire Alarm [Score: +2]: Manual fire alarm pull stations are provided in accordance with NFPA 101(12), Sec. 19.3.4.2. The fire alarm system is monitored by USA Central Station Alarm Corporation.
- 12. Smoke Detection and Alarm [Score: +3]: This score was assigned per instruction in Footnote *g* to this Worksheet. The zone is protected with quick-response sprinklers.
- 13. Automatic Sprinklers [Score: +10]: The entire facility is protected by a supervised, wet-pipe automatic fire sprinkler system.

#### Zone 2 – Main Level North Wing and Lobby Area: WORKSHEET 4.7.2. OCCUPANY RISK PARAMETER FACTORS

- 1. Resident Mobility (*M*) [Value assigned = 3.2]: It was reported that some residents in this zone may need assistance with evacuation.
- Patient Density (D) [Value assigned = 1.5]: There is bed capacity for up to nine (9) residents in the North Wing. The zone also contains the facility's main lobby. It was reported that there are a maximum of 7 residents in the lobby area at any one time.
- 3. Zone Location (*L*) [Value assigned = 1.1]: This zone is less than one-half floor height above grade.
- 4. Ratio of Patients to Attendants (*T*) [Value assigned = 1.2]: This score was assigned to ensure that the FSES addresses the "worst-case scenario". It was reported that there are three (3) staff persons on duty on the night shift, but one staff person makes rounds every 2 hours.
- 5. Patient Average Age (A) [Value assigned = 1.2]: Residents using this zone average over 65 years of age.

### WORKSHEET 4.7.6. SAFETY PARAMETERS and SAFETY PARAMETER VALUES

- Construction [Score: 0]: The building was assigned a Type II(000) construction type.
- Interior Finish (Corridors and Exits) [Score: 0]: Walls in corridors and exits were determined to be of masonry and plaster. Documentation was provided certifying that:
  - Most wall and ceiling finishes [i.e. aesthetics ("home front facades")] in the North Wing carry a Class A (25 or less) flame spread rating, while some of the wood finishes were treated with Flame Control Fire Retardant Coating to achieve a Class B (26 75) flame spread rating, and
  - The acoustical ceiling tile carries a Class A (25 or less) flame spread rating.
- Interior Finish (Rooms) [Score: +3]: Walls in rooms were determined to be of masonry, plaster and gypsum wallboard. Documentation was provided certifying that the acoustical ceiling tile carries a Class A (25 or less) flame spread rating.
- Corridor Partitions/Walls [Score: 0]: Corridor walls were determined to be constructed of glazed block and plaster, but terminate at the acoustical tile ceiling. For this reason, NFPA 101A(13), Sec. 4.6.4.2 requires that they be graded as "<½ hour".</li>
- Doors to Corridor [Score: +1]: Corridor doors in this zone were found to be of 1<sup>3</sup>/<sub>4</sub>-inch-thick solid wood construction.
- Zone Dimensions [Score: 0]: This zone measures approximately 110 feet in length and has no dead ends.

 Vertical Openings [Score: 0]: This score was assigned per Footnote *e* to this Worksheet – Parameter 1 is based on a first floor zone. Vertical openings were found to be enclosed with construction providing a minimum 1-hour fire resistance.

- Hazardous Areas [Score: 0]: No hazardous area deficiencies were found in this zone.
- Smoke Control [Score: 0]: A smoke barrier serves this zone.

10. Emergency Movement Routes [Score: -2]:

A review of the Statement of Deficiencies from the 08/02/2018 fire/life safety recertification survey revealed that Zumbrota Care Center was cited for the presence of interior finish materials mounted on the corridor walls in the North Wing that diminished the width of the existing corridors resulting in a reduction of corridor width from 84¾ inches to 75¾ inches along the entire length of the corridor (see data tag K211). While the resulting clear width of the corridors still exceeds the 4 ft clear width required by NFPA 101(12), Sec. 19.2.3.4, the reduction of the original 84¾-inch corridor width does not meet the requirements of NFPA 101(12), Sec. 4.6.7.5.

- Manual Fire Alarm [Score: +2]: Manual fire alarm pull stations are provided in accordance with NFPA 101(12), Sec. 19.3.4.2. The fire alarm system is monitored by USA Central Station Alarm Corporation.
- 12. Smoke Detection and Alarm [Score: +3]: This score was assigned per instruction in Footnote *g* to this Worksheet. The zone is protected with quick-response sprinklers.
- 13. Automatic Sprinklers [Score: +10]: The entire facility is protected by a supervised, wet-pipe automatic fire sprinkler system.

### Zone 3 – Main Level South Wing Dayroom:

### WORKSHEET 4.7.2. OCCUPANY RISK PARAMETER FACTORS

- 1. Resident Mobility (*M*) [Value assigned = 3.2]: It was reported that some residents in this zone may need assistance with evacuation.
- Patient Density (D) [Value assigned = 1.5]: There are no sleeping rooms in this zone; it is used as a day room, chapel and activity space. It was reported that there are a maximum of 20 residents in the space at any one time.
- 3. Zone Location (*L*) [Value assigned = 1.1]: This zone is less than one-half floor height above grade.
- 4. Ratio of Patients to Attendants (*T*) [Value assigned = 1.5]: This score was assigned to ensure that the FSES addresses the "worst-case scenario". It was reported that there is at least one (1) staff person on duty when residents are present in this zone.
- 5. Patient Average Age (A) [Value assigned = 1.2]: Residents using this zone average over 65 years of age.

### WORKSHEET 4.7.6. SAFETY PARAMETERS and SAFETY PARAMETER VALUES

1. Construction [Score: 0]:

The building was assigned a Type II(000) construction type.

2. Interior Finish (Corridors and Exits) [Score: +3]:

Walls in corridors and exits were determined to be of masonry, gypsum wallboard and plaster. Documentation was provided certifying that the acoustical ceiling tile carries a Class A (25 or less) flame spread rating.

- Interior Finish (Rooms) [Score: +3]: Walls in this room were determined to be of masonry, plaster and gypsum wallboard. Documentation was provided certifying that the acoustical ceiling tile carries a Class A (25 or less) flame spread rating.
- Corridor Partitions/Walls [Score: 0]: Corridor walls were determined to be constructed of glazed masonry block and plaster and gypsum wallboard on metal studs, but terminate at the acoustical tile ceiling. For this reason, NFPA 101A(13), Sec. 4.6.4.2 requires that they be graded as "<½ hour".</li>

- Doors to Corridor [Score: +1]: Corridor doors in this zone were found to be of 1<sup>3</sup>/<sub>4</sub>-inch-thick solid wood construction mounted in metal frames.
- Zone Dimensions [Score: +1]: This zone measures approximately 40 feet in length and has no dead ends.
- Vertical Openings [Score: 0]: This score was assigned per Footnote *e* to this Worksheet – Parameter 1 is based on a first floor zone. Vertical openings were found to be enclosed with construction providing a minimum 1-hour fire resistance.
- Hazardous Areas [Score: 0]: No hazardous area deficiencies were found in this zone.
- 9. Smoke Control [Score: 0]: A smoke barrier serves this zone.
- 10. Emergency Movement Routes [Score: -2]:

A review of the Statement of Deficiencies from the 08/02/2018 fire/life safety recertification survey revealed that Zumbrota Care Center was cited for the presence of interior finish materials mounted on the corridor walls in the South Wing through which this room exits that diminished the width of the existing corridors resulting in a reduction of corridor width from 84¾ inches to 75¾ inches along the entire length of the corridor (see data tag K211). While the resulting clear width of the corridors still exceeds the 4 ft clear width required by NFPA 101(12), Sec. 19.2.3.4, the reduction of the original 84¾-inch corridor width does not meet the requirements of NFPA 101(12), Sec. 4.6.7.5.

- Manual Fire Alarm [Score: +2]: Manual fire alarm pull stations are provided in accordance with NFPA 101(12), Sec. 19.3.4.2. The fire alarm system is monitored by USA Central Station Alarm Corporation.
- 12. Smoke Detection and Alarm [Score: +3]: This score was assigned per instruction in Footnote g to this Worksheet. The zone is protected with automatic smoke detection and quick-response sprinklers.
- Automatic Sprinklers [Score: +10]:
   The entire facility is protected by a supervised, wet-pipe automatic sprinkler system.

# Zone 4 – Main Level West Wing:

# WORKSHEET 4.7.2. OCCUPANY RISK PARAMETER FACTORS

- 1. Resident Mobility (*M*) [Value assigned = 3.2]: It was reported that some residents in the zone may need assistance with evacuation.
- 2. Patient Density (D) [Value assigned = 1.5]: There is bed capacity for up to 17 residents in this zone.
- 3. Zone Location (*L*) [Value assigned = 1.1]: This zone is less than one-half floor height above grade.
- 4. Ratio of Patients to Attendants (*T*) [Value assigned = 1.2]: This score was assigned to ensure that the FSES addresses the "worst-case scenario". It was reported that there are three (3) staff persons on duty on the night shift, but one staff person makes rounds every 2 hours.
- 5. Patient Average Age (A) [Value assigned = 1.2]: Residents using this zone average over 65 years of age.

# WORKSHEET 4.7.6. SAFETY PARAMETERS and SAFETY PARAMETER VALUES

 Construction [Score: 0]: The building was assigned a Type II(000) construction type. 2. Interior Finish (Corridors and Exits) [Score: 0]:

Walls in corridors and exits were determined to be of gypsum wallboard. Documentation was provided certifying that:

- Most wall and ceiling finishes [i.e. aesthetics ("home front facades")] in the zone carry a Class A (25 or less) flame spread rating, while some of the wood finishes were treated with Flame Control Fire Retardant Coating to achieve a Class B (26 75) flame spread rating, and
- The acoustical ceiling tile carries a Class A (25 or less) flame spread rating.
- Interior Finish (Rooms) [Score: +3]: Walls in rooms were determined to be of gypsum wallboard. While most ceilings in rooms were found to be gypsum wallboard, acoustical ceiling tile was found in some rooms. Documentation was provided certifying that the acoustical ceiling tile carries a Class A (25 or less) flame spread rating.
- Corridor Partitions/Walls [Score: 0]: Corridor walls were determined to be constructed of gypsum wallboard on metal studs, but terminate at the acoustical tile ceiling. For this reason, NFPA 101A(13), Sec. 4.6.4.2 requires that they be graded as " <½ hour".
- Doors to Corridor [Score: +1]: Corridor doors in this zone were found to be of 1<sup>3</sup>/<sub>4</sub>-inch-thick solid wood construction mounted in metal frames.
- 6. Zone Dimensions [Score: 0]:

This zone measures approximately 100 feet in length and has no dead ends.

- Vertical Openings [Score: 0]: This score was assigned per Footnote *e* to this Worksheet – Parameter 1 is based on a first floor zone. Vertical openings were found to be enclosed with construction providing a minimum 1-hour fire resistance.
- Hazardous Areas [Score: 0]: No hazardous area deficiencies were found in this zone.
- 9. Smoke Control [Score: 0]: A smoke barrier serves this zone.
- 10. Emergency Movement Routes [Score: -2]:

A review of the Statement of Deficiencies from the 08/02/2018 fire/life safety recertification survey revealed that Zumbrota Care Center was cited for the presence of interior finish materials mounted on the corridor walls in this zone that diminished the width of the existing corridors resulting in a reduction of corridor width from 84¾ inches to 75¾ inches along the entire length of the corridor (see data tag K211). While the resulting clear width of the corridors still exceeds the 4 ft clear width required by NFPA 101(12), Sec. 19.2.3.4, the reduction of the original 84¾-inch corridor width does not meet the requirements of NFPA 101(12), Sec. 4.6.7.5.

11. Manual Fire Alarm [Score: +2]:

Manual fire alarm pull stations are provided in accordance with NFPA 101(12), Sec. 19.3.4.2. The fire alarm system is monitored by USA Central Station Alarm Corporation.

12. Smoke Detection and Alarm [Score: +3]:

This score was assigned per instruction in Footnote g to this Worksheet. Automatic smoke detectors provided for door release service were found at the smoke barrier doors and other doors allowed to be held open in accordance with NFPA 101(12), Sections 19.2.2.2.7 and 7.2.1.8.2. The zone is protected with automatic smoke detection and quick-response sprinklers.

13. Automatic Sprinklers [Score: +10]: The entire facility is protected by a supervised, wet-pipe automatic sprinkler system.

#### Zone 5 – 2014 Addition, Lower Level: WORKSHEET 4.7.2. OCCUPANY RISK PARAMETER FACTORS

- 1. Resident Mobility (*M*) [Value assigned = 3.2]: It was reported that some residents in the zone may need assistance with evacuation.
- 2. Patient Density (*D*) [Value assigned = 1.0]: There are no sleeping rooms in this zone; it houses an OT/PT suite and the facility's main kitchen. It was reported that there are a maximum of two (2) residents in this zone at any one time.
- Zone Location (L) [Value assigned = 1.1]: This value was assigned per the instruction in NFPA 101A(13), Sec. 4.5.3.2. Although the facility is two stories in height, it sits on a sloping grade. As a result, this zone has direct access to the exterior at grade level.
- 4. Ratio of Patients to Attendants (*T*) [Value assigned = 1.0]: It was reported that there is at least one (1) staff person for each resident present in this zone.
- 5. Patient Average Age (A) [Value assigned = 1.2]: Residents using this zone average over 65 years of age.

### WORKSHEET 4.7.6. SAFETY PARAMETERS and SAFETY PARAMETER VALUES

- Construction [Score: 0]: The building was assigned a Type II(000) construction type.
- Interior Finish (Corridors and Exits) [Score: +3]: Walls in corridors and exits were determined to be of masonry and gypsum wallboard. Documentation was provided certifying that the acoustical ceiling tile carries a Class A (25 or less) flame spread rating.
- Interior Finish (Rooms) [Score: +3]: Walls in rooms were determined to be of masonry and gypsum wallboard. Documentation was provided certifying that the acoustical ceiling tile carries a Class A (25 or less) flame spread rating.
- Corridor Partitions/Walls [Score: +2]: Corridor walls were determined to be constructed of masonry and gypsum wallboard installed on both sides of steel studs.
- Doors to Corridor [Score: +1]: Corridor doors in this zone were found to be a mixture of labeled 45-minute, 60-minute and 90-minute doors.
- 6. Zone Dimensions [Score: 0]:

This score was assigned per Footnote c to this Worksheet. The zone measures approximately 155 feet in length and has no dead ends, but has fewer than 31 residents.

- 7. Vertical Openings [Score: 0]: This score was assigned per Footnote *e* to this Worksheet – Parameter 1 is based on a first floor zone. Based on observation, interview of the Environmental Services Director and review of building construction drawings, the exit stairway located at the east end of the building is enclosed with construction providing a minimum 2-hour fire resistance. Vertical openings in the original (1964) building, however, were found to be enclosed with construction providing a minimum 1-hour fire resistance. Because the original (1964) building serves as part of the means of egress from the 2014 addition and the two buildings are not separated by a minimum 2-hour-rated fire barrier wall, this Parameter was scored as "≥1 hr to <2 hr".</p>
- Hazardous Areas [Score: 0]: No hazardous area deficiencies were found in this zone.
- 9. Smoke Control [Score: 0]: A smoke barrier serves this zone.
- 10. Emergency Movement Routes [Score: 0]: There are two remote exits from this zone.

- Manual Fire Alarm [Score: +2]: Manual fire alarm pull stations are provided in accordance with NFPA 101(12), Sec. 19.3.4.2. The fire alarm system is monitored by USA Central Station Alarm Corporation.
- Smoke Detection and Alarm [Score: +3]: This score was assigned per instruction in Footnote g to this Worksheet. The zone is protected with corridor smoke detection and quick-response sprinklers.
- Automatic Sprinklers [Score: +10]: The entire facility is protected by a supervised, wet-pipe automatic sprinkler system.

#### Zone 6 – South Wing and 2014 Addition, Upper Level: WORKSHEET 4.7.2. OCCUPANY RISK PARAMETER FACTORS

- 1. Resident Mobility (*M*) [Value assigned = 3.2]: It was reported that some residents in the zone may need assistance with evacuation.
- 2. Patient Density (D) [Value assigned = 2.0]: This score was assigned to ensure that the FSES addresses the "worst-case scenario". This zone consists of the 2014 addition and the South Wing of the existing building, with the exception of the South Wing dayroom space. There is bed capacity for up to 24 residents in this zone. The zone also contains the facility's main dining room, which has an occupant load of 35.
- Zone Location (L) [Value assigned = 1.1]: This value was assigned per the instruction in NFPA 101A(13), Sec. 4.5.3.2. Although the facility is two stories in height, it sits on a sloping grade. As a result, this zone has direct access to the exterior at grade level.
- 4. Ratio of Patients to Attendants (*T*) [Value assigned = 1.5]: It was reported that there is one (1) staff person on duty in this zone on the night shift and there are at least three (3) staff persons present when residents are in the dining room.
- 5. Patient Average Age (A) [Value assigned = 1.2]: Residents using this zone average over 65 years of age.

### WORKSHEET 4.7.6. SAFETY PARAMETERS and SAFETY PARAMETER VALUES

- Construction [Score: 0]: The building was assigned a Type II(000) construction type.
- Interior Finish (Corridors and Exits) [Score: +3]: Based on interview and observation, it was determined that the wall and ceiling finishes [i.e. aesthetics ("home front facades") and wooden structure (archway) at the set of cross-corridor doors leading from Mill River to the South Wing of the existing building] in this zone are constructed of noncombustible material (e.g. metal and cement board). The acoustical ceiling tile carries a Class A (25 or less) flame spread rating.
- Interior Finish (Rooms) [Score: +3]: Walls in rooms were determined to be of masonry, plaster and gypsum wallboard. Documentation was provided certifying that the acoustical ceiling tile carries a Class A (25 or less) flame spread rating.
- 4. Corridor Partitions/Walls [Score: 0]: Corridor walls were determined to be constructed of glazed masonry block, plaster and gypsum wallboard. Three (3) non-fire-rated glass vision panels were found in the corridor wall at the nurse station. As a result, the corridor walls were graded as "<½ hour".</li>
- Doors to Corridor [Score: +1]: Corridor doors in this zone were found to be of 1<sup>3</sup>/<sub>4</sub>-inch-thick solid wood construction mounted in metal frames.

6. Zone Dimensions [Score: 0]:

This score was assigned per Footnote h to this Worksheet. The zone measures approximately 190 feet in length and has no dead ends. Based on review of the building's CODE REVIEW PLAN – MAIN LEVEL, it was determined that the zone area is approximately 20,900 ft<sup>2</sup> and the maximum distance from any point to reach a door in a smoke barrier, as measured along the natural path of egress travel, is 194 ft.

7. Vertical Openings [Score: 0]:

This score was assigned per Footnote *e* to this Worksheet – Parameter 1 is based on a first floor zone. Based on observation, interview of the Environmental Services Director and review of building construction drawings, the exit stairway located at the east end of the building is enclosed with construction providing a minimum 2-hour fire resistance. Vertical openings in the original (1964) building, however, were found to be enclosed with construction providing a minimum 1-hour fire resistance. Because the original (1964) building serves as part of the means of egress from the 2014 addition and the two buildings are not separated by a minimum 2-hour-rated fire barrier wall, this Parameter was scored as " $\geq 1$  hr to <2 hr".

8. Hazardous Areas [Score: 0]:

No hazardous area deficiencies were found in this zone.

9. Smoke Control [Score: 0]:

A smoke barrier serves this zone.

10. Emergency Movement Routes [Score: -2]:

This score was assigned for the following reasons:

- Access to the southwest exit from this zone is through the day room, which does not meet the requirements of NFPA 101(12), Sec. 19.2.5.4.
- A review of the Statement of Deficiencies from the 08/02/2018 fire/life safety recertification survey revealed that Zumbrota Care Center was cited for the presence of interior finish materials mounted on the corridor walls in the South Wing of the existing building that diminished the width of the existing corridors resulting in a reduction of corridor width from 84¾ inches to 75¾ inches along the entire length of the corridor (see data tag K211). While the resulting clear width of the corridors still exceeds the 4 ft clear width required by NFPA 101(12), Sec. 19.2.3.4, the reduction of the original 84¾-inch corridor width does not meet the requirements of NFPA 101(12), Sec. 4.6.7.5.
- Manual Fire Alarm [Score: +2]: Manual fire alarm pull stations are provided in accordance with NFPA 101(12), Sec. 19.3.4.2. The fire alarm system is monitored by USA Central Station Alarm Corporation.
- Smoke Detection and Alarm [Score: +3]: This score was assigned per instruction in Footnote g to this Worksheet. The zone is protected with corridor smoke detection and quick-response sprinklers.
- Automatic Sprinklers [Score: +10]: The entire facility is protected by a supervised, wet-pipe automatic sprinkler system.

\* \* \* \* \* \* \* \* \* \* \*

It must be noted that the scores and values assigned to the parameters in the tables on the FSES worksheets are based on conditions found between 0815 hours and 1220 hours on 09/13/2018. Any changes in those conditions after this date could affect these scores and values, either positively or negatively. Again, based on this evaluation, Zumbrota Care Center **has** achieved a passing score on the FSES. No other assessment of the level of safety in this facility is either intended or implied by *Fire Safety Resources, LLC*.

#### FIRE SAFETY EVALUATION SYSTEM HEALTH CARE FACILITIES

(NFPA 101A, "Guide on Alternative Approaches to Life Safety" 2013 Edition)

Complete the following worksheets for each fire/smoke zone\*.

Where conditions are the same in several zones, one set of worksheets can be used for those zones.

\* Fire/smoke zone is a space separated from all other spaces by floors, horizontal exits, or smoke barriers

Step 1 — Complete Cover Sheet using Worksheet 4.7.1.

### WORKSHEET 4.7.1 - COVER SHEET

ZONE\_1\_OF\_6\_ZONES

NAME OF FACILITY	ADDRESS OF FACILITY		
ZUMBROTA CARE CENTER	433 MILLST. ZU	MBROTA MN 55992	
ZONE(S) EVALUATED	)	)	
ORIGINAL BUILDING, BASE	MENT LEVEL		
PROVIDER/VENDOR NO.	DATE OF SURVEY		
245376	09/13/2018		
SURVEYOR SIGNATURE	TITLE	OFFICE	DATE
Robert J. Untille	PRESIDENT	FIRE SAFETY RESOURCES, LLC	09/17/2019
	110211	RESOURCES, LLC	- 171 120 10
FIRE AUTHORITY SIGNATURE	TITLE	OFFICE	DATE
Thomas Linhoff 12424	Fire Safety Supervisor	MN State Fire Marshal	09-25-2018
$\mathcal{U}$			

ADDITIONAL COMMENTS:

CMS FORMS SHALL BE COMPLETED AND RETAINED AS PART OF THE SURVEY RECORD.

Step 2 — Determine Occupancy Risk Parameter Factors using Worksheet 4.7.2.

For each Risk Parameter in Worksheet 7.2, select and circle the appropriate risk factor value. Choose only one for each of the five Risk Parameters.

Ri	sk Parameters		Risk F	actor V	alues						
1.	Patient	Mobility Status	Mobile		Limited	Mobility	V Not M	obile	N	lot Movable	
Mobility (M)	Risk Factor	1.0		1	.6	3.	2		4.5		
2.	Patient	No. of Patients	1–5		6-	10	11-	-30		>30	
	Density (D)	Risk Factor 1.0			1	.2	1.	1.5		2.0	
3.	Zone	Floor	1 <sup>st</sup>	2 <sup>nd</sup> (	or 3 <sup>rd</sup>	4	<sup>th</sup> to 6 <sup>th</sup>	7 <sup>th</sup> an Abov		Basements	
	Location (L)	Risk Factor	1.1		1.2		1.4	1.6		1.6	
4.	Ratio of Patients to	<u>Patients</u> Attendant	<u>1–2</u> 1	3	<u>3–5</u> 1		<u>6–10</u> <u>&gt;1</u>		)	One or More None	
	Attendants (T)	Risk Factor	1.0		1.1		1.2	1.5		4.0*	
5.	Patient Average	Age	Unde	er 65 Yea Ye	rs and Ove ar	er 1	65 Ye	ವರ್ಷದ ಸಂಭದ್ಧ ಭಾಷ	ver or inger	1 Year and	
	Age (A)	Risk Factor		1.0				1.2			

#### WORKSHEET 4.7.2 – OCCUPANCY RISK PARAMETER FACTORS

\*A risk factor of 4.0 is charged to any zone that houses patients without any staff in immediate attendance.

#### Step 3 — Compute Occupancy Risk Factor (F) using Worksheet 4.7.3.

- (1) Transfer the circled risk factor values from Worksheet 4.7.2 to the corresponding blocks in Worksheet 4.7.3.
- (2) Compute F by multiplying the risk factor values as indicated in Worksheet 4.7.3.

#### WORKSHEET 4.7.3 - OCCUPANCY RISK FACTOR CALCULATION

	м	D	L	т	А	F
OCCUPANCY RISK	x		<b>x</b> 🗌 :	x 🗌 )	< 🗌 =	1.6

- Step 4 Compute Adjusted Building Status (R) Use Worksheets 4.7.4 or 4.7.5.
  - (1) If building is classified as "NEW" use Worksheet 4.7.4. If building is classified as "Existing" use Worksheet 4.7.5.
  - (2) Transfer the value of F from Worksheet 4.7.3 to Worksheets 4.7.4 or 4.7.5, as appropriate. Calculate R.
  - (3) Transfer R to the block labeled R in Worksheet 4.7.9.
  - (4) In Worksheets 4.7.4 and 4.7.5, results are always rounded up (i.e., 3.2 is rounded to 4.0).

### WORKSHEET 4.7.4 ADJUSTED OCCUPANCY RISK FACTOR (NEW)

F R

WORKSHEET 4.7.5 ADJUSTED OCCUPANCY RISK FACTOR (EXISTING)



#### Step 5 — Determine Safety Parameter Values using Worksheet 4.7.6.

- (1) Select and circle the safety value for each safety parameter that best describes the conditions in the zone.
- (2) Choose only one value for each of the 13 parameters.
- (3) If two or more appear to apply, choose the one with the lowest point value.

#### WORKSHEET 4.7.6 - SAFETY PARAMETER VALUES

Safety Parameters			Param	eters Va	alues		
1. Construction		Combustible				Non-Com	bustible
		Types III, IV, and V	/			Types I	and II
Floor or Zone	000	111 20	0 211, 2	нн	000	111	222, 322, 442
First	-2	0 -2	2 0		0	2	2
Second	-7	-2 -4	-2		-2	2	4
Third	-9	-7 -9			-7	2	4
4th and Above	-13	-7 -1	3 -7		-9	-7	4
2. Interior Finish (Corridors and Exits)	Class C -5(0) <sup>f</sup>	Class B 0(3) <sup>f</sup>	Clas				
3. Interior Finish	Class C	Class B	Clas	s A			
(Rooms)	-3(1) <sup>f</sup>	1(3) <sup>f</sup>	(3	)			
4. Corridor	None or Incomplete	<¹/₂ hour	>1/2 to <			≥1 hour	
Partitions/Walls	-10(0) <sup>a</sup>	$\bigcirc$	1(0	)) <sup>a</sup>		2(0) <sup>a</sup>	
5. Doors to Corridor	No Door	<20 min FPR	≥ 20 mi	in FPR		in FPR and Closure	
	-10	0	100	)) <sup>d</sup>		2(0) <sup>d</sup>	
6. Zone Dimensions	D	ead End			No Dea	d Ends >30 ft. and	Zone Length Is
	>100 ft. >	50 ft. to 100 ft.	30 ft. to 50 ft.	>15	0 ft.	100 ft. to 150 ft	
	-6(0) <sup>b</sup>	-4(0) <sup>b</sup>	-2(0) <sup>b</sup>	-2(0)	<sup>c</sup> (0) <sup>h</sup>	0(0) <sup>h</sup>	(1)
7. Vertical Openings	Open 4 or More	Open 2 or 3		En	closed with	n Indicated Fire Re	esistance
	Floors	Floors	<1			hr. to <2 hr.	≥2 hr.
	-14	-10	C	1		2(0) <sup>e</sup> )	3(0) <sup>e</sup>
8. Hazardous Areas	Double D	eficiency		Single	Deficiency	/	No Deficiencies
	In Zone	Outside Zor	ie In Z	lone	In A	djacent Zone	
	-11	-5	-	6		-2	(0)
9. Smoke Control	No Control	Smoke Barrier	Mecha	nically As	sisted Syst	ems	
	<b>T</b> (0) C	Serves Zone			y Zone	3	
	-5(0) <sup>c</sup>	(0)			3		
10. Emergency	<2 Routes		Multi	ole Routes	5		Direct Exit(s)
Movement		Deficient	W/O H	orizontal		Horizontal	
Routes	-8	Delicient	Ex	tit(s)		Exit(s)	
		-2	(	0)		1	5
11. Manual Fire Alarm	No Manual Fi	re Alarm		Manu	al Fire Alar	m	
			W/O F.	D. Conn.	V	V/F.D. Conn.	
	-4			1		(2)	
12. Smoke Detection and Alarm	None	Corridor Only	Room	s Only	1	rridor and bit. Spaces	Total Spaces in Zone
	0(3) <sup>g</sup> )	2(3) <sup>g</sup>	3(	(3) <sup>g</sup>		4	5
13. Automatic Sprinklers	None	Corridor and Habit. Space	E	ntire Iding			
1	0	8	(	10)			

<sup>a</sup> Use (0) where parameter 5 is -10.

<sup>b</sup> Use (0) where parameter 10 is -8.

<sup>c</sup> Use (0) on floor with fewer than 31

patients (existing buildings only).

<sup>d</sup> Use (0) where parameter 4 is -10.

<sup>f</sup> Use () if the area of Class B or C interior finish in the corridor and exit or room is protected by automatic sprinklers and Parameter 13 is 0; use () if the room with existing Class C interior finish is protected by automatic sprinklers, Parameter 4 is greater than or equal to 1, and Parameter 13 is 0.
<sup>g</sup> Use this value in addition to Parameter 13 if the entire zone is protected with quick-

<sup>e</sup> Use (0) where parameter 4 is -10.
<sup>e</sup> Use (0) where Parameter 1 is based on first floor zone or on an unprotected type of construction (columns)

marked "000" or "200"). For SI Units: 1 ft.<sup>2</sup> = 0.3048 m<sup>2</sup> <sup>h</sup> Use (0) where zone area  $\leq$  22,500 ft.<sup>2</sup> and distance from any point to reach a door in smoke barrier is  $\leq$  200 ft.

response automatic sprinklers.

- Step 6 Compute Individual Safety Evaluations using Worksheet 4.7.7.
  - (1) Transfer each of the 13 circled Safety Parameter Values from Worksheet 4.7.6 to every unshaded block in the line with the corresponding Safety Parameter in Worksheet 4.7.7. For Safety Parameter 13 (Sprinklers) the value entered in the People Movement Safety column is recorded in Worksheet 4.7.7 as 1/2 the corresponding value circled in Worksheet 4.7.6.
  - (2) Add the four columns, keeping in mind that any negative numbers deduct.
  - (3) Transfer the resulting total values for S1, S2, S3, S4 to blocks labeled S1, S2, S3, S4 in Worksheet 4.7.9 on page 4 of this sheet.

### WORKSHEET 4.7.7 - INDIVIDUAL SAFETY EVALUATIONS

Safety Parameters	Containment Safety (S <sub>1</sub> )	Extinguishment Safety (S <sub>2</sub> )	People Movement Safety (S <sub>3</sub> )	General Safety (S₄)
1. Construction	-2	-2		-2
2. Interior Finish (Corr. and Exit)	3		3	3
3. Interior Finish (Rooms)	3			3
4. Corridor Partitions and Walls	0			0
5. Doors to Corridor	1		1	I
6. Zone Dimensions			1	1
7. Vertical Openings	0		0	0
8. Hazardous Areas	0	0		õ
9. Smoke Control			0	0
10. Emergency Movement Routes			0	0
11. Manual Fire Alarm		2		2
12. Smoke Detection and Alarm		3	3	3
13. Automatic Sprinklers	10	10	10 ÷ 2 = 5	10
Total Value	S1= 15	<b>S</b> <sub>2</sub> = 13	S₃= 13	S4= 21

Step 7 — Determine Mandatory Safety Requirement values using Worksheet 4.7.8A, 4.7.8B, or 4.7.8C.

- (1) Using the facility type (i.e., Hospital or Nursing Home), classification (i.e., New, Existing or Rehabilitated) and the floor where the zone is located, circle the appropriate value in each of the three columns found in Worksheet 4.7.8A, 4.7.8B, or 4.7.8C.
- (2) Transfer the three circled values to the blocks marked Sa, Sb, and Sc in Worksheet 4.7.9.
- (3) The Mandatory Safety Requirement value for basements are based on the distance of the basement level from the closest level of discharge (See 4.6.1.2 and 4.6.1.3).

### WORKSHEET 4.7.8A - MANDATORY SAFETY REQUIREMENTS – NEW HOSPITALS, EXISTING HOSPITALS OR NEW NURSING HOMES

Zone Location		ainment (Sa)		iishment S₀)	People Movement (Sc)		
	New	Existing	New	Existing	New	Existing	
1 <sup>st</sup> story	11	5	15(12)ª	4	8(5) <sup>a</sup>	1	
2 <sup>nd</sup> or 3 <sup>rd</sup> story <sup>b</sup>	15	9	17(14) <sup>a</sup>	6	10(7)ª	3	
4 <sup>th</sup> story or higher, but not high rise	18	9	19(16)ª	6	11(8)ª	3	
High rise	18	17	19(16)ª	16	11(8) <sup>a</sup>	7	

a. Use () in zones that do not contain patient sleeping rooms.

b. For a 2<sup>nd</sup> story zone location in a sprinklered EXISTING hospital, as an alternative to the mandatory safety requirement values set specified in the table, the following mandatory values set shall be permitted to be used: Sa=7, Sb=10, and Sc=7

### WORKSHEET 4.7.8B - MANDATORY SAFETY REQUIREMENTS – EXISTING NURSING HOMES

Zone Location	Containment (Sa)	Extinguishment (Sb)	People Movement (Sc)
1 <sup>st</sup> story	0	10	0
2 <sup>nd</sup> story	2	10	2
3 <sup>rd</sup> story	6	14	2
4 <sup>th</sup> story or higher	8	16	2

### WORKSHEET 4.7.8C - MANDATORY SAFETY REQUIREMENTS – MAJOR REHABILITATION IN NONSPRINKLERED EXISTING HOSPITALS

Zone Location	Containment (Sa)	Extinguishment (Sb)	People Movement (Sc)
1 <sup>st</sup> story	13	17(14)*	8(5)*
2 <sup>nd</sup> or 3 <sup>rd</sup> story	17	19(16)*	10(7)*
4 <sup>th</sup> story or higher	18	19(16)*	11(8)*

\*Use ( ) in zones that do not contain patient sleeping rooms.

Step 8 — Identify Zone Fire Safety Equivalency using Worksheet 4.7.9.

- (1) Transfer the three circled values from Worksheet 4.7.8A, 4.7.8B, or 4.7.8C to the blocks marked Sa, Sb, and Sc in Worksheet 4.7.9.
- (2) For each row check "Yes" if the value in the answer block is zero or greater. Check "No" if the value in the answer block is a negative number.

### WORKSHET 4.7.9 - ZONE FIRE SAFETY EQUIVALENCY EVALUATION

						YES	NO
Containment Safety (S <sub>1</sub> )	minus	Mandatory Containment (Sa)	≥ 0	S1 Sa 15 — 2	C = 13	1	
Extinguishment Safety (S₂)	minus	Mandatory Extinguishment (Sb)	≥ 0	S <sub>2</sub> S <sub>b</sub> 13 - 10	E 3	1	
People Movement Safety (S₃)	minus	Mandatory People Movement (Sc)	≥0	S <sub>3</sub> S <sub>c</sub> 13 — 2	P 11	1	
General Safety (S₄)	minus	Occupancy Risk (R)	≥ 0	S4 R 21 — 1	G = 20	1	

Step 9 — Evaluate other considerations not previously addressed using Worksheet 4.7.10.

Complete one copy of this separate worksheet for each facility.

For each consideration, select and mark the appropriate column.

#### WORKSHEET 4.7.10 FACILITY FIRE SAFETY REQUIREMENTS WORKSHEET

	•	Met	Not Met	Not Applic.
A.	Building utilities conform to the requirements of Section 9.1.	$\checkmark$		$\ge$
В.	In new facilities only, life-support systems, alarms, emergency communication systems, and illumination of generator set locations are powered as prescribed by 18.5.1.2 and 18.5.1.3.			$\checkmark$
C.	Heating and air conditioning systems conform with the air conditioning, heating, and ventilating systems requirements within Section 9.2, except for enclosure of vertical openings, which have been considered in Safety Parameter 7 of Worksheet 4.7.6.	1		$\left \right>$
D.	Fuel-burning space heaters and portable electrical space heaters are not used.	1		>
E.	There are no flue-fed incinerators.	$\checkmark$		
F.	An evacuation plan is provided and fire drills conducted in accordance with 18.7.1/18.7.2 and 19.7.1/19.7.2.	1		$\succ$
G.	Smoking regulations have been adopted and implemented in accordance with 18.7.4 and 19.7.4.	1		$\geq$
H.	Draperies, upholstered furniture, mattresses, furnishings, and decoration combustibility is limited in accordance with 18.7.5 and 19.7.5.	$\checkmark$		
I.	Fire extinguishers are provided in accordance with the requirements of 18.3.5.12 and 19.3.5.12.	1		$\geq$
J.	Exit signs are provided in accordance with the requirements of 18.2.10.1 and 19.2.10.	$\checkmark$		
K.	Emergency lighting is provided in accordance with 18.2.9.1 or 19.2.9.1.	1		
L.	Standpipes are provided in all new high rise buildings as required by 18.4.2.			$\checkmark$

Step 10 — Determine the equivalency Conclusion to determine if the level of life safety is at least equivalent to that prescribed by the Life Safety Code using Worksheet 4.7.11.

# WORKSHEET 4.7.11- CONCLUSIONS

1.	$\times$	All of the checks in Worksheet 4.7.9 are in the "Yes" column and all applicable considerations in Worksheet 4.7.10 are marked as "Met". The level of safety is at least equivalent to that prescribed by NFPA 101, <i>Life Safety Code</i> , for health care occupancies.
2.		All of the checks in Worksheet 4.7.9 are in the "Yes" column and all considerations in Worksheet 4.7.10 marked as "Not Met" have been evaluated and mitigated to the satisfaction of the AHJ. The level of safety is at least equivalent to that prescribed by NFPA 101, <i>Life Safety Code</i> , for health care occupancies
3.		One or more of the checks on Worksheet 4.7.9 are in the "No" column or any considerations in Worksheet 4.7.10 marked as "Not Met" have NOT been evaluated and mitigated to the satisfaction of the AHJ. The level of safety is not shown by this system to be equivalent to that prescribed by NFPA 101, <i>Life Safety Code</i> , for health care occupancies.
#### FIRE SAFETY EVALUATION SYSTEM HEALTH CARE FACILITIES

(NFPA 101A, "Guide on Alternative Approaches to Life Safety" 2013 Edition)

Complete the following worksheets for each fire/smoke zone\*.

Where conditions are the same in several zones, one set of worksheets can be used for those zones.

\* Fire/smoke zone is a space separated from all other spaces by floors, horizontal exits, or smoke barriers

Step 1 — Complete Cover Sheet using Worksheet 4.7.1.

# WORKSHEET 4.7.1 - COVER SHEET

ZONE 2 OF 6 ZONES

NAME OF FACILITY	ADDRESS OF FACILITY		
ZUMBROTA CARE CENTER	433 MILL ST. ZUM	BROTA, MN 55992	
ZONE(S) EVALUATED	)	)	
MAIN LEVEL, NORTH WING	E LOBBY AREA		
PROVIDER/VENDOR NO.	DATE OF SURVEY		
245376	09/13/2018		
SURVEYOR SIGNATURE	TITLE	OFFICE	DATE
Robert S. Imhote		Fiar Same	
SURVEYOR ID	PRESIDENT	TIKE OAFETY	09/17/2018
		FIRE SAFETY RESOURCES, LLC	
FIRE AUTHORITY SIGNATURE	TITLE	OFFICE	DATE
Thomas Linhoff 12424	Fire Safety Supervisor	MN State Fire Marshal	09-25-2018
W			

ADDITIONAL COMMENTS:

CMS FORMS SHALL BE COMPLETED AND RETAINED AS PART OF THE SURVEY RECORD.

Step 2 — Determine Occupancy Risk Parameter Factors using Worksheet 4.7.2.

For each Risk Parameter in Worksheet 7.2, select and circle the appropriate risk factor value. Choose only one for each of the five Risk Parameters.

Ri	sk Parameters		Risk F	actor V	alues					
1.	Patient	Mobility Status	Mobile	Mobile Limited		Mobility	lobility Not Mobile		Not Movable	
	Mobility (M)	Risk Factor	1.0		1.6		3.	3.2		4.5
2.	Patient	No. of Patients	1–5		6-	·10	11-	-30		>30
	Density (D)	Risk Factor	1.0		1.2 (1.5		1.5 2.0		2.0	
3.	Zone	Floor	1 <sup>st</sup>	2 <sup>nd</sup> (	or 3 <sup>rd</sup> 4 <sup>th</sup>		4 <sup>th</sup> to 6 <sup>th</sup> 7 <sup>th</sup> Ab			Basements
	Location (L)	Risk Factor	1.1		1.2		1.4	1.6		1.6
4.	Ratio of Patients to	Patients Attendant	<u>1–2</u> <u>3</u>		<u>3–5</u> 6-		<u>6–10</u> 1	<u>&gt;10</u> 1	2	One or More None
	Attendants (T)	Risk Factor	1.0		1.1		1.2	1.5		4.0*
5.	Patient Average Age <i>(A)</i>	Age	Unde	r 65 Yea Ye	rs and Ove ar	er 1	65 Ye		ver or inger	1 Year and
		Risk Factor		1.0				(1.2)	l	

#### WORKSHEET 4.7.2 – OCCUPANCY RISK PARAMETER FACTORS

\*A risk factor of 4.0 is charged to any zone that houses patients without any staff in immediate attendance.

#### Step 3 — Compute Occupancy Risk Factor (F) using Worksheet 4.7.3.

- (1) Transfer the circled risk factor values from Worksheet 4.7.2 to the corresponding blocks in Worksheet 4.7.3.
- (2) Compute F by multiplying the risk factor values as indicated in Worksheet 4.7.3.

#### WORKSHEET 4.7.3 - OCCUPANCY RISK FACTOR CALCULATION

- Step 4 Compute Adjusted Building Status (R) Use Worksheets 4.7.4 or 4.7.5.
  - (1) If building is classified as "NEW" use Worksheet 4.7.4. If building is classified as "Existing" use Worksheet 4.7.5.
  - (2) Transfer the value of F from Worksheet 4.7.3 to Worksheets 4.7.4 or 4.7.5, as appropriate. Calculate R.
  - (3) Transfer R to the block labeled R in Worksheet 4.7.9.
  - (4) In Worksheets 4.7.4 and 4.7.5, results are always rounded up (i.e., 3.2 is rounded to 4.0).

#### WORKSHEET 4.7.4 ADJUSTED OCCUPANCY RISK FACTOR (NEW)



WORKSHEET 4.7.5 ADJUSTED OCCUPANCY RISK FACTOR (EXISTING)

0.6 x 
$$\overline{1.6} = \frac{R}{4.6} = 5$$

#### Step 5 — Determine Safety Parameter Values using Worksheet 4.7.6.

- (1) Select and circle the safety value for each safety parameter that best describes the conditions in the zone.
- (2) Choose only one value for each of the 13 parameters.
- (3) If two or more appear to apply, choose the one with the lowest point value.

#### WORKSHEET 4.7.6 - SAFETY PARAMETER VALUES **Safety Parameters Parameters Values** 1 Construction Non-Combustible Combustible Types III, IV, and V Types I and II 211, 2HH 000 222, 322, 442 Floor or Zone 000 111 200 111 First -2 0 -2 0 (0)2 2 Second -7 -2 -4 -2 -2 2 4 2 4 Third -7 -9 -7 -7 -9 4th and Above -13 -7 -13 -7 -9 -7 4 2. Interior Finish Class C Class B Class A (Corridors and Exits) -5(0) 0(3)<sup>f</sup> 3 3. Interior Finish Class C Class B Class A -3(1)<sup>f</sup> (Rooms) $1(3)^{f}$ (3)<1/2 hour >1/2 to <1 hour 4. Corridor None or Incomplete ≥1 hour Partitions/Walls -10(0)<sup>a</sup> 0 $1(0)^{a}$ $2(0)^{a}$ 5. Doors to Corridor ≥ 20 min FPR and No Door <20 min FPR ≥ 20 min FPR Auto Closure -10 0 (1(0)d 2(0)<sup>d</sup> Dead End No Dead Ends >30 ft, and Zone Length Is 6. Zone Dimensions >100 ft. >50 ft. to 100 ft. 30 ft. to 50 ft. >150 ft. 100 ft. to 150 ft. <100 ft. -6(0)<sup>b</sup> $-4(0)^{b}$ $-2(0)^{b}$ -2(0)c (0)h 0(0)<sup>h</sup> 1 Enclosed with Indicated Fire Resistance 7. Vertical Openings Open 4 or More Open 2 or 3 <1 hr. ≥1 hr. to <2 hr. ≥2 hr. Floors Floors -10 3(0)<sup>e</sup> -14 0 $2(0)^{e}$ Single Deficiency No Deficiencies 8. Hazardous Areas **Double Deficiency** In Zone **Outside Zone** In Zone In Adjacent Zone 0) -11 -5 -6 -2 No Control 9. Smoke Control Smoke Barrier Mechanically Assisted Systems by Zone Serves Zone -5(0)<sup>c</sup> 0 3 10. Emergency <2 Routes **Multiple Routes** Direct Exit(s) Movement W/O Horizontal Horizontal Deficient Exit(s) Exit(s) Routes -8 5 -2 0 1 11. Manual Fire Alarm No Manual Fire Alarm Manual Fire Alarm W/O F.D. Conn. W/F.D. Conn. 2) 1 -4 Total Spaces 12. Smoke Detection Corridor and Corridor Only Rooms Only None and Alarm Habit. Spaces in Zone 0(3)<sup>g</sup> 2(3)<sup>g</sup> 3(3)<sup>g</sup> 4 5 Corridor and Entire 13. Automatic None Habit. Space Building Sprinklers 0 8 10

<sup>a</sup> Use (0) where parameter 5 is -10.

<sup>b</sup> Use (0) where parameter 10 is -8.

<sup>c</sup> Use (0) on floor with fewer than 31

patients (existing buildings only).

<sup>d</sup> Use (0) where parameter 4 is -10.

protected by automatic sprinklers and Parameter 13 is 0; use () if the room with existing Class C interior finish is protected by automatic sprinklers, Parameter 4 is greater than or equal to 1, and Parameter 13 is 0. <sup>g</sup> Use this value in addition to Parameter 13 if the entire zone is protected with quick-response automatic sprinklers.

<sup>f</sup> Use ( ) if the area of Class B or C interior finish in the corridor and exit or room is

 <sup>e</sup> Use (0) where Parameter 1 is based on first floor zone or on an unprotected type of construction (columns marked "000" or "200").
 For SI Units: 1 ft.<sup>2</sup> = 0.3048 m<sup>2</sup>

<sup>h</sup> Use (0) where zone area  $\leq$  22,500 ft.<sup>2</sup> and distance from any point to reach a door in smoke barrier is  $\leq$  200 ft.

#### Step 6 — Compute Individual Safety Evaluations using Worksheet 4.7.7.

- (1) Transfer each of the 13 circled Safety Parameter Values from Worksheet 4.7.6 to every unshaded block in the line with the corresponding Safety Parameter in Worksheet 4.7.7. For Safety Parameter 13 (Sprinklers) the value entered in the People Movement Safety column is recorded in Worksheet 4.7.7 as 1/2 the corresponding value circled in Worksheet 4.7.6.
- (2) Add the four columns, keeping in mind that any negative numbers deduct.
- (3) Transfer the resulting total values for S1, S2, S3, S4 to blocks labeled S1, S2, S3, S4 in Worksheet 4.7.9 on page 4 of this sheet.

## WORKSHEET 4.7.7 - INDIVIDUAL SAFETY EVALUATIONS

Safety Parameters	Containment Safety (S <sub>1</sub> )	Extinguishment Safety (S <sub>2</sub> )	People Movement Safety (S <sub>3</sub> )	General Safety (S₄)
1. Construction	0	0		0
2. Interior Finish (Corr. and Exit)	0		0	0
3. Interior Finish (Rooms)	3			3
4. Corridor Partitions and Walls	0			0
5. Doors to Corridor	1			1
6. Zone Dimensions			0	0
7. Vertical Openings	0		0	0
8. Hazardous Areas	0	0		0
9. Smoke Control			0	0
10. Emergency Movement Routes			-2	-2
11. Manual Fire Alarm		2		2
12. Smoke Detection and Alarm		3	3	3
13. Automatic Sprinklers	10	10	l© ÷2=5	10
Total Value	S1= 14	S2= 15	S3= 7	S4= )7

Step 7 — Determine Mandatory Safety Requirement values using Worksheet 4.7.8A, 4.7.8B, or 4.7.8C.

- (1) Using the facility type (i.e., Hospital or Nursing Home), classification (i.e., New, Existing or Rehabilitated) and the floor where the zone is located, circle the appropriate value in each of the three columns found in Worksheet 4.7.8A, 4.7.8B, or 4.7.8C.
- (2) Transfer the three circled values to the blocks marked Sa, Sb, and Sc in Worksheet 4.7.9.
- (3) The Mandatory Safety Requirement value for basements are based on the distance of the basement level from the closest level of discharge (See 4.6.1.2 and 4.6.1.3).

## WORKSHEET 4.7.8A - MANDATORY SAFETY REQUIREMENTS – NEW HOSPITALS, EXISTING HOSPITALS OR NEW NURSING HOMES

Zone Location	Containment (Sa)			ishment S <sub>b</sub> )	People Movement (S <sub>c</sub> )	
	New	Existing	New	Existing	New	Existing
1 <sup>st</sup> story	11	5	15(12)ª	4	8(5)ª	1
2 <sup>nd</sup> or 3 <sup>rd</sup> story <sup>b</sup>	15	9	17(14)ª	6	10(7) <sup>a</sup>	3
4 <sup>th</sup> story or higher, but not high rise	18	9	19(16)ª	6	11(8) <sup>a</sup>	3
High rise	18	17	19(16) <sup>a</sup>	16	11(8)ª	7

a. Use () in zones that do not contain patient sleeping rooms.

b. For a 2<sup>nd</sup> story zone location in a sprinklered EXISTING hospital, as an alternative to the mandatory safety requirement values set specified in the table, the following mandatory values *set* shall be permitted to be used: Sa=7, Sb=10, and Sc=7

#### WORKSHEET 4.7.8B - MANDATORY SAFETY REQUIREMENTS – EXISTING NURSING HOMES

Zone Location	Containment (Sa)	Extinguishment (Sb)	People Movement (Sc)
1 <sup>st</sup> story	0	10	0
2 <sup>nd</sup> story	2	10	2
3 <sup>rd</sup> story	6	14	2
4 <sup>th</sup> story or higher	8	16	2

## WORKSHEET 4.7.8C - MANDATORY SAFETY REQUIREMENTS – MAJOR REHABILITATION IN NONSPRINKLERED EXISTING HOSPITALS

Zone Location	Containment (Sa)	Extinguishment (Sb)	People Movement (Sc)
1 <sup>st</sup> story	13	17(14)*	8(5)*
2 <sup>nd</sup> or 3 <sup>rd</sup> story	17	19(16)*	10(7)*
4 <sup>th</sup> story or higher	18	19(16)*	11(8)*

\*Use ( ) in zones that do not contain patient sleeping rooms.

Step 8 — Identify Zone Fire Safety Equivalency using Worksheet 4.7.9.

- (1) Transfer the three circled values from Worksheet 4.7.8A, 4.7.8B, or 4.7.8C to the blocks marked Sa, Sb, and Sc in Worksheet 4.7.9.
- (2) For each row check "Yes" if the value in the answer block is zero or greater. Check "No" if the value in the answer block is a negative number.

#### WORKSHET 4.7.9 - ZONE FIRE SAFETY EQUIVALENCY EVALUATION

						YES	NO
Containment Safety (S <sub>1</sub> )	minus	Mandatory Containment (Sa)	≥ 0	S1 S	$\begin{array}{c} \mathbf{S}_{a} & \mathbf{C} \\ \mathbf{O} & \mathbf{E} \end{bmatrix} \begin{bmatrix} \mathbf{I}_{4} \end{bmatrix}$	1	
Extinguishment Safety (S₂)	minus	Mandatory Extinguishment (Sb)	≥ 0		Sb E 10 = 5	1	
People Movement Safety (S₃)	minus	Mandatory People Movement (Sc)	≥0	S₃ 5 □ − [	Sc P 0 <b>=</b> 1	1	
General Safety (S₄)	minus	Occupancy Risk (R)	≥ 0	S₄ F	<b>R G</b> 5 <b>=</b> 12	1	

Step 9 — Evaluate other considerations not previously addressed using Worksheet 4.7.10.

Complete one copy of this separate worksheet for each facility.

For each consideration, select and mark the appropriate column.

#### WORKSHEET 4.7.10 FACILITY FIRE SAFETY REQUIREMENTS WORKSHEET

	-	Met	Not Met	Not Applic.
A.	Building utilities conform to the requirements of Section 9.1.	J		$\ge$
В.	In new facilities only, life-support systems, alarms, emergency communication systems, and illumination of generator set locations are powered as prescribed by 18.5.1.2 and 18.5.1.3.			1
C.	Heating and air conditioning systems conform with the air conditioning, heating, and ventilating systems requirements within Section 9.2, except for enclosure of vertical openings, which have been considered in Safety Parameter 7 of Worksheet 4.7.6.	1		$\left \right>$
D.	Fuel-burning space heaters and portable electrical space heaters are not used.	1		$\geq$
E.	There are no flue-fed incinerators.	1		Í
F.	An evacuation plan is provided and fire drills conducted in accordance with 18.7.1/18.7.2 and 19.7.1/19.7.2.	1		$\succ$
G.	Smoking regulations have been adopted and implemented in accordance with 18.7.4 and 19.7.4.	V		$\ge$
Н.	Draperies, upholstered furniture, mattresses, furnishings, and decoration combustibility is limited in accordance with 18.7.5 and 19.7.5.	$\checkmark$		
I.	Fire extinguishers are provided in accordance with the requirements of 18.3.5.12 and 19.3.5.12.	1		$\geq$
J.	Exit signs are provided in accordance with the requirements of 18.2.10.1 and 19.2.10.	$\checkmark$		
K.	Emergency lighting is provided in accordance with 18.2.9.1 or 19.2.9.1.	1		
L.	Standpipes are provided in all new high rise buildings as required by 18.4.2.			$\checkmark$

Step 10 — Determine the equivalency Conclusion to determine if the level of life safety is at least equivalent to that prescribed by the Life Safety Code using Worksheet 4.7.11.

## WORKSHEET 4.7.11- CONCLUSIONS

L			
	1.	$\boxtimes$	All of the checks in Worksheet 4.7.9 are in the "Yes" column and all applicable considerations in Worksheet 4.7.10 are marked as "Met". The level of safety is at least equivalent to that prescribed by NFPA 101, <i>Life Safety Code</i> , for health care occupancies.
	2.		All of the checks in Worksheet 4.7.9 are in the "Yes" column and all considerations in Worksheet 4.7.10 marked as "Not Met" have been evaluated and mitigated to the satisfaction of the AHJ. The level of safety is at least equivalent to that prescribed by NFPA 101, <i>Life Safety Code</i> , for health care occupancies
	3.		One or more of the checks on Worksheet 4.7.9 are in the "No" column or any considerations in Worksheet 4.7.10 marked as "Not Met" have NOT been evaluated and mitigated to the satisfaction of the AHJ. The level of safety is not shown by this system to be equivalent to that prescribed by NFPA 101, <i>Life Safety Code</i> , for health care occupancies.

#### FIRE SAFETY EVALUATION SYSTEM HEALTH CARE FACILITIES

(NFPA 101A, "Guide on Alternative Approaches to Life Safety" 2013 Edition)

Complete the following worksheets for each fire/smoke zone\*.

Where conditions are the same in several zones, one set of worksheets can be used for those zones.

\* Fire/smoke zone is a space separated from all other spaces by floors, horizontal exits, or smoke barriers

Step 1 — Complete Cover Sheet using Worksheet 4.7.1.

## WORKSHEET 4.7.1 - COVER SHEET

ZONE\_3\_OF\_6\_ZONES

NAME OF FACILITY	ADDRESS OF FACILITY					
ZUMBROTA CARE CENTER	433 MILL ST., ZUMBROTA, MN 55992					
ZONE(S) EVALUATED	)	)				
MAIN LEVEL, SOUTH WING D.	AYROOM					
PROVIDER/VENDOR NO.	DATE OF SURVEY	6				
245376	09/13/2018					
SURVEYOR SIGNATURE	TITLE	OFFICE	DATE			
Lobert S. Smithelle	~	Fire Sarray				
SURVEYOR ID	PRESIDENT	The safery	09/17/2018			
		FIRE SAFETY RESOURCES, LLC				
FIRE AUTHORITY SIGNATURE	TITLE	OFFICE	DATE			
Thomas Linhoff 12424	Fire Safety Supervisor	MN State Fire Marshal	09-25-2018			
$\mathcal{U}$						

ADDITIONAL COMMENTS:

CMS FORMS SHALL BE COMPLETED AND RETAINED AS PART OF THE SURVEY RECORD.

Step 2 — Determine Occupancy Risk Parameter Factors using Worksheet 4.7.2.

For each Risk Parameter in Worksheet 7.2, select and circle the appropriate risk factor value. Choose only one for each of the five Risk Parameters.

Ri	sk Parameters		Risk F	actor V	alues					
1.	Patient	Mobility Status	Mobile Limited Mobility		y Not Mobile		Not Movable			
	Mobility (M)	Risk Factor	1.0		1	1.6		3.2		4.5
2.	Patient	No. of Patients	1–5		6-	10	11–30		>30	
	Density (D)	Risk Factor	1.0	1.2		.2	1.5		2.0	
3.	Zone	Floor	1 <sup>st</sup>	2 <sup>nd</sup> (	or 3 <sup>rd</sup> 4 <sup>th</sup>		th to 6 <sup>th</sup> 7 <sup>th</sup> an Abov			Basements
	Location (L)	Risk Factor	1.1	1	1.2		1.4	1.6		1.6
4.	Ratio of Patients to	Patients Attendant	<u>1–2</u> <u>3</u>		<u>3–5</u> 1		<u>6–10</u> 1	<u>&gt;10</u> 1	<u>)</u>	One or More None
	Attendants (T)	Risk Factor	1.0		1.1		1.2	(1.5	>	4.0*
5.	Patient Average Age <i>(A)</i>	Age	Unde	er 65 Year Yea	rs and Ove ar	er 1	65 Ye		ver or inger	1 Year and
		Risk Factor		1.0			(1.2)			

#### WORKSHEET 4.7.2 – OCCUPANCY RISK PARAMETER FACTORS

\*A risk factor of 4.0 is charged to any zone that houses patients without any staff in immediate attendance.

#### Step 3 — Compute Occupancy Risk Factor (F) using Worksheet 4.7.3.

- (1) Transfer the circled risk factor values from Worksheet 4.7.2 to the corresponding blocks in Worksheet 4.7.3.
- (2) Compute F by multiplying the risk factor values as indicated in Worksheet 4.7.3.

#### WORKSHEET 4.7.3 - OCCUPANCY RISK FACTOR CALCULATION

	м	D	L	т	А	F
OCCUPANCY RISK	3.2 X	1.5	<b>X</b> [.]	X 1.5	x 1.2 =	9.5

- Step 4 Compute Adjusted Building Status (R) Use Worksheets 4.7.4 or 4.7.5.
  - (1) If building is classified as "NEW" use Worksheet 4.7.4. If building is classified as "Existing" use Worksheet 4.7.5.
  - (2) Transfer the value of F from Worksheet 4.7.3 to Worksheets 4.7.4 or 4.7.5, as appropriate. Calculate R.
  - (3) Transfer R to the block labeled R in Worksheet 4.7.9.
  - (4) In Worksheets 4.7.4 and 4.7.5, results are always rounded up (i.e., 3.2 is rounded to 4.0).

## WORKSHEET 4.7.4 ADJUSTED OCCUPANCY RISK FACTOR (NEW)



WORKSHEET 4.7.5 ADJUSTED OCCUPANCY RISK FACTOR (EXISTING)

0.6 x  $\frac{F}{9.5} = \frac{R}{5.1} = 6$ 

#### Step 5 — Determine Safety Parameter Values using Worksheet 4.7.6.

- (1) Select and circle the safety value for each safety parameter that best describes the conditions in the zone.
- (2) Choose only one value for each of the 13 parameters.
- (3) If two or more appear to apply, choose the one with the lowest point value.

#### WORKSHEET 4.7.6 - SAFETY PARAMETER VALUES **Parameters Values** Safety Parameters 1. Construction Combustible Non-Combustible Types III, IV, and V Types I and II 222, 322, 442 Floor or Zone 000 111 200 211, 2HH 000 111 First -2 0 -2 0 0) 2 2 2 -2 Second -7 4 -2 -2 4 4 Third -9 -7 -9 -7 -7 2 4th and Above -13 -7 -13 -7 -7 4 -9 2. Interior Finish Class C Class B Class A $0(3)^{f}$ (Corridors and Exits) $-5(0)^{f}$ (3)3. Interior Finish Class C Class B Class A (Rooms) $-3(1)^{f}$ $1(3)^{f}$ (3) 4. Corridor None or Incomplete $<^{1}/_{2}$ hour >1/2 to <1 hour ≥1 hour Partitions/Walls -10(0)<sup>a</sup> 0) $1(0)^{a}$ 2(0)<sup>a</sup> 5. Doors to Corridor ≥ 20 min FPR and No Door <20 min FPR ≥ 20 min FPR Auto Closure 1(0)<sup>d</sup> -10 0 2(0)<sup>d</sup> Dead End No Dead Ends >30 ft. and Zone Length Is 6. Zone Dimensions <100 ft. >100 ft. >50 ft. to 100 ft. 30 ft. to 50 ft. >150 ft. 100 ft. to 150 ft. $-6(0)^{b}$ $-4(0)^{b}$ -2(0)b 0(0)<sup>h</sup> -2(0)<sup>c</sup> (0)<sup>h</sup> 1 Open 4 or More Open 2 or 3 Enclosed with Indicated Fire Resistance 7. Vertical Openings ≥2 hr. Floors Floors <1 hr. ≥1 hr. to <2 hr. -14 -10 0 2(0)<sup>e</sup> $3(0)^{e}$ Single Deficiency No Deficiencies 8. Hazardous Areas **Double Deficiency** In Adjacent Zone In Zone **Outside Zone** In Zone -11 -5 -6 -2 (0)9. Smoke Control No Control Smoke Barrier Mechanically Assisted Systems Serves Zone by Zone -5(0)<sup>c</sup> 0 3 Multiple Routes Direct Exit(s) 10. Emergency <2 Routes Movement W/O Horizontal Horizontal Deficient Routes Exit(s) Exit(s) -8 -2 0 1 5 11. Manual Fire Alarm No Manual Fire Alarm Manual Fire Alarm W/O F.D. Conn. W/FD Conn 1 2 -4 12. Smoke Detection Corridor and Total Spaces Corridor Only Rooms Only None and Alarm Habit. Spaces in Zone 0(3)<sup>g</sup> 2(3)<sup>g</sup> 3(3)g) 4 5 Corridor and Entire 13. Automatic None Habit. Space Building

<sup>a</sup> Use (0) where parameter 5 is -10.

<sup>b</sup> Use (0) where parameter 10 is -8.

<sup>c</sup> Use (0) on floor with fewer than 31

patients (existing buildings only).

<sup>d</sup> Use (0) where parameter 4 is -10.

<sup>f</sup> Use ( ) if the area of Class B or C interior finish in the corridor and exit or room is protected by automatic sprinklers and Parameter 13 is 0; use ( ) if the room with existing Class C interior finish is protected by automatic sprinklers, Parameter 4 is greater than or equal to 1, and Parameter 13 is 0.

<sup>g</sup> Use this value in addition to Parameter 13 if the entire zone is protected with quickresponse automatic sprinklers.

10

<sup>e</sup> Use (0) where Parameter 1 is based on first floor zone or on an unprotected type of construction (columns marked "000" or "200"). For SI Units: 1 ft.<sup>2</sup> = 0.3048 m<sup>2</sup>

0

8

<sup>h</sup> Use (0) where zone area ≤ 22,500 ft.<sup>2</sup> and distance from any point to reach a door in smoke barrier is ≤ 200 ft.

Form CMS-2786T (10/2016)

Sprinklers

Step 6 — Compute Individual Safety Evaluations using Worksheet 4.7.7.

- (1) Transfer each of the 13 circled Safety Parameter Values from Worksheet 4.7.6 to every unshaded block in the line with the corresponding Safety Parameter in Worksheet 4.7.7. For Safety Parameter 13 (Sprinklers) the value entered in the People Movement Safety column is recorded in Worksheet 4.7.7 as 1/2 the corresponding value circled in Worksheet 4.7.6.
- (2) Add the four columns, keeping in mind that any negative numbers deduct.
- (3) Transfer the resulting total values for S1, S2, S3, S4 to blocks labeled S1, S2, S3, S4 in Worksheet 4.7.9 on page 4 of this sheet.

## WORKSHEET 4.7.7 - INDIVIDUAL SAFETY EVALUATIONS

Safety Parameters	Containment Safety (S <sub>1</sub> )	Extinguishment Safety (S <sub>2</sub> )	People Movement Safety (S <sub>3</sub> )	General Safety (S₄)
1. Construction	0	0		0
2. Interior Finish (Corr. and Exit)	3		3	3
3. Interior Finish (Rooms)	3		$\geq$	3
4. Corridor Partitions and Walls	0			Ó
5. Doors to Corridor			1	]
6. Zone Dimensions			}	l
7. Vertical Openings	0		0	0
8. Hazardous Areas	0	0		0
9. Smoke Control			0	0
10. Emergency Movement Routes			-2	-2
11. Manual Fire Alarm		2		2
12. Smoke Detection and Alarm		3	3	3
13. Automatic Sprinklers	10	10	30 ÷2=5	10
Total Value	S1= 17	S₂= 15	S <sub>3</sub> = ))	<b>S</b> 4= 21

Step 7 — Determine Mandatory Safety Requirement values using Worksheet 4.7.8A, 4.7.8B, or 4.7.8C.

- (1) Using the facility type (i.e., Hospital or Nursing Home), classification (i.e., New, Existing or Rehabilitated) and the floor where the zone is located, circle the appropriate value in each of the three columns found in Worksheet 4.7.8A, 4.7.8B, or 4.7.8C.
- (2) Transfer the three circled values to the blocks marked Sa, Sb, and Sc in Worksheet 4.7.9.
- (3) The Mandatory Safety Requirement value for basements are based on the distance of the basement level from the closest level of discharge (See 4.6.1.2 and 4.6.1.3).

## WORKSHEET 4.7.8A - MANDATORY SAFETY REQUIREMENTS – NEW HOSPITALS, EXISTING HOSPITALS OR NEW NURSING HOMES

Zone Location		ainment (S <sub>a</sub> )		iishment S₀)	People Movement (Sc)		
	New	Existing	New	Existing	New	Existing	
1 <sup>st</sup> story	11	5	15(12)ª	4	8(5) <sup>a</sup>	1	
2 <sup>nd</sup> or 3 <sup>rd</sup> story <sup>b</sup>	15	9	17(14)ª	6	10(7)ª	3	
4 <sup>th</sup> story or higher, but not high rise	18	9	19(16)ª	6	11(8) <sup>a</sup>	3	
High rise	18	17	19(16)ª	16	11(8) <sup>a</sup>	7	

a. Use ( ) in zones that do not contain patient sleeping rooms.

b. For a 2<sup>nd</sup> story zone location in a sprinklered EXISTING hospital, as an alternative to the mandatory safety requirement values set specified in the table, the following mandatory values *set* shall be permitted to be used: Sa=7, Sb=10, and Sc=7

## WORKSHEET 4.7.8B - MANDATORY SAFETY REQUIREMENTS – EXISTING NURSING HOMES

Zone Location	Containment (Sa)	Extinguishment (Sb)	People Movement (Sc)		
1 <sup>st</sup> story	0	(10)	0		
2 <sup>nd</sup> story	2	10	2		
3 <sup>rd</sup> story	6	14	2		
4 <sup>th</sup> story or higher	8	16	2		

## WORKSHEET 4.7.8C - MANDATORY SAFETY REQUIREMENTS – MAJOR REHABILITATION IN NONSPRINKLERED EXISTING HOSPITALS

Zone Location	Containment (Sa)	Extinguishment (Sb)	People Movement (Sc)
1 <sup>st</sup> story	13	17(14)*	8(5)*
2 <sup>nd</sup> or 3 <sup>rd</sup> story	17	19(16)*	10(7)*
4 <sup>th</sup> story or higher	18	19(16)*	11(8)*

\*Use ( ) in zones that do not contain patient sleeping rooms.

Step 8 — Identify Zone Fire Safety Equivalency using Worksheet 4.7.9.

- (1) Transfer the three circled values from Worksheet 4.7.8A, 4.7.8B, or 4.7.8C to the blocks marked Sa, Sb, and Sc in Worksheet 4.7.9.
- (2) For each row check "Yes" if the value in the answer block is zero or greater. Check "No" if the value in the answer block is a negative number.

#### WORKSHET 4.7.9 - ZONE FIRE SAFETY EQUIVALENCY EVALUATION

						YES	NO
Containment Safety (S₁)	minus	Mandatory Containment (Sa)	≥ 0	S1 Sa 17 — O	с = 17	1	
Extinguishment Safety (S₂)	minus	Mandatory Extinguishment (Sb)	≥ 0	S₂ Sb 15 — 10	E E 5	Ţ	
People Movement Safety (S <sub>3</sub> )	minus	Mandatory People Movement (Sc)	≥0	S <sub>3</sub> S <sub>c</sub> <u>  </u> — O	Р = [1]	$\checkmark$	ii.
General Safety (S₄)	minus	Occupancy Risk (R)	≥ 0	S4 R 21 — 6	G = 15	$\checkmark$	

Step 9 — Evaluate other considerations not previously addressed using Worksheet 4.7.10.

Complete one copy of this separate worksheet for each facility.

For each consideration, select and mark the appropriate column.

#### WORKSHEET 4.7.10 FACILITY FIRE SAFETY REQUIREMENTS WORKSHEET

		Met	Not Met	Not Applic.
A.	Building utilities conform to the requirements of Section 9.1.	1		$\ge$
В.	In new facilities only, life-support systems, alarms, emergency communication systems, and illumination of generator set locations are powered as prescribed by 18.5.1.2 and 18.5.1.3.			1
C.	Heating and air conditioning systems conform with the air conditioning, heating, and ventilating systems requirements within Section 9.2, except for enclosure of vertical openings, which have been considered in Safety Parameter 7 of Worksheet 4.7.6.	1		$\left \right>$
D.	Fuel-burning space heaters and portable electrical space heaters are not used.	1		$\geq$
E.	There are no flue-fed incinerators.	$\checkmark$		
F.	An evacuation plan is provided and fire drills conducted in accordance with 18.7.1/18.7.2 and 19.7.1/19.7.2.	J		$\succ$
G.	Smoking regulations have been adopted and implemented in accordance with 18.7.4 and 19.7.4.	1		$\bowtie$
H.	Draperies, upholstered furniture, mattresses, furnishings, and decoration combustibility is limited in accordance with 18.7.5 and 19.7.5.	J		
l.	Fire extinguishers are provided in accordance with the requirements of 18.3.5.12 and 19.3.5.12.	J		$\geq$
J.	Exit signs are provided in accordance with the requirements of 18.2.10.1 and 19.2.10.	J		
K.	Emergency lighting is provided in accordance with 18.2.9.1 or 19.2.9.1.	$\checkmark$		
L.	Standpipes are provided in all new high rise buildings as required by 18.4.2.			$\checkmark$

Step 10 — Determine the equivalency Conclusion to determine if the level of life safety is at least equivalent to that prescribed by the Life Safety Code using Worksheet 4.7.11.

## WORKSHEET 4.7.11- CONCLUSIONS

1.	All of the checks in Worksheet 4.7.9 are in the "Yes" column and all applicable considerations in Worksheet 4.7.10 are marked as "Met". The level of safety is at least equivalent to that prescribed by NFPA 101, <i>Life Safety Code</i> , for health care occupancies.
2.	All of the checks in Worksheet 4.7.9 are in the "Yes" column and all considerations in Worksheet 4.7.10 marked as "Not Met" have been evaluated and mitigated to the satisfaction of the AHJ. The level of safety is at least equivalent to that prescribed by NFPA 101, <i>Life Safety Code</i> , for health care occupancies
3.	One or more of the checks on Worksheet 4.7.9 are in the "No" column or any considerations in Worksheet 4.7.10 marked as "Not Met" have NOT been evaluated and mitigated to the satisfaction of the AHJ. The level of safety is not shown by this system to be equivalent to that prescribed by NFPA 101, <i>Life Safety Code</i> , for health care occupancies.

#### FIRE SAFETY EVALUATION SYSTEM HEALTH CARE FACILITIES

(NFPA 101A, "Guide on Alternative Approaches to Life Safety" 2013 Edition)

Complete the following worksheets for each fire/smoke zone\*.

Where conditions are the same in several zones, one set of worksheets can be used for those zones.

\* Fire/smoke zone is a space separated from all other spaces by floors, horizontal exits, or smoke barriers

Step 1 — Complete Cover Sheet using Worksheet 4.7.1.

## WORKSHEET 4.7.1 - COVER SHEET

ZONE 4 OF 6 ZONES

NAME OF FACILITY	ADDRESS OF FACILITY		
ZUMBROTA CARE CENTER	433 MILL ST. ZUMBR	OTA MH 55992	
ZONE(S) EVALUATED	)	)	
MAIN LEVEL, WEST WING			
PROVIDER/VENDOR NO.	DATE OF SURVEY		
245376	09/13/2018		
SURVEYOR SIGNATURE	TITLE	OFFICE	DATE
SURVEYOR ID	PRESIDENT	FIRE SAFETY RESOURCES, LLC	09/17/2018
FIRE AUTHORITY SIGNATURE	TITLE	OFFICE	DATE
Thomas Linhoff 12424	Fire Safety Supervisor	MN State Fire Marshal	09-25-2018
W	an mite oo naar aan kendaalikiki bir daha kan		

ADDITIONAL COMMENTS:

CMS FORMS SHALL BE COMPLETED AND RETAINED AS PART OF THE SURVEY RECORD.

Step 2 — Determine Occupancy Risk Parameter Factors using Worksheet 4.7.2.

For each Risk Parameter in Worksheet 7.2, select and circle the appropriate risk factor value. Choose only one for each of the five Risk Parameters.

Ri	sk Parameters		Risk F	actor V	alues						
1.	Patient	Mobility Status	Mobile Limited Mobility				Not Mobile			Not Movable	
	Mobility (M)	Risk Factor	1.0		1.6		3.2		4.5		
2.	2. Patient	No. of Patients	1–5	1–5		10 11-		11–30		>30	
	Density (D)	Risk Factor	1.0		1.2		1.5		2.0		
3.	Zone	Floor	1 <sup>st</sup>	1 <sup>st</sup> 2 <sup>nd</sup> c		4 <sup>th</sup>	to 6 <sup>th</sup> 7 <sup>th</sup> ar Abov			Basements	
	Location (L)	Risk Factor	1.1		1.2		1.4	1.6		1.6	
4.	Ratio of Patients to	Patients Attendant	<u>1–2</u> 1	3	<u>3–5</u> 1	<u>6–10</u> 1		<u>&gt;10</u> 1	!	One or More None	
	Attendants (T)	Risk Factor	1.0		1.1		1.2)	1.5		4.0*	
5.	Patient Average	Age	Unde	er 65 Yea Ye	rs and Ove ar	er 1	65 Years and Over or 1 Year and Younger				
	Age (A)	Risk Factor		1.0				(1.2)			

#### WORKSHEET 4.7.2 – OCCUPANCY RISK PARAMETER FACTORS

\*A risk factor of 4.0 is charged to any zone that houses patients without any staff in immediate attendance.

#### Step 3 — Compute Occupancy Risk Factor (F) using Worksheet 4.7.3.

- (1) Transfer the circled risk factor values from Worksheet 4.7.2 to the corresponding blocks in Worksheet 4.7.3.
- (2) Compute F by multiplying the risk factor values as indicated in Worksheet 4.7.3.

## WORKSHEET 4.7.3 - OCCUPANCY RISK FACTOR CALCULATION

	M	D	L	Т	A	F	
OCCUPANCY RISK	3.2 X	1.5	<b>x</b> ].(	x 1.2	x 1.2	= 7.6	

- Step 4 Compute Adjusted Building Status (R) Use Worksheets 4.7.4 or 4.7.5.
  - (1) If building is classified as "NEW" use Worksheet 4.7.4. If building is classified as "Existing" use Worksheet 4.7.5.
  - (2) Transfer the value of F from Worksheet 4.7.3 to Worksheets 4.7.4 or 4.7.5, as appropriate. Calculate R.
  - (3) Transfer R to the block labeled R in Worksheet 4.7.9.
  - (4) In Worksheets 4.7.4 and 4.7.5, results are always rounded up (i.e., 3.2 is rounded to 4.0).

## WORKSHEET 4.7.4 ADJUSTED OCCUPANCY RISK FACTOR (NEW)



## WORKSHEET 4.7.5 ADJUSTED OCCUPANCY RISK FACTOR (EXISTING)

0.6 x  $\frac{F}{1.6} = \frac{R}{4.6} = 5$ 

#### Step 5 — Determine Safety Parameter Values using Worksheet 4.7.6.

- (1) Select and circle the safety value for each safety parameter that best describes the conditions in the zone.
- (2) Choose only one value for each of the 13 parameters.
- (3) If two or more appear to apply, choose the one with the lowest point value.

# WORKSHEET 4.7.6 - SAFETY PARAMETER VALUES

Safety Parameters				Param	eters Va	alues			
1. Construction	Combustible					Non-Combustible			
		Types II	II, IV, and V	Types I				es I and	
Floor or Zone	000 111		200	211, 21	нн	000	1	11	222, 322, 442
First	-2	0	-2	0		(0)	(0) 2		2
Second	-7	-2	-4	-2		-2		2	4
Third	-9	-7	-9	-7		-7		2	4
4th and Above	-13	-7	-13	-7		-9	_	-7	4
2. Interior Finish	Class C		Class B	Clas	s A				
(Corridors and Exits)	-5(0) <sup>f</sup>		0)3) <sup>f</sup>	3					
3. Interior Finish	Class C		Class B	Clas	s A				
(Rooms)	-3(1) <sup>f</sup>		1(3) <sup>f</sup>	(3	)	_			
4. Corridor	None or Incomple	е	<1/2 hour	>1/2 to <	1 hour		≥1 hour		
Partitions/Walls	-10(0) <sup>a</sup>	(	0)	1(0	) <sup>a</sup>		2(0) <sup>a</sup>		
5. Doors to Corridor	No Door	<20	min FPR	≥ 20 min FPR			≥ 20 min FPR and Auto Closure		
	-10		0	(1(0) <sup>d</sup>			2(0) <sup>d</sup>		
6. Zone Dimensions		Dead End	ł			No Dea	d Ends >30 ft	and Zo	ne Length Is
	>100 ft.	>50 ft. to	100 ft. 3	0 ft. to 50 ft.	>15	0 ft.	ft. 100 ft. to 150		<100 ft.
	-6(0) <sup>b</sup>	-4(0	) <sup>b</sup>	-2(0) <sup>b</sup>	-2(0)	<sup>c</sup> (0) <sup>h</sup>	(0(0) <sup>h</sup>		1
7. Vertical Openings	Open 4 or More	Oper	n 2 or 3		En	closed with	n Indicated Fi	re Resis	tance
	Floors	FI	oors	<1	hr.	≥1	≥1 hr. to <2 hr.		≥2 hr.
	-14		-10	0			2(0) <sup>e</sup>		3(0) <sup>e</sup>
8. Hazardous Areas	Doubl	e Deficienc	eficiency		Single	Deficiency	1	_	No Deficiencies
	In Zone	O	utside Zone	In Zone		In A	djacent Zone		
	-11		-5	-6		-2			$\bigcirc$
9. Smoke Control	No Control		e Barrier	Mechanically Assis					
	5(0) <sup>6</sup>	Serve	Serves Zone		by Zone				
	-5(0)°		$\bigcirc$	3					
10. Emergency	<2 Routes		<u> </u>	Multiple Routes					Direct Exit(s)
Movement Routes	-8	D	eficient	W/O Horizontal Exit(s)			Horizontal Exit(s)		
			(-2)		0		1		5
11. Manual Fire Alarm	No Manua	I Fire Alarr	m		Manua	al Fire Alar	m		
				W/O F.	D. Conn.	V	WF.D. Conn.		
		4		1			2		
12. Smoke Detection and Alarm	None	Corr	idor Only	Room	Rooms Only		rridor and bit. Spaces		Total Spaces in Zone
	0(3) <sup>g</sup> )	1	2(3) <sup>g</sup>	3(	3) <sup>g</sup>		4		5
13. Automatic Sprinklers	None		dor and . Space	Ei	ntire Iding				
	0		8	(10)					

<sup>a</sup> Use (0) where parameter 5 is -10.

<sup>b</sup> Use (0) where parameter 10 is -8.

<sup>c</sup> Use (0) on floor with fewer than 31

patients (existing buildings only).

<sup>d</sup> Use (0) where parameter 4 is -10.

<sup>f</sup> Use ( ) if the area of Class B or C interior finish in the corridor and exit or room is protected by automatic sprinklers and Parameter 13 is 0; use ( ) if the room with existing Class C interior finish is protected by automatic sprinklers, Parameter 4 is greater than or equal to 1, and Parameter 13 is 0. <sup>g</sup> Use this value in addition to Parameter 13 if the entire zone is protected with quick-

response automatic sprinklers. <sup>e</sup> Use (0) where Parameter 1 is based on first floor zone <sup>h</sup> Use (0) where zone area ≤ 22,500 ft.<sup>2</sup> and distance from any point to or on an unprotected type of construction (columns reach a door in smoke barrier is ≤ 200 ft. marked "000" or "200"). For SI Units: 1 ft.<sup>2</sup> = 0.3048 m<sup>2</sup>

#### Step 6 — Compute Individual Safety Evaluations using Worksheet 4.7.7.

- (1) Transfer each of the 13 circled Safety Parameter Values from Worksheet 4.7.6 to every unshaded block in the line with the corresponding Safety Parameter in Worksheet 4.7.7. For Safety Parameter 13 (Sprinklers) the value entered in the People Movement Safety column is recorded in Worksheet 4.7.7 as 1/2 the corresponding value circled in Worksheet 4.7.6.
- (2) Add the four columns, keeping in mind that any negative numbers deduct.
- (3) Transfer the resulting total values for S1, S2, S3, S4 to blocks labeled S1, S2, S3, S4 in Worksheet 4.7.9 on page 4 of this sheet.

## WORKSHEET 4.7.7 - INDIVIDUAL SAFETY EVALUATIONS

Safety Parameters	Containment Safety (S <sub>1</sub> )	Extinguishment Safety (S <sub>2</sub> )	People Movement Safety (S <sub>3</sub> )	General Safety (S₄)
1. Construction	0	0		0
2. Interior Finish (Corr. and Exit)	0		0	0
3. Interior Finish (Rooms)	3			3
4. Corridor Partitions and Walls	0			0
5. Doors to Corridor			]	
6. Zone Dimensions			0	0
7. Vertical Openings	0		0	0
8. Hazardous Areas	0	0		0
9. Smoke Control			0	0
10. Emergency Movement Routes			-2	-2
11. Manual Fire Alarm		2		2
12. Smoke Detection and Alarm		3	3	3
13. Automatic Sprinklers	16	ID	10 ÷2=5	10
Total Value	S1= 14	<b>S<sub>2</sub>=</b> 15	S3= 7	S4= 17

Step 7 — Determine Mandatory Safety Requirement values using Worksheet 4.7.8A, 4.7.8B, or 4.7.8C.

- (1) Using the facility type (i.e., Hospital or Nursing Home), classification (i.e., New, Existing or Rehabilitated) and the floor where the zone is located, circle the appropriate value in each of the three columns found in Worksheet 4.7.8A, 4.7.8B, or 4.7.8C.
- (2) Transfer the three circled values to the blocks marked Sa, Sb, and Sc in Worksheet 4.7.9.
- (3) The Mandatory Safety Requirement value for basements are based on the distance of the basement level from the closest level of discharge (See 4.6.1.2 and 4.6.1.3).

## WORKSHEET 4.7.8A - MANDATORY SAFETY REQUIREMENTS – NEW HOSPITALS, EXISTING HOSPITALS OR NEW NURSING HOMES

Zone Location	Containment (Sa)		Extinguishment (S <sub>b</sub> )		People Movement (Sc)	
	New	Existing	New	Existing	New	Existing
1 <sup>st</sup> story	11	5	15(12)ª	4	8(5) <sup>a</sup>	1
2 <sup>nd</sup> or 3 <sup>rd</sup> story <sup>b</sup>	15	9	17(14) <sup>a</sup>	6	10(7) <sup>a</sup>	3
4 <sup>th</sup> story or higher, but not high rise	18	9	19(16)ª	6	11(8)ª	3
High rise	18	17	19(16)ª	16	11(8)ª	7

a. Use () in zones that do not contain patient sleeping rooms.

b. For a 2<sup>nd</sup> story zone location in a sprinklered EXISTING hospital, as an alternative to the mandatory safety requirement values set specified in the table, the following mandatory values *set* shall be permitted to be used: Sa=7, Sb=10, and Sc=7

#### WORKSHEET 4.7.8B - MANDATORY SAFETY REQUIREMENTS – EXISTING NURSING HOMES

Zone Location	Containment (Sa)	Extinguishment (Sb)	People Movement (Sc)
1 <sup>st</sup> story	0	(10)	0
2 <sup>nd</sup> story	2	10	2
3 <sup>rd</sup> story	6	14	2
4 <sup>th</sup> story or higher	8	16	2

## WORKSHEET 4.7.8C - MANDATORY SAFETY REQUIREMENTS – MAJOR REHABILITATION IN NONSPRINKLERED EXISTING HOSPITALS

Zone Location	Containment (Sa)	Extinguishment (Sb)	People Movement (Sc)
1 <sup>st</sup> story	13	17(14)*	8(5)*
2 <sup>nd</sup> or 3 <sup>rd</sup> story	17	19(16)*	10(7)*
4 <sup>th</sup> story or higher	18	19(16)*	11(8)*

\*Use () in zones that do not contain patient sleeping rooms.

Step 8 — Identify Zone Fire Safety Equivalency using Worksheet 4.7.9.

- (1) Transfer the three circled values from Worksheet 4.7.8A, 4.7.8B, or 4.7.8C to the blocks marked Sa, Sb, and Sc in Worksheet 4.7.9.
- (2) For each row check "Yes" if the value in the answer block is zero or greater. Check "No" if the value in the answer block is a negative number.

#### WORKSHET 4.7.9 - ZONE FIRE SAFETY EQUIVALENCY EVALUATION

						YES	NO
Containment Safety (S <sub>1</sub> )	minus	Mandatory Containment (Sa)	≥ 0	S1 Sa 14 — O	с = Ц	1	
Extinguishment Safety (S <sub>2</sub> )	minus	Mandatory Extinguishment (Sb)	≥ 0	S <sub>2</sub> S <sub>b</sub> 15 — 10	Е <b>=</b> 5	1	
People Movement Safety (S <sub>3</sub> )	minus	Mandatory People Movement (Sc)	≥0	$\begin{bmatrix} S_3 & S_c \\ 7 & - \end{bmatrix} \bigcirc$	Р <b>—</b> 7	$\checkmark$	<i>.</i>
General Safety (S₄)	minus	Occupancy Risk (R)	≥ 0	S₄ R [1] — [5]	G 12	$\checkmark$	

Step 9 — Evaluate other considerations not previously addressed using Worksheet 4.7.10.

Complete one copy of this separate worksheet for each facility.

For each consideration, select and mark the appropriate column.

#### WORKSHEET 4.7.10 FACILITY FIRE SAFETY REQUIREMENTS WORKSHEET

	-	Met	Not Met	Not Applic.
A.	Building utilities conform to the requirements of Section 9.1.	1		$\ge$
В.	In new facilities only, life-support systems, alarms, emergency communication systems, and illumination of generator set locations are powered as prescribed by 18.5.1.2 and 18.5.1.3.			1
C.	Heating and air conditioning systems conform with the air conditioning, heating, and ventilating systems requirements within Section 9.2, except for enclosure of vertical openings, which have been considered in Safety Parameter 7 of Worksheet 4.7.6.	1		$\left \right>$
D.	Fuel-burning space heaters and portable electrical space heaters are not used.	1		$\geq$
E.	There are no flue-fed incinerators.	1		
F.	An evacuation plan is provided and fire drills conducted in accordance with 18.7.1/18.7.2 and 19.7.1/19.7.2.	1		$\succ$
G.	Smoking regulations have been adopted and implemented in accordance with 18.7.4 and 19.7.4.	7		$\geq$
Н.	Draperies, upholstered furniture, mattresses, furnishings, and decoration combustibility is limited in accordance with 18.7.5 and 19.7.5.	1		
I.	Fire extinguishers are provided in accordance with the requirements of 18.3.5.12 and 19.3.5.12.	$\checkmark$		$\ge$
J.	Exit signs are provided in accordance with the requirements of 18.2.10.1 and 19.2.10.	1		
K.	Emergency lighting is provided in accordance with 18.2.9.1 or 19.2.9.1.	$\checkmark$		
L.	Standpipes are provided in all new high rise buildings as required by 18.4.2.		-	$\checkmark$

Step 10 — Determine the equivalency Conclusion to determine if the level of life safety is at least equivalent to that prescribed by the Life Safety Code using Worksheet 4.7.11.

# WORKSHEET 4.7.11- CONCLUSIONS

1.	All of the checks in Worksheet 4.7.9 are in the "Yes" column and all applicable considerations in Worksheet 4.7.10 are marked as "Met". The level of safety is at least equivalent to that prescribed by NFPA 101, <i>Life Safety Code</i> , for health care occupancies.
2.	All of the checks in Worksheet 4.7.9 are in the "Yes" column and all considerations in Worksheet 4.7.10 marked as "Not Met" have been evaluated and mitigated to the satisfaction of the AHJ. The level of safety is at least equivalent to that prescribed by NFPA 101, <i>Life Safety Code</i> , for health care occupancies
3.	One or more of the checks on Worksheet 4.7.9 are in the "No" column or any considerations in Worksheet 4.7.10 marked as "Not Met" have NOT been evaluated and mitigated to the satisfaction of the AHJ. The level of safety is not shown by this system to be equivalent to that prescribed by NFPA 101, <i>Life Safety Code</i> , for health care occupancies.

#### FIRE SAFETY EVALUATION SYSTEM HEALTH CARE FACILITIES

(NFPA 101A, "Guide on Alternative Approaches to Life Safety" 2013 Edition)

Complete the following worksheets for each fire/smoke zone\*.

Where conditions are the same in several zones, one set of worksheets can be used for those zones.

\* Fire/smoke zone is a space separated from all other spaces by floors, horizontal exits, or smoke barriers

Step 1 — Complete Cover Sheet using Worksheet 4.7.1.

# WORKSHEET 4.7.1 - COVER SHEET

ZONE 5 OF 6 ZONES

			tore a descent of the Address of the				
NAME OF FACILITY	ADDRESS OF FACILITY						
ZUMBROTA CARE CENTER 433 MILL ST., ZUMBROTA, MN 55992							
ZONE(S) EVALUATED	)	1					
2014 ADDITION, LOWER LEVEL	-						
PROVIDER/VENDOR NO.	DATE OF SURVEY						
245376	09/13/2018						
SURVEYOR SIGNATURE	TITLE	OFFICE	DATE				
Robert S. Inhalte	Durantes	FIDE GALLEN					
SURVEYOR ID	PRESIDENT	FIRE SAFETY RESOURCES, LLC	09/17/2018				
		KESOURCES, LLC					
FIRE AUTHORITY SIGNATURE	TITLE	OFFICE	DATE				
Thomas Linhoff 12424	Fire Safety Supervisor	MN State Fire Marshal	09-25-2018				
$\mathcal{W}^{-}$							

ADDITIONAL COMMENTS:

CMS FORMS SHALL BE COMPLETED AND RETAINED AS PART OF THE SURVEY RECORD.

Step 2 — Determine Occupancy Risk Parameter Factors using Worksheet 4.7.2.

For each Risk Parameter in Worksheet 7.2, select and circle the appropriate risk factor value. Choose only one for each of the five Risk Parameters.

Ri	sk Parameters		Risk F	actor V	alues						
1.	Patient	Mobility Status	Mobile Limited Mo		Mobility	lobility Not Mobile		Not Movable			
	Mobility (M)	Risk Factor	1.0		1.6		(3.2)		4.5		
2.	Patient	No. of Patients	1–5	1–5 6–10		1–5 6–10 11–30		11–30		>30	
	Density (D)	Risk Factor	(1.0)		1.	1.2		1.5		2.0	
3.	Zone	Floor	1 <sup>st</sup>	2 <sup>nd</sup> or 3 <sup>rd</sup>		4	<sup>th</sup> to 6 <sup>th</sup> 7 <sup>th</sup> ar Abov			Basements	
	Location (L)	Risk Factor	1.1	1.2		1.4		1.6		1.6	
4.	Ratio of Patients to	<u>Patients</u> Attendant	<u>1–2</u> 1	3	<u>3–5</u> 1		<u>6–10</u> 1	<u>6–10</u> <u>&gt;10</u> 1 1		One or More None	
	Attendants (T)	Risk Factor	(1.0)	1.1		1.2		1.5		4.0*	
5.	Patient Average	Age	Unde	r 65 Yea Ye	rs and Ove ar	er 1	65 Ye		/er or nger	1 Year and	
	Age (A)	Risk Factor		1.0				(1.2)			

## WORKSHEET 4.7.2 – OCCUPANCY RISK PARAMETER FACTORS

\*A risk factor of 4.0 is charged to any zone that houses patients without any staff in immediate attendance.

#### Step 3 — Compute Occupancy Risk Factor (F) using Worksheet 4.7.3.

- (1) Transfer the circled risk factor values from Worksheet 4.7.2 to the corresponding blocks in Worksheet 4.7.3.
- (2) Compute F by multiplying the risk factor values as indicated in Worksheet 4.7.3.

#### WORKSHEET 4.7.3 - OCCUPANCY RISK FACTOR CALCULATION

	м	D	L	т	Α	F	
OCCUPANCY RISK	3.2 X	1.0	<b>X</b> ].1	<b>X</b> 1,0	x 1.2 :	4.2	

- Step 4 Compute Adjusted Building Status (R) Use Worksheets 4.7.4 or 4.7.5.
  - (1) If building is classified as "NEW" use Worksheet 4.7.4. If building is classified as "Existing" use Worksheet 4.7.5.
  - (2) Transfer the value of F from Worksheet 4.7.3 to Worksheets 4.7.4 or 4.7.5, as appropriate. Calculate R.
  - (3) Transfer R to the block labeled R in Worksheet 4.7.9.
  - (4) In Worksheets 4.7.4 and 4.7.5, results are always rounded up (i.e., 3.2 is rounded to 4.0).

#### WORKSHEET 4.7.4 ADJUSTED OCCUPANCY RISK FACTOR (NEW)



WORKSHEET 4.7.5 ADJUSTED OCCUPANCY RISK FACTOR (EXISTING)

F = R = 2.5 = 3

#### Step 5 — Determine Safety Parameter Values using Worksheet 4.7.6.

- (1) Select and circle the safety value for each safety parameter that best describes the conditions in the zone.
- (2) Choose only one value for each of the 13 parameters.
- (3) If two or more appear to apply, choose the one with the lowest point value.

#### **Safety Parameters Parameters Values** 1. Construction Non-Combustible Combustible Types III, IV, and V Types I and II 211, 2HH 000 222, 322, 442 Floor or Zone 000 111 200 111 First -2 0 -2 0 (0)2 2 -7 -2 -4 -2 -2 2 4 Second 2 4 -9 -7 -7 Third -9 -7 -9 -7 4 4th and Above -13 -7 -13 -7 2. Interior Finish Class C Class B Class A $0(3)^{f}$ (Corridors and Exits) $-5(0)^{f}$ (3)3. Interior Finish Class C Class B Class A (Rooms) $-3(1)^{i}$ $1(3)^{f}$ 3) None or Incomplete <1/2 hour >1/2 to <1 hour 4. Corridor ≥1 hour Partitions/Walls -10(0)<sup>a</sup> 0 1(0)<sup>a</sup> (2(0)<sup>a</sup> 5. Doors to Corridor ≥ 20 min FPR and No Door <20 min FPR ≥ 20 min FPR Auto Closure 1(0)<sup>d</sup> 2(0)<sup>d</sup> -10 0 No Dead Ends >30 ft. and Zone Length Is 6. Zone Dimensions Dead End >100 ft. >50 ft. to 100 ft. 30 ft. to 50 ft. >150 ft. 100 ft. to 150 ft. <100 ft. -6(0)<sup>b</sup> $-4(0)^{b}$ $-2(0)^{b}$ -2(0)9(0)h 0(0)<sup>h</sup> 1 7. Vertical Openings Open 4 or More Open 2 or 3 Enclosed with Indicated Fire Resistance ≥2 hr. Floors <1 hr. ≥1 hr. to <2 hr. Floors 3(0)<sup>e</sup> -14 -10 0 2(0)<sup>e</sup>) **Double Deficiency** 8. Hazardous Areas Single Deficiency No Deficiencies In Zone Outside Zone In Zone In Adjacent Zone 0) -11 -5 -6 -2 Mechanically Assisted Systems No Control Smoke Barrier 9. Smoke Control Serves Zone by Zone -5(0)° 0 3 Multiple Routes Direct Exit(s) 10. Emergency <2 Routes Movement W/O Horizontal Horizontal Deficient Routes Exit(s) Exit(s) -8 -2 5 0 1 11. Manual Fire Alarm No Manual Fire Alarm Manual Fire Alarm W/O F.D. Conn. W/F.D. Conn. (2)1 -4 Total Spaces Corridor and 12. Smoke Detection Corridor Only Rooms Only None and Alarm in Zone Habit. Spaces 0(3)<sup>g</sup> 2(3)g 3(3)<sup>g</sup> 4 5 Corridor and Entire 13. Automatic None Habit. Space Building Sprinklers 0 8 (10)

WORKSHEET 4.7.6 - SAFETY PARAMETER VALUES

<sup>a</sup> Use (0) where parameter 5 is -10.

<sup>b</sup> Use (0) where parameter 10 is -8.

<sup>c</sup> Use (0) on floor with fewer than 31

patients (existing buildings only).

<sup>d</sup> Use (0) where parameter 4 is -10.

<sup>f</sup> Use ( ) if the area of Class B or C interior finish in the corridor and exit or room is protected by automatic sprinklers and Parameter 13 is 0; use () if the room with existing Class C interior finish is protected by automatic sprinklers, Parameter 4 is greater than or equal to 1, and Parameter 13 is 0.

<sup>e</sup> Use (0) where Parameter 1 is based on first floor zone or on an unprotected type of construction (columns

marked "000" or "200"). For SI Units: 1 ft.2 = 0.3048 m2 <sup>g</sup> Use this value in addition to Parameter 13 if the entire zone is protected with quickresponse automatic sprinklers. <sup>h</sup> Use (0) where zone area ≤ 22,500 ft.<sup>2</sup> and distance from any point to

reach a door in smoke barrier is ≤ 200 ft.

#### Step 6 — Compute Individual Safety Evaluations using Worksheet 4.7.7.

- (1) Transfer each of the 13 circled Safety Parameter Values from Worksheet 4.7.6 to every unshaded block in the line with the corresponding Safety Parameter in Worksheet 4.7.7. For Safety Parameter 13 (Sprinklers) the value entered in the People Movement Safety column is recorded in Worksheet 4.7.7 as 1/2 the corresponding value circled in Worksheet 4.7.6.
- (2) Add the four columns, keeping in mind that any negative numbers deduct.
- (3) Transfer the resulting total values for S1, S2, S3, S4 to blocks labeled S1, S2, S3, S4 in Worksheet 4.7.9 on page 4 of this sheet.

## WORKSHEET 4.7.7 - INDIVIDUAL SAFETY EVALUATIONS

Safety Parameters	Containment Safety (S <sub>1</sub> )	Extinguishment Safety (S₂)	People Movement Safety (S <sub>3</sub> )	General Safety (S₄)
1. Construction	Ô	0		0
2. Interior Finish (Corr. and Exit)	3		3	3
3. Interior Finish (Rooms)	3			3
4. Corridor Partitions and Walls	2			2
5. Doors to Corridor		>	١	1
6. Zone Dimensions		>	0	. 0
7. Vertical Openings	0		0	0
8. Hazardous Areas	0	0	>	0
9. Smoke Control			0	0
10. Emergency Movement Routes			0	0
11. Manual Fire Alarm		2		2
12. Smoke Detection and Alarm		3	3	3
13. Automatic Sprinklers	10	10	10 ÷2=5	10
Total Value	<b>S</b> 1= 19	S2= 15	S3= 12	S4= 24

Step 7 — Determine Mandatory Safety Requirement values using Worksheet 4.7.8A, 4.7.8B, or 4.7.8C.

- (1) Using the facility type (i.e., Hospital or Nursing Home), classification (i.e., New, Existing or Rehabilitated) and the floor where the zone is located, circle the appropriate value in each of the three columns found in Worksheet 4.7.8A, 4.7.8B, or 4.7.8C.
- (2) Transfer the three circled values to the blocks marked Sa, Sb, and Sc in Worksheet 4.7.9.
- (3) The Mandatory Safety Requirement value for basements are based on the distance of the basement level from the closest level of discharge (See 4.6.1.2 and 4.6.1.3).

## WORKSHEET 4.7.8A - MANDATORY SAFETY REQUIREMENTS – NEW HOSPITALS, EXISTING HOSPITALS OR NEW NURSING HOMES

Zone Location	Containment (Sa)			ishment b <sub>b</sub> )	People Movement (Sc)	
	New	Existing	New	Existing	New	Existing
1 <sup>st</sup> story	11	5	15(12)ª	4	8(5) <sup>a</sup>	1
2 <sup>nd</sup> or 3 <sup>rd</sup> story <sup>b</sup>	15	9	17(14)ª	6	10(7) <sup>a</sup>	3
4 <sup>th</sup> story or higher, but not high rise	18	9	19(16)ª	6	11(8)ª	3
High rise	18	17	19(16)ª	16	11(8)ª	7

a. Use ( ) in zones that do not contain patient sleeping rooms.

b. For a 2<sup>nd</sup> story zone location in a sprinklered EXISTING hospital, as an alternative to the mandatory safety requirement values set specified in the table, the following mandatory values *set* shall be permitted to be used: Sa=7, Sb=10, and Sc=7

## WORKSHEET 4.7.8B - MANDATORY SAFETY REQUIREMENTS – EXISTING NURSING HOMES

Zone Location	Containment (Sa)	Extinguishment (Sb)	People Movement (Sc)	
1 <sup>st</sup> story	Ó	10	Ô	
2 <sup>nd</sup> story	2	10	2	
3 <sup>rd</sup> story	6	14	2	
4 <sup>th</sup> story or higher	8	16	2	

## WORKSHEET 4.7.8C - MANDATORY SAFETY REQUIREMENTS – MAJOR REHABILITATION IN NONSPRINKLERED EXISTING HOSPITALS

Zone Location	Containment (Sa)	Extinguishment (Sb)	People Movemen (Sc)	
1 <sup>st</sup> story	13	17(14)*	8(5)*	
2 <sup>nd</sup> or 3 <sup>rd</sup> story	17	19(16)*	10(7)*	
4 <sup>th</sup> story or higher	18	19(16)*	11(8)*	

\*Use ( ) in zones that do not contain patient sleeping rooms.

Step 8 — Identify Zone Fire Safety Equivalency using Worksheet 4.7.9.

- (1) Transfer the three circled values from Worksheet 4.7.8A, 4.7.8B, or 4.7.8C to the blocks marked Sa, Sb, and Sc in Worksheet 4.7.9.
- (2) For each row check "Yes" if the value in the answer block is zero or greater. Check "No" if the value in the answer block is a negative number.

## WORKSHET 4.7.9 - ZONE FIRE SAFETY EQUIVALENCY EVALUATION

						YES	NO
Containment Safety (S <sub>1</sub> )	minus	Mandatory Containment (Sa)	≥ 0	S <sub>1</sub> S <sub>a</sub> 19 — O	с = 19	1	
Extinguishment Safety (S₂)	minus	Mandatory Extinguishment (Sb)	≥ 0	S₂ Sb 15 — 10	E S	1	
People Movement Safety (S₃)	minus	Mandatory People Movement (Sc)	≥0	S <sub>3</sub> S <sub>c</sub> 12 — O	P 12	1	
General Safety (S₄)	minus	Occupancy Risk (R)	≥ 0	S4 R 24 — 3	G = 21	)	

Step 9 — Evaluate other considerations not previously addressed using Worksheet 4.7.10.

Complete one copy of this separate worksheet for each facility.

For each consideration, select and mark the appropriate column.

#### WORKSHEET 4.7.10 FACILITY FIRE SAFETY REQUIREMENTS WORKSHEET

	·•1	Met	Not Met	Not Applic.
A.	Building utilities conform to the requirements of Section 9.1.	1		$\mathbf{\mathbf{\times}}$
В.	In new facilities only, life-support systems, alarms, emergency communication systems, and illumination of generator set locations are powered as prescribed by 18.5.1.2 and 18.5.1.3.			J
C.	Heating and air conditioning systems conform with the air conditioning, heating, and ventilating systems requirements within Section 9.2, except for enclosure of vertical openings, which have been considered in Safety Parameter 7 of Worksheet 4.7.6.	1		$\left \right>$
D.	Fuel-burning space heaters and portable electrical space heaters are not used.	7		$\geq$
E.	There are no flue-fed incinerators.	J		
F.	An evacuation plan is provided and fire drills conducted in accordance with 18.7.1/18.7.2 and 19.7.1/19.7.2.	J		$\geq$
G.	Smoking regulations have been adopted and implemented in accordance with 18.7.4 and 19.7.4.	1		$\geq$
Н.	Draperies, upholstered furniture, mattresses, furnishings, and decoration combustibility is limited in accordance with 18.7.5 and 19.7.5.	1		1
١.	Fire extinguishers are provided in accordance with the requirements of 18.3.5.12 and 19.3.5.12.	$\checkmark$		$\geq$
J.	Exit signs are provided in accordance with the requirements of 18.2.10.1 and 19.2.10.	J		
K.	Emergency lighting is provided in accordance with 18.2.9.1 or 19.2.9.1.	J		
L.	Standpipes are provided in all new high rise buildings as required by 18.4.2.			$\checkmark$

Step 10 — Determine the equivalency Conclusion to determine if the level of life safety is at least equivalent to that prescribed by the Life Safety Code using Worksheet 4.7.11.

# WORKSHEET 4.7.11- CONCLUSIONS

1.	$\times$	All of the checks in Worksheet 4.7.9 are in the "Yes" column and all applicable considerations in Worksheet 4.7.10 are marked as "Met". The level of safety is at least equivalent to that prescribed by NFPA 101, <i>Life Safety Code</i> , for health care occupancies.
2.		All of the checks in Worksheet 4.7.9 are in the "Yes" column and all considerations in Worksheet 4.7.10 marked as "Not Met" have been evaluated and mitigated to the satisfaction of the AHJ. The level of safety is at least equivalent to that prescribed by NFPA 101, <i>Life Safety Code</i> , for health care occupancies
3.		One or more of the checks on Worksheet 4.7.9 are in the "No" column or any considerations in Worksheet 4.7.10 marked as "Not Met" have NOT been evaluated and mitigated to the satisfaction of the AHJ. The level of safety is not shown by this system to be equivalent to that prescribed by NFPA 101, <i>Life Safety Code</i> , for health care occupancies.

## FIRE SAFETY EVALUATION SYSTEM HEALTH CARE FACILITIES

(NFPA 101A, "Guide on Alternative Approaches to Life Safety" 2013 Edition)

Complete the following worksheets for each fire/smoke zone\*.

Where conditions are the same in several zones, one set of worksheets can be used for those zones.

\* Fire/smoke zone is a space separated from all other spaces by floors, horizontal exits, or smoke barriers

Step 1 — Complete Cover Sheet using Worksheet 4.7.1.

## WORKSHEET 4.7.1 - COVER SHEET

	12	ZONEOF	ZONES
NAME OF FACILITY	ADDRESS OF FACILITY		
ZUMBROTA CARE CENTER	433 MILL ST., ZUMB	ROTA MN 55992	
ZONE(S) EVALUATED	)	1	100 0000 (p. 1000 0000 0000 0000 0000
South WING \$ 2014 ADDH	TION, UPPER LEVEL		
PROVIDER/VENDOR NO.	DATE OF SURVEY		
245376	09/13/2018		
SURVEYOR SIGNATURE	TITLE	OFFICE	DATE
Rebert & Intalta	PRESIDENT	FIRE SAFER	
SURVEYORID	TRESTURN	FIRE SAFETY RESOURCES, LLC	09/17/2018
FIRE AUTHORITY SIGNATURE	TITLE	OFFICE	DATE
Thomas Linhoff 12424	Fire Safety Supervisor	MN State Fire Marshal	09-25-2018
(1)			

ADDITIONAL COMMENTS:

CMS FORMS SHALL BE COMPLETED AND RETAINED AS PART OF THE SURVEY RECORD.

Step 2 — Determine Occupancy Risk Parameter Factors using Worksheet 4.7.2.

For each Risk Parameter in Worksheet 7.2, select and circle the appropriate risk factor value. Choose only one for each of the five Risk Parameters.

Ri	isk Parameters		Risk F	Factor Val	lues							
1.	Patient	Mobility Status	Mobile Limited Mobility		Mobility	ty Not Mobile		Not Movable				
	Mobility (M)	Risk Factor	1.0		1.6		(3.2)		4.5			
2.	Patient	No. of Patients	1–5		6—	10	11–30		11–30 >3			
	Density (D)	Risk Factor	1.0		1.2		1.5			(2.0)		
3.	Zone	Floor	1 <sup>st</sup>	2 <sup>nd</sup> or	or 3 <sup>rd</sup> 4		or 3 <sup>rd</sup> 4 <sup>th</sup>		to 6 <sup>th</sup>	7 <sup>th</sup> and Above		Basements
	Location (L)	Risk Factor	(1.1)	1.2	2		1.4	1.6		1.6		
4.	Ratio of Patients to	<u>Patients</u> Attendant	<u>1-2</u> 1	<u>3-</u> (	<u>3–5</u> 1		<u>-10</u> 1	<u>&gt;10</u> 1		One or More None		
	Attendants ( <i>T</i> )	Attendants (7) Risk Factor 1.0		1.1	1.1		1.2	(1.5)	)	4.0*		
5.	Patient Average	Age	Unde	r 65 Years : Year		r 1	65 Ye	ears and Ov You		1 Year and		
	Age (A)	Risk Factor		1.0	4-7-1			(1.2)				

#### WORKSHEET 4.7.2 – OCCUPANCY RISK PARAMETER FACTORS

\*A risk factor of 4.0 is charged to any zone that houses patients without any staff in immediate attendance.

Step 3 — Compute Occupancy Risk Factor (F) using Worksheet 4.7.3.

- (1) Transfer the circled risk factor values from Worksheet 4.7.2 to the corresponding blocks in Worksheet 4.7.3.
- (2) Compute F by multiplying the risk factor values as indicated in Worksheet 4.7.3.

## WORKSHEET 4.7.3 - OCCUPANCY RISK FACTOR CALCULATION

	М	D	L	т	А	F
OCCUPANCY RISK	3.2 X	2.0	x 1.1	X 1.5	x 1.2	= 12.7

Step 4 — Compute Adjusted Building Status (R) - Use Worksheets 4.7.4 or 4.7.5.

- (1) If building is classified as "NEW" use Worksheet 4.7.4. If building is classified as "Existing" use Worksheet 4.7.5.
- (2) Transfer the value of F from Worksheet 4.7.3 to Worksheets 4.7.4 or 4.7.5, as appropriate. Calculate R.
- (3) Transfer R to the block labeled R in Worksheet 4.7.9.
- (4) In Worksheets 4.7.4 and 4.7.5, results are always rounded up (i.e., 3.2 is rounded to 4.0).





# WORKSHEET 4.7.5 ADJUSTED OCCUPANCY RISK FACTOR (EXISTING)



#### Step 5 — Determine Safety Parameter Values using Worksheet 4.7.6.

- (1) Select and circle the safety value for each safety parameter that best describes the conditions in the zone.
- (2) Choose only one value for each of the 13 parameters.
- (3) If two or more appear to apply, choose the one with the lowest point value.

## WORKSHEET 4.7.6 - SAFETY PARAMETER VALUES

Safety Parameters	Parameters Values							
1. Construction		Combustible Types III, IV, and V	,				ombusti	
Floor or Zone	000			000		s I and		
First	-2	111 20 0 -2			000	11		222, 322, 442
Second	-2	-2 -4		3		<u> </u>		2
Third	-7	-7 -9	and the second se	Manager and the second second	-2 -7		- management	4
4th and Above	-13	-7 -1		in the second second second	-7	-7		4
		-1 -1.		(	-9	-/		4
2. Interior Finish (Corridors and Exits)	Class C -5(0) <sup>f</sup>	Class B 0(3) <sup>f</sup>	Clas	ss A	_			
3. Interior Finish	Class C	Class B	Clas	ss A				HOM
(Rooms)	-3(1) <sup>f</sup>	1(3) <sup>f</sup>		3)				
4. Corridor	None or Incomplete	<ul> <li>&lt;1/2 hour</li> </ul>	>1/2 to <	1 hour		≥1 hour		
Partitions/Walls	-10(0) <sup>a</sup>	(0)	1(0			2(0) <sup>a</sup>	1	
5. Doors to Corridor	No Door	<20 min FPR	≥ 20 m	in FPR		n FPR and Closure		
	-10	0	(1)0) <sup>d</sup>			2(0) <sup>d</sup>		
6. Zone Dimensions		Dead End				No Dead Ends >30 ft. and		e Length Is
	>100 ft.	>100 ft. >50 ft. to 100 ft.		>15	50 ft.	100 ft. to 150		
	-6(0) <sup>b</sup>	-4(0) <sup>b</sup>	-2(0) <sup>b</sup>	-2(0)	(0) <sup>h</sup>	0(0) <sup>h</sup>		1
7. Vertical Openings	Open 4 or More	Open 2 or 3				Indicated Fire	Resista	ance
	Floors	Floors	<1 hr.			≥1 hr. to <2 hr.		≥2 hr.
-	-14	-10	C	)		2(0) <sup>e</sup>		3(0) <sup>e</sup>
8. Hazardous Areas	Double	Deficiency	Single Defi		Deficiency	eficiency		lo Deficiencies
	In Zone	Outside Zone				djacent Zone	1	
	-11	-5	-6			-2		( <b>0</b> )
9. Smoke Control	No Control	Smoke Barrier	Mechanically Assisted Systems		ms			
	- (-) 0	Serves Zone			Zone			
	-5(0) <sup>c</sup>	()	0		3		1	
10. Emergency	<2 Routes		Multip	ole Routes	;			Direct Exit(s)
Movement Routes	-8	Deficient	independent of the	W/O Horizontal Exit(s)		Horizontal Exit(s)		
		(-2)	-	0	-	1		5
11. Manual Fire Alarm	No Manual I			Manual Fire Alarm				
			W/O F.I	D. Conn.	W	F.D. Conn.	1	
	-4			1		(2)		
12. Smoke Detection and Alarm	None	Corridor Only	Rooms	s Only	and the second se	idor and Spaces	-	Total Spaces in Zone
	0(3) <sup>g</sup>	2(3) <sup>g</sup> )		3) <sup>g</sup>		4		5
l3. Automatic Sprinklers	None	Corridor and Habit. Space	Er	ntire ding				
	0	8	(1	0)				

<sup>a</sup> Use (0) where parameter 5 is -10.

<sup>b</sup> Use (0) where parameter 10 is -8.

<sup>c</sup> Use (0) on floor with fewer than 31 patients (existing buildings only).

<sup>d</sup> Use (0) where parameter 4 is -10.

 <sup>e</sup> Use (0) where Parameter 1 is based on first floor zone or on an unprotected type of construction (columns marked "000" or "200").
 For SI Units: 1 ft.<sup>2</sup> = 0.3048 m<sup>2</sup> <sup>f</sup> Use () if the area of Class B or C interior finish in the corridor and exit or room is protected by automatic sprinklers and Parameter 13 is 0; use () if the room with existing Class C interior finish is protected by automatic sprinklers, Parameter 4 is greater than or equal to 1, and Parameter 13 is 0.

<sup>g</sup> Use this value in addition to Parameter 13 if the entire zone is protected with quick-response automatic sprinklers.

<sup>h</sup> Use (0) where zone area ≤ 22,500 ft.<sup>2</sup> and distance from any point to reach a door in smoke barrier is ≤ 200 ft. Step 6 — Compute Individual Safety Evaluations using Worksheet 4.7.7.

- (1) Transfer each of the 13 circled Safety Parameter Values from Worksheet 4.7.6 to every unshaded block in the line with the corresponding Safety Parameter in Worksheet 4.7.7. For Safety Parameter 13 (Sprinklers) the value entered in the People Movement Safety column is recorded in Worksheet 4.7.7 as 1/2 the corresponding value circled in Worksheet 4.7.6.
- (2) Add the four columns, keeping in mind that any negative numbers deduct.
- (3) Transfer the resulting total values for S1, S2, S3, S4 to blocks labeled S1, S2, S3, S4 in Worksheet 4.7.9 on page 4 of this sheet.

Safety Parameters	Containment Safety (S <sub>1</sub> )	Extinguishment Safety (S <sub>2</sub> )	People Movement Safety (S <sub>3</sub> )	General Safety (S₄)
1. Construction	0	0		0
2. Interior Finish (Corr. and Exit)	3		3	3
3. Interior Finish (Rooms)	3			3
4. Corridor Partitions and Walls	0			0
5. Doors to Corridor	19 Marca			1
6. Zone Dimensions			0	0
7. Vertical Openings	0		0	0
8. Hazardous Areas	0	0		0
9. Smoke Control			0	0
10. Emergency Movement Routes			-2	-2
11. Manual Fire Alarm		2		2
12. Smoke Detection and Alarm		3	3	3
13. Automatic Sprinklers	10	10	10 ÷2=5	10
Total Value	S1= )7	S <sub>2</sub> = 15	S3= 10	S4= 20

#### WORKSHEET 4.7.7 - INDIVIDUAL SAFETY EVALUATIONS

Step 7 — Determine Mandatory Safety Requirement values using Worksheet 4.7.8A, 4.7.8B, or 4.7.8C.

- (1) Using the facility type (i.e., Hospital or Nursing Home), classification (i.e., New, Existing or Rehabilitated) and the floor where the zone is located, circle the appropriate value in each of the three columns found in Worksheet 4.7.8A, 4.7.8B, or 4.7.8C.
- (2) Transfer the three circled values to the blocks marked Sa, Sb, and Sc in Worksheet 4.7.9.
- (3) The Mandatory Safety Requirement value for basements are based on the distance of the basement level from the closest level of discharge (See 4.6.1.2 and 4.6.1.3).

## WORKSHEET 4.7.8A - MANDATORY SAFETY REQUIREMENTS – NEW HOSPITALS, EXISTING HOSPITALS OR NEW NURSING HOMES

Zone Location	Containment (S <sub>a</sub> )			iishment S₀)	People Movement (S <sub>c</sub> )	
	New	Existing	New	Existing	New	Existing
1 <sup>st</sup> story	11	5	15(12) <sup>a</sup>	4	8(5) <sup>a</sup>	1
2 <sup>nd</sup> or 3 <sup>rd</sup> story <sup>b</sup>	15	9	17(14) <sup>a</sup>	6	10(7) <sup>a</sup>	3
4 <sup>th</sup> story or higher, but not high rise	18	9	19(16)ª	6	11(8)ª	3
High rise	18	17	19(16) <sup>a</sup>	16	11(8)ª	7

a. Use () in zones that do not contain patient sleeping rooms.

b. For a 2<sup>nd</sup> story zone location in a sprinklered EXISTING hospital, as an alternative to the mandatory safety requirement values set specified in the table, the following mandatory values set shall be permitted to be used: Sa=7, Sb=10, and Sc=7

## WORKSHEET 4.7.8B - MANDATORY SAFETY REQUIREMENTS – EXISTING NURSING HOMES

Zone Location	Containment (Sa)	Extinguishment (Sb)	People Movement (Sc)	
1 <sup>st</sup> story	$\bigcirc$	10	0	
2 <sup>nd</sup> story	2	10	2	
3 <sup>rd</sup> story	6	14		
4 <sup>th</sup> story or higher	8	16	2	

# WORKSHEET 4.7.8C - MANDATORY SAFETY REQUIREMENTS – MAJOR REHABILITATION IN NONSPRINKLERED EXISTING HOSPITALS

Zone Location	Containment Extinguishment (Sa) (Sb)		People Movement (Sc)		
1 <sup>st</sup> story	13	17(14)*	8(5)*		
2 <sup>nd</sup> or 3 <sup>rd</sup> story	17	19(16)*	10(7)*		
4 <sup>th</sup> story or higher	18	19(16)*	11(8)*		

\*Use ( ) in zones that do not contain patient sleeping rooms.

Step 8 — Identify Zone Fire Safety Equivalency using Worksheet 4.7.9.

- (1) Transfer the three circled values from Worksheet 4.7.8A, 4.7.8B, or 4.7.8C to the blocks marked Sa, Sb, and Sc in Worksheet 4.7.9.
- (2) For each row check "Yes" if the value in the answer block is zero or greater. Check "No" if the value in the answer block is a negative number.

# WORKSHET 4.7.9 - ZONE FIRE SAFETY EQUIVALENCY EVALUATION

						YES	NO
Containment Safety (S <sub>1</sub> )	minus	Mandatory Containment (Sa)	≥ 0	S1 S1	$S_a$ C O = 17	1	
Extinguishment Safety (S₂)	minus	Mandatory Extinguishment (Sb)	≥ 0	Г	Sb E 10 = 5	1	
People Movement Safety (S₃)	minus	Mandatory People Movement (Sc)	≥0	S <sub>3</sub> S	ο <b>Ρ</b>	1	
General Safety (S₄)	minus	Occupancy Risk (R)	≥ 0	S4 F	G = 12	1	

Step 9 — Evaluate other considerations not previously addressed using Worksheet 4.7.10.

Complete one copy of this separate worksheet for each facility.

For each consideration, select and mark the appropriate column.

# WORKSHEET 4.7.10 FACILITY FIRE SAFETY REQUIREMENTS WORKSHEET

	~	Met	Not Met	Not Applic.
Α.	Building utilities conform to the requirements of Section 9.1.	1		$\searrow$
В.	In new facilities only, life-support systems, alarms, emergency communication systems, and illumination of generator set locations are powered as prescribed by 18.5.1.2 and 18.5.1.3.			1
C.	Heating and air conditioning systems conform with the air conditioning, heating, and ventilating systems requirements within Section 9.2, except for enclosure of vertical openings, which have been considered in Safety Parameter 7 of Worksheet 4.7.6.	1		$\times$
D.	Fuel-burning space heaters and portable electrical space heaters are not used.	1		$\mathbf{\mathbf{x}}$
E.	There are no flue-fed incinerators.	1		
F.	An evacuation plan is provided and fire drills conducted in accordance with 18.7.1/18.7.2 and 19.7.1/19.7.2.	1		$\searrow$
G.	Smoking regulations have been adopted and implemented in accordance with 18.7.4 and 19.7.4.	J		$\bigtriangledown$
H.	Draperies, upholstered furniture, mattresses, furnishings, and decoration combustibility is limited in accordance with 18.7.5 and 19.7.5.	1		
I.	Fire extinguishers are provided in accordance with the requirements of 18.3.5.12 and 19.3.5.12.	J		$\geq$
J.	Exit signs are provided in accordance with the requirements of 18.2.10.1 and 19.2.10.	J	-inic-	
K.	Emergency lighting is provided in accordance with 18.2.9.1 or 19.2.9.1.	$\checkmark$		
L.	Standpipes are provided in all new high rise buildings as required by 18.4.2.			$\checkmark$

Step 10 — Determine the equivalency Conclusion to determine if the level of life safety is at least equivalent to that prescribed by the Life Safety Code using Worksheet 4.7.11.

# WORKSHEET 4.7.11- CONCLUSIONS

1		
1.	X	All of the checks in Worksheet 4.7.9 are in the "Yes" column and all applicable considerations in Worksheet 4.7.10 are marked as "Met". The level of safety is at least equivalent to that prescribed by NFPA 101, <i>Life Safety Code</i> , for health care occupancies.
2.		All of the checks in Worksheet 4.7.9 are in the "Yes" column and all considerations in Worksheet 4.7.10 marked as "Not Met" have been evaluated and mitigated to the satisfaction of the AHJ. The level of safety is at least equivalent to that prescribed by NFPA 101, <i>Life Safety Code</i> , for health care occupancies
3.		One or more of the checks on Worksheet 4.7.9 are in the "No" column or any considerations in Worksheet 4.7.10 marked as "Not Met" have NOT been evaluated and mitigated to the satisfaction of the AHJ. The level of safety is not shown by this system to be equivalent to that prescribed by NFPA 101, <i>Life Safety Code</i> , for health care occupancies.



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered August 20, 2018

Ms. Krista Siddiqui, Administrator Zumbrota Care Center 433 Mill Street Zumbrota, MN 55992

Re: State Nursing Home Licensing Orders - Project Number S5376028

Dear Ms. Siddiqui:

The above facility was surveyed on July 30, 2018 through August 2, 2018 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 <u>only a suggestion</u> 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 <u>http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm</u>. 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
Zumbrota Care Center August 20, 2018 Page 2

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 you should contact Gary Nederhoff, Unit Supervisor at (507) 206-2731 or at gary.nederhoff@state.mn.us.

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,

Kumala Fiske Downing

Kamala Fiske-Downing Licensing and Certification Program Minnesota Department of Health P.O. Box 64900 St. Paul, MN 55164-0900 Telephone: (651) 201-4112 Fax: (651) 215-9697 Email: <u>Kamala.Fiske-Downing@state.mn.us</u>

cc: Licensing and Certification File

Minnesc	ta Department of He	alth				
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00917	B. WING		08/0	2/2018
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
ZUMBRO	DTA CARE CENTER	433 MILL ZUMBRO	STREET FA, MN 5599	92		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 000	Initial Comments		2 000			
	*****ATTEI	NTION*****				
	NH LICENSING	CORRECTION ORDER				
	144A.10, this correct pursuant to a surver found that the defict herein are not corrected shall with a schedule of f the Minnesota Depa Determination of wh corrected requires of requirements of the number and MN Ru When a rule contain comply with any of lack of compliance. re-inspection with a result in the assess	hether a violation has been				
	You may request a that may result fron orders provided tha the Department wit	hearing on any assessments n non-compliance with these t a written request is made to hin 15 days of receipt of a ent for non-compliance.				
	receipt of State lice the Minnesota Depa Informational Bullet http://www.health.si	participate in the electronic nsure orders consistent with artment of Health in 14-01, available at tate.mn.us/divs/fpc/profinfo/inf clicensing orders are				
Minnesota D	epartment of Health Y DIRECTOR'S OR PROVID	DER/SUPPLIER REPRESENTATIVE'S SIGN	NATURE	TITLE		(X6) DATE
	ically Signed					08/29/18

STATE FORM

If continuation sheet 1 of 39

STATEMEN	ta Department of He	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00917	B. WING		08/02/2018	
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	ATE, ZIP CODE		
ZUMBRO	DTA CARE CENTER		_ STREET DTA, MN 55992	2		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE	(X5) COMPLETE DATE
2 000	Department of Hea you electronically. is necessary for Sta enter the word "corr text. You must then State licensure proc completion date, the corrected prior to el Minnesota Departm On July 30, 31, 201 surveyors of this De above provider and orders are issued. electronic plan of cor reviewed these ordet they will be complet Minnesota Departm the State Licensing federal software. Ta assigned to Minness Nursing Homes. The assigned tag n column entitled " II	Ith orders being submitted to Although no plan of correction ate Statutes/Rules, please rected" in the box available for indicate in the electronic cess, under the heading e date your orders will be ectronically submitting to the nent of Health. 8 and August 1 and 2, 2018, epartment's staff visited the the following correction Please indicate in your prrection that you have ers, and identify the date wher				
	"Summary Stateme and replaces the "T correction order. Th findings which are i after the statement, evidence by." Follow	ent of Deficiencies" column to Comply" portion of the his column also includes the n violation of the state statute "This Rule is not met as wing the surveyors findings Method of Correction and				
	FOURTH COLUMN "PROVIDER'S PLA	RD THE HEADING OF THE WHICH STATES, N OF CORRECTION." THIS RAL DEFICIENCIES ONLY.				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION (X3) DATE COMP	SURVEY PLETED	
		00917	B. WING	08/0	08/02/2018	
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
ZUMBRO	TA CARE CENTER	433 MILL ZUMBRO	STREET TA, MN 559	92		
(X4) ID			ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX TAG		/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	COMPLET DATE	
2 000	Continued From pa	ge 2	2 000			
	THIS WILL APPEA	R ON EACH PAGE.				
	PLAN OF CORREC	QUIREMENT TO SUBMIT A CTION FOR VIOLATIONS OF E STATUTES/RULES.				
2 255	MN Rule 4658.007 Assurance Commit	0 Quality Assessment and tee	2 255		9/10/18	
	assessment and as of the administrator services, the medic designated by the r three other member representing discip resident care. The assurance committ respect to which quinecessary and dev appropriate plans of quality deficiencies address, at a minin reporting, infection pharmacy services					
	by: Based on interview failed to develop ar Assurance and Per (QAPI) plan to corr deficiencies with id physician review of	ent is not met as evidenced and record review, the facility d implement a Quality formance Improvement ect and identify quality entified areas for lack of treatment and auxiliary orders had the potential to affect 44 of ng in the facility.		The Administrator has communicated with the Medical Team as well as facility staff and reeducated on the necessity of bringing any system change to the QAPI committee for review and approval. This deficiency had the potential to affect 44 of 45 residents. To more completely address this deficient practice, a subject line will be added to the QAPI minutes to include proposed or suggested system changes by medical		

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	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,			SURVEY
		00917	B. WING		08/0	2/2018
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
UMBRC	TA CARE CENTER	433 MILL ZUMBRO	STREET TA, MN 559	92		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 255	During interview on interim director of n Physician Order Sh the orders included care plan, and lack The IDON stated I w orders are being sig addition, the orders orders. During interview on IDON stated Physic print out the medica he wanted to addre narrative notes. Ho related to the visits, treatment and auxil she would guess al and P-F was physic one resident. During interview on administrator stated physician was not re the time of the inter stated I was aware. medical director) in treatment and medi asked why he need admission. The ac been signing for all residents up until M she would have exp communicated to h	ge 3 7/30/18, at 5:56 p.m., the bursing (IDON) reviewed R22's beet, dated 7/9/18, and verified review of medications and ed review of treatment orders. will find out if the treatment gned every 60 days. In clacked to include auxiliary 7/31/18, at 12:09 p.m., the cian (P)-F preference was to ations for residents only and ass the treatments in his wever, the progress notes lacked to include a review of iary orders. The IDON stated I residents included the same cian for every resident except 8/2/18, at 3:09 p.m., the d she was not aware the eviewing treatment orders. At view registered nurse (RN)-C . Physician (P)-F (facility formed he wanted to sign all ication orders on admit and led to see these after general dministrator stated P-F had treatments orders on larch. The administrator stated bected the request of P-F to be erself, the assistant director of erim director of nursing, so a		team or ZHS staff to be d conclusion of each quarte meeting to address any ir changes in processes to changes are made withou involvement of the medic facility leadership.	liscussed at the erly QAPI mprovements or ensure that no ut the express	
	accommodate P-F's	8/2/18, at 3:44 p.m., the				

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
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NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
ZUMBRO	DTA CARE CENTER		L STREET DTA, MN 55992	2		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETI DATE
2 255	Continued From pa	ge 4	2 255			
	aware of P-F's requorders.	lest regarding the treatment				
	indicated Our QAPI systems that affect satisfaction, quality	I) Plan, reviewed 10/23/17, plan focus areas includes all				
	The quality assurant the quality assurant procedures. The quic could appoint staff to performance audits enhanced or improvision then audit the system	HOD OF CORRECTION: ace committee could review ce program, policies and ality assurance committee to perform routine system(s) to identify areas that could be ved on. The committee could oms in place and the e ongoing compliance.				
	TIME PERIOD FOF (21) days.	R CORRECTION: Twenty-one				
2 830	MN Rule 4658.0520 Proper Nursing Car	) Subp. 1 Adequate and re; General	2 830			9/10/18
	receive nursing car custodial care, and individual needs an the comprehensive plan of care as des 4658.0405. A nursi of bed as much as written order from t	general. A resident must e and treatment, personal and supervision based on d preferences as identified in resident assessment and scribed in parts 4658.0400 and ng home resident must be out possible unless there is a he attending physician that the in in bed or the resident bed.	1			

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STATEME	ota Department of He NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	LE CONSTRUCTION (X3	) DATE SURVEY COMPLETED	
		00917	B. WING		08/02/2018	
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
ZUMBRO	OTA CARE CENTER	433 MILL				
			TA, MN 559	PROVIDER'S PLAN OF CORRECTION	()(5)	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		
2 830	Continued From pa	ge 5	2 830			
	by: Based on observati review, the facility fa efficacy of intervent integrity and healing on the left foot for 1 to provide treatmen for 1 of 1 resident (I Findings include: R14's quarterly Min assessment dated 9 admission date of 2 was dependent on 9 (ADLs). The MDS id diagnoses which ind (condition with eleva neuropathy (damag feet), and periphera problem in which na flow to your limbs). R14's progress note arterial ulcer to the measurement of 1.2 Upon review of upc was not measured a measurement of 0.1 R14's progress note arterial ulcer to the "punched out" appe 2/10/18, a partial th	imum Data Set (MDS) an 5/18/18, identified R14 with an 2/22/16, had intact cognition, staff for activities of daily living dentified R14 had medical cluded diabetes mellitus ated blood sugars), diabetic res nerves in your legs and al vascular disease (circulatory arrowed arteries reduce blood e dated, 2/24/18, revealed an left top 4th toe with a 2 centimeters (cm) x 1.2 cm. oming progress notes, wound again until 7/31/18, revealing a		R#14 arterial ulcer to top of 4th digit L foot and arterial ulcer to Left great toe were measured. R#43's care plan was updated to inclu- interventions for head/neck positionin request for OT to screen for wheelcha positioning was submitted 8-17-18 All residents with skin ulcers will have wounds measured and documented of weekly. All residents with positioning needs of the head/neck will be review ensure interventions were developed address positioning needs. All licensed nurses were re-educated the Skin Ulcer protocol as it relates to monitoring and measuring wounds an the need to implement written therapy recommendations. Random chart audits will be complete the DON/designee 3x's/week for 4 we and then 2 audits monthly thereafter t ensure wounds are measured weekly Random chart audits will be complete the DON/designee 3x's/week for 4 we and then 2 audits monthly thereafter t ensure therapy recommendations are implemented for wheelchair positionir Audit results will be brought to the QA committee for review and further recommendations.	ude g. A air their on ed to to on d on d on y eeks o by eeks o	

STATEMEN	ta Department of He T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
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NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	ATE, ZIP CODE		
ZUMBRO	DTA CARE CENTER	433 MILL ZUMBRO	STREET TA, MN 55992	2		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETI DATE
2 830	Continued From pa	ige 6	2 830			
		e dated 2/17/18, left great toe ent was 2 cm x 3.5 cm x 0.1 cm				
	R14's progress note dated 2/24/18, left great toe wound measurement was 2 cm x 3.5 cm. 100 % eschar tissue type. Upon review of further progress notes, wound was not measured again until 7/31/18, after surveyor asking for the measurement 2.0 x 3.5 cm.					
	revealed R14 was on 2/1/18, and was management. Reve continue the use of iodosorb/solosite to	physician visit dated 3/9/18, evaluated by vascular surgery to continue with conservative ealed a recommendation to equal mixture of all areas of ulceration. gel wound dressing with				
	revealed left lateral with normal saline, mixture to ulcer bas	cian order dated 4/19/18, 1st toe cleanse ulcer base apply iodosorb/hydrogel 50:50 se with a cotton swab, cover and secure with roll gauze.				
		cian order dated 7/10/18 does sing change orders.				
	identified to continu dressings to left toe eschar and reduce worsen, again reco	try note dated 4/26/18, le betadine and gauze es 1 and 4 to maintain dry risk of infection. If things mmend vascular specialist vasive testing of lower				
magasta D	revealed an exam of	tor visit note dated 7/10/18, of lower extremities, with a act to left foot great toe and				

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED		
		00917	B. WING		08/	02/2018		
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE				
ZUMBROTA CARE CENTER 433 MILL STREET ZUMBROTA, MN 55992								
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE		
2 830	4th digit at this time practitioner, recomm lower extremities, a given to resident. R14's physician pro- revealed, "We will of consult with vascula R14's care plan init be at risk for impair by history of diabeti goal was identified symptoms of infect inspect skin weekly monitor effectivene the doctor. During interview on stated, "I have som foot and they are no has been 6 months	age 7 e, managed by facility nurse mend heel cushions to both and diabetic foot education ogress notes dated 7/23/18, continue with wound care and ar surgery as needed." iated 9/8/17, identified R14 to red skin integrity as evidenced ic neuropathic foot ulcers. A for ulcers to heal without ion. Interventions to include; r, observe skin daily and ss of treatment and report to 7/30/18, at 12:59 p.m. R14 e sores on my toes on my left of getting any better, I bet it ." They are putting some kind ad they change the dressing						
	sitting up in her who dressed, wearing w (shoes that reduce the forefoot, which	on 7/31/18, at 12:43 p.m. eelchair in her room, well hite socks and Darco shoes, weight-bearing pressure on promotes faster healing when ulcerations are present).						
	(LPN)-A stated she dressing change to that R14's wounds measured since the February 2018. Wh a wound was gettin	a.m. licensed practical nurse had already did R14's her left foot. LPN-A verified on her left foot had not ey were identified back in hen asked how they monitor if g better LPN-A stated, "I red it weekly we would have a						

	D PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING:			E SURVEY PLETED
		00917	B. WING		08/	02/2018
AME OF PF	ROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, S	TATE, ZIP CODE		
UMBROT	TA CARE CENTER		. STREET DTA, MN 55992	2		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 830	Continued From pa	ge 8	2 830			
!	better idea if they a	re getting better or not."				
	verified R14's woun being measured on guess if we measur	o.m. registered nurse (RN)-B, nds on her left foot were not a regular basis, and stated, I red the wounds on a regular asier for us to tell if the wound				
1 1 1	8:36 a.m. registered to do wound care o toe. RN-C measure measurements; Lef	ion and interview on 8/2/18, at d nurse (RN)-C was observed n left great toe and left fourth d both toes with the following ft great toe measurement: 2.6 ft 4th toe measurement was				
	verified the length c declined by 0.6 cm, have not been mon 2018. RN-C stated be measured once progression of the v	a.m. registered nurse (RN)-C of the wound on the great toe and that wounds for R14 itored weekly since February , I think these wounds should a week so we can see the wound, in fact I just put that y, we should be measuring all e a week.				
     	nursing (IDON), ver increase in R14's le stated, "All wounds	a.m. the interim director of rified there was a 0.6 cm off great toe wound. The IDON should be getting a weekly e are able to monitor the y."				
I	not find any docum wounds on R14's le	a.m. IDON stated she could entation saying the two off foot were unavoidable, peripheral vascular disease.				
	Facility document, S	Skin Ulcer Protocol, updated				

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NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
ZUMBR	OTA CARE CENTER		. STREET DTA, MN 55992	2		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACT) CROSS-REFERENCED TO T DEFICIENC'	ION SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
2 830	11/1/15, identified repressure ulcers or of clinically unavoidab services will be provimonitor progress of revealed, assessme concerns, and wour weekly at a minimu measurements in codepth, and the pressitunneling. If not showeeks, medical door new treatment order POSITIONING: R43's quarterly Min assessment, dated one assist with bed transfers, had diagr cognitive impairmer R43's current care prelated to diagnosis process and kyphos of the upper (thorace hunchback appearato independently an encourage to get ou monitor for changes motion (PROM) to I splint/brace to lowe Decline in range of contractures related to diagnosis bilateral AFO's (ank extremities twice data are to a contractive to the contractive of the contractive to the contractures related to a contractures related to a contractures related to a contracture to contracture to a contrac	esidents will not develop other skin ulcers unless le. And appropriate care and vided to prevent, treat and f all healing ulcers. Page 6, ent and monitoring of skin nd round documentation m the size of the wound, entimeters in length, width and ence of any undermining or owing improvement in last 2-4 ctor should be contacted for rs. imum Data Set (MDS) an 7/6/18, identified R43 required mobility, total assist for noses of dementia and severe		DEFICIENC	Υ)	

STATEMEN	ota Department of He NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING: _	CONSTRUCTION	(X3) DATE SURVEY COMPLETED 08/02/2018	
		00917	B. WING			
NAME OF I	PROVIDER OR SUPPLIER		DDRESS, CITY, ST	TATE, ZIP CODE		
UMBRO	DTA CARE CENTER		. STREET DTA, MN 55992	2		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
	seated upright in a positioning chair) in hanging straight do p.m., R43 was seat her room. R43's he in front of her. Whe lifted her head up to R43 was observed seated in a Broda of her room. R43's he in front of her. R43 able to lift her head she was done, look straight in front of her R43 was observed	on 7/30/18, at 1:11 p.m., Broda chair (tilt-in-space her room. R43's head was wn in front of her. At 6:22 ted upright in a Broda chair in ad was hanging straight down en surveyor spoke to R43, R43 o speak to surveyor. on 7/31/18, at 12:48 p.m., chair, in an upright position, in ad was hanging straight down lifted her head up (but was no fully straight up) and when ting up her head hung down her. on 8/1/18, at 8:16 a.m., Broda chair in the dining				
	front of her. On 8/1/18, at 7:16 a stated R43's head p down in front of her had worked at the f stated R43 was on working here until r ago. When asked it therapy for head po think residents can hospice. I have new department work w		ł			
	(OT)-E stated R43 therapy (OT) in Oct her head. When as head positioning, O	a.m., occupational therapist had received occupational tober 2017, for positioning of ked what was done for R43's 0T-E stated lateral supports neelchair and routine resting or				

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED	
		00917	917 B. WING		08/	08/02/2018	
NAME OF F	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, ST	TATE, ZIP CODE			
ZUMBRO	DTA CARE CENTER		STREET TA, MN 55992	2			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	SUMMARY STATEMENT OF DEFICIENCIESIDPROVIDER'S PLAN OF COR(EACH DEFICIENCY MUST BE PRECEDED BY FULLPREFIX(EACH CORRECTIVE ACTIONREGULATORY OR LSC IDENTIFYING INFORMATION)TAGCROSS-REFERENCED TO THE ADDITIONDEFICIENCY)CROSS-REFERENCED TO THE ADDITIONDEFICIENCY		ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE		
2 830	Continued From participation of bed to allow a being in chair all data holding R43's head R43 received OT the R43's OT recommer provided by OT-E maintenance of the sitting in wheelchair pressure relief. What needed for better haneeded to lift head strengthen neck marka's care plan lac for head positioning. On 8/1/18, at 1:10 provided by Strengthen neck marka's care plan lac for head positioning. On 8/1/18, at 1:10 provided by Strengthen neck marka's care plan lac for head positioning. On 8/1/18, at 1:10 provided to lift head strengthen neck marka's care plan lac for head positioning. On 8/1/18, at 1:10 provided to lift head strengthen neck marka's care plan lac for head position has the nursing (IDON) state strength down. Whe regarding R43's head was on hospice untany splinting or any position has been to be on R43's care nursing assistants a for the nursing assistants a for the nursing assistants and the nursing assistants a	Ige 11 stretching of neck, versus by. OT-E stated a brace for upright was not tried, when herapy. endations, dated 10/19/17, ead, alternate in bed with r to allow for comfort and en sitting in chair tilt back as ead/neck positioning. Cue as during activities/mealtime to uscles for better positioning. ked the OT recommendations g. o.m., the interim director of ted R43 had extreme nfirmed R43's head hung en queried what had been done ad position, IDON stated R43 iil recently. We have not done thing like that, R43's head ong term. o.m., the IDON stated she ed the OT recommendations e plan, communicated to the and placed on the care guide	2 830	DEFICIENCY	0		
	director of nursing of to comprehensively implement interven provided care in a r	OD FOR CORRECTION: The or designee could direct staff assess residents, and tions to ensure residents are manor to promote their highest oring program could be r to assure ongoing					

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	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E SURVEY PLETED
		00917	B. WING	08/	02/2018
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE	
ZUMBRO	OTA CARE CENTER		STREET TA, MN 559	92	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLET DATE
2 830	Continued From pa	ge 12	2 830		
	assessment and ef in response to resid completed.	fective care plan interventions lent care needs are			
	TIME PERIOD FOF (21) days.	R CORRECTION: Twenty one			
2 860	Proper Nursing Car	) Subp. 2 F. Adequate and re; Hands-Feet or determining adequate and	2 860		9/10/18
	proper care. The c adequate and prop E. per care and att	riteria for determining			
	by:	ent is not met as evidenced			
	review the facility fa provided to 2 of 2 re	on, interview and record ailed to ensure nail care was esidents (R14, R42) reviewed / living (ADL's) and whom was for care.		R#14's nails were trimmed and cleaned. R#42's nails were trimmed and cleaned. All residents have plans of care that must be followed. All residents that are dependent upon staff for nail care will be reviewed and will have nails trimmed	
	Findings include:			and/or cleaned as needed. All Nursing staff were re-educated on the	
	admission date of 2 type 2 diabetes me	sheet identified a current 2/22/16, and a diagnosis of llitus, chronic obstructive (COPD), and anxiety disorder.		policy for nail care and the need to follow the plan of care. Random observational audits of nail care will be completed by the DON/designee 3x's/week for 4 weeks, then 2 audits	
	assessment dated intact cognition and	nimum Data Set (MDS) an 5/18/18, identified R14 to have required one person h personal hygiene.		monthly thereafter to ensure ongoing compliance. Audit results will be brought to the QAPI committee for review and further recommendations	
	Care plan dated 6/5	5/18, identified R14 needs one			

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STATEMEN	ta Department of He	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
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ZUMBRO	DTA CARE CENTER		. STREET )TA, MN 55992	2		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE
2 860	Continued From pa	ge 13	2 860			
	and COPD, with an	nail care related to diabetes approach to have nurse to th bathing as needed.				
	identified R14 (by ro on Monday am. Undated, nursing a	cument, "Bath Schedule," oom number) will get a bath ssistant care guide identified and bath on Mondays.				
	12:30 p.m. R14 is s dressed and is note fingernails. R14 sta fingernails, "They c really could be clea	and interview on 7/30/18, at sitting up in her wheelchair well ed to have untrimmed, jagged ated, in regards to her ould use a trimming, they ned." They tell me that only a n because I am diabetic.				
	12:43 p.m. R14 is s room and stated sh	and interview on 7/31/18, at hitting in her wheelchair in her he is waiting for her son to he dentist. R14's fingernails and jagged.				
	9:45 a.m. R14 is lyi one had clipped he her fingernails and though don't they, a observed to have a	and interview on 8/01/18, at ng in her bed and verified no r fingernails yet. R14 looks at stated, "They sure need it and they are kind of dirty." R14 dark substance under some ngernails, and the left middle	ŀ			
	medication aide (TI get their nails clippe aides do it unless th the nurse has to do	8/1/18, at 9:53 a.m. trained MA)-A verified the residents ed on their bath days, the ne resident is diabetic, then it . TMA-A further verified ails are untrimmed and on Mondays.				

679B11

If continuation sheet 14 of 39

(EACH DEFICIENCY REGULATORY OR L pontinued From pa uring interview on actical nurse (LPI ive brown substant of that there are se e clipped. Further 14's because she pould be doing it co ound to clip the re- st haven't had tim uring interview on rector of nursing ( sidents need to h	433 MILL ZUMBRC MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) Age 14 8/1/18, at 9:55 a.m. licensed N)-A- verified R14's fingernails nce underneath some of them some jagged nails that need to r verified a nurse needs to clip is diabetic and stated, they on her bath days, "I used to go esident's nails, but honestly I	STREET DTA, MN 5599	TATE, ZIP CODE 2 PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	RRECTION	02/2018 (X5) COMPLETE DATE
CARE CENTER SUMMARY STA (EACH DEFICIENCY REGULATORY OR L Dentinued From para uring interview on actical nurse (LPI ive brown substant id that there are se a clipped. Further 14's because she iould be doing it co ound to clip the re- st haven't had time uring interview on rector of nursing ( sidents need to h	433 MILL ZUMBRC MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) age 14 8/1/18, at 9:55 a.m. licensed N)-A- verified R14's fingernails nce underneath some of them some jagged nails that need to r verified a nurse needs to clip is diabetic and stated, they on her bath days, "I used to go esident's nails, but honestly I ne." 8/1/18, at 10:12 a.m. interim (IDON) verified diabetic	STREET DTA, MN 5599	2 PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE	N SHOULD BE	COMPLETE
SUMMARY STA (EACH DEFICIENCY REGULATORY OR L ontinued From pa uring interview on actical nurse (LPI ive brown substan d that there are se clipped. Further 14's because she ould be doing it co ound to clip the re st haven't had tim uring interview on rector of nursing ( sidents need to h	ZUMBRC TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) age 14 8/1/18, at 9:55 a.m. licensed N)-A- verified R14's fingernails nce underneath some of them some jagged nails that need to r verified a nurse needs to clip is diabetic and stated, they on her bath days, "I used to go esident's nails, but honestly I ne." 8/1/18, at 10:12 a.m. interim (IDON) verified diabetic	ID     PREFIX       TAG     2 860	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE	N SHOULD BE	COMPLETE
(EACH DEFICIENCY REGULATORY OR L pontinued From pa uring interview on actical nurse (LPI ive brown substant of that there are se e clipped. Further 14's because she pould be doing it co ound to clip the re- st haven't had tim uring interview on rector of nursing ( sidents need to h	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) age 14 8/1/18, at 9:55 a.m. licensed N)-A- verified R14's fingernails nce underneath some of them some jagged nails that need to r verified a nurse needs to clip is diabetic and stated, they on her bath days, "I used to go esident's nails, but honestly I ne." 8/1/18, at 10:12 a.m. interim (IDON) verified diabetic	PREFIX TAG 2 860	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE	N SHOULD BE	COMPLETE
uring interview on actical nurse (LPI ave brown substand that there are se clipped. Further 14's because she would be doing it co ound to clip the re st haven't had tim uring interview on rector of nursing ( sidents need to h	8/1/18, at 9:55 a.m. licensed N)-A- verified R14's fingernails nce underneath some of them some jagged nails that need to r verified a nurse needs to clip is diabetic and stated, they on her bath days, "I used to go esident's nails, but honestly I ne." 8/1/18, at 10:12 a.m. interim (IDON) verified diabetic				
actical nurse (LPI type brown substant of that there are se e clipped. Further 14's because she would be doing it co ound to clip the re- st haven't had time uring interview on rector of nursing ( sidents need to h	N)-A- verified R14's fingernails nce underneath some of them some jagged nails that need to r verified a nurse needs to clip is diabetic and stated, they on her bath days, "I used to go esident's nails, but honestly I ne." 8/1/18, at 10:12 a.m. interim (IDON) verified diabetic				
rector of nursing ( sidents need to h	(IDON) verified diabetic				
	further verified they should be least weekly on their bath				
lmission date of 3 be 2 diabetes me id hemiplegia (pa	3/21/18, and a diagnosis of Ilitus with diabetic neuropathy ralysis of one side of the				
5/18, identified R4	42 to have intact cognition and				
ie person assist f	rom licensed staff weekly with				
entified R42 (by ro n Thursday am. ndated, nursing a	oom number) will get a bath ssistant care guide identified				
	mission date of 3 e 2 diabetes me d hemiplegia (pa dy), following a d 2's quarterly min /18, identified R- juired one perso rsonal hygiene. re plan dated 5/7 e person assist f I care related to dated facility doo ntified R42 (by n Thursday am. dated, nursing a 2 to be diabetic s	uired one person extensive assist with sonal hygiene. re plan dated 5/7/18, identified R42 needed e person assist from licensed staff weekly with I care related to diabetes. dated facility document, "Bath Schedule," ntified R42 (by room number) will get a bath Thursday am. dated, nursing assistant care guide identified 2 to be diabetic and bath on Thursdays. ring observation on 7/30/18, at 6:03 p.m. R42	mission date of 3/21/18, and a diagnosis of e 2 diabetes mellitus with diabetic neuropathy d hemiplegia (paralysis of one side of the dy), following a cerebral infarct (stroke). 2's quarterly minimum data set (MDS) dated /18, identified R42 to have intact cognition and juired one person extensive assist with rsonal hygiene. re plan dated 5/7/18, identified R42 needed e person assist from licensed staff weekly with I care related to diabetes. dated facility document, "Bath Schedule," ntified R42 (by room number) will get a bath Thursday am. dated, nursing assistant care guide identified 2 to be diabetic and bath on Thursdays. ring observation on 7/30/18, at 6:03 p.m. R42	mission date of 3/21/18, and a diagnosis of e 2 diabetes mellitus with diabetic neuropathy d hemiplegia (paralysis of one side of the dy), following a cerebral infarct (stroke). 2's quarterly minimum data set (MDS) dated /18, identified R42 to have intact cognition and juired one person extensive assist with rsonal hygiene. re plan dated 5/7/18, identified R42 needed e person assist from licensed staff weekly with I care related to diabetes. dated facility document, "Bath Schedule," ntified R42 (by room number) will get a bath Thursday am. dated, nursing assistant care guide identified 2 to be diabetic and bath on Thursdays. ring observation on 7/30/18, at 6:03 p.m. R42	mission date of 3/21/18, and a diagnosis of e 2 diabetes mellitus with diabetic neuropathy d hemiplegia (paralysis of one side of the dy), following a cerebral infarct (stroke). 2's quarterly minimum data set (MDS) dated /18, identified R42 to have intact cognition and juired one person extensive assist with 'sonal hygiene. re plan dated 5/7/18, identified R42 needed e person assist from licensed staff weekly with I care related to diabetes. dated facility document, "Bath Schedule," ntified R42 (by room number) will get a bath Thursday am. dated, nursing assistant care guide identified 2 to be diabetic and bath on Thursdays. ring observation on 7/30/18, at 6:03 p.m. R42

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
					-	
		00917	B. WING		08/	02/2018
NAME OF F	PROVIDER OR SUPPLIER		DDRESS, CITY, ST	TATE, ZIP CODE		
ZUMBRO	DTA CARE CENTER		. STREET DTA, MN 55992	2		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACT) CROSS-REFERENCED TO T DEFICIENC'	ION SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
2 860	Continued From page 15 is noted to have long painted pink fingernails on her right hand. A dark brown substance was noted under all of her fingernails. Left hand was contracted and unable to see the fingernails. During observation on 7/31/18, at 12:23 p.m. R42 is sitting up to the table in the dining room is feeding self, eating with her right hand. R42 continues to have long, untrimmed pink-painted nails with brown-looking substance under the fingernails.		2 860			
	10:02 a.m. R42 is I remain unclipped w underneath the righ verified she gets he stated, "I do want n kind of long and the supposed to clip m Nursing assistant ( out R42's left hand nails are long untrir	and interview on 8/1/18, at ying in her bed, fingernails vith unknown brown substance th hand fingernails. R42 er baths on Thursdays and ny fingernails clipped, they are ey are kind of dirty." They are y nails on my bath day. NA)-A was trying to straighten to see the fingernails, and mmed with unknown brown f some of the nails.				
	stated R42's finger substance underne that they are long a	a 8/1/18, at 10:06 a.m. NA-A nails all have dark brown eath the pink painted nails and and need to be clipped and her stated, "Only the nurse s, she is diabetic."				
	registered nurse (R are long, and have	n 8/1/18, at 10:08 a.m. RN)-B verified R42's fingernails brown debris underneath the They need to be cleaned."				
	director of nursing	n 8/1/18, at 10:12 a.m. interim (IDON) verified diabetic have their nails trimmed by a				

STATEMEN	ota Department of He NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00917	B. WING		08/	02/2018
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
ZUMBRO	DTA CARE CENTER		_ STREET DTA, MN 55992	2		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
2 860	Continued From pa	ige 16	2 860			
		l further verified they should at least weekly on their bath				
	indicated residents on hands and feet of needed between baspecial instructions	Nail Care, dated 11/20/17, will be provided with nail care on bath day as needed and as aths. Check care plan for . If diabetic, clean and file Nurse to trim nails. If resident e and re-approach.				
	The director of nurs educate responsibl residents' dependa residents' compreh DON or designee c	THOD OF CORRECTION: sing and/or designee could e staff to provide care to nt on facility staff, based on ensively assessed needs. The could conduct audits of t cares to ensure diabetic nail t consistently.				
	TIME PERIOD FOR (21) days.	R CORRECTION: Twenty-one				
2 895	MN Rule 4658.052 Motion	5 Subp. 2.B Rehab - Range of	2 895			9/10/18
	that is directed towa through positioning implemented and n comprehensive res of nursing services	motion. A supportive program ard prevention of deformities and range of motion must be naintained. Based on the ident assessment, the director must coordinate the ursing care plan which				
	receives appropriat	h a limited range of motion te treatment and services to notion and to prevent further				

STATEMEN	ta Department of He TOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			DATE SURVEY COMPLETED
		00917	B. WING		08/02/2018
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE	
ZUMBRO	DTA CARE CENTER	433 MILL ZUMBRO	STREET TA, MN 559	92	
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PRÉFIX TAG		/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	E DATE
2 895	Continued From pa	ge 17	2 895		
	decrease in range of	of motion.			
	by:	ent is not met as evidenced		R#42 PROM program was added to th	e
	review, the facility	ailed to provide services to notion (ROM) of upper 1 resident (R42) reviewed for		care plan and NAR assignment sheet staff caring for R42 were re-educated the plan. R#42 was referred back to C for splinting needs, R#42's care plan w	and on )T
	Findings include:			be updated as needed based on the assessment. Residents that require ROM for upper	
	face sheet included side of the body),	noses according to the undated I: Hemiplegia (paralysis of one following cerebral infarct ft dominant side, and Major er.		extremities will be reviewed to ensure ROM program/needs are on the care p Staff responsible for care planning RO programs, including splinting needs we re-educated on the process of care planning therapy recommendations.	М
	day, Minimum Data dated 7/5/18, indica required extensive activities of daily liv	Payment System (PPS) 90 a Set (MDS) an assessment ated intact cognition and assistance of staff with ing (ADLs). Further identified on in range of motion to one and lower extremity.		Random chart audits will be complete the DON/designee 3x's/week for 4 wee and then 2 audits monthly thereafter to ensure therapy recommendations are implemented for ROM needs. Audit re- will be brought to the QAPI committee review and further recommendations	sults
	mobility related to d evidenced by inabil to remain free of co identified R42 requi (PROM) to lower ex hand/forearm splint	ted 5/7/18, identified impaired liagnosis of hemiplegia as ity to ambulate. R42's goal is ontractures. The care plan also ired passive range of motion stremities and the use of a left t to be put on in the am and e. (Care plan did not identify extremities).			
	sheet, indicated sta	ated, resident assignment iff were to remember to place orearm on in the am and off at			

STATEMEN	<u>ota Department of He</u> NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00917	B. WING		08/	02/2018
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
ZUMBRO	DTA CARE CENTER		. STREET DTA, MN 55992	2		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 895	Continued From pa	ge 18	2 895			
	bedtime. PROM was not identified as a task.					
	Review of the occupational therapy (OT) Discharge Summary dated 7/13/18, included R42 needs: requires daily range of motion and hygiene program for left upper extremity in order to maintain joint mobility, prevent contractures and skin integrity issues. Staff training completed with no questions, staff reports feeling confident with the range of motion program.					
	R42's undated, Self-Range of for Shoulders, Arms, Wrists a indicated staff to do with flex a fingers to do thumb, pointer a	s, Wrists and Fingers, with flex and extend of p pointer and middle finger nd pinky together, slow stretch nuch as possible. Further ate handwashing and skin	1			
	left hand is noted to open her hand whe grips noted on left h don't ever use a sp	7/30/18, at 5:59 p.m. R42's b be contracted, and unable to in asked. No splints or palm nand/forearm. R42 stated, "I lint. No one does range of m unless I go to those				
	is sitting in her whe	on 7/31/18, at 12:23 p.m. R42 elchair up to the table in the noted to not be wearing a				
	is lying down in her assistant (NA)-A tri fingers to see her fi ouch, [curse words she was sorry and	on 8/1/18, at 10:02 a.m. R42 bed on her back. Nursing ed to straighten out R42's left ngernails, R42 stated, "Ouch, ] that hurts!" NA-A told R42 R42 stated, Oh my fingers hur Resident was not observed to	t			

	ta Department of He TOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00917	B. WING		08/	02/2018
NAME OF F	PROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, ST	TATE, ZIP CODE		
ZUMBRO	OTA CARE CENTER		. STREET )TA, MN 55992	2		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 895	Continued From pa	ge 19	2 895			
	be wearing a splint on her left hand.					
	assistant (NA)-D sta sheet R42 is suppor hand, if there was r would be on our car verified she did not NA-D could not find During observation 12:59 p.m. R42 was dressed, no splint n R42's left hand was her thumb tucked b asked was unable t the assist of her rig supposed to be wea contractures." I wa (LPN) for several ye	<ul> <li>8/2/18, at 12:55 p.m. nursing ated, according to our care sed to have a splint on her left ange of motion to do for her it re sheet and it is not. NA-D do PROM for R42 today.</li> <li>I R42's splint in her room.</li> <li>and interview on 8/2/18, at s sitting in her wheelchair, well noted to be on her left hand.</li> <li>a closed fist position with behind her fingers. R42 when to open her left hand even with ht hand. R42 stated, "I am aring a splint to help prevent s a licensed practical nurse ears you know.</li> <li>8/2/18, at 1:07 p.m. nursing</li> </ul>				
	assistant (NA)-E ve	erified R42 used to wear a nember that last time R42 had				
	registered nurse (R wearing the splint to	8/2/18, at 1:08 p.m. N)-C verified R42 is not b her left hand like the care -C stated the splint would help ures.				
	therapist (PT) revie R42 was in occupa 7/11/18, and should to put be put on in t bedtime to help pre	8/2/18, at 1:16 p.m. physical wed R42's record and verified tional therapy from 4/5/18, to I have a splint to her left hand he morning and remove at vent contractures. PT further				
	verified she should hand and highly rec	be getting PROM to her left				

STATEMEN	ta Department of He T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,			E SURVEY PLETED
		00917	B. WING		08/	02/2018
NAME OF F	PROVIDER OR SUPPLIER		DDRESS, CITY, S	TATE, ZIP CODE		02/2010
ZUMBRO	TA CARE CENTER		. STREET DTA, MN 5599	2		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 895	Continued From pa	age 20	2 895			
	director of nursing is discharged from recommendations is copies of the forms and make copies to communication boo The nurse will then will be put on the re During interview on registered nurse (R contacted her on 7, implementation of a RN-A stated, "I sho program in right aw During interview via occupational therap they haven't been of think it was July 13 nursing staff and the about doing that." receiving hand hyg upper extremity dat having the range of half weeks the resis stiffness, pain, and surveyor asked if it hand to be in a pos over the thumb. OT started working witt I started doing rang was done I would p fingers, so if her ha it's from not doing t	bk and the residents chart. update the care plan and that esident assignment sheet. N/2/18, at 1:34 p.m. N/-A verified therapy had /11/18, about the a PROM program for R42. build have put the PROM				
		torative Nursing Program				
nnesota De ATE FORM	epartment of Health		6899 6	79B11	If continucti	on sheet 21 c

	ta Department of He T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00917	B. WING		08/	02/2018
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	ATE, ZIP CODE		
ZUMBRO	DTA CARE CENTER		_ STREET DTA, MN 55992	2		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC'	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
2 895	Continued From pa	ige 21	2 895			
	motion exercises m scheduled, and doo record. further indi assistance, staff ap for the device or pr and direction to tea SUGGESTED MET The administrator, designee could dev care by the interdis residents with limite appropriate therapy facility could update educate staff on the periodically to ensu recommended ther completed, and res reviewed by the qua	17, indicated passive range of nust be care planned, cumented in the medical cated with splint or brace oplies, manipulates, and cares ovide verbal cues, guidance, ch the resident to use it. THOD OF CORRECTION: director of nursing (DON), or velop and implement a plan of ciplinary team to ensure ed range of motion receive the v recommendations. The e policies and procedures, ese changes, and audit ire resident(s) are receiving apy services. Audits could be ults of these audits are ality assessment and vement (QAPI) committee liance.				
	(21) days.	R CORRECTION: Twenty-one				
2 910	MN Rule 4658.052 Incontinence	5 Subp. 5 A.B Rehab -	2 910			9/10/18
	have a continuous management to rec unnecessary use o comprehensive res home must ensure A. a resident w without an indwellir	ho enters a nursing home ng catheter is not catheterized 's clinical condition indicates				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION (	X3) DATE SURVEY COMPLETED
		00917	B. WING		08/02/2018
NAME OF I	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY,	STATE, ZIP CODE	
ZUMBRO	OTA CARE CENTER		. STREET DTA, MN 559	92	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMP
2 910	B. a resident w receives appropriat prevent urinary trac	age 22 ho is incontinent of bladder te treatment and services to ct infections and to restore as der function as possible.	2 910		
	by: Based on observat review, the facility f treatment and serv resident (R14), rev Findings include: R14's quarterly Mir assessment dated admit date of 2/22/ dependent on staff (ADLs). Further ide indwelling catheter R14's face sheet p following diagnoses personal history of R14's Physician Or physician on 4/19/1 catheter on the 17t of urine, with 16 Fr R14's Physician tra- indicated the use o Foley catheter to be	rinted 8/1/18, identified the s: retention of urine and urinary tract infections. rder Sheet dated and signed by I8 identified to change Foley h of every month, for retention ench, 10 milliliter (ml) balloon. anscribed order, dated 7/8/18, f 18 French 30 ml balloon e changed the 5th of every		R#14 MD was updated on recent ca changes and new orders were obta All residents with catheters were re- to ensure physician orders are follow written. Licensed nursing staff were re-educ on following physician orders r/t cat size and on the need to notify the physician when frequent catheter ch are needed. Random chart and observational au will be completed by the DON/desig 3x's/week for 4 weeks and then 2 a monthly thereafter to ensure physic orders are being followed as it relate catheter size. Audit results will be to to the QAPI committee for review an further recommendations.	ined. viewed wed as cated heter nanges idits udits ian es to prought
	R14's Physician tra indicated the use o Foley catheter to b month. (not signed	nscribed order, dated 7/8/18, f 18 French 30 ml balloon e changed the 5th of every			

08/02/20	2018
	(X5) COMPLET DATE

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00917	B. WING		08/02/2018	
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	TATE, ZIP CODE		
ZUMBRC	DTA CARE CENTER		. STREET )TA, MN 55992	2		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE
2 910	was no longer pater around the lumen. with an 18 French 3 Moderate amount of output. Catheter is p R14's progress note nursing assistant al with urine, catheter urine output. Attem to resistance. Cath with 30 cc balloon, f ml output immediate noted on Foley cath have a leak. R14's progress note catheter leaking, st was low (just above the catheter to leak though continued to French 30 cc with n placed upper thigh and prevent pulling R14's progress note Foley catheter leaking out further than rece and yellow/light yell tuning. Leg strap a	e dated 7/8/18, Foley catheter nt and was leaking urine 16 French catheter replaced 30 cc balloon Foley catheter. If sediment noted with initial patent at this time. e dated 7/13/18, at 2:02 a.m. erted writer, brief saturated collection bag and tubing, no upt to flush not successful due eter change with 18 French tolerated without incident. 900 ely following the change, neter removed the balloon did e dated, 7/18/18, at 10:55 p.m. trap to hold catheter in place the knee) possibly causing . Catheter was advanced o leak. Catheter changed 16 o further issues. Strap was area to hold catheter in place of catheter. e dated 7/30/18, at 11:47 p.m. ing and tubing appeared to be commended. Tubing advanced ow urine noted in catheter pplied to upper thigh to hold				
	reported the Cathet Catheter changed v discomfort from res	ater in the shift it was er was leaking again. vith no issues, c/o pain, ident. Yellow/light yellow urine be. (Size of catheter not				

STATEMEN	ta Department of He	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00917	B. WING		08/02/20	
NAME OF F	PROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, ST	TATE, ZIP CODE		
ZUMBRO	DTA CARE CENTER		. STREET DTA, MN 55992	2		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF (	CORRECTION	(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC	HE APPROPRIATE	COMPLET DATE
2 910	Continued From pa	ige 25	2 910			
	stated I have had a	7/30/18, at 12:47 p.m. R14 catheter for a while now, and d before it was supposed to.				
		7/31/18, at 12:45 p.m. R14 e a new catheter put in last working right.				
	7:25 a.m. R14 is lyi night gown and nur assisting R14 with	and interview on 8/1/18, at ng in bed, dressed in facility sing assistant (NA)-B is catheter care. NA-B verified e is an 18 French catheter ml) balloon.				
	practical nurse (LPI an 18 French 30 cc and the only physic was a size 16 Frenc 2/12/18. LPN-A fur changed the order medical record to a	8/1/18, at 8:53 a.m. licensed N)-A verified R14 currently has Foley catheter in at this time ians order for R14's catheter ch, 10 ml balloon, signed on ther verified one of the nurses of the catheter in the electronic in 18 French 30 ml balloon der from the physician on				
	registered nurse (R has a size 18 Frence place, with no curre that size. RN-A func- catheter changed 5 no documentation t stated the more you at risk you are for a	8/1/18, at 9:05 a.m. N)-A verified R14 currently ch 30 ml balloon catheter in ent signed physician order for ther verified R14 has had her times in the last month with to notify the doctor. RN-A u change a catheter the more in infection, with R14's history tor should have been updated.				
	director of nursing (	8/1/18, at 9:39 a.m. interim (IDON) verified R14 currently ch 30 ml balloon catheter in				

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	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00917	B. WING		08/02/2018	
NAME OF F	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, ST	ATE, ZIP CODE		
ZUMBRO	DTA CARE CENTER		_ STREET DTA, MN 55992	2		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
2 910	Continued From pa	ge 26	2 910			
	that size. IDON fur catheter changed 5 2018, with various s notifying the physic expectation would k notified of that man with her history of u	ent signed physician order for ther verified R14 has had her times in the month of July, sizes of catheters, without ian. IDON stated, my be the doctor should be y catheter changes, especially irinary tract infections, and that ould be following the as written.				
	administrator, direct designee could revision following physician change according to practices/procedure educated as necess following the physic Foley catheter to er or designee, should placement by all nu residents effected a QAPI to ensure cor need for further edu	HOD OF CORRECTION: The tor of nursing (DON) or iew and revise policies for orders for a Foley catheter o evidence based es. Nursing staff could be sary to the importance of cian orders prior to inserting a nsure correct size. The DON d audit Foley catheter irsing staff assigned to and take that information to inpliance and determine the ucation/monitoring/compliance R CORRECTION: Twenty-one				
21300	(21) days. MN Rule 4658.0710 Orders and Physicia	) Subp. 4 A-C Admission an Evaluations	21300			9/10/18
	Subp. 4. Physician physician or physici A. review the re of care, including m and progress notes	visits. At each visit, a ian's designee must: esident's comprehensive plan nedications and treatments,				

If continuation sheet 27 of 39

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			ATE SURVEY OMPLETED
		00917	B. WING	c	8/02/2018
NAME OF	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY,	STATE, ZIP CODE	
ZUMBRO	DTA CARE CENTER		STREET DTA, MN 559	92	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLET DATE
21300	Continued From pa	ige 27	21300		
	C. sign and date	e all orders.			
	by: Based on observati review, the facility for reviewed treatment routine visits for 16 R43, R45, R9, R10 R18, R20 and R42) orders. Findings include: R17's Face Sheet, diagnoses of Alzhei pulmonary embolish hypertension, nutrit disorder, combined failure and obesity. R17's Physician Or certified nurse prac- included review of r The order sheets la of R17's treatments R22's Face Sheet, diagnoses of chron disease, chronic dia atrial fibrillation, and prostate, nutritional During observation 3:18 p.m., R22 stat	ent is not met as evidenced ion, interview and document ailed to ensure the physician is and auxiliary orders during of 16 residents (R17, R22, , R31, R40, R2, R6, R13, R14, ) reviewed for signed physician dated 8/1/18, included imer's disease, chronic m, obstructive sleep apnea, ional deficiency, anxiety systolic and diastolic heart der Sheet, signed by a stitioner, dated 7/26/18, medications and care plan. acked documentation of review is and auxiliary orders. dated 8/1/18, included ic obstructive pulmonary astolic heart failure, chronic emia, malignant neoplasm of deficiency and sleep apnea. and interview, on 7/30/18, at ed he had a catheter in place. bag was observed to be 's wheelchair.		R 17, 22, 43, 45, 9, 10, 31, 40, 2, 6, 13, 14, 18, 20, and 42 physician orders including medication, treatments and auxiliary orders were reviewed and sign by the physician. All other residents' physician orders for medication, treatments and auxiliary orders were reviewed and signed by the physician. Nursing staff were re-educated on the requirement of the physician to review th resident's total plan of care, including medication and treatment orders during routine visits and to sign and date all orders Random chart audits will be completed the DON/designee 3x's/week for 4 week and then 2 audits monthly thereafter to ensure ongoing compliance. Audit resu will be brought to the QAPI committee for review and further recommendations.	he by ks

STATEMEN	ta Department of He T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00917	B. WING		08/02/2018	
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	TATE, ZIP CODE		
ZUMBRO	DTA CARE CENTER	433 MILL ZUMBRO	STREET TA, MN 55992	2		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
21300		-	21300			
	review of medicatio	titioner, dated 7/9/18, included ons and care plan. The order imentation of review of R22's ciliary orders.				
	diagnoses of chron	dated 8/1/18, included ic pain, kyphosis, peripheral steoarthritis and dementia.				
	certified nurse practincluded review of r The order sheets la	der Sheet, signed by a titioner, dated 6/21/18, medications and care plan. acked documentation of review s and auxiliary orders.				
	diagnoses of chron	dated 8/1/18, included ic pain, kyphosis, peripheral steoarthritis and dementia.				
	physician, dated 7/ medications and ca	der Sheet, signed by the 10/18, included review of are plan. The order sheets ion of review of R45's siliary orders.				
	IDON stated Physic print out the medica he wanted to addre narrative notes. Ho related to R17, R22 include a review of The IDON stated sl	7/31/18, at 12:09 p.m., the cian (P)-F preference was to ations for residents only and ess the treatments in his wever, the progress notes 2, R43, & R45, lacked to treatment and auxiliary orders. he would guess all residents and P-F was physician for ept one resident.				
	11/3/17, with diagnornation non-pressure chror	dicated, R9 admitted on oses that included, nic ulcer of left calf, venous neral), atrial fib, heart failure				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		E SURVEY PLETED
		00917	B. WING		08/02/2018	
NAME OF I	PROVIDER OR SUPPLIER		DRESS, CITY, S	STATE, ZIP CODE		
ZUMBRO	DTA CARE CENTER	433 MILL ZUMBRO	STREET TA, MN 5599	92		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
21300	Continued From pa	ige 29	21300			
	and hypertension.					
		gned ordered for medications ed medications only.				
	from visit dated 7/9 medications orders	urse practitioner progress note /18, indicated review of , review of systems and was r to continue dressing changes er twice daily.				
	treatment, dietary, o	documentation indicated or ancillary orders were ed by nurse practitioner during				
		dicated, R10 admitted on ses that included stroke, heart e heart failure and				
	R10's most recent s medications dated only.	signed ordered for 6/7/18, showed medications				
	note from visit date	nurse practitioner progress d 6/7/18, indicated review of and review of systems.				
	treatment, dietary, o	documentation indicated or ancillary orders were ed by nurse practitioner during				
	11/4/16, with diagno	dicated, R31 admitted on oses that include heart attack, g, urinary retention and hearing				
	R31's most recent	signed ordered for				
inesota D ATE FORI	epartment of Health M		6899 6	679B11	If continuati	on sheet 30 o

STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	CONSTRUCTION		E SURVEY PLETED
		00917	B. WING		08/02/2018	
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
ZUMBRO	DTA CARE CENTER		_ STREET DTA, MN 55992	2		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETI DATE
21300	Continued From pa	age 30	21300			
	medications dated only.	6/4/18, showed medications				
	note from visit date	nurse practitioner progress d 6/4/2018, indicated review o and review of systems.	f			
	treatment, dietary, o	documentation indicated or ancillary orders were ed by nurse practitioner during				
	12/29/17, with diag supranuclear optha condition that cause vision, speech, mov anxiety disorder, ur	dicated, R40 admitted on noses that include progress Ilmoplegia (neurodegenerative es problems with balance, vement and swallowing), inary retention, major r and delusional disorder.				
	visit dated 6/26/18, medications orders	physician's progress note from indicated review of and review of systems and signed by the physician on				
	treatment, dietary, o	documentation indicated or ancillary orders were ed by physician during this visit				
	diagnoses of deme disturbance, major	ated 8/1/18, included ntia with behavioral depressive disorder, anxiety of cardiac pacemaker, and				
	physician, dated 7/2 medications and ca	er Sheet, signed by the 24/18, included review of are plan. The order sheets ion of review of R2's				

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION		E SURVEY PLETED
		00917	B. WING		08/02/2018	
NAME OF F	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, ST	TATE, ZIP CODE		
ZUMBRO	TA CARE CENTER		. STREET )TA, MN 55992	2		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE
21300	Continued From pa	ge 31	21300			
	treatments and aux	iliary orders.				
	diagnoses of diabet major depressive d	ated 8/1/18, included tes mellitus, hypertension, isorder, anemia, dizziness and idness, and insomnia.				
	physician, dated 7/2 medications and ca	er Sheet, signed by the I7/18, included review of re plan. The order sheets on of review of R6's iliary orders.				
	diagnoses of type 2 major depressive d	dated 8/1/18, included diabetes mellitus, obesity, isorder, contracture of the ct with hemiplegia of the right ire.				
	physician, dated 6/2 medications and ca	der Sheet, signed by a 19/18, included review of re plan. The order sheets on of review of R13's iliary orders.				
	diagnoses of type d neuropathy, urinary insomnia, anxiety, r	dated 8/1/18, included iabetes mellitus with diabetic retention, pulmonary edema, norbid obesity, diastolic heart cardiac pacemaker, and				
	physician, dated 7/ medications and ca lacked documentati treatments and aux	der Sheet, signed by the I0/18, included review of re plan. The order sheets on of review of R14's iliary orders, to include Foley en R14 utilized a Foley				

(EACH DEFICIENCY REGULATORY OR L Continued From pa R18's Face Sheet, liagnoses of anxiet constipation, gastrif licer. R18's Physician Or bysician, dated 6/	433 MILL ZUMBRO TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	B. WING DRESS, CITY, ST STREET TA, MN 55992 ID PREFIX TAG 21300		08/02/2018 (X5) COMPLETI DATE
A CARE CENTER SUMMARY STA (EACH DEFICIENCY REGULATORY OR L Continued From pa R18's Face Sheet, liagnoses of anxiet constipation, gastri lcer. R18's Physician Or bysician, dated 6/	433 MILL ZUMBRO	STREET TA, MN 55992 ID PREFIX TAG	2 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	COMPLET
SUMMARY STA (EACH DEFICIENCY REGULATORY OR L Continued From pa R18's Face Sheet, liagnoses of anxiet constipation, gastrif lcer. R18's Physician Or bysician, dated 6/	ZUMBRO TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) age 32 dated 8/1/18, included ty disorder, low back pain,	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	COMPLET
(EACH DEFICIENCY REGULATORY OR L Continued From pa R18's Face Sheet, liagnoses of anxiet constipation, gastrif licer. R18's Physician Or bysician, dated 6/	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) Ige 32 dated 8/1/18, included ty disorder, low back pain,	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	COMPLET
R18's Face Sheet, liagnoses of anxiet constipation, gastrii llcer. R18's Physician Or bhysician, dated 6/	dated 8/1/18, included ty disorder, low back pain,	21300		
liagnoses of anxie onstipation, gastri llcer. R18's Physician Or hysician, dated 6/	ty disorder, low back pain,			
hysician, dated 6/				
	der Sheet, signed by a 12/18, included review of are plan. The order sheets ion of review of R18's ciliary orders.			
liagnoses of type 2 hronic diastolic he brillation, phantom ailure with hypoxia				
urse practitioner, of f medications and acked documentat	dated 6/25/18, included review care plan. The order sheets ion of review of R20's			
liagnoses of toxic o ollowing a stroke o ailure, cardiomega etention, major de nsomnia, chronic o	encephalopathy, hemiplegia on left side, congestive heart ly, hypertension, urinary pressive disorder, anemia, obstructive pulmonary disease,			
hysician, dated 6/ nedications and ca acked documentat	19/18, included review of are plan. The order sheets ion of review of R42's			
	nd stage 3 kidney 20's Physician Or urse practitioner, of medications and cked documentat eatments and aux 42's Face Sheet, agnoses of toxic of llowing a stroke of ilure, cardiomega stention, major de somnia, chronic of eizures, sleep apr age 5. 42's Physician Or hysician, dated 6/ edications and ca cked documentat eatments and aux	42's Physician Order Sheet, signed by a hysician, dated 6/19/18, included review of edications and care plan. The order sheets cked documentation of review of R42's eatments and auxiliary orders. uring interview on 8/1/18, at 1:09 p.m.	<ul> <li>and stage 3 kidney disease.</li> <li>20's Physician Order Sheet, signed by certified urse practitioner, dated 6/25/18, included review medications and care plan. The order sheets cked documentation of review of R20's eatments and auxiliary orders.</li> <li>42's Face Sheet, dated 8/1/18, included agnoses of toxic encephalopathy, hemiplegia llowing a stroke on left side, congestive heart ilure, cardiomegaly, hypertension, urinary stention, major depressive disorder, anemia, somnia, chronic obstructive pulmonary disease, eizures, sleep apnea and chronic kidney disease age 5.</li> <li>42's Physician Order Sheet, signed by a hysician, dated 6/19/18, included review of edications and care plan. The order sheets cked documentation of review of R42's eatments and auxiliary orders.</li> <li>uring interview on 8/1/18, at 1:09 p.m.</li> </ul>	nd stage 3 kidney disease. 20's Physician Order Sheet, signed by certified urse practitioner, dated 6/25/18, included review medications and care plan. The order sheets cked documentation of review of R20's eatments and auxiliary orders. 42's Face Sheet, dated 8/1/18, included agnoses of toxic encephalopathy, hemiplegia llowing a stroke on left side, congestive heart ilure, cardiomegaly, hypertension, urinary tention, major depressive disorder, anemia, somnia, chronic obstructive pulmonary disease, sizures, sleep apnea and chronic kidney disease age 5. 42's Physician Order Sheet, signed by a hysician, dated 6/19/18, included review of edications and care plan. The order sheets cked documentation of review of R42's eatments and auxiliary orders. uring interview on 8/1/18, at 1:09 p.m.

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	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:			E SURVEY PLETED
		00917	B. WING		08/	02/2018
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE	·	
ZUMBRC	TA CARE CENTER		. STREET DTA, MN 55992	2		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
21300	Continued From pa	ige 33	21300			
	reason why our doo and just signs the r because he though We have alerted hi	RN)-B said, "I can't tell a lie, the ctor quit signing the treatments nd [medication] orders now, is it he had to sign every page." m that he only has to sign the hat we are aware of this sing to fix that.				
	regulated physician actual face to face reviewing the resid- including medication	10/20/17, indicated each visit will minimally consist of contact with the resident, ents total plan of care, ons and treatments, writing a h is signed and dated as well				
	designee could wor and administrator to signed and dated a DON or designee of	of Correction: The DON or rk with the medical director o ensure the physician had Il orders. The administrator, could also perform audits of determine if the physician provided.				
	Time Period for Co days.	rrection: Twenty-one (21)				
21375	MN Rule 4658.080 Program	0 Subp. 1 Infection Control;	21375			9/10/18
	home must establis	on control program. A nursing sh and maintain an infection signed to provide a safe and nt.				
	This MN Requirem by:	ent is not met as evidenced				

STATEME	ota Department of He NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP A. BUILDING	LE CONSTRUCTION	(X3) DATE S COMPL	
		00917	B. WING		08/02	2/2018
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
ZUMBRO	DTA CARE CENTER	433 MILL ZUMBRO	STREET TA, MN 559	92		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	SUMMARY STATEMENT OF DEFICIENCIES       ID         (EACH DEFICIENCY MUST BE PRECEDED BY FULL       PREFIX         REGULATORY OR LSC IDENTIFYING INFORMATION)       TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		
21375	Continued From pa	ge 34	21375			
	review, the facility fa standards of practic providing peri cares was observed durin Findings include: During observation 7:16 a.m., nursing a gloves, cleansed Re (urine) incontinent p buttocks (gloves rel incontinent product down R43's shirt, to towards her and rer walkie-talkie in her staff, put R43's lotic linens in a bag and R43's feet. The inter walked into R43's ro R43 into a Broda of to wash my hands r NA-C after providin verified she had no washed hands after On 8/1/18, at 1:21 p would expect glove washed after provic On 8/2/18, at 11:05 nursing stated she contaminated, staff before touching oth hygiene. The Hand Hygiene indicated Procedure	of morning cares on 8/1/18, at assistant (NA)-C applied 43's peri area, removed wet oroduct, cleansed R43's mained on), applied a clean , pulled up R43's pants, pulled buched a comb, rolled R43 moved gloves. NA-C held a hand to communicate with on bottle away, placed dirty applied heel protectors to frim director of nursing (IDON) boom to assist with transferring nair. NA-C stated I am going now. During interview with g R43's morning care, NA-C t removed her gloves and r providing peri cares for R43.		Staff caring for R#43 were re-edu proper handwashing. All residents must have cares pro that ensure current standards of p for infection control are followed. All nursing staff were re-educated proper handwashing after providin pericare. Random observational audits will completed by the DON/designee 3x's/week for 4 weeks, then 2 aud monthly thereafter to ensure ongo compliance. Audit results will be to to the QAPI committee for review further recommendations.	ovided bractice d on ng be dits bing brought	

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _			E SURVEY PLETED
		00917	B. WING		08/02/2018	
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	TATE, ZIP CODE		
ZUMBRO	DTA CARE CENTER	433 MILL ZUMBRO	STREET	2		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC'	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
21375	Continued From pa	ge 35	21375			
	gloves.					
	A policy for glove us provided.	se was requested, but not				
	The director of nurs on the need to follo	HOD OF CORRECTION: ing could in-service all staff w infection control practices to d of infection from resident to rs and staff.				
	TIME PERIOD FOF (21) days.	R CORRECTION: Twenty-one				
21426	MN St. Statute 144, Prevention And Cor	A.04 Subd. 3 Tuberculosis htrol	21426			9/10/18
	maintain a compreh infection control pro- current tuberculosis issued by the Uniter Control and Preven Tuberculosis Elimin Morbidity and Morta This program must infection control pla unpaid employees, residents, and volun Health shall provide regarding implement	e provider must establish and hensive tuberculosis ogram according to the most infection control guidelines d States Centers for Disease tion (CDC), Division of lation, as published in CDC's ality Weekly Report (MMWR). include a tuberculosis n that covers all paid and contractors, students, nteers. The Department of technical assistance ntation of the guidelines.				
	be maintained by th					

Minnesota Department of Health         STATEMENT OF DEFICIENCIES         AND PLAN OF CORRECTION         (X1) PROVIDER/SUPPLIER/CLIA         IDENTIFICATION NUMBER:         00917		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		IDENTIFICATION NUMBER:	A. BUILDING:		08/02/2018	
		00917				
NAME OF I	PROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY,	STATE, ZIP CODE		
ZUMBRO	DTA CARE CENTER		. STREET DTA, MN 559	92		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTIO	N	(X5)
PRÉFIX TAG		/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)		COMPLETE DATE
21426	Continued From page 36		21426			
	This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure 1 of 5 employees (E-A) had a tuberculosis (TB) symptom screening and two step tuberculosis skin test (TST) completed; failed to ensure 2 of 5 residents (R40 and R10) had TB symptom screening and failed to ensure 1 of 5 residents (R45) had the second step TST completed. This had the potential to affect all 45 residents in the facility, staff and visitors.			Corrected.		
	Findings include:					
	EMPLOYEE TB SYMPTOM SCREEN AND TST: EA had a hire date of 3/28/18. The facility failed to complete a TB symptom screening and first and second step TST upon hire as required.					
	resources (HR)-C s on file for E-A's TB	8/2/18, at 8:58 a.m., human stated the facility had nothing screen and first and second stated I must have missed filed ormation.				
		on 12/29/17, and R10 was The resident records lacked a	ł			
		8/2/18, at 1:08 p.m., N)-A stated I could not find a n for R40 and R10.				
	step TST on 12/19/ 12/21/17 of 0 millim	on 1/17/18. R45 had a first 17, with read results on neters and negative. R45's ras given on 1/2/17, however				

Minnesota Department of Hea STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00917	B. WING		08/	02/2018
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
ZUMBRO	OTA CARE CENTER		_ STREET DTA, MN 55992	2		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
21426	Continued From page 37		21426			
	R45's record lacked the read results of the second step TST.					
	During interview on 8/2/18, at 1:08 p.m., RN-A stated R45's second step TST read results were not completed.					
	The facility policy Employee Tuberculosis (TB) Prevention and Control, dated reviewed/revised 6/5/17, indicated Procedure: B. b. All employees having contact with our residents will have TB test results on file before contact with residents. This may be accomplished by a T-spot blood test (IGRA) or baseline TB screening at the time of hire. Baseline TB screening consists of two components: i. assessing for current symptoms of active TB disease and ii. testing for the presence of infection by administering a two step TST or a single IGRA or proof a chest x-ray that identifies they are free from TB.					
	Prevention and Cor 6/5/17, indicated Pr admitted to (care co a written assessme for TB along with an IGRA or a standard	tesident Tuberculosis ntrol, dated reviewed/revised rocedure: B. b. Each resident enter) will be required to have ent of the resident's risk factors ny current TB symptoms. A I tow step TST will be initiated er admission to the care	3			
	director of nursing of policies and proced The director of nurs	THOD OF CORRECTION: The could review tuberculosis lures to ensure compliance. sing could monitor compliance "ST for employees and				
	TIME PERIOD FOR (21) days.	R CORRECTION: Twenty-one				

AND PLAN OF CORRECTION IDENTIFIC		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING		(X3) DATE SURVEY COMPLETED 08/02/2018			
		00917						
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE								
UMBRO	TA CARE CENTER		L STREET OTA, MN 55992	2				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN PREFIX (EACH CORRECTIVE TAG CROSS-REFERENCED DEFICI		ACTION SHOULD BE COMPLE TO THE APPROPRIATE DATE			