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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: 679B
Facility ID: 00917

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245376**

2. STATE VENDOR OR MEDICAID NO.
(L2) **766119300**

3. NAME AND ADDRESS OF FACILITY
(L3) **ZUMBROTA CARE CENTER**
(L4) **433 MILL STREET**
(L5) **ZUMBROTA, MN** (L6) **55992**

4. TYPE OF ACTION: **7** (L8)

1. Initial
2. Recertification
3. Termination
4. CHOW
5. Validation
6. Complaint
7. On-Site Visit
8. Full Survey After Complaint
9. Other

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9) **12/17/2003**

6. DATE OF SURVEY **09/15/2018** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

12. Total Facility Beds **50** (L18)
13. Total Certified Beds **50** (L17)

10. THE FACILITY IS CERTIFIED AS:
X A. In Compliance With Program Requirements Compliance Based On:
____1. Acceptable POC
B. Not in Compliance with Program Requirements and/or Applied Waivers:

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

* Code: **A** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	50			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date:
Gary Nederhoff, Unit Supervisor 10/04/2018 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Douglas Larson, Enforcement Specialist 10/04/2018 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
12/01/1986
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal

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

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
00220
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
09/19/2018
(L33)

DETERMINATION APPROVAL

FORM CMS-1539 (7-84) (Destroy Prior Editions)

020499

Protecting, Maintaining and Improving the 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,

Douglas Larson, Enforcement Specialist

An equal opportunity employer.

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,

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

An equal opportunity employer.

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

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(L4) **433 MILL STREET**
(L5) **ZUMBROTA, MN** (L6) **55992**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9) **12/17/2003**

6. DATE OF SURVEY **08/02/2018** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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02 SNF/NF/Dual	**06 PRTF**	**10 NF**	**14 CORF**	
03 SNF/NF/Distinct	**07 X-Ray**	**11 ICF/IID**	**15 ASC**	
04 SNF	**08 OPT/SP**	**12 RHC**	**16 HOSPICE**	

FISCAL YEAR ENDING DATE: (L35)
09/30

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

12.Total Facility Beds **50** (L18)

13.Total Certified Beds **50** (L17)

10.THE FACILITY IS CERTIFIED AS:

A. In Compliance With Program Requirements Compliance Based On:
____1. Acceptable POC

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	50			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

An FSES survey was completed and the facility received a passing score. Refer to enclosed FSES for additional information.

17. SURVEYOR SIGNATURE Date :
Danette Bakken, HFE II 09/10/2018 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 09/14/2018 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
12/01/1986
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30)

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

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

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
00220
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

P r o t e c t i n g , M a i n t a i n i n g a n d I m p r o v i n g t h e H e a l t h o f A l l M i n n e s o t a n s

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:

> Opportunity to Correct - the facility is allowed an opportunity to correct identified deficiencies before remedies are imposed;
>
> Electronic Plan of Correction - when a plan of correction will be due and the information to be contained in that document;
>
> Remedies - 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;
>
> Potential Consequences - 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:
http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_idr.cfm

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

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,

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: Kamala.Fiske-Downing@state.mn.us

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245376	A. BUILDING ______ B. WING ______	08/02/2018

NAME OF 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)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments A survey with CMS Appendix Z Emergency Preparedness Requirements, was conducted on July 30, 31, August 1 & 2, 2018, during a recertification survey. The facility is NOT in compliance with the Appendix Z Emergency Preparedness Requirements.	E 000		
E 041 SS=C	Hospital CAH and LTC Emergency Power CFR(s): 483.73(e) (e) Emergency and standby power systems. The hospital must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section and in the policies and procedures plan set forth in paragraphs (b)(1)(i) and (ii) of this section. §483.73(e), §485.625(e) (e) Emergency and standby power systems. The [LTC facility and the CAH] must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section. §482.15(e)(1), §483.73(e)(1), §485.625(e)(1) Emergency generator location. The generator must be located in accordance with the location requirements found in the Health Care Facilities Code (NFPA 99 and Tentative Interim Amendments TIA 12-2, TIA 12-3, TIA 12-4, TIA 12-5, and TIA 12-6), Life Safety Code (NFPA 101 and Tentative Interim Amendments TIA 12-1, TIA 12-2, TIA 12-3, and TIA 12-4), and NFPA 110, when a new structure is built or when an existing structure or building is renovated. 482.15(e)(2), §483.73(e)(2), §485.625(e)(2) Emergency generator inspection and testing. The	E 041		8/24/18

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 08/29/2018

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245376	A. BUILDING ______ B. WING ______	08/02/2018

NAME OF 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)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 041	Continued From page 1 [hospital, CAH and LTC facility] must implement the emergency power system inspection, testing, and maintenance requirements found in the Health Care Facilities Code, NFPA 110, and Life Safety Code. 482.15(e)(3), §483.73(e)(3), §485.625(e)(3) Emergency generator fuel. [Hospitals, CAHs and LTC facilities] that maintain an onsite fuel source to power emergency generators must have a plan for how it will keep emergency power systems operational during the emergency, unless it evacuates. *[For hospitals at §482.15(h), LTC at §483.73(g), and CAHs §485.625(g):] The standards incorporated by reference in this section are approved for incorporation by reference by the Director of the Office of the Federal Register in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. You may obtain the material from the sources listed below. You may inspect a copy at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202-741-6030, or go to: http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html. If any changes in this edition of the Code are incorporated by reference, CMS will publish a document in the Federal Register to announce the changes. (1) National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02169, www.nfpa.org, 1.617.770.3000.	E 041		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245376	A. BUILDING ______ B. WING ______	08/02/2018

NAME OF 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)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 041	Continued From page 2 (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 facility did not provide an essential electrical system in accordance with NFPA 99 (2012) 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 -	E 041	An emergency stop push-button control was installed on the outside of the generator on 8/24/2018.	

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E 041	Continued From page 3 either located outside of the generator enclosure -or- inside the facility. This deficient practice was confirmed by the Facility Maintenance Director at the time of discovery. Refer to K - 0911.	E 041		
F 000	INITIAL COMMENTS On July 30 and 31, 2018 and August 1 and 2, 2018, a standard survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with requirements of 42 CFR Part 483, Subpart B, and Requirements for Long Term Care Facilities. The plan of correction will serve as your facility's allegation of compliance. Since your facility is enrolled in the electronic Plan of Correction (ePOC), a signature is not required at the bottom of the first page of the CMS-2567 form. Upon receipt of an acceptable ePOC an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, interview and record	F 677	R#14's nails were trimmed and cleaned.	9/10/18

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F 677	Continued From page 4 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. Findings include: R14's resident face sheet identified a current admission date of 2/22/16, and a diagnosis of type 2 diabetes mellitus, chronic obstructive pulmonary disease (COPD), and anxiety disorder. R14's quarterly, Minimum Data Set (MDS) an assessment dated 5/18/18, identified R14 to have intact cognition and required one person extensive assist with personal hygiene. Care plan dated 6/5/18, identified R14 needs one person assist with nail care related to diabetes and COPD, with an approach to have nurse to provide nail care with bathing as needed. Undated facility document, "Bath Schedule," identified R14 (by room number) will get a bath on Monday am. Undated, nursing assistant care guide identified R14 to be diabetic and bath on Mondays. During observation and interview on 7/30/18, at 12:30 p.m. R14 is sitting up in her wheelchair well dressed and is noted to have untrimmed, jagged fingernails. R14 stated, in regards to her fingernails, "They could use a trimming, they really could be cleaned." They tell me that only a nurse can clip them because I am diabetic. During observation and interview on 7/31/18, at 12:43 p.m. R14 is sitting in her wheelchair in her room and stated she is waiting for her son to	F 677	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 and/or cleaned as needed. All Nursing staff were re-educated on the 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 monthly thereafter to ensure ongoing compliance. Audit results will be brought to the QAPI committee for review and further recommendations	

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F 677	Continued From page 5 come bring her to the dentist. R14's fingernails remain untrimmed and jagged. During observation and interview on 8/01/18, at 9:45 a.m. R14 is lying in her bed and verified no one had clipped her fingernails yet. R14 looks at her fingernails and stated, "They sure need it though don't they, and they are kind of dirty." R14 observed to have a dark substance under some of the untrimmed fingernails, and the left middle fingernail is jagged. During interview on 8/1/18, at 9:53 a.m. trained medication aide (TMA)-A verified the residents get their nails clipped on their bath days, the aides do it unless the resident is diabetic, then the nurse has to do it . TMA-A further verified R14's is diabetic, nails are untrimmed and receives her baths on Mondays. During interview on 8/1/18, at 9:55 a.m. licensed practical nurse (LPN)-A- verified R14's fingernails have brown substance underneath some of them and that there are some jagged nails that need to be clipped. Further verified a nurse needs to clip R14's because she is diabetic and stated, they should be doing it on her bath days, "I used to go around to clip the resident's nails, but honestly I just haven't had time." During interview on 8/1/18, at 10:12 a.m. interim director of nursing (IDON) verified diabetic residents need to have their nails trimmed by a licensed nurse and further verified they should be getting nail care at least weekly on their bath days. R42's resident face sheet identified a current admission date of 3/21/18, and a diagnosis of	F 677		

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F 677	Continued From page 6	F 677		

type 2 diabetes mellitus with diabetic neuropathy and hemiplegia (paralysis of one side of the body), following a cerebral infarct (stroke).

R42's quarterly minimum data set (MDS) dated 7/5/18, identified R42 to have intact cognition and required one person extensive assist with personal hygiene.

Care plan dated 5/7/18, identified R42 needed one person assist from licensed staff weekly with nail care related to diabetes.

Undated facility document, "Bath Schedule," identified R42 (by room number) will get a bath on Thursday am.
Undated, nursing assistant care guide identified R42 to be diabetic and bath on Thursdays.

During observation on 7/30/18, at 6:03 p.m. R42 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.

During observation and interview on 8/1/18, at 10:02 a.m. R42 is lying in her bed, fingernails remain unclipped with unknown brown substance underneath the right hand fingernails. R42 verified she gets her baths on Thursdays and stated, "I do want my fingernails clipped, they are kind of long and they are kind of dirty." They are

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F 677	Continued From page 7 supposed to clip my nails on my bath day. Nursing assistant (NA)-A was trying to straighten out R42's left hand to see the fingernails, and nails are long untrimmed with unknown brown substance on top of some of the nails. During interview on 8/1/18, at 10:06 a.m. NA-A stated R42's fingernails all have dark brown substance underneath the pink painted nails and that they are long and need to be clipped and cleaned. NA-A further stated, "Only the nurse can do [R42's] nails, she is diabetic." During interview on 8/1/18, at 10:08 a.m. registered nurse (RN)-B verified R42's fingernails are long, and have brown debris underneath the nails, and stated, "They need to be cleaned." During interview on 8/1/18, at 10:12 a.m. interim director of nursing (IDON) verified diabetic residents need to have their nails trimmed by a licensed nurse, and further verified they should be getting nail care at least weekly on their bath days. Facility document, Nail Care, dated 11/20/17, indicated residents will be provided with nail care on hands and feet on bath day as needed and as needed between baths. Check care plan for special instructions. If diabetic, clean and file nails as ordered. Nurse to trim nails. If resident refuses notify nurse and re-approach.	F 677		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to	F 684		9/10/18

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F 684	Continued From page 8 facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to adequately monitor efficacy of interventions to promote intact skin integrity and healing of two non-pressure wounds on the left foot for 1 of 1 resident (R14) also failed to provide treatment regarding head positioning for 1 of 1 resident (R43). Findings include: R14's quarterly Minimum Data Set (MDS) an assessment dated 5/18/18, identified R14 with an admission date of 2/22/16, had intact cognition, was dependent on staff for activities of daily living (ADLs). The MDS identified R14 had medical diagnoses which included diabetes mellitus (condition with elevated blood sugars), diabetic neuropathy (damages nerves in your legs and feet), and peripheral vascular disease (circulatory problem in which narrowed arteries reduce blood flow to your limbs). R14's progress note dated, 2/24/18, revealed an arterial ulcer to the left top 4th toe with a measurement of 1.2 centimeters (cm) x 1.2 cm. Upon review of upcoming progress notes, wound was not measured again until 7/31/18, revealing a measurement of 0.7 cm x 0.8 cm. R14's progress note dated, 2/16/18, revealed an arterial ulcer to the left top great toe with a	F 684	R#14 arterial ulcer to top of 4th digit Left foot and arterial ulcer to Left great toe were measured. R#43's care plan was updated to include interventions for head/neck positioning. A request for OT to screen for wheelchair positioning was submitted 8-17-18 All residents with skin ulcers will have their wounds measured and documented on weekly. All residents with positioning needs of the head/neck will be reviewed to ensure interventions were developed to address positioning needs. All licensed nurses were re-educated on the Skin Ulcer protocol as it relates to monitoring and measuring wounds and on the need to implement written therapy recommendations. Random chart audits will be complete by the DON/designee 3x's/week for 4 weeks and then 2 audits monthly thereafter to ensure wounds are measured weekly. Random chart audits will be complete by the DON/designee 3x's/week for 4 weeks and then 2 audits monthly thereafter to ensure therapy recommendations are implemented for wheelchair positioning. Audit results will be brought to the QAPI committee for review and further recommendations.	

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F 684	Continued From page 9 "punched out" appearance. Further revealed on 2/10/18, a partial thickness open area was present upon removal of (R14's) grippy socks, with no measurements documented. R14's progress note dated 2/17/18, left great toe wound measurement 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. R14's Wound Care physician visit dated 3/9/18, revealed R14 was evaluated by vascular surgery on 2/1/18, and was to continue with conservative management. Revealed a recommendation to continue the use of equal mixture of iodosorb/solosite to all areas of ulceration. (Solosite is a hydrogel wound dressing with preservatives). R14's signed physician order dated 4/19/18, revealed left lateral 1st toe cleanse ulcer base with normal saline, apply iodosorb/hydrogel 50:50 mixture to ulcer base with a cotton swab, cover with dry soft gauze and secure with roll gauze. R14's signed physician order dated 7/10/18 does not reveal any dressing change orders. R14's onsite Podiatry note dated 4/26/18, identified to continue betadine and gauze dressings to left toes 1 and 4 to maintain dry eschar and reduce risk of infection. If things worsen, again recommend vascular specialist consult and non-invasive testing of lower	F 684		

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F 684	Continued From page 10 extremities. R14's Medical Doctor visit note dated 7/10/18, revealed an exam of lower extremities, with a plan: bandaging intact to left foot great toe and 4th digit at this time, managed by facility nurse practitioner, recommend heel cushions to both lower extremities, and diabetic foot education given to resident. R14's physician progress notes dated 7/23/18, revealed, "We will continue with wound care and consult with vascular surgery as needed." R14's care plan initiated 9/8/17, identified R14 to be at risk for impaired skin integrity as evidenced by history of diabetic neuropathic foot ulcers. A goal was identified for ulcers to heal without symptoms of infection. Interventions to include; inspect skin weekly, observe skin daily and monitor effectiveness of treatment and report to the doctor. During interview on 7/30/18, at 12:59 p.m. R14 stated, "I have some sores on my toes on my left foot and they are not getting any better, I bet it has been 6 months." They are putting some kind of medicine on it and they change the dressing every day. R14 was observed on 7/31/18, at 12:43 p.m. sitting up in her wheelchair in her room, well dressed, wearing white socks and Darco shoes, (shoes that reduce weight-bearing pressure on the forefoot, which promotes faster healing when forefoot wounds or ulcerations are present). On 8/1/18, at 9:22 a.m. licensed practical nurse (LPN)-A stated she had already did R14's	F 684		

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F 684	Continued From page 11 dressing change to her left foot. LPN-A verified that R14's wounds on her left foot had not measured since they were identified back in February 2018. When asked how they monitor if a wound was getting better LPN-A stated, "I guess if we measured it weekly we would have a better idea if they are getting better or not." On 8/1/18, at 1:09 p.m. registered nurse (RN)-B, verified R14's wounds on her left foot were not being measured on a regular basis, and stated, I guess if we measured the wounds on a regular basis it would be easier for us to tell if the wound is getting better. During an observation and interview on 8/2/18, at 8:36 a.m. registered nurse (RN)-C was observed to do wound care on left great toe and left fourth toe. RN-C measured both toes with the following measurements; Left great toe measurement: 2.6 cm x 3.5 cm and left 4th toe measurement was 0.7 cm x 0.6 cm. On 8/2/18, at 9:09 a.m. registered nurse (RN)-C verified the length of the wound on the great toe declined by 0.6 cm, and that wounds for R14 have not been monitored weekly since February 2018. RN-C stated, I think these wounds should be measured once a week so we can see the progression of the wound, in fact I just put that order in on Tuesday, we should be measuring all of our wounds once a week. On 8/2/18, at 9:10 a.m. the interim director of nursing (IDON), verified there was a 0.6 cm increase in R14's left great toe wound. The IDON stated, "All wounds should be getting a weekly measurement so we are able to monitor the wound more closely."	F 684		

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On 8/2/18, at 11:15 a.m. IDON stated she could not find any documentation saying the two wounds on R14's left foot were unavoidable, other than she had peripheral vascular disease.

Facility document, Skin Ulcer Protocol, updated 11/1/15, identified residents will not develop pressure ulcers or other skin ulcers unless clinically unavoidable. And appropriate care and services will be provided to prevent, treat and monitor progress of all healing ulcers. Page 6, revealed, assessment and monitoring of skin concerns, and wound round documentation weekly at a minimum the size of the wound, measurements in centimeters in length, width and depth, and the presence of any undermining or tunneling. If not showing improvement in last 2-4 weeks, medical doctor should be contacted for new treatment orders.
POSITIONING:

R43's quarterly Minimum Data Set (MDS) an assessment, dated 7/6/18, identified R43 required one assist with bed mobility, total assist for transfers, had diagnoses of dementia and severe cognitive impairment.

R43's current care plan included impaired mobility related to diagnosis of advanced dementia process and kyphosis (an exaggerated curvature of the upper (thoracic) spine that creates a hunchback appearance) as evidenced by inability to independently ambulate. Approaches included encourage to get out of bed three times per day, monitor for changes in abilities, passive range of motion (PROM) to lower extremities and splint/brace to lower extremities twice daily. Decline in range of motion (ROM), at risk for

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contractures related to osteoarthritis and dementia. Approaches included staff will place bilateral AFO's (ankle-foot orthosis) to lower extremities twice daily when up in chair. R43's care plan lacked interventions for head/neck positioning.

R43 was observed on 7/30/18, at 1:11 p.m., seated upright in a Broda chair (tilt-in-space positioning chair) in her room. R43's head was hanging straight down in front of her. At 6:22 p.m., R43 was seated upright in a Broda chair in her room. R43's head was hanging straight down in front of her. When surveyor spoke to R43, R43 lifted her head up to speak to surveyor.

R43 was observed on 7/31/18, at 12:48 p.m., seated in a Broda chair, in an upright position, in her room. R43's head was hanging straight down in front of her. R43 lifted her head up (but was not able to lift her head fully straight up) and when she was done, looking up her head hung down straight in front of her.

R43 was observed on 8/1/18, at 8:16 a.m., seated upright in a Broda chair in the dining room. R43's head was hanging straight down in front of her.

On 8/1/18, at 7:16 a.m., nursing assistant (NA)-C stated R43's head position (hanging straight down in front of her) had been that way since she had worked at the facility (one year ago). NA-C stated R43 was on hospice from the time I started working here until recently, a couple of months ago. When asked if R43 had received any therapy for head positioning, NA-C stated I do not think residents can have therapy when on hospice. I have never seen the therapy

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F 684	Continued From page 14 department work with R43. On 8/1/18, at 10:23 a.m., occupational therapist (OT)-E stated R43 had received occupational therapy (OT) in October 2017, for positioning of her head. When asked what was done for R43's head positioning, OT-E stated lateral supports were applied on wheelchair and routine resting on top of bed to allow stretching of neck, versus being in chair all day. OT-E stated a brace for holding R43's head upright was not tried, when R43 received OT therapy. R43's OT recommendations, dated 10/19/17, provided by OT-E read, alternate in bed with sitting in wheelchair to allow for comfort and pressure relief. When sitting in chair tilt back as needed for better head/neck positioning. Cue as needed to lift head during activities/mealtime to strengthen neck muscles for better positioning. R43's care plan lacked the OT recommendations for head positioning. On 8/1/18, at 1:10 p.m., the interim director of nursing (IDON) stated R43 had extreme kyphosis. IDON confirmed R43's head hung straight down. When queried what had been done regarding R43's head position, IDON stated R43 was on hospice until recently. We have not done any splinting or anything like that, R43's head position has been long term. On 8/2/18, at 2:12 p.m., the IDON stated she would have expected the OT recommendations to be on R43's care plan, communicated to the nursing assistants and placed on the care guide for the nursing assistants. A policy for positioning was requested, but not	F 684		

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F 684	Continued From page 15 provided.	F 684		
F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to provide services to maintain range of motion (ROM) of upper extremities for 1 of 1 resident (R42) reviewed for ROM. Findings include: R42's current diagnoses according to the undated face sheet included: Hemiplegia (paralysis of one side of the body), following cerebral infarct (stroke) affecting left dominant side, and Major Depressive Disorder.	F 688	R#42 PROM program was added to the care plan and NAR assignment sheet and staff caring for R42 were re-educated on the plan. R#42 was referred back to OT for splinting needs, R#42's care plan will be updated as needed based on the assessment. Residents that require ROM for upper extremities will be reviewed to ensure ROM program/needs are on the care plan. Staff responsible for care planning ROM programs, including splinting needs were re-educated on the process of care	9/10/18

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F 688	Continued From page 16 R42's Prospective Payment System (PPS) 90 day, Minimum Data Set (MDS) an assessment dated 7/5/18, indicated intact cognition and required extensive assistance of staff with activities of daily living (ADLs). Further identified a functional limitation in range of motion to one side in the upper and lower extremity. R42's care plan, dated 5/7/18, identified impaired mobility related to diagnosis of hemiplegia as evidenced by inability to ambulate. R42's goal is to remain free of contractures. The care plan also identified R42 required passive range of motion (PROM) to lower extremities and the use of a left hand/forearm splint to be put on in the am and taken off at bedtime. (Care plan did not identify PROM to the upper extremities). R42's current, undated, resident assignment sheet, indicated staff were to remember to place splint on left hand/forearm on in the am and off at 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 Motion Exercises for Shoulders, Arms, Wrists and Fingers, indicated staff to do with flex and extend of fingers to do thumb, pointer and middle finger together, Do ring and pinky together, slow stretch to open fingers as much as possible. Further indicated to complete handwashing and skin	F 688	planning therapy recommendations. Random chart audits will be complete by the DON/designee 3x's/week for 4 weeks and then 2 audits monthly thereafter to ensure therapy recommendations are implemented for ROM needs. Audit results will be brought to the QAPI committee for review and further recommendations.	

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F 688	Continued From page 17	F 688		

check after stretching and apply lotion to hands.

During observation 7/30/18, at 5:59 p.m. R42's left hand is noted to be contracted, and unable to open her hand when asked. No splints or palm grips noted on left hand/forearm. R42 stated, "I don't ever use a splint. No one does range of motion to my left arm unless I go to those exercises.

During observation on 7/31/18, at 12:23 p.m. R42 is sitting in her wheelchair up to the table in the dining room and is noted to not be wearing a hand splint.

During observation on 8/1/18, at 10:02 a.m. R42 is lying down in her bed on her back. Nursing assistant (NA)-A tried to straighten out R42's left fingers to see her fingernails, R42 stated, "Ouch, ouch, [curse words] that hurts!" NA-A told R42 she was sorry and R42 stated, Oh my fingers hurt leave them alone! Resident was not observed to be wearing a splint on her left hand.

During interview on 8/2/18, at 12:55 p.m. nursing assistant (NA)-D stated, according to our care sheet R42 is supposed to have a splint on her left hand, if there was range of motion to do for her it would be on our care sheet and it is not. NA-D verified she did not do PROM for R42 today. NA-D could not find R42's splint in her room.

During observation and interview on 8/2/18, at 12:59 p.m. R42 was sitting in her wheelchair, well dressed, no splint noted to be on her left hand. R42's left hand was in a closed fist position with her thumb tucked behind her fingers. R42 when asked was unable to open her left hand even with the assist of her right hand. R42 stated, "I am

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F 688	Continued From page 18	F 688		

supposed to be wearing a splint to help prevent contractures." I was a licensed practical nurse (LPN) for several years you know.

During interview on 8/2/18, at 1:07 p.m. nursing assistant (NA)-E verified R42 used to wear a splint, but can't remember that last time R42 had it on.

During interview on 8/2/18, at 1:08 p.m. registered nurse (RN)-C verified R42 is not wearing the splint to her left hand like the care plan indicated. RN-C stated the splint would help to prevent contractures.

During interview on 8/2/18, at 1:16 p.m. physical therapist (PT) reviewed R42's record and verified R42 was in occupational therapy from 4/5/18, to 7/11/18, and should have a splint to her left hand to put be put on in the morning and remove at bedtime to help prevent contractures. PT further verified she should be getting PROM to her left hand and highly recommends it.

During interview on 8/2/18, at 1:27 p.m. interim director of nursing (IDON) stated when a resident is discharged from therapy, they will give their recommendations to nursing. Nursing will make copies of the forms and give to the wing nurses and make copies to put in the therapy communication book and the residents chart. The nurse will then update the care plan and that will be put on the resident assignment sheet.

During interview on 8/2/18, at 1:34 p.m. registered nurse (RN)-A verified therapy had contacted her on 7/11/18, about the implementation of a PROM program for R42. RN-A stated, "I should have put the PROM

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F 688	Continued From page 19 program in right away." During interview via phone on 8/2/18, at 2:21 p.m. occupational therapist (OT) stated, "I am shocked they haven't been doing [R42's] range of motion, I think it was July 13, 2018, when I trained all of the nursing staff and they told me they felt confident about doing that." OT verified R42 should be receiving hand hygiene and PROM to her left upper extremity daily. OT stated, a result of not having the range of motion for the last two and a half weeks the resident could suffer from joint stiffness, pain, and poor positioning. This surveyor asked if it was normal for R42's left hand to be in a position as follows: fingers curled over the thumb. OT responded, when I first started working with (R42) she did that, but when I started doing range of motion every day, when I was done I would position her thumb over her fingers, so if her hand has been in that position, it's from not doing the range of motion, a harmful affect. I do recommend the splint should be worn. Facility policy, Restorative Nursing Program Policy, dated 9/22/17, indicated passive range of motion exercises must be care planned, scheduled, and documented in the medical record. further indicated with splint or brace assistance, staff applies, manipulates, and cares for the device or provide verbal cues, guidance, and direction to teach the resident to use it.	F 688		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to	F 690		9/10/18

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F 690	Continued From page 20 maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure appropriate treatment and services were provided to 1 of 1 resident (R14), reviewed for urinary catheter. Findings include:	F 690	R#14 MD was updated on recent catheter changes and new orders were obtained. All residents with catheters were reviewed to ensure physician orders are followed as written. Licensed nursing staff were re-educated	

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F 690	Continued From page 21 R14's quarterly Minimum Data Set (MDS) an assessment dated 5/18/18, identified R14 with an admit date of 2/22/16, had intact cognition, was dependent on staff for activities of daily living (ADLs). Further identified R14 to have an indwelling catheter. R14's face sheet printed 8/1/18, identified the following diagnoses: retention of urine and personal history of urinary tract infections. R14's Physician Order Sheet dated and signed by physician on 4/19/18 identified to change Foley catheter on the 17th of every month, for retention of urine, with 16 French, 10 milliliter (ml) balloon. R14's Physician transcribed order, dated 7/8/18, indicated the use of 18 French 30 ml balloon Foley catheter to be changed the 5th of every month. (not signed by physician). R14's care plan, dated 9/8/17, revealed risk of infection related to invasive procedure as evidenced by Foley catheter. Goal is resident will remain free from infection while having a Foley catheter. Approach is to monitor for signs and symptoms of infection, report abnormal labs, use appropriate hand hygiene, use appropriate equipment and assist with pericare twice a day and as needed. R14's electronic treatment administration sheet (ETAR), dated 7/18, identified 2 different orders: On 4/17/18, change Foley catheter on the 17th of every month with 16 French 10 ml balloon. On 7/8/18, change Foley catheter on the 17th of every month with 18 French 30 ml balloon. No treatments for either order were documented for the month of July. Review of August ETAR,	F 690	on following physician orders r/t catheter size and on the need to notify the physician when frequent catheter changes are needed. Random chart and observational audits will be completed by the DON/designee 3x's/week for 4 weeks and then 2 audits monthly thereafter to ensure physician orders are being followed as it relates to catheter size. Audit results will be brought to the QAPI committee for review and further recommendations.	

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F 690	Continued From page 22	F 690		

revealed no documentation of Foley catheter change.

R14's progress note dated 6/17/18, at 7:38 a.m. catheter changed as ordered. (Does not identify size of catheter used).

R14's progress note dated 6/6/18, at 2:12 a.m. resident used call light "I feel myself getting wet." Foley catheter in place, urine in the tubing. Deflated and reflated balloon with 10 cc. Every hour resident activated the call light with the same statement of feeling wet in brief. Brief with a moderate saturation of urine. Changed Foley catheter, 16 French with 10 cc balloon.

R14's progress note dated 7/5/18, at 2:21 a.m. (R14) alerted the staff, "feel like I am wetting myself again." deflated and re-inflated the balloon, attempt to flush unsuccessful unable to advance flush. Order calls for 16 French 10 cc balloon. Changed per order instruction. Brief was soiled with urine. Change the treatment order for monthly changes to reflect the Foley catheter change.

R14's progress note dated 7/8/18, Foley catheter was no longer patent and was leaking urine around the lumen. 16 French catheter replaced with an 18 French 30 cc balloon Foley catheter. Moderate amount of sediment noted with initial output. Catheter is patent at this time.

R14's progress note dated 7/13/18, at 2:02 a.m. nursing assistant alerted writer, brief saturated with urine, catheter collection bag and tubing, no urine output. Attempt to flush not successful due to resistance. Catheter change with 18 French with 30 cc balloon, tolerated without incident. 900

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F 690	Continued From page 23	F 690		

ml output immediately following the change, noted on Foley catheter removed the balloon did have a leak.

R14's progress note dated, 7/18/18, at 10:55 p.m. catheter leaking , strap to hold catheter in place was low (just above the knee) possibly causing the catheter to leak. Catheter was advanced though continued to leak. Catheter changed 16 French 30 cc with no further issues. Strap was placed upper thigh area to hold catheter in place and prevent pulling of catheter.

R14's progress note dated 7/30/18, at 11:47 p.m. Foley catheter leaking and tubing appeared to be out further than recommended. Tubing advanced and yellow/light yellow urine noted in catheter tuning. Leg strap applied to upper thigh to hold catheter in place. Later in the shift it was reported the Catheter was leaking again. Catheter changed with no issues, c/o pain, discomfort from resident. Yellow/light yellow urine flowing from the tube. (Size of catheter not documented).

During interview on 7/30/18, at 12:47 p.m. R14 stated I have had a catheter for a while now, and it had to be replaced before it was supposed to.

During interview on 7/31/18, at 12:45 p.m. R14 stated, I had to have a new catheter put in last night, it just wasn't working right.

During observation and interview on 8/1/18, at 7:25 a.m. R14 is lying in bed, dressed in facility night gown and nursing assistant (NA)-B is assisting R14 with catheter care. NA-B verified the catheter in place is an 18 French catheter with a 30 milliliter (ml) balloon.

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F 690	Continued From page 24	F 690		

During interview on 8/1/18, at 8:53 a.m. licensed practical nurse (LPN)-A verified R14 currently has an 18 French 30 cc Foley catheter in at this time and the only physicians order for R14's catheter was a size 16 French, 10 ml balloon, signed on 2/12/18. LPN-A further verified one of the nurses changed the order of the catheter in the electronic medical record to an 18 French 30 ml balloon without a signed order from the physician on 7/8/18.

During interview on 8/1/18, at 9:05 a.m. registered nurse (RN)-A verified R14 currently has a size 18 French 30 ml balloon catheter in place, with no current signed physician order for that size. RN-A further verified R14 has had her catheter changed 5 times in the last month with no documentation to notify the doctor. RN-A stated the more you change a catheter the more at risk you are for an infection, with R14's history of infection the doctor should have been updated.

During interview on 8/1/18, at 9:39 a.m. interim director of nursing (IDON) verified R14 currently has a size 18 French 30 ml balloon catheter in place, with no current signed physician order for that size. IDON further verified R14 has had her catheter changed 5 times in the month of July, 2018, with various sizes of catheters, without notifying the physician. IDON stated, my expectation would be the doctor should be notified of that many catheter changes, especially with her history of urinary tract infections, and that the nursing staff should be following the physician's orders as written.

Policy for physician orders was requested and not received.

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F 711 SS=E	Physician Visits - Review Care/Notes/Order CFR(s): 483.30(b)(1)-(3) §483.30(b) Physician Visits The physician must- §483.30(b)(1) Review the resident's total program of care, including medications and treatments, at each visit required by paragraph (c) of this section; §483.30(b)(2) Write, sign, and date progress notes at each visit; and §483.30(b)(3) Sign and date all orders with the exception of influenza and pneumococcal vaccines, which may be administered per physician-approved facility policy after an assessment for contraindications. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure the physician reviewed treatments and auxillary orders during routine visits for 16 of 16 residents (R17, R22, R43, R45, R9, R10, R31, R40, R2, R6, R13, R14, R18, R20 and R42) reviewed for signed physician orders. Findings include: R17's Face Sheet, dated 8/1/18, included diagnoses of Alzheimer's disease, chronic pulmonary embolism, obstructive sleep apnea, hypertension, nutritional deficiency, anxiety disorder, combined systolic and diastolic heart failure and obesity. R17's Physician Order Sheet, signed by a certified nurse practitioner, dated 7/26/18,	F 711	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 signed 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 the 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 by the DON/designee 3x's/week for 4 weeks and then 2 audits monthly thereafter to ensure ongoing compliance. Audit results	9/10/18

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F 711	Continued From page 26 included review of medications and care plan. The order sheets lacked documentation of review of R17's treatments and auxiliary orders. R22's Face Sheet, dated 8/1/18, included diagnoses of chronic obstructive pulmonary disease, chronic diastolic heart failure, chronic atrial fibrillation, anemia, malignant neoplasm of prostate, nutritional deficiency and sleep apnea. During observation and interview, on 7/30/18, at 3:18 p.m., R22 stated he had a catheter in place. A catheter drainage bag was observed to be hanging under R22's wheelchair. R22's Physician Order Sheet, signed by a certified nurse practitioner, dated 7/9/18, included review of medications and care plan. The order sheets lacked documentation of review of R22's treatments and auxiliary orders. R43's Face Sheet, dated 8/1/18, included diagnoses of chronic pain, kyphosis, peripheral vascular disease, osteoarthritis and dementia. R43's Physician Order Sheet, signed by a certified nurse practitioner, dated 6/21/18, included review of medications and care plan. The order sheets lacked documentation of review of R43's treatments and auxiliary orders. R45's Face Sheet, dated 8/1/18, included diagnoses of chronic pain, kyphosis, peripheral vascular disease, osteoarthritis and dementia. R45's Physician Order Sheet, signed by the physician, dated 7/10/18, included review of medications and care plan. The order sheets lacked documentation of review of R45's	F 711	will be brought to the QAPI committee for review and further recommendations.	

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	245376	A. BUILDING ______ B. WING ______	08/02/2018

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F 711	Continued From page 27 treatments and auxiliary orders. During interview on 7/31/18, at 12:09 p.m., the IDON stated Physician (P)-F preference was to print out the medications for residents only and he wanted to address the treatments in his narrative notes. However, the progress notes related to R17, R22, R43, & R45, lacked to include a review of treatment and auxiliary orders. The IDON stated she would guess all residents included the same and P-F was physician for every resident except one resident. R9's Face sheet indicated, R9 admitted on 11/3/17, with diagnoses that included, non-pressure chronic ulcer of left calf, venous insufficiency (peripheral), atrial fib, heart failure and hypertension. R9's most recent signed ordered for medications dated 7/9/18, showed medications only. R9's most recent nurse practitioner progress note from visit dated 7/9/18, indicated review of medications orders, review of systems and was noted to have order to continue dressing changes to left lower leg ulcer twice daily. However, no other documentation indicated treatment, dietary, or ancillary orders were reviewed and signed by nurse practitioner during this visit. R10's face sheet indicated, R10 admitted on 2/1/18, with diagnoses that included stroke, heart disease, congestive heart failure and hypertenstion. R10's most recent signed ordered for medications dated 6/7/18, showed medications	F 711		

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F 711	Continued From page 28 only. R10's most recent nurse practitioner progress note from visit dated 6/7/18, indicated review of medications orders and review of systems. However, no other documentation indicated treatment, dietary, or ancillary orders were reviewed and signed by nurse practitioner during this visit. R31's face sheet indicated, R31 admitted on 11/4/16, with diagnoses that include heart attack, difficulty swallowing, urinary retention and hearing loss. R31's most recent signed ordered for medications dated 6/4/18, showed medications only. R31's most recent nurse practitioner progress note from visit dated 6/4/2018, indicated review of medications orders and review of systems. However, no other documentation indicated treatment, dietary, or ancillary orders were reviewed and signed by nurse practitioner during this visit. R40's face sheet indicated, R40 admitted on 12/29/17, with diagnoses that include progress supranuclear opthalmoplegia (neurodegenerative condition that causes problems with balance, vision, speech, movement and swallowing), anxiety disorder, urinary retention, major depressive disorder and delusional disorder. R40's most recent physician's progress note from visit dated 6/26/18, indicated review of	F 711		

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F 711	Continued From page 29	F 711		

medications orders and review of systems and was electronically signed by the physician on 6/26/18.

However, no other documentation indicated treatment, dietary, or ancillary orders were reviewed and signed by physician during this visit.
R2's Face Sheet, dated 8/1/18, included diagnoses of dementia with behavioral disturbance, major depressive disorder, anxiety disorder, presence of cardiac pacemaker, and insomnia.

R2's Physician Order Sheet, signed by the physician, dated 7/24/18, included review of medications and care plan. The order sheets lacked documentation of review of R2's treatments and auxiliary orders.

R6's Face Sheet, dated 8/1/18, included diagnoses of diabetes mellitus, hypertension, major depressive disorder, anemia, dizziness and giddiness, legal blindness, and insomnia.

R6's Physician Order Sheet, signed by the physician, dated 7/17/18, included review of medications and care plan. The order sheets lacked documentation of review of R6's treatments and auxiliary orders.

R13's Face Sheet, dated 8/1/18, included diagnoses of type 2 diabetes mellitus, obesity, major depressive disorder, contracture of the knee, cerebral infarct with hemiplegia of the right side, and heart failure.

R13's Physician Order Sheet, signed by a physician, dated 6/19/18, included review of medications and care plan. The order sheets

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F 711	Continued From page 30 lacked documentation of review of R13's treatments and auxiliary orders. R14's Face Sheet, dated 8/1/18, included diagnoses of type diabetes mellitus with diabetic neuropathy, urinary retention, pulmonary edema, insomnia, anxiety, morbid obesity, diastolic heart failure, presence of cardiac pacemaker, and asthma. R14's Physician Order Sheet, signed by the physician, dated 7/10/18, included review of medications and care plan. The order sheets lacked documentation of review of R14's treatments and auxiliary orders, to include foley catheter orders, when R14 utilized a foley catheter. R18's Face Sheet, dated 8/1/18, included diagnoses of anxiety disorder, low back pain, constipation, gastritis, and unstageable pressure ulcer. R18's Physician Order Sheet, signed by a physician, dated 6/12/18, included review of medications and care plan. The order sheets lacked documentation of review of R18's treatments and auxiliary orders. R20's Face Sheet, dated 8/1/18, included diagnoses of type 2 diabetes mellitus, anemia, chronic diastolic heart failure, hypertension, atrial fibrillation, phantom limb pain, chronic respiratory failure with hypoxia, dementia, insomnia, anemia, and stage 3 kidney disease. R20's Physician Order Sheet, signed by certified nurse practitioner, dated 6/25/18, included review of medications and care plan. The order sheets	F 711		

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F 711	Continued From page 31 lacked documentation of review of R20's treatments and auxiliary orders. R42's Face Sheet, dated 8/1/18, included diagnoses of toxic encephalopathy, hemiplegia following a stroke on left side, congestive heart failure, cardiomegaly, hypertension, urinary retention, major depressive disorder, anemia, insomnia, chronic obstructive pulmonary disease, seizures, sleep apnea and chronic kidney disease stage 5. R42's Physician Order Sheet, signed by a physician, dated 6/19/18, included review of medications and care plan. The order sheets lacked documentation of review of R42's treatments and auxiliary orders. During interview on 8/1/18, at 1:09 p.m. registered nurse (RN)-B said, "I can't tell a lie, the reason why our doctor quit signing the treatments and just signs the md [medication] orders now, is because he thought he had to sign every page." We have alerted him that he only has to sign the last page, so now that we are aware of this problem, we are going to fix that. Facility policy, "Physician visits" reviewed/amended 10/20/17, indicated each regulated physician visit will minimally consist of actual face to face contact with the resident, reviewing the residents total plan of care, including medications and treatments, writing a progress note which is signed and dated as well as signing all new orders.	F 711		
F 867 SS=F	QAPI/QAA Improvement Activities CFR(s): 483.75(g)(2)(ii)	F 867		9/10/18

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F 867 Continued From page 32

§483.75(g) Quality assessment and assurance.

§483.75(g)(2) The quality assessment and assurance committee must:
(ii) Develop and implement appropriate plans of action to correct identified quality deficiencies;
This REQUIREMENT is not met as evidenced by:
Based on interview and record review, the facility failed to develop and implement a Quality Assurance and Performance Improvement (QAPI) plan to correct and identify quality deficiencies with identified areas for lack of physician review of treatment and auxiliary orders for residents. This had the potential to affect 44 of 45 residents residing in the facility.

Finding included:

During interview on 7/30/18, at 5:56 p.m., the interim director of nursing (IDON) reviewed R22's Physician Order Sheet, dated 7/9/18, and verified the orders included review of medications and care plan, and lacked review of treatment orders. The IDON stated I will find out if the treatment orders are being signed every 60 days. In addition, the orders lacked to include auxiliary orders.

During interview on 7/31/18, at 12:09 p.m., the IDON stated Physician (P)-F preference was to print out the medications for residents only and he wanted to address the treatments in his narrative notes. However, the progress notes related to the visits, lacked to include a review of treatment and auxiliary orders. The IDON stated she would guess all residents included the same and P-F was physician for every resident except one resident.

F 867 (Plan of correction)

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 team or ZHS staff to be discussed at the conclusion of each quarterly QAPI meeting to address any improvements or changes in processes to ensure that no changes are made without the express involvement of the medical team and the facility leadership.

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F 867	Continued From page 33 During interview on 8/2/18, at 3:09 p.m., the administrator stated she was not aware the physician was not reviewing treatment orders. At the time of the interview registered nurse (RN)-C stated I was aware. Physician (P)-F (facility medical director) informed he wanted to sign all treatment and medication orders on admit and asked why he needed to see these after general admission. The administrator stated P-F had been signing for all treatments orders on residents up until March. The administrator stated she would have expected the request of P-F to be communicated to herself, the assistant director of nursing and the interim director of nursing, so a decision could be made whether we could accommodate P-F's request or not. During interview on 8/2/18, at 3:44 p.m., the administrator stated health unit coordinator was aware of P-F's request regarding the treatment orders. The facility Quality Assurance Process Improvement (QAPI) Plan, reviewed 10/23/17, indicated Our QAPI plan focus areas includes all systems that affect resident and family satisfaction, quality of care and services provided, and quality of life for persons living and working in our organization.	F 867		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the	F 880		9/10/18

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F 880	Continued From page 34 development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.	F 880		

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F 880	Continued From page 35 (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure current standards of practice for infection control when providing peri cares for 1 of 1 resident (R3), who was observed during morning cares. Findings include: During observation of morning cares on 8/1/18, at 7:16 a.m., nursing assistant (NA)-C applied gloves, cleansed R43's peri area, removed wet (urine) incontinent product, cleansed R43's buttocks (gloves remained on), applied a clean incontinent product, pulled up R43's pants, pulled down R43's shirt, touched a comb, rolled R43 towards her and removed gloves. NA-C held a walkie-talkie in her hand to communicate with	F 880	Staff caring for R#43 were re-educated on proper handwashing. All residents must have cares provided that ensure current standards of practice 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 brought to the QAPI committee for review and further recommendations.	

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F 880	Continued From page 36	F 880		

staff, put R43's lotion bottle away, placed dirty linens in a bag and applied heel protectors to R43's feet. The interim director of nursing (IDON) walked into R43's room to assist with transferring R43 into a Broda chair. NA-C stated I am going to wash my hands now. During interview with NA-C after providing R43's morning care, NA-C verified she had not removed her gloves and washed hands after providing peri cares for R43.

On 8/1/18, at 1:21 p.m., the IDON stated she would expect gloves to be removed and hands washed after providing peri cares.

On 8/2/18, at 11:05 a.m., the assistant director of nursing stated she would expect when gloves are contaminated, staff should remove the gloves before touching other surfaces and perform hand hygiene.

The Hand Hygiene policy, reviewed 8/2011, indicated Procedure: A. All staff will practice hand hygiene: 2. Before applying and after removing gloves.

A policy for glove use was requested, but not provided.

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

F5376026

PRINTED: 09/10/2018
FORM APPROVED
OMB NO. 0938-0391

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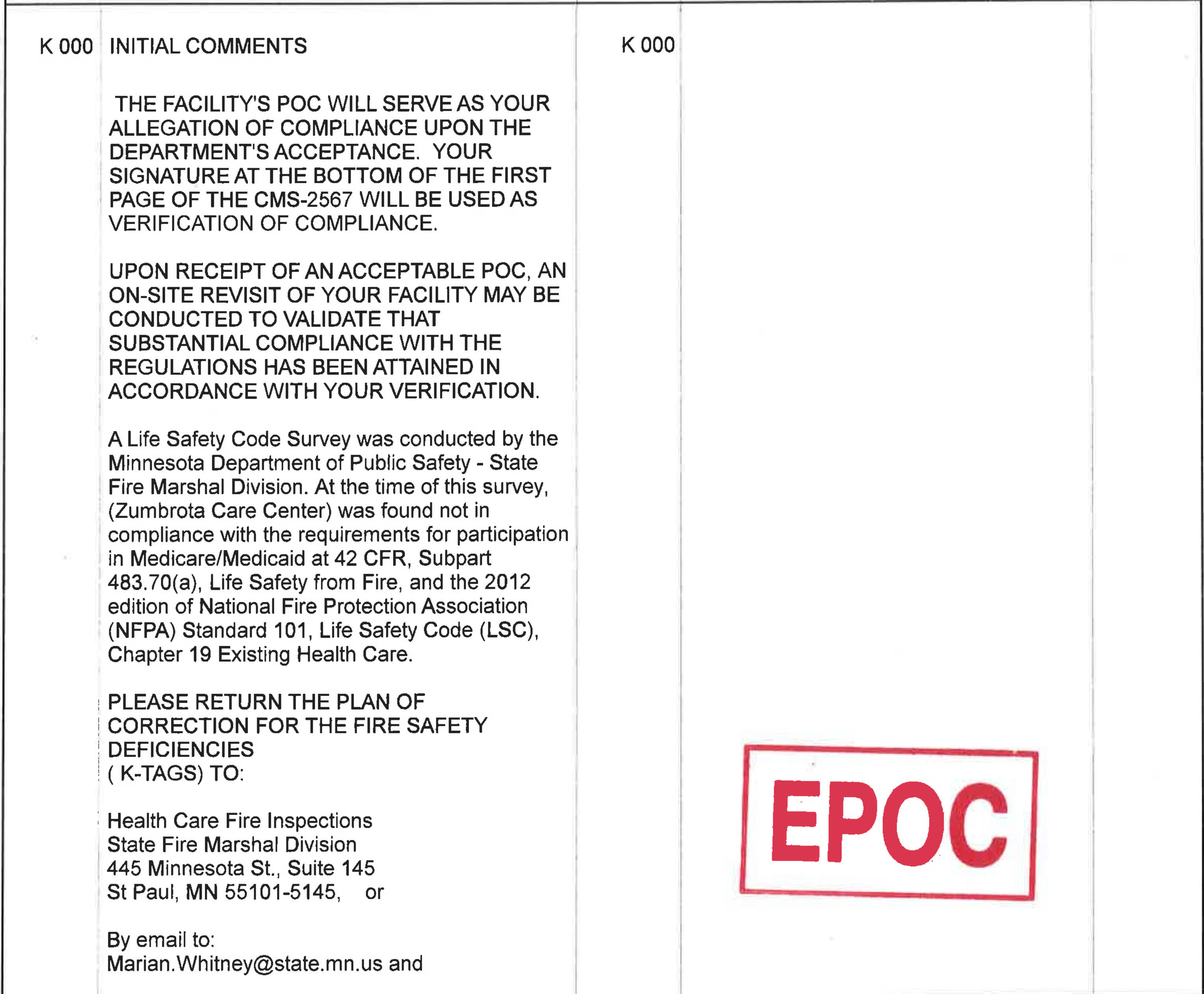

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K 000	INITIAL COMMENTS THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ON-SITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety - State Fire Marshal Division. At the time of this survey, (Zumbrota Care Center) was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: Health Care Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St Paul, MN 55101-5145, or By email to: Marian.Whitney@state.mn.us and	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		08/29/2018

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

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K 000	Continued From page 1 Angela.Kappenman@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. Zumbrota Care Center is a 1-story building. The building was constructed at 3 different times. The original building was constructed in 1964 and was determined to be of Type II(000) construction, with a partial basement. In 1968, an addition was constructed that was determined to be of Type II(000) construction, with no basement. In 2014 a 2-story addition was constructed that was determined to be of Type II(000) construction with a basement. The building is protected by a full fire sprinkler system. The facility has a fire alarm system with full corridor smoke detection and spaces open to the corridors that is monitored for automatic fire department notification. The facility has a capacity of 50 beds and had a census of 44 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is **NOT MET** as evidenced by:	K 000		
K 211 SS=F	Means of Egress - General CFR(s): NFPA 101	K 211		9/13/18

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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)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 211	Continued From page 2 Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 This REQUIREMENT is not met as evidenced by: 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 within the smoke compartment/ Facility. Findings Include: On facility tour between 09:00 AM and 12:00 PM on 08/02/2018, observations and staff interview revealed the following: The installation of the interior finishes in the North, South and West corridors has diminished the width of an existing corridor. The corridors width was reduced from 84-3/4 inches to 75-3/4 inches the entire length of each corridor. NOTE: This deficiency need not be corrected if an FSES can establish that the facility has a level of fire safety equivalent to the required by the Life safety Code This deficient practice was confirmed by the Facility Maintenance Director at the time of discovery.	K 211	In order to gain compliance with K0211, an FSES survey will be conducted at the Zumbrota Care Center. Zumbrota Care Center will achieve a passing FSES score by September 13, 2018.	
K 918	Electrical Systems - Essential Electric Syste	K 918		8/24/18

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245376	A. BUILDING **01 - MAIN BUILDING 01** B. WING	**08/02/2018**

NAME OF 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)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 918 SS=D	Continued From page 3 CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This REQUIREMENT is not met as evidenced by: The facility failed to comply with Life Safety Code	K 918	In order to gain compliance with K0918,	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245376	A. BUILDING **01 - MAIN BUILDING 01** B. WING	**08/02/2018**

NAME OF 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)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 918	Continued From page 4 (6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70)) This deficient practice could affect the safety of all (44) the residents, staff and visitors within the smoke compartment/ Facility. Findings Include: On facility tour between 09:00 AM and 12:00 PM on 08/02/2018, observations and staff interview revealed the following: Observation during the inspection revealed there is no emergency stop button for the generator - either located outside of the generator enclosure -or- inside the facility This deficient practice was confirmed by the Facility Maintenance Director at the time of discovery.	K 918	an emergency stop push-button control was installed on the outside of the generator on 8/24/2018.	

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
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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®* (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.

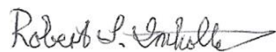
The following factors served as the basis for this evaluation:

- 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 L. Imholte
President, *Fire Safety Resources, LLC*

Enclosures

RLI/rli

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-hour-rated 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*® (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.

<u>All Zones – WORKSHEET 4.7.10. FACILITY FIRE SAFETY REQUIREMENTS WORKSHEET</u>

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.
2. 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.
3. 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.
4. 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".
5. Doors to Corridor [Score: +1]:
   Corridor doors in this zone were found to be of 1¾-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.
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. 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.

<u>Zone 2 – Main Level North Wing and Lobby Area</u>:

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.
2. 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

1. 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 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.
3. 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 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".
5. Doors to Corridor [Score: +1]:
   Corridor doors in this zone were found to be of 1¾-inch-thick solid wood construction.
6. Zone Dimensions [Score: 0]:
   This zone measures approximately 110 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 first floor zone. 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: -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.
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. 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.
2. 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.
3. 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.
4. 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".

5. Doors to Corridor [Score: +1]:
   Corridor doors in this zone were found to be of 1¾-inch-thick solid wood construction mounted in metal frames.
6. Zone Dimensions [Score: +1]:
   This zone measures approximately 40 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 first floor zone. 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: -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.
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. 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.

<u>Zone 4 – Main Level West Wing</u>:

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

1. 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.
3. 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.
4. 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".
5. Doors to Corridor [Score: +1]:
   Corridor doors in this zone were found to be of 1¾-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.
7. 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.
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]:
    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.
3. 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

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 and gypsum wallboard. Documentation was provided certifying that the acoustical ceiling tile carries a Class A (25 or less) flame spread rating.
3. 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.
4. Corridor Partitions/Walls [Score: +2]:
   Corridor walls were determined to be constructed of masonry and gypsum wallboard installed on both sides of steel studs.
5. 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".
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.

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. The zone is protected with corridor 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 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.
3. 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

1. Construction [Score: 0]:
   The building was assigned a Type II(000) construction type.
2. 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.
3. 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".
5. Doors to Corridor [Score: +1]:
   Corridor doors in this zone were found to be of 1¾-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^2 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 "≥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.
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. The zone is protected with corridor smoke detection and quick-response sprinklers.
13. 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 Mill St, Zumbrota, MN 55992		
ZONE(S) EVALUATED: Original Building, Basement Level			
PROVIDER/VENDOR NO.: 245376	DATE OF SURVEY: 09/13/2018		
SURVEYOR SIGNATURE: Robert L. Imholte	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

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.

WORKSHEET 4.7.2 – OCCUPANCY RISK PARAMETER FACTORS

Risk Parameters	Risk Factor Values					
1. Patient Mobility *(M)*	Mobility Status	Mobile	Limited Mobility		Not Mobile	Not Movable
	Risk Factor	1.0	1.6		3.2	4.5
2. Patient Density *(D)*	No. of Patients	1–5	6–10		11–30	>30
	Risk Factor	1.0	1.2		1.5	2.0
3. Zone Location *(L)*	Floor	1st	2nd or 3rd	4th to 6th	7th and Above	Basements
	Risk Factor	1.1	1.2	1.4	1.6	(1.6)
4. Ratio of Patients to Attendants *(T)*	Patients / Attendant	1–2 / 1	3–5 / 1	6–10 / 1	>10 / 1	One or More / None
	Risk Factor	1.0	1.1	1.2	1.5	4.0*
5. Patient Average Age *(A)*	Age	Under 65 Years and Over 1 Year		65 Years and Over or 1 Year and Younger		
	Risk Factor	1.0		1.2		

*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		T		A		F
OCCUPANCY RISK	☐	X	☐	X	☐	X	☐	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)

		F		R
0.6	X	1.6	=	1

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				Non-Combustible Types I and II		
Floor or Zone	000	111	200	211, 2HH	000	111	222, 322, 442
First	-2	0	-2	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

Safety Parameters					
2. Interior Finish (Corridors and Exits)	Class C	Class B	Class A		
	-5(0)[f]	0(3)[f]	3		
3. Interior Finish (Rooms)	Class C	Class B	Class A		
	-3(1)[f]	1(3)[f]	3		
4. Corridor Partitions/Walls	None or Incomplete	<½ hour	>½ to <1 hour	≥1 hour	
	-10(0)[a]	0	1(0)[a]	2(0)[a]	
5. Doors to Corridor	No Door	<20 min FPR	≥ 20 min FPR	≥ 20 min FPR and Auto Closure	
	-10	0	1(0)[d]	2(0)[d]	

6. Zone Dimensions	Dead End			No Dead Ends >30 ft. and Zone Length Is		
	>100 ft.	>50 ft. to 100 ft.	30 ft. to 50 ft.	>150 ft.	100 ft. to 150 ft.	<100 ft.
	-6(0)[b]	-4(0)[b]	-2(0)[b]	-2(0)[c] (0)[h]	0(0)[h]	1

Safety Parameters					
7. Vertical Openings	Open 4 or More Floors	Open 2 or 3 Floors	Enclosed with Indicated Fire Resistance		
			<1 hr.	≥1 hr. to <2 hr.	≥2 hr.
	-14	-10	0	2(0)[e]	3(0)[e]
8. Hazardous Areas	Double Deficiency		Single Deficiency		No Deficiencies
	In Zone	Outside Zone	In Zone	In Adjacent Zone	
	-11	-5	-6	-2	0
9. Smoke Control	No Control	Smoke Barrier Serves Zone	Mechanically Assisted Systems by Zone		
	-5(0)[c]	0	3		
10. Emergency Movement Routes	<2 Routes	Multiple Routes			Direct Exit(s)
		Deficient	W/O Horizontal Exit(s)	Horizontal Exit(s)	
	-8	-2	0	1	5
11. Manual Fire Alarm	No Manual Fire Alarm		Manual Fire Alarm		
			W/O F.D. Conn.	W/F.D. Conn.	
	-4		1	2	
12. Smoke Detection and Alarm	None	Corridor Only	Rooms Only	Corridor and Habit. Spaces	Total Spaces in Zone
	0(3)[g]	2(3)[g]	3(3)[g]	4	5
13. Automatic Sprinklers	None	Corridor and Habit. Space	Entire Building		
	0	8	10		

[a] Use (0) where parameter 5 is -10.

[b] Use (0) where parameter 10 is -8.

[c] Use (0) on floor with fewer than 31 patients (existing buildings only).

[d] Use (0) where parameter 4 is -10.

[e] 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

[f] 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.

[g] Use this value in addition to Parameter 13 if the entire zone is protected with quick-response automatic sprinklers.

[h] Use (0) where zone area ≤ 22,500 ft.² 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_1)	Extinguishment Safety (S_2)	People Movement Safety (S_3)	General Safety (S_4)
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	1
6. Zone Dimensions			1	1
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	S_1= 15	S_2= 13	S_3= 13	S_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 S_a, S_b, and S_c 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_a)		Extinguishment (S_b)		People Movement (S_c)	
	New	Existing	New	Existing	New	Existing
1st story	11	5	15(12)[a]	4	8(5)[a]	1
2nd or 3rd story[b]	15	9	17(14)[a]	6	10(7)[a]	3
4th 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 2nd 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)
1st story	0	10	0
2nd story	2	10	2
3rd story	6	14	2
4th 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)
1st story	13	17(14)*	8(5)*
2nd or 3rd story	17	19(16)*	10(7)*
4th 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_1)	minus	Mandatory Containment (Sa)	≥ 0	S_1 15 — S_a 2 = C 13	√	
Extinguishment Safety (S_2)	minus	Mandatory Extinguishment (Sb)	≥ 0	S_2 13 — S_b 10 = E 3	√	
People Movement Safety (S_3)	minus	Mandatory People Movement (Sc)	≥0	S_3 13 — S_c 2 = P 11	√	
General Safety (S_4)	minus	Occupancy Risk (R)	≥ 0	S_4 21 — R 1 = G 20	√	

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.	√		X
B.	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.			√
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.	√		X
D.	Fuel-burning space heaters and portable electrical space heaters are not used.	√		X
E.	There are no flue-fed incinerators.	√		
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.	√		X
G.	Smoking regulations have been adopted and implemented in accordance with 18.7.4 and 19.7.4.	√		X
H.	Draperies, upholstered furniture, mattresses, furnishings, and decoration combustibility is limited in accordance with 18.7.5 and 19.7.5.	√		
I.	Fire extinguishers are provided in accordance with the requirements of 18.3.5.12 and 19.3.5.12.	√		X
J.	Exit signs are provided in accordance with the requirements of 18.2.10.1 and 19.2.10.	√		
K.	Emergency lighting is provided in accordance with 18.2.9.1 or 19.2.9.1.	√		
L.	Standpipes are provided in all new high rise buildings as required by 18.4.2.			√

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, *Life Safety Code*, 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, *Life Safety Code*, 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, *Life Safety Code*, 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, ZUMBROTA, MN 55992		
ZONE(S) EVALUATED: MAIN LEVEL, NORTH WING & LOBBY AREA			
PROVIDER/VENDOR NO.	DATE OF SURVEY		
245376	09/13/2018		
SURVEYOR SIGNATURE	TITLE	OFFICE	DATE
Robert S. Imholte	PRESIDENT	FIRE SAFETY RESOURCES, LLC	09/17/2018
SURVEYOR ID			
FIRE AUTHORITY SIGNATURE	TITLE	OFFICE	DATE
Thomas Linhoff 12424	Fire Safety Supervisor	MN State Fire Marshal	09-25-2018

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.

WORKSHEET 4.7.2 – OCCUPANCY RISK PARAMETER FACTORS

Risk Parameters	Risk Factor Values					
1. Patient Mobility *(M)*	Mobility Status	Mobile	Limited Mobility	Not Mobile	Not Movable	
	Risk Factor	1.0	1.6	3.2	4.5	
2. Patient Density *(D)*	No. of Patients	1–5	6–10	11–30	>30	
	Risk Factor	1.0	1.2	1.5	2.0	
3. Zone Location *(L)*	Floor	1st	2nd or 3rd	4th to 6th	7th and Above	Basements
	Risk Factor	1.1	1.2	1.4	1.6	1.6
4. Ratio of Patients to Attendants *(T)*	Patients / Attendant	1–2 / 1	3–5 / 1	6–10 / 1	>10 / 1	One or More / None
	Risk Factor	1.0	1.1	1.2	1.5	4.0*
5. Patient Average Age *(A)*	Age	Under 65 Years and Over 1 Year		65 Years and Over or 1 Year and Younger		
	Risk Factor	1.0		1.2		

*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		T		A		F
OCCUPANCY RISK	3.2	X	1.5	X	1.1	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)

F	R

WORKSHEET 4.7.5 ADJUSTED OCCUPANCY RISK FACTOR (EXISTING)

		F		R	
0.6	X	7.6	=	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

1. Construction

Floor or Zone	Combustible Types III, IV, and V: 000	111	200	211, 2HH	Non-Combustible Types I and II: 000	111	222, 322, 442
First	-2	0	-2	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

Safety Parameters	Parameters Values					
2. Interior Finish (Corridors and Exits)	Class C	Class B	Class A			
	-5(0)[f]	0(3)[f]	3			
3. Interior Finish (Rooms)	Class C	Class B	Class A			
	-3(1)[f]	1(3)[f]	3			
4. Corridor Partitions/Walls	None or Incomplete	<1/2 hour	>1/2 to <1 hour	≥1 hour		
	-10(0)[a]	0	1(0)[a]	2(0)[a]		
5. Doors to Corridor	No Door	<20 min FPR	≥ 20 min FPR	≥ 20 min FPR and Auto Closure		
	-10	0	1(0)[d]	2(0)[d]		
6. Zone Dimensions	Dead End			No Dead Ends >30 ft. and Zone Length Is		
	>100 ft.	>50 ft. to 100 ft.	30 ft. to 50 ft.	>150 ft.	100 ft. to 150 ft.	<100 ft.
	-6(0)[b]	-4(0)[b]	-2(0)[b]	-2(0)[c] (0)[h]	0(0)[h]	1
7. Vertical Openings	Open 4 or More Floors	Open 2 or 3 Floors	Enclosed with Indicated Fire Resistance: <1 hr.	≥1 hr. to <2 hr.	≥2 hr.	
	-14	-10	0	2(0)[e]	3(0)[e]	
8. Hazardous Areas	Double Deficiency: In Zone	Outside Zone	Single Deficiency: In Zone	In Adjacent Zone	No Deficiencies	
	-11	-5	-6	-2	0	
9. Smoke Control	No Control	Smoke Barrier Serves Zone	Mechanically Assisted Systems by Zone			
	-5(0)[c]	0	3			
10. Emergency Movement Routes	<2 Routes	Multiple Routes: Deficient	W/O Horizontal Exit(s)	Horizontal Exit(s)	Direct Exit(s)	
	-8	-2	0	1	5	
11. Manual Fire Alarm	No Manual Fire Alarm	Manual Fire Alarm: W/O F.D. Conn.	W/F.D. Conn.			
	-4	1	2			
12. Smoke Detection and Alarm	None	Corridor Only	Rooms Only	Corridor and Habit. Spaces	Total Spaces in Zone	
	0(3)[g]	2(3)[g]	3(3)[g]	4	5	
13. Automatic Sprinklers	None	Corridor and Habit. Space	Entire Building			
	0	8	10			

[a] Use (0) where parameter 5 is -10.
[b] Use (0) where parameter 10 is -8.
[c] Use (0) on floor with fewer than 31 patients (existing buildings only).
[d] Use (0) where parameter 4 is -10.
[e] 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 m^2

[f] 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.
[g] Use this value in addition to Parameter 13 if the entire zone is protected with quick-response automatic sprinklers.
[h] Use (0) where zone area ≤ 22,500 ft.^{2} 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_1)	Extinguishment Safety (S_2)	People Movement Safety (S_3)	General Safety (S_4)
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	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	S_1= 14	S_2= 15	S_3= 7	S_4= 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 S_a, S_b, and S_c 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_a)		Extinguishment (S_b)		People Movement (S_c)	
	New	Existing	New	Existing	New	Existing
1st story	11	5	15(12)[a]	4	8(5)[a]	1
2nd or 3rd story[b]	15	9	17(14)[a]	6	10(7)[a]	3
4th 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 2nd 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)
1st story	0	10	0
2nd story	2	10	2
3rd story	6	14	2
4th 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)
1st story	13	17(14)*	8(5)*
2nd or 3rd story	17	19(16)*	10(7)*
4th 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_1)	minus	Mandatory Containment (Sa)	≥ 0	S_1 14 — S_a 0 = C 14	√	
Extinguishment Safety (S_2)	minus	Mandatory Extinguishment (Sb)	≥ 0	S_2 15 — S_b 10 = E 5	√	
People Movement Safety (S_3)	minus	Mandatory People Movement (Sc)	≥0	S_3 7 — S_c 0 = P 7	√	
General Safety (S_4)	minus	Occupancy Risk (R)	≥ 0	S_4 17 — R 5 = G 12	√	

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.	√		X
B.	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.			√
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.	√		X
D.	Fuel-burning space heaters and portable electrical space heaters are not used.	√		X
E.	There are no flue-fed incinerators.	√		
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.	√		X
G.	Smoking regulations have been adopted and implemented in accordance with 18.7.4 and 19.7.4.	√		X
H.	Draperies, upholstered furniture, mattresses, furnishings, and decoration combustibility is limited in accordance with 18.7.5 and 19.7.5.	√		
I.	Fire extinguishers are provided in accordance with the requirements of 18.3.5.12 and 19.3.5.12.	√		X
J.	Exit signs are provided in accordance with the requirements of 18.2.10.1 and 19.2.10.	√		
K.	Emergency lighting is provided in accordance with 18.2.9.1 or 19.2.9.1.	√		
L.	Standpipes are provided in all new high rise buildings as required by 18.4.2.			√

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, *Life Safety Code*, 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, *Life Safety Code*, 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, *Life Safety Code*, 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 DAYROOM			
PROVIDER/VENDOR NO.	DATE OF SURVEY		
245376	09/13/2018		
SURVEYOR SIGNATURE	TITLE	OFFICE	DATE
Robert S. [illegible]	PRESIDENT	FIRE SAFETY RESOURCES, LLC	09/17/2018
SURVEYOR ID			
FIRE AUTHORITY SIGNATURE	TITLE	OFFICE	DATE
Thomas Linhoff 12424	Fire Safety Supervisor	MN State Fire Marshal	09-25-2018

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.

WORKSHEET 4.7.2 – OCCUPANCY RISK PARAMETER FACTORS

Risk Parameters	Risk Factor Values					
1. Patient Mobility *(M)*	Mobility Status	Mobile	Limited Mobility	Not Mobile	Not Movable	
	Risk Factor	1.0	1.6	(3.2)	4.5	
2. Patient Density *(D)*	No. of Patients	1–5	6–10	11–30	>30	
	Risk Factor	1.0	1.2	(1.5)	2.0	
3. Zone Location *(L)*	Floor	1st	2nd or 3rd	4th to 6th	7th and Above	Basements
	Risk Factor	(1.1)	1.2	1.4	1.6	1.6
4. Ratio of Patients to Attendants *(T)*	Patients / Attendant	1–2 / 1	3–5 / 1	6–10 / 1	>10 / 1	One or More / None
	Risk Factor	1.0	1.1	1.2	(1.5)	4.0*
5. Patient Average Age *(A)*	Age	Under 65 Years and Over 1 Year		65 Years and Over or 1 Year and Younger		
	Risk Factor	1.0		(1.2)		

*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		T		A		F
OCCUPANCY RISK	3.2	X	1.5	X	1.1	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)

F	R

WORKSHEET 4.7.5 ADJUSTED OCCUPANCY RISK FACTOR (EXISTING)

		F		R	
0.6	X	9.5	=	5.7	= 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

Safety Parameters	Parameters Values						
1. Construction	Combustible Types III, IV, and V				Non-Combustible Types I and II		
Floor or Zone	000	111	200	211, 2HH	000	111	222, 322, 442
First	-2	0	-2	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

Safety Parameters	Parameters Values			
2. Interior Finish (Corridors and Exits)	Class C	Class B	Class A	
	-5(0)[f]	0(3)[f]	3	
3. Interior Finish (Rooms)	Class C	Class B	Class A	
	-3(1)[f]	1(3)[f]	3	
4. Corridor Partitions/Walls	None or Incomplete	<½ hour	>½ to <1 hour	≥1 hour
	-10(0)[a]	0	1(0)[a]	2(0)[a]
5. Doors to Corridor	No Door	<20 min FPR	≥ 20 min FPR	≥ 20 min FPR and Auto Closure
	-10	0	1(0)[d]	2(0)[d]

Safety Parameters	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)[b]	-4(0)[b]	-2(0)[b]	-2(0)[c] (0)[h]	0(0)[h]	1

Safety Parameters	Parameters Values				
7. Vertical Openings	Open 4 or More Floors	Open 2 or 3 Floors	Enclosed with Indicated Fire Resistance		
			<1 hr.	≥1 hr. to <2 hr.	≥2 hr.
	-14	-10	0	2(0)[e]	3(0)[e]
8. Hazardous Areas	Double Deficiency		Single Deficiency		No Deficiencies
	In Zone	Outside Zone	In Zone	In Adjacent Zone	
	-11	-5	-6	-2	0
9. Smoke Control	No Control	Smoke Barrier Serves Zone	Mechanically Assisted Systems by Zone		
	-5(0)[c]	0	3		
10. Emergency Movement Routes	<2 Routes	Multiple Routes			Direct Exit(s)
		Deficient	W/O Horizontal Exit(s)	Horizontal Exit(s)	
	-8	-2	0	1	5
11. Manual Fire Alarm	No Manual Fire Alarm		Manual Fire Alarm		
			W/O F.D. Conn.	W/F.D. Conn.	
	-4		1	2	
12. Smoke Detection and Alarm	None	Corridor Only	Rooms Only	Corridor and Habit. Spaces	Total Spaces in Zone
	0(3)[g]	2(3)[g]	3(3)[g]	4	5
13. Automatic Sprinklers	None	Corridor and Habit. Space	Entire Building		
	0	8	10		

[a] Use (0) where parameter 5 is -10.

[b] Use (0) where parameter 10 is -8.

[c] Use (0) on floor with fewer than 31 patients (existing buildings only).

[d] Use (0) where parameter 4 is -10.

[e] 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

[f] 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.

[g] Use this value in addition to Parameter 13 if the entire zone is protected with quick-response automatic sprinklers.

[h] Use (0) where zone area ≤ 22,500 ft.² 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_1)	Extinguishment Safety (S_2)	People Movement Safety (S_3)	General Safety (S_4)
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	1		1	1
6. Zone Dimensions			1	1
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	S_1= 17	S_2= 15	S_3= 11	S_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 S_a, S_b, and S_c 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_a)		Extinguishment (S_b)		People Movement (S_c)	
	New	Existing	New	Existing	New	Existing
1st story	11	5	15(12)[a]	4	8(5)[a]	1
2nd or 3rd story[b]	15	9	17(14)[a]	6	10(7)[a]	3
4th 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 2nd 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)
1st story	0	10	0
2nd story	2	10	2
3rd story	6	14	2
4th 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)
1st story	13	17(14)*	8(5)*
2nd or 3rd story	17	19(16)*	10(7)*
4th 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_1)	minus	Mandatory Containment (Sa)	≥ 0	S_1 17 — S_a 0 = C 17	√	
Extinguishment Safety (S_2)	minus	Mandatory Extinguishment (Sb)	≥ 0	S_2 15 — S_b 10 = E 5	√	
People Movement Safety (S_3)	minus	Mandatory People Movement (Sc)	≥0	S_3 11 — S_c 0 = P 11	√	
General Safety (S_4)	minus	Occupancy Risk (R)	≥ 0	S_4 21 — R 6 = G 15	√	

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.	√		X
B.	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.			√
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.	√		X
D.	Fuel-burning space heaters and portable electrical space heaters are not used.	√		X
E.	There are no flue-fed incinerators.	√		
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.	√		X
G.	Smoking regulations have been adopted and implemented in accordance with 18.7.4 and 19.7.4.	√		X
H.	Draperies, upholstered furniture, mattresses, furnishings, and decoration combustibility is limited in accordance with 18.7.5 and 19.7.5.	√		
I.	Fire extinguishers are provided in accordance with the requirements of 18.3.5.12 and 19.3.5.12.	√		X
J.	Exit signs are provided in accordance with the requirements of 18.2.10.1 and 19.2.10.	√		
K.	Emergency lighting is provided in accordance with 18.2.9.1 or 19.2.9.1.	√		
L.	Standpipes are provided in all new high rise buildings as required by 18.4.2.			√

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, *Life Safety Code*, 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, *Life Safety Code*, 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, *Life Safety Code*, 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, Zumbrota, MN 55992		
ZONE(S) EVALUATED			
Main Level, West Wing			
PROVIDER/VENDOR NO.	DATE OF SURVEY		
245376	09/13/2018		
SURVEYOR SIGNATURE	TITLE	OFFICE	DATE
Robert L. [illegible]	President	Fire Safety Resources, LLC	09/17/2018
SURVEYOR ID			
FIRE AUTHORITY SIGNATURE	TITLE	OFFICE	DATE
Thomas Linhoff 12424	Fire Safety Supervisor	MN State Fire Marshal	09-25-2018

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.

WORKSHEET 4.7.2 – OCCUPANCY RISK PARAMETER FACTORS

Risk Parameters	Risk Factor Values					
1. Patient Mobility *(M)*	Mobility Status	Mobile	Limited Mobility	Not Mobile	Not Movable	
	Risk Factor	1.0	1.6	3.2	4.5	
2. Patient Density *(D)*	No. of Patients	1–5	6–10	11–30	>30	
	Risk Factor	1.0	1.2	1.5	2.0	
3. Zone Location *(L)*	Floor	1st	2nd or 3rd	4th to 6th	7th and Above	Basements
	Risk Factor	1.1	1.2	1.4	1.6	1.6
4. Ratio of Patients to Attendants *(T)*	Patients / Attendant	1–2 / 1	3–5 / 1	6–10 / 1	>10 / 1	One or More / None
	Risk Factor	1.0	1.1	1.2	1.5	4.0*
5. Patient Average Age *(A)*	Age	Under 65 Years and Over 1 Year		65 Years and Over or 1 Year and Younger		
	Risk Factor	1.0		1.2		

*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		T		A		F
OCCUPANCY RISK	3.2	X	1.5	X	1.1	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)

F	R

WORKSHEET 4.7.5 ADJUSTED OCCUPANCY RISK FACTOR (EXISTING)

		F		R
0.6	X	7.6	=	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

Floor or Zone	Combustible Types III, IV, and V: 000	111	200	211, 2HH	Non-Combustible Types I and II: 000	111	222, 322, 442
First	-2	0	-2	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

Safety Parameters					
2. Interior Finish (Corridors and Exits)	Class C	Class B	Class A		
	-5(0)[f]	0(3)[f]	3		
3. Interior Finish (Rooms)	Class C	Class B	Class A		
	-3(1)[f]	1(3)[f]	3		
4. Corridor Partitions/Walls	None or Incomplete	<½ hour	>½ to <1 hour	≥1 hour	
	-10(0)[a]	0	1(0)[a]	2(0)[a]	
5. Doors to Corridor	No Door	<20 min FPR	≥ 20 min FPR	≥ 20 min FPR and Auto Closure	
	-10	0	1(0)[d]	2(0)[d]	

6. Zone Dimensions

Dead End: >100 ft.	>50 ft. to 100 ft.	30 ft. to 50 ft.	No Dead Ends >30 ft. and Zone Length Is: >150 ft.	100 ft. to 150 ft.	<100 ft.
-6(0)[b]	-4(0)[b]	-2(0)[b]	-2(0)[c] (0)[h]	0(0)[h]	1

7. Vertical Openings

Open 4 or More Floors	Open 2 or 3 Floors	Enclosed with Indicated Fire Resistance: <1 hr.	≥1 hr. to <2 hr.	≥2 hr.
-14	-10	0	2(0)[e]	3(0)[e]

8. Hazardous Areas

Double Deficiency: In Zone	Outside Zone	Single Deficiency: In Zone	In Adjacent Zone	No Deficiencies
-11	-5	-6	-2	0

9. Smoke Control

No Control	Smoke Barrier Serves Zone	Mechanically Assisted Systems by Zone
-5(0)[c]	0	3

10. Emergency Movement Routes

<2 Routes	Multiple Routes: Deficient	W/O Horizontal Exit(s)	Horizontal Exit(s)	Direct Exit(s)
-8	-2	0	1	5

11. Manual Fire Alarm

No Manual Fire Alarm	Manual Fire Alarm: W/O F.D. Conn.	W/F.D. Conn.
-4	1	2

12. Smoke Detection and Alarm

None	Corridor Only	Rooms Only	Corridor and Habit. Spaces	Total Spaces in Zone
0(3)[g]	2(3)[g]	3(3)[g]	4	5

13. Automatic Sprinklers

None	Corridor and Habit. Space	Entire Building
0	8	10

[a] Use (0) where parameter 5 is -10.
[b] Use (0) where parameter 10 is -8.
[c] Use (0) on floor with fewer than 31 patients (existing buildings only).
[d] Use (0) where parameter 4 is -10.
[e] 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

[f] 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.
[g] Use this value in addition to Parameter 13 if the entire zone is protected with quick-response automatic sprinklers.
[h] Use (0) where zone area ≤ 22,500 ft.² 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_1)	Extinguishment Safety (S_2)	People Movement Safety (S_3)	General Safety (S_4)
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	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	S_1= 14	S_2= 15	S_3= 7	S_4= 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 S_a, S_b, and S_c 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_a)		Extinguishment (S_b)		People Movement (S_c)	
	New	Existing	New	Existing	New	Existing
1st story	11	5	15(12)[a]	4	8(5)[a]	1
2nd or 3rd story[b]	15	9	17(14)[a]	6	10(7)[a]	3
4th 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 2nd 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)
1st story	(0)	(10)	(0)
2nd story	2	10	2
3rd story	6	14	2
4th 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)
1st story	13	17(14)*	8(5)*
2nd or 3rd story	17	19(16)*	10(7)*
4th 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_1)	minus	Mandatory Containment (Sa)	≥ 0	S_1 14 − S_a 0 = C 14	√	
Extinguishment Safety (S_2)	minus	Mandatory Extinguishment (Sb)	≥ 0	S_2 15 − S_b 10 = E 5	√	
People Movement Safety (S_3)	minus	Mandatory People Movement (Sc)	≥0	S_3 7 − S_c 0 = P 7	√	
General Safety (S_4)	minus	Occupancy Risk (R)	≥ 0	S_4 17 − R 5 = G 12	√	

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.	√		X
B.	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.			√
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.	√		X
D.	Fuel-burning space heaters and portable electrical space heaters are not used.	√		X
E.	There are no flue-fed incinerators.	√		
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.	√		X
G.	Smoking regulations have been adopted and implemented in accordance with 18.7.4 and 19.7.4.	√		X
H.	Draperies, upholstered furniture, mattresses, furnishings, and decoration combustibility is limited in accordance with 18.7.5 and 19.7.5.	√		
I.	Fire extinguishers are provided in accordance with the requirements of 18.3.5.12 and 19.3.5.12.	√		X
J.	Exit signs are provided in accordance with the requirements of 18.2.10.1 and 19.2.10.	√		
K.	Emergency lighting is provided in accordance with 18.2.9.1 or 19.2.9.1.	√		
L.	Standpipes are provided in all new high rise buildings as required by 18.4.2.			√

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, *Life Safety Code*, 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, *Life Safety Code*, 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, *Life Safety Code*, 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

NAME OF FACILITY	ADDRESS OF FACILITY		
ZUMBROTA CARE CENTER	433 MILL ST., ZUMBROTA, MN 55992		
ZONE(S) EVALUATED: 2014 ADDITION, LOWER LEVEL			
PROVIDER/VENDOR NO.: 245376	DATE OF SURVEY: 09/13/2018		
SURVEYOR SIGNATURE: Robert S. [illegible]	TITLE: PRESIDENT	OFFICE: FIRE SAFETY RESOURCES, LLC	DATE: 09/17/2018
SURVEYOR ID			
FIRE AUTHORITY SIGNATURE: Thomas Linhoff 12424	TITLE: Fire Safety Supervisor	OFFICE: MN State Fire Marshal	DATE: 09-25-2018

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.

WORKSHEET 4.7.2 – OCCUPANCY RISK PARAMETER FACTORS

Risk Parameters	Risk Factor Values					
1. Patient Mobility *(M)*	Mobility Status	Mobile	Limited Mobility	Not Mobile	Not Movable	
	Risk Factor	1.0	1.6	3.2	4.5	
2. Patient Density *(D)*	No. of Patients	1–5	6–10	11–30	>30	
	Risk Factor	1.0	1.2	1.5	2.0	
3. Zone Location *(L)*	Floor	1st	2nd or 3rd	4th to 6th	7th and Above	Basements
	Risk Factor	1.1	1.2	1.4	1.6	1.6
4. Ratio of Patients to Attendants *(T)*	Patients / Attendant	1–2 / 1	3–5 / 1	6–10 / 1	>10 / 1	One or More / None
	Risk Factor	1.0	1.1	1.2	1.5	4.0*
5. Patient Average Age *(A)*	Age	Under 65 Years and Over 1 Year		65 Years and Over or 1 Year and Younger		
	Risk Factor	1.0		1.2		

*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		T		A		F
OCCUPANCY RISK	3.2	X	1.0	X	1.1	X	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)

F	R

WORKSHEET 4.7.5 ADJUSTED OCCUPANCY RISK FACTOR (EXISTING)

		F		R	
0.6	X	4.2	=	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.

WORKSHEET 4.7.6 – SAFETY PARAMETER VALUES

Safety Parameters	Parameters Values						
1. Construction	Combustible Types III, IV, and V				Non-Combustible Types I and II		
Floor or Zone	000	111	200	211, 2HH	000	111	222, 322, 442
First	-2	0	-2	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

Safety Parameters					
2. Interior Finish (Corridors and Exits)	Class C	Class B	Class A		
	-5(0)[f]	0(3)[f]	3		
3. Interior Finish (Rooms)	Class C	Class B	Class A		
	-3(1)[f]	1(3)[f]	3		
4. Corridor Partitions/Walls	None or Incomplete	<½ hour	>½ to <1 hour	≥1 hour	
	-10(0)[a]	0	1(0)[a]	2(0)[a]	
5. Doors to Corridor	No Door	<20 min FPR	≥ 20 min FPR	≥ 20 min FPR and Auto Closure	
	-10	0	1(0)[d]	2(0)[d]	

6. Zone Dimensions	Dead End			No Dead Ends >30 ft. and Zone Length Is		
	>100 ft.	>50 ft. to 100 ft.	30 ft. to 50 ft.	>150 ft.	100 ft. to 150 ft.	<100 ft.
	-6(0)[b]	-4(0)[b]	-2(0)[b]	-2(0)[b] (0)[h]	0(0)[h]	1

Safety Parameters					
7. Vertical Openings	Open 4 or More Floors	Open 2 or 3 Floors	Enclosed with Indicated Fire Resistance		
			<1 hr.	≥1 hr. to <2 hr.	≥2 hr.
	-14	-10	0	2(0)[e]	3(0)[e]
8. Hazardous Areas	Double Deficiency		Single Deficiency		No Deficiencies
	In Zone	Outside Zone	In Zone	In Adjacent Zone	
	-11	-5	-6	-2	0
9. Smoke Control	No Control	Smoke Barrier Serves Zone	Mechanically Assisted Systems by Zone		
	-5(0)[c]	0	3		
10. Emergency Movement Routes	<2 Routes	Multiple Routes			Direct Exit(s)
		Deficient	W/O Horizontal Exit(s)	Horizontal Exit(s)	
	-8	-2	0	1	5
11. Manual Fire Alarm	No Manual Fire Alarm		Manual Fire Alarm		
			W/O F.D. Conn.	W/F.D. Conn.	
	-4		1	2	
12. Smoke Detection and Alarm	None	Corridor Only	Rooms Only	Corridor and Habit. Spaces	Total Spaces in Zone
	0(3)[g]	2(3)[g]	3(3)[g]	4	5
13. Automatic Sprinklers	None	Corridor and Habit. Space	Entire Building		
	0	8	10		

[a] Use (0) where parameter 5 is -10.
[b] Use (0) where parameter 10 is -8.
[c] Use (0) on floor with fewer than 31 patients (existing buildings only).
[d] Use (0) where parameter 4 is -10.
[e] 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

[f] 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.
[g] Use this value in addition to Parameter 13 if the entire zone is protected with quick-response automatic sprinklers.
[h] Use (0) where zone area ≤ 22,500 ft.² 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_1)	Extinguishment Safety (S_2)	People Movement Safety (S_3)	General Safety (S_4)
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	2			2
5. Doors to Corridor	1		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			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	S_1= 19	S_2= 15	S_3= 12	S_4= 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 S_a, S_b, and S_c 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_a)		Extinguishment (S_b)		People Movement (S_c)	
	New	Existing	New	Existing	New	Existing
1st story	11	5	15(12)[a]	4	8(5)[a]	1
2nd or 3rd story[b]	15	9	17(14)[a]	6	10(7)[a]	3
4th 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 2nd 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)
1st story	0	10	0
2nd story	2	10	2
3rd story	6	14	2
4th 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)
1st story	13	17(14)*	8(5)*
2nd or 3rd story	17	19(16)*	10(7)*
4th 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_1)	minus	Mandatory Containment (Sa)	≥ 0	S_1 19 — S_a 0 = C 19	√	
Extinguishment Safety (S_2)	minus	Mandatory Extinguishment (Sb)	≥ 0	S_2 15 — S_b 10 = E 5	√	
People Movement Safety (S_3)	minus	Mandatory People Movement (Sc)	≥0	S_3 12 — S_c 0 = P 12	√	
General Safety (S_4)	minus	Occupancy Risk (R)	≥ 0	S_4 24 — R 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

		Met	Not Met	Not Applic.
A.	Building utilities conform to the requirements of Section 9.1.	√		X
B.	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.			√
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.	√		X
D.	Fuel-burning space heaters and portable electrical space heaters are not used.	√		X
E.	There are no flue-fed incinerators.	√		
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.	√		X
G.	Smoking regulations have been adopted and implemented in accordance with 18.7.4 and 19.7.4.	√		X
H.	Draperies, upholstered furniture, mattresses, furnishings, and decoration combustibility is limited in accordance with 18.7.5 and 19.7.5.	√		
I.	Fire extinguishers are provided in accordance with the requirements of 18.3.5.12 and 19.3.5.12.	√		X
J.	Exit signs are provided in accordance with the requirements of 18.2.10.1 and 19.2.10.	√		
K.	Emergency lighting is provided in accordance with 18.2.9.1 or 19.2.9.1.	√		
L.	Standpipes are provided in all new high rise buildings as required by 18.4.2.			√

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, *Life Safety Code*, 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, *Life Safety Code*, 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, *Life Safety Code*, 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 6 OF 6 ZONES

NAME OF FACILITY	ADDRESS OF FACILITY		
ZUMBROTA CARE CENTER	433 MILL ST, ZUMBROTA, MN 55992		
ZONE(S) EVALUATED			
SOUTH WING & 2014 ADDITION, UPPER LEVEL			
PROVIDER/VENDOR NO.	DATE OF SURVEY		
245376	09/13/2018		
SURVEYOR SIGNATURE	TITLE	OFFICE	DATE
Robert L. [signature]	PRESIDENT	FIRE SAFETY RESOURCES, LLC	09/17/2018
SURVEYOR ID			
FIRE AUTHORITY SIGNATURE	TITLE	OFFICE	DATE
Thomas Linhoff 12424	Fire Safety Supervisor	MN State Fire Marshal	09-25-2018

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.

WORKSHEET 4.7.2 – OCCUPANCY RISK PARAMETER FACTORS

Risk Parameters	Risk Factor Values					
1. Patient Mobility *(M)*	Mobility Status	Mobile	Limited Mobility	Not Mobile	Not Movable	
	Risk Factor	1.0	1.6	(3.2)	4.5	
2. Patient Density *(D)*	No. of Patients	1–5	6–10	11–30	>30	
	Risk Factor	1.0	1.2	1.5	(2.0)	
3. Zone Location *(L)*	Floor	1st	2nd or 3rd	4th to 6th	7th and Above	Basements
	Risk Factor	(1.1)	1.2	1.4	1.6	1.6
4. Ratio of Patients to Attendants *(T)*	Patients / Attendant	1–2 / 1	3–5 / 1	6–10 / 1	>10 / 1	One or More / None
	Risk Factor	1.0	1.1	1.2	(1.5)	4.0*
5. Patient Average Age *(A)*	Age	Under 65 Years and Over 1 Year	65 Years and Over or 1 Year and Younger			
	Risk Factor	1.0	(1.2)			

*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		T		A		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 4.7.4 ADJUSTED OCCUPANCY RISK FACTOR (NEW)

F	R

WORKSHEET 4.7.5 ADJUSTED OCCUPANCY RISK FACTOR (EXISTING)

	F		R
0.6 X	12.7	=	7.6 =8

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

[a] Use (0) where parameter 5 is -10.

[b] Use (0) where parameter 10 is -8.

[c] Use (0) on floor with fewer than 31 patients (existing buildings only).

[d] Use (0) where parameter 4 is -10.

[e] 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

[f] 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.

[g] Use this value in addition to Parameter 13 if the entire zone is protected with quick-response automatic sprinklers.

[h] Use (0) where zone area ≤ 22,500 ft.² 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_1)	Extinguishment Safety (S_2)	People Movement Safety (S_3)	General Safety (S_4)
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	1		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	10 ÷ 2 = 5	10
Total Value	S_1= 17	S_2= 15	S_3= 10	S_4= 20

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 S_a, S_b, and S_c 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_a)		Extinguishment (S_b)		People Movement (S_c)	
	New	Existing	New	Existing	New	Existing
1st story	11	5	15(12)[a]	4	8(5)[a]	1
2nd or 3rd story[b]	15	9	17(14)[a]	6	10(7)[a]	3
4th 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 2nd 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)
1st story	0	10	0
2nd story	2	10	2
3rd story	6	14	2
4th 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)
1st story	13	17(14)*	8(5)*
2nd or 3rd story	17	19(16)*	10(7)*
4th 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.

WORKSHEET 4.7.9 - ZONE FIRE SAFETY EQUIVALENCY EVALUATION

					YES	NO
Containment Safety (S_1)	minus	Mandatory Containment (Sa)	≥ 0	S_1 17 — S_a 0 = C 17	√	
Extinguishment Safety (S_2)	minus	Mandatory Extinguishment (Sb)	≥ 0	S_2 15 — S_b 10 = E 5	√	
People Movement Safety (S_3)	minus	Mandatory People Movement (Sc)	≥0	S_3 10 — S_c 0 = P 10	√	
General Safety (S_4)	minus	Occupancy Risk (R)	≥ 0	S_4 20 — R 8 = G 12	√	

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.	√		X
B.	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.			√
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.	√		X
D.	Fuel-burning space heaters and portable electrical space heaters are not used.	√		X
E.	There are no flue-fed incinerators.	√		
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.	√		X
G.	Smoking regulations have been adopted and implemented in accordance with 18.7.4 and 19.7.4.	√		X
H.	Draperies, upholstered furniture, mattresses, furnishings, and decoration combustibility is limited in accordance with 18.7.5 and 19.7.5.	√		
I.	Fire extinguishers are provided in accordance with the requirements of 18.3.5.12 and 19.3.5.12.	√		X
J.	Exit signs are provided in accordance with the requirements of 18.2.10.1 and 19.2.10.	√		
K.	Emergency lighting is provided in accordance with 18.2.9.1 or 19.2.9.1.	√		
L.	Standpipes are provided in all new high rise buildings as required by 18.4.2.			√

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, *Life Safety Code*, 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, *Life Safety Code*, 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, *Life Safety Code*, for health care occupancies.

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 only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the order within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

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

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

the Suggested Method of Correction and the Time Period For Correction.

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

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

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

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: Kamala.Fiske-Downing@state.mn.us

cc: Licensing and Certification File

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00917	A. BUILDING: ______ B. WING ______	08/02/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ZUMBROTA CARE CENTER	**433 MILL STREET ZUMBROTA, MN 55992**

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm The State licensing orders are delineated on the attached Minnesota	2 000		

Minnesota Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		08/29/18

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2 000	Continued From page 1 Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. On July 30, 31, 2018 and August 1 and 2, 2018, surveyors of this Department's staff visited the above provider and the following correction orders are issued. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed. Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled " ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY.	2 000		

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2 000	Continued From page 2 THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000		
2 255	MN Rule 4658.0070 Quality Assessment and Assurance Committee A nursing home must maintain a quality assessment and assurance committee consisting of the administrator, the director of nursing services, the medical director or other physician designated by the medical director, and at least three other members of the nursing home's staff, representing disciplines directly involved in resident care. The quality assessment and assurance committee must identify issues with respect to which quality assurance activities are necessary and develop and implement appropriate plans of action to correct identified quality deficiencies. The committee must address, at a minimum, incident and accident reporting, infection control, and medications and pharmacy services. This MN Requirement is not met as evidenced by: Based on interview and record review, the facility failed to develop and implement a Quality Assurance and Performance Improvement (QAPI) plan to correct and identify quality deficiencies with identified areas for lack of physician review of treatment and auxiliary orders for residents. This had the potential to affect 44 of 45 residents residing in the facility. Finding included:	2 255	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	9/10/18

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During interview on 7/30/18, at 5:56 p.m., the interim director of nursing (IDON) reviewed R22's Physician Order Sheet, dated 7/9/18, and verified the orders included review of medications and care plan, and lacked review of treatment orders. The IDON stated I will find out if the treatment orders are being signed every 60 days. In addition, the orders lacked to include auxiliary orders.

During interview on 7/31/18, at 12:09 p.m., the IDON stated Physician (P)-F preference was to print out the medications for residents only and he wanted to address the treatments in his narrative notes. However, the progress notes related to the visits, lacked to include a review of treatment and auxiliary orders. The IDON stated she would guess all residents included the same and P-F was physician for every resident except one resident.

During interview on 8/2/18, at 3:09 p.m., the administrator stated she was not aware the physician was not reviewing treatment orders. At the time of the interview registered nurse (RN)-C stated I was aware. Physician (P)-F (facility medical director) informed he wanted to sign all treatment and medication orders on admit and asked why he needed to see these after general admission. The administrator stated P-F had been signing for all treatments orders on residents up until March. The administrator stated she would have expected the request of P-F to be communicated to herself, the assistant director of nursing and the interim director of nursing, so a decision could be made whether we could accommodate P-F's request or not.

During interview on 8/2/18, at 3:44 p.m., the administrator stated health unit coordinator was

team or ZHS staff to be discussed at the conclusion of each quarterly QAPI meeting to address any improvements or changes in processes to ensure that no changes are made without the express involvement of the medical team and the facility leadership.

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2 255	Continued From page 4 aware of P-F's request regarding the treatment orders. The facility Quality Assurance Process Improvement (QAPI) Plan, reviewed 10/23/17, indicated Our QAPI plan focus areas includes all systems that affect resident and family satisfaction, quality of care and services provided, and quality of life for persons living and working in our organization. SUGGESTED METHOD OF CORRECTION: The quality assurance committee could review the quality assurance program, policies and procedures. The quality assurance committee could appoint staff to perform routine system(s) performance audits to identify areas that could be enhanced or improved on. The committee could then audit the systems in place and the committee to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 255		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed.	2 830		9/10/18

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This MN Requirement is not met as evidenced by:
Based on observation, interview and document review, the facility failed to adequately monitor efficacy of interventions to promote intact skin integrity and healing of two non-pressure wounds on the left foot for 1 of 1 resident (R14) also failed to provide treatment regarding head positioning for 1 of 1 resident (R43).

Findings include:

R14's quarterly Minimum Data Set (MDS) an assessment dated 5/18/18, identified R14 with an admission date of 2/22/16, had intact cognition, was dependent on staff for activities of daily living (ADLs). The MDS identified R14 had medical diagnoses which included diabetes mellitus (condition with elevated blood sugars), diabetic neuropathy (damages nerves in your legs and feet), and peripheral vascular disease (circulatory problem in which narrowed arteries reduce blood flow to your limbs).

R14's progress note dated, 2/24/18, revealed an arterial ulcer to the left top 4th toe with a measurement of 1.2 centimeters (cm) x 1.2 cm. Upon review of upcoming progress notes, wound was not measured again until 7/31/18, revealing a measurement of 0.7 cm x 0.8 cm.

R14's progress note dated, 2/16/18, revealed an arterial ulcer to the left top great toe with a "punched out" appearance. Further revealed on 2/10/18, a partial thickness open area was present upon removal of (R14's) grippy socks, with no measurements documented.

R#14 arterial ulcer to top of 4th digit Left foot and arterial ulcer to Left great toe were measured.
R#43's care plan was updated to include interventions for head/neck positioning. A request for OT to screen for wheelchair positioning was submitted 8-17-18
All residents with skin ulcers will have their wounds measured and documented on weekly. All residents with positioning needs of the head/neck will be reviewed to ensure interventions were developed to address positioning needs.
All licensed nurses were re-educated on the Skin Ulcer protocol as it relates to monitoring and measuring wounds and on the need to implement written therapy recommendations.
Random chart audits will be complete by the DON/designee 3x's/week for 4 weeks and then 2 audits monthly thereafter to ensure wounds are measured weekly.
Random chart audits will be complete by the DON/designee 3x's/week for 4 weeks and then 2 audits monthly thereafter to ensure therapy recommendations are implemented for wheelchair positioning.
Audit results will be brought to the QAPI committee for review and further recommendations.

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R14's progress note dated 2/17/18, left great toe wound measurement 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.

R14's Wound Care physician visit dated 3/9/18, revealed R14 was evaluated by vascular surgery on 2/1/18, and was to continue with conservative management. Revealed a recommendation to continue the use of equal mixture of iodosorb/solosite to all areas of ulceration. (Solosite is a hydrogel wound dressing with preservatives).

R14's signed physician order dated 4/19/18, revealed left lateral 1st toe cleanse ulcer base with normal saline, apply iodosorb/hydrogel 50:50 mixture to ulcer base with a cotton swab, cover with dry soft gauze and secure with roll gauze.

R14's signed physician order dated 7/10/18 does not reveal any dressing change orders.

R14's onsite Podiatry note dated 4/26/18, identified to continue betadine and gauze dressings to left toes 1 and 4 to maintain dry eschar and reduce risk of infection. If things worsen, again recommend vascular specialist consult and non-invasive testing of lower extremities.

R14's Medical Doctor visit note dated 7/10/18, revealed an exam of lower extremities, with a plan: bandaging intact to left foot great toe and

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4th digit at this time, managed by facility nurse practitioner, recommend heel cushions to both lower extremities, and diabetic foot education given to resident.

R14's physician progress notes dated 7/23/18, revealed, "We will continue with wound care and consult with vascular surgery as needed."

R14's care plan initiated 9/8/17, identified R14 to be at risk for impaired skin integrity as evidenced by history of diabetic neuropathic foot ulcers. A goal was identified for ulcers to heal without symptoms of infection. Interventions to include; inspect skin weekly, observe skin daily and monitor effectiveness of treatment and report to the doctor.

During interview on 7/30/18, at 12:59 p.m. R14 stated, "I have some sores on my toes on my left foot and they are not getting any better, I bet it has been 6 months." They are putting some kind of medicine on it and they change the dressing every day.

R14 was observed on 7/31/18, at 12:43 p.m. sitting up in her wheelchair in her room, well dressed, wearing white socks and Darco shoes, (shoes that reduce weight-bearing pressure on the forefoot, which promotes faster healing when forefoot wounds or ulcerations are present).

On 8/1/18, at 9:22 a.m. licensed practical nurse (LPN)-A stated she had already did R14's dressing change to her left foot. LPN-A verified that R14's wounds on her left foot had not measured since they were identified back in February 2018. When asked how they monitor if a wound was getting better LPN-A stated, "I guess if we measured it weekly we would have a

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better idea if they are getting better or not."

On 8/1/18, at 1:09 p.m. registered nurse (RN)-B, verified R14's wounds on her left foot were not being measured on a regular basis, and stated, I guess if we measured the wounds on a regular basis it would be easier for us to tell if the wound is getting better.

During an observation and interview on 8/2/18, at 8:36 a.m. registered nurse (RN)-C was observed to do wound care on left great toe and left fourth toe. RN-C measured both toes with the following measurements; Left great toe measurement: 2.6 cm x 3.5 cm and left 4th toe measurement was 0.7 cm x 0.6 cm.

On 8/2/18, at 9:09 a.m. registered nurse (RN)-C verified the length of the wound on the great toe declined by 0.6 cm, and that wounds for R14 have not been monitored weekly since February 2018. RN-C stated, I think these wounds should be measured once a week so we can see the progression of the wound, in fact I just put that order in on Tuesday, we should be measuring all of our wounds once a week.

On 8/2/18, at 9:10 a.m. the interim director of nursing (IDON), verified there was a 0.6 cm increase in R14's left great toe wound. The IDON stated, "All wounds should be getting a weekly measurement so we are able to monitor the wound more closely."

On 8/2/18, at 11:15 a.m. IDON stated she could not find any documentation saying the two wounds on R14's left foot were unavoidable, other than she had peripheral vascular disease.

Facility document, Skin Ulcer Protocol, updated

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11/1/15, identified residents will not develop pressure ulcers or other skin ulcers unless clinically unavoidable. And appropriate care and services will be provided to prevent, treat and monitor progress of all healing ulcers. Page 6, revealed, assessment and monitoring of skin concerns, and wound round documentation weekly at a minimum the size of the wound, measurements in centimeters in length, width and depth, and the presence of any undermining or tunneling. If not showing improvement in last 2-4 weeks, medical doctor should be contacted for new treatment orders.

POSITIONING:

R43's quarterly Minimum Data Set (MDS) an assessment, dated 7/6/18, identified R43 required one assist with bed mobility, total assist for transfers, had diagnoses of dementia and severe cognitive impairment.

R43's current care plan included impaired mobility related to diagnosis of advanced dementia process and kyphosis (an exaggerated curvature of the upper (thoracic) spine that creates a hunchback appearance) as evidenced by inability to independently ambulate. Approaches included encourage to get out of bed three times per day, monitor for changes in abilities, passive range of motion (PROM) to lower extremities and splint/brace to lower extremities twice daily. Decline in range of motion (ROM), at risk for contractures related to osteoarthritis and dementia. Approaches included staff will place bilateral AFO's (ankle-foot orthosis) to lower extremities twice daily when up in chair. R43's care plan lacked interventions for head/neck positioning.

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R43 was observed on 7/30/18, at 1:11 p.m., seated upright in a Broda chair (tilt-in-space positioning chair) in her room. R43's head was hanging straight down in front of her. At 6:22 p.m., R43 was seated upright in a Broda chair in her room. R43's head was hanging straight down in front of her. When surveyor spoke to R43, R43 lifted her head up to speak to surveyor.

R43 was observed on 7/31/18, at 12:48 p.m., seated in a Broda chair, in an upright position, in her room. R43's head was hanging straight down in front of her. R43 lifted her head up (but was not able to lift her head fully straight up) and when she was done, looking up her head hung down straight in front of her.

R43 was observed on 8/1/18, at 8:16 a.m., seated upright in a Broda chair in the dining room. R43's head was hanging straight down in front of her.

On 8/1/18, at 7:16 a.m., nursing assistant (NA)-C stated R43's head position (hanging straight down in front of her) had been that way since she had worked at the facility (one year ago). NA-C stated R43 was on hospice from the time I started working here until recently, a couple of months ago. When asked if R43 had received any therapy for head positioning, NA-C stated I do not think residents can have therapy when on hospice. I have never seen the therapy department work with R43.

On 8/1/18, at 10:23 a.m., occupational therapist (OT)-E stated R43 had received occupational therapy (OT) in October 2017, for positioning of her head. When asked what was done for R43's head positioning, OT-E stated lateral supports were applied on wheelchair and routine resting on

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top of bed to allow stretching of neck, versus being in chair all day. OT-E stated a brace for holding R43's head upright was not tried, when R43 received OT therapy.

R43's OT recommendations, dated 10/19/17, provided by OT-E read, alternate in bed with sitting in wheelchair to allow for comfort and pressure relief. When sitting in chair tilt back as needed for better head/neck positioning. Cue as needed to lift head during activities/mealtime to strengthen neck muscles for better positioning. R43's care plan lacked the OT recommendations for head positioning.

On 8/1/18, at 1:10 p.m., the interim director of nursing (IDON) stated R43 had extreme kyphosis. IDON confirmed R43's head hung straight down. When queried what had been done regarding R43's head position, IDON stated R43 was on hospice until recently. We have not done any splinting or anything like that, R43's head position has been long term.

On 8/2/18, at 2:12 p.m., the IDON stated she would have expected the OT recommendations to be on R43's care plan, communicated to the nursing assistants and placed on the care guide for the nursing assistants.

A policy for positioning was requested, but not provided.

SUGGEST METHOD FOR CORRECTION: The director of nursing or designee could direct staff to comprehensively assess residents, and implement interventions to ensure residents are provided care in a manor to promote their highest well-being. A monitoring program could be established in order to assure ongoing

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2 830	Continued From page 12 assessment and effective care plan interventions in response to resident care needs are completed. TIME PERIOD FOR CORRECTION: Twenty one (21) days.	2 830		
2 860	MN Rule 4658.0520 Subp. 2 F. Adequate and Proper Nursing Care; Hands-Feet Subp. 2. Criteria for determining adequate and proper care. The criteria for determining adequate and proper care include: E. per care and attention to hands and feet. Fingernails and toenails must be kept clean and trimmed. This MN Requirement is not met as evidenced by: Based on observation, interview and record 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. Findings include: R14's resident face sheet identified a current admission date of 2/22/16, and a diagnosis of type 2 diabetes mellitus, chronic obstructive pulmonary disease (COPD), and anxiety disorder. R14's quarterly, Minimum Data Set (MDS) an assessment dated 5/18/18, identified R14 to have intact cognition and required one person extensive assist with personal hygiene. Care plan dated 6/5/18, identified R14 needs one	2 860	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 and/or cleaned as needed. All Nursing staff were re-educated on the 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 monthly thereafter to ensure ongoing compliance. Audit results will be brought to the QAPI committee for review and further recommendations	9/10/18

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2 860	Continued From page 13	2 860		

person assist with nail care related to diabetes and COPD, with an approach to have nurse to provide nail care with bathing as needed.

Undated facility document, "Bath Schedule," identified R14 (by room number) will get a bath on Monday am.
Undated, nursing assistant care guide identified R14 to be diabetic and bath on Mondays.

During observation and interview on 7/30/18, at 12:30 p.m. R14 is sitting up in her wheelchair well dressed and is noted to have untrimmed, jagged fingernails. R14 stated, in regards to her fingernails, "They could use a trimming, they really could be cleaned." They tell me that only a nurse can clip them because I am diabetic.

During observation and interview on 7/31/18, at 12:43 p.m. R14 is sitting in her wheelchair in her room and stated she is waiting for her son to come bring her to the dentist. R14's fingernails remain untrimmed and jagged.

During observation and interview on 8/01/18, at 9:45 a.m. R14 is lying in her bed and verified no one had clipped her fingernails yet. R14 looks at her fingernails and stated, "They sure need it though don't they, and they are kind of dirty." R14 observed to have a dark substance under some of the untrimmed fingernails, and the left middle fingernail is jagged.

During interview on 8/1/18, at 9:53 a.m. trained medication aide (TMA)-A verified the residents get their nails clipped on their bath days, the aides do it unless the resident is diabetic, then the nurse has to do it . TMA-A further verified R14's is diabetic, nails are untrimmed and receives her baths on Mondays.

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During interview on 8/1/18, at 9:55 a.m. licensed practical nurse (LPN)-A- verified R14's fingernails have brown substance underneath some of them and that there are some jagged nails that need to be clipped. Further verified a nurse needs to clip R14's because she is diabetic and stated, they should be doing it on her bath days, "I used to go around to clip the resident's nails, but honestly I just haven't had time."

During interview on 8/1/18, at 10:12 a.m. interim director of nursing (IDON) verified diabetic residents need to have their nails trimmed by a licensed nurse and further verified they should be getting nail care at least weekly on their bath days.

R42's resident face sheet identified a current admission date of 3/21/18, and a diagnosis of type 2 diabetes mellitus with diabetic neuropathy and hemiplegia (paralysis of one side of the body), following a cerebral infarct (stroke).

R42's quarterly minimum data set (MDS) dated 7/5/18, identified R42 to have intact cognition and required one person extensive assist with personal hygiene.

Care plan dated 5/7/18, identified R42 needed one person assist from licensed staff weekly with nail care related to diabetes.

Undated facility document, "Bath Schedule," identified R42 (by room number) will get a bath on Thursday am.
Undated, nursing assistant care guide identified R42 to be diabetic and bath on Thursdays.

During observation on 7/30/18, at 6:03 p.m. R42

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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.

During observation and interview on 8/1/18, at 10:02 a.m. R42 is lying in her bed, fingernails remain unclipped with unknown brown substance underneath the right hand fingernails. R42 verified she gets her baths on Thursdays and stated, "I do want my fingernails clipped, they are kind of long and they are kind of dirty." They are supposed to clip my nails on my bath day. Nursing assistant (NA)-A was trying to straighten out R42's left hand to see the fingernails, and nails are long untrimmed with unknown brown substance on top of some of the nails.

During interview on 8/1/18, at 10:06 a.m. NA-A stated R42's fingernails all have dark brown substance underneath the pink painted nails and that they are long and need to be clipped and cleaned. NA-A further stated, "Only the nurse can do [R42's] nails, she is diabetic."

During interview on 8/1/18, at 10:08 a.m. registered nurse (RN)-B verified R42's fingernails are long, and have brown debris underneath the nails, and stated, "They need to be cleaned."

During interview on 8/1/18, at 10:12 a.m. interim director of nursing (IDON) verified diabetic residents need to have their nails trimmed by a

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	licensed nurse, and further verified they should be getting nail care at least weekly on their bath days.			
	Facility document, Nail Care, dated 11/20/17, indicated residents will be provided with nail care on hands and feet on bath day as needed and as needed between baths. Check care plan for special instructions. If diabetic, clean and file nails as ordered. Nurse to trim nails. If resident refuses notify nurse and re-approach.			
	SUGGESTED METHOD OF CORRECTION: The director of nursing and/or designee could educate responsible staff to provide care to residents' dependant on facility staff, based on residents' comprehensively assessed needs. The DON or designee could conduct audits of dependent resident cares to ensure diabetic nail care needs are met consistently.			
	TIME PERIOD FOR CORRECTION: Twenty-one (21) days.			
2 895	MN Rule 4658.0525 Subp. 2.B Rehab - Range of Motion	2 895		9/10/18
	Subp. 2. Range of motion. A supportive program that is directed toward prevention of deformities through positioning and range of motion must be implemented and maintained. Based on the comprehensive resident assessment, the director of nursing services must coordinate the development of a nursing care plan which provides that:			
	B. a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and to prevent further			

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2 895	Continued From page 17 decrease in range of motion. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the facility failed to provide services to maintain range of motion (ROM) of upper extremities for 1 of 1 resident (R42) reviewed for ROM. Findings include: R42's current diagnoses according to the undated face sheet included: Hemiplegia (paralysis of one side of the body), following cerebral infarct (stroke) affecting left dominant side, and Major Depressive Disorder. R42's Prospective Payment System (PPS) 90 day, Minimum Data Set (MDS) an assessment dated 7/5/18, indicated intact cognition and required extensive assistance of staff with activities of daily living (ADLs). Further identified a functional limitation in range of motion to one side in the upper and lower extremity. R42's care plan, dated 5/7/18, identified impaired mobility related to diagnosis of hemiplegia as evidenced by inability to ambulate. R42's goal is to remain free of contractures. The care plan also identified R42 required passive range of motion (PROM) to lower extremities and the use of a left hand/forearm splint to be put on in the am and taken off at bedtime. (Care plan did not identify PROM to the upper extremities). R42's current, undated, resident assignment sheet, indicated staff were to remember to place splint on left hand/forearm on in the am and off at	2 895	R#42 PROM program was added to the care plan and NAR assignment sheet and staff caring for R42 were re-educated on the plan. R#42 was referred back to OT for splinting needs, R#42's care plan will be updated as needed based on the assessment. Residents that require ROM for upper extremities will be reviewed to ensure ROM program/needs are on the care plan. Staff responsible for care planning ROM programs, including splinting needs were re-educated on the process of care planning therapy recommendations. Random chart audits will be complete by the DON/designee 3x's/week for 4 weeks and then 2 audits monthly thereafter to ensure therapy recommendations are implemented for ROM needs. Audit results will be brought to the QAPI committee for review and further recommendations	

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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 Motion Exercises for Shoulders, Arms, Wrists and Fingers, indicated staff to do with flex and extend of fingers to do thumb, pointer and middle finger together, Do ring and pinky together, slow stretch to open fingers as much as possible. Further indicated to complete handwashing and skin check after stretching and apply lotion to hands.

During observation 7/30/18, at 5:59 p.m. R42's left hand is noted to be contracted, and unable to open her hand when asked. No splints or palm grips noted on left hand/forearm. R42 stated, "I don't ever use a splint. No one does range of motion to my left arm unless I go to those exercises.

During observation on 7/31/18, at 12:23 p.m. R42 is sitting in her wheelchair up to the table in the dining room and is noted to not be wearing a hand splint.

During observation on 8/1/18, at 10:02 a.m. R42 is lying down in her bed on her back. Nursing assistant (NA)-A tried to straighten out R42's left fingers to see her fingernails, R42 stated, "Ouch, ouch, [curse words] that hurts!" NA-A told R42 she was sorry and R42 stated, Oh my fingers hurt leave them alone! Resident was not observed to

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be wearing a splint on her left hand.

During interview on 8/2/18, at 12:55 p.m. nursing assistant (NA)-D stated, according to our care sheet R42 is supposed to have a splint on her left hand, if there was range of motion to do for her it would be on our care sheet and it is not. NA-D verified she did not do PROM for R42 today. NA-D could not find R42's splint in her room.

During observation and interview on 8/2/18, at 12:59 p.m. R42 was sitting in her wheelchair, well dressed, no splint noted to be on her left hand. R42's left hand was in a closed fist position with her thumb tucked behind her fingers. R42 when asked was unable to open her left hand even with the assist of her right hand. R42 stated, "I am supposed to be wearing a splint to help prevent contractures." I was a licensed practical nurse (LPN) for several years you know.

During interview on 8/2/18, at 1:07 p.m. nursing assistant (NA)-E verified R42 used to wear a splint, but can't remember that last time R42 had it on.

During interview on 8/2/18, at 1:08 p.m. registered nurse (RN)-C verified R42 is not wearing the splint to her left hand like the care plan indicated. RN-C stated the splint would help to prevent contractures.

During interview on 8/2/18, at 1:16 p.m. physical therapist (PT) reviewed R42's record and verified R42 was in occupational therapy from 4/5/18, to 7/11/18, and should have a splint to her left hand to put be put on in the morning and remove at bedtime to help prevent contractures. PT further verified she should be getting PROM to her left hand and highly recommends it.

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During interview on 8/2/18, at 1:27 p.m. interim director of nursing (IDON) stated when a resident is discharged from therapy, they will give their recommendations to nursing. Nursing will make copies of the forms and give to the wing nurses and make copies to put in the therapy communication book and the residents chart. The nurse will then update the care plan and that will be put on the resident assignment sheet.

During interview on 8/2/18, at 1:34 p.m. registered nurse (RN)-A verified therapy had contacted her on 7/11/18, about the implementation of a PROM program for R42. RN-A stated, "I should have put the PROM program in right away."

During interview via phone on 8/2/18, at 2:21 p.m. occupational therapist (OT) stated, "I am shocked they haven't been doing [R42's] range of motion, I think it was July 13, 2018, when I trained all of the nursing staff and they told me they felt confident about doing that." OT verified R42 should be receiving hand hygiene and PROM to her left upper extremity daily. OT stated, a result of not having the range of motion for the last two and a half weeks the resident could suffer from joint stiffness, pain, and poor positioning. This surveyor asked if it was normal for R42's left hand to be in a position as follows: fingers curled over the thumb. OT responded, when I first started working with (R42) she did that, but when I started doing range of motion every day, when I was done I would position her thumb over her fingers, so if her hand has been in that position, it's from not doing the range of motion, a harmful affect. I do recommend the splint should be worn.

Facility policy, Restorative Nursing Program

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2 895	Continued From page 21 Policy, dated 9/22/17, indicated passive range of motion exercises must be care planned, scheduled, and documented in the medical record. further indicated with splint or brace assistance, staff applies, manipulates, and cares for the device or provide verbal cues, guidance, and direction to teach the resident to use it. SUGGESTED METHOD OF CORRECTION: The administrator, director of nursing (DON), or designee could develop and implement a plan of care by the interdisciplinary team to ensure residents with limited range of motion receive the appropriate therapy recommendations. The facility could update policies and procedures, educate staff on these changes, and audit periodically to ensure resident(s) are receiving recommended therapy services. Audits could be completed, and results of these audits are reviewed by the quality assessment and performance improvement (QAPI) committee could ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 895		
2 910	MN Rule 4658.0525 Subp. 5 A.B Rehab - Incontinence Subp. 5. Incontinence. A nursing home must have a continuous program of bowel and bladder management to reduce incontinence and the unnecessary use of catheters. Based on the comprehensive resident assessment, a nursing home must ensure that: A. a resident who enters a nursing home without an indwelling catheter is not catheterized unless the resident's clinical condition indicates that catheterization was necessary; and	2 910		9/10/18

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2 910	Continued From page 22 B. a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure appropriate treatment and services were provided to 1 of 1 resident (R14), reviewed for urinary catheter. Findings include: R14's quarterly Minimum Data Set (MDS) an assessment dated 5/18/18, identified R14 with an admit date of 2/22/16, had intact cognition, was dependent on staff for activities of daily living (ADLs). Further identified R14 to have an indwelling catheter. R14's face sheet printed 8/1/18, identified the following diagnoses: retention of urine and personal history of urinary tract infections. R14's Physician Order Sheet dated and signed by physician on 4/19/18 identified to change Foley catheter on the 17th of every month, for retention of urine, with 16 French, 10 milliliter (ml) balloon. R14's Physician transcribed order, dated 7/8/18, indicated the use of 18 French 30 ml balloon Foley catheter to be changed the 5th of every month. (not signed by physician). R14's care plan, dated 9/8/17, revealed risk of infection related to invasive procedure as	2 910	R#14 MD was updated on recent catheter changes and new orders were obtained. All residents with catheters were reviewed to ensure physician orders are followed as written. Licensed nursing staff were re-educated on following physician orders r/t catheter size and on the need to notify the physician when frequent catheter changes are needed. Random chart and observational audits will be completed by the DON/designee 3x's/week for 4 weeks and then 2 audits monthly thereafter to ensure physician orders are being followed as it relates to catheter size. Audit results will be brought to the QAPI committee for review and further recommendations.	

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2 910	Continued From page 23 evidenced by Foley catheter. Goal is resident will remain free from infection while having a Foley catheter. Approach is to monitor for signs and symptoms of infection, report abnormal labs, use appropriate hand hygiene, use appropriate equipment and assist with pericare twice a day and as needed. R14's electronic treatment administration sheet (ETAR), dated 7/18, identified 2 different orders: On 4/17/18, change Foley catheter on the 17th of every month with 16 French 10 ml balloon. On 7/8/18, change Foley catheter on the 17th of every month with 18 French 30 ml balloon. No treatments for either order were documented for the month of July. Review of August ETAR, revealed no documentation of Foley catheter change. R14's progress note dated 6/17/18, at 7:38 a.m. catheter changed as ordered. (Does not identify size of catheter used). R14's progress note dated 6/6/18, at 2:12 a.m. resident used call light "I feel myself getting wet." Foley catheter in place, urine in the tubing. Deflated and reflated balloon with 10 cc. Every hour resident activated the call light with the same statement of feeling wet in brief. Brief with a moderate saturation of urine. Changed Foley catheter, 16 French with 10 cc balloon. R14's progress note dated 7/5/18, at 2:21 a.m. (R14) alerted the staff, "feel like I am wetting myself again." deflated and re-inflated the balloon, attempt to flush unsuccessful unable to advance flush. Order calls for 16 French 10 cc balloon. Changed per order instruction. Brief was soiled with urine. Change the treatment order for monthly changes to reflect the Foley	2 910		

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2 910	Continued From page 24	2 910		

catheter change.

R14's progress note dated 7/8/18, Foley catheter was no longer patent and was leaking urine around the lumen. 16 French catheter replaced with an 18 French 30 cc balloon Foley catheter. Moderate amount of sediment noted with initial output. Catheter is patent at this time.

R14's progress note dated 7/13/18, at 2:02 a.m. nursing assistant alerted writer, brief saturated with urine, catheter collection bag and tubing, no urine output. Attempt to flush not successful due to resistance. Catheter change with 18 French with 30 cc balloon, tolerated without incident. 900 ml output immediately following the change, noted on Foley catheter removed the balloon did have a leak.

R14's progress note dated, 7/18/18, at 10:55 p.m. catheter leaking , strap to hold catheter in place was low (just above the knee) possibly causing the catheter to leak. Catheter was advanced though continued to leak. Catheter changed 16 French 30 cc with no further issues. Strap was placed upper thigh area to hold catheter in place and prevent pulling of catheter.

R14's progress note dated 7/30/18, at 11:47 p.m. Foley catheter leaking and tubing appeared to be out further than recommended. Tubing advanced and yellow/light yellow urine noted in catheter tuning. Leg strap applied to upper thigh to hold catheter in place. Later in the shift it was reported the Catheter was leaking again. Catheter changed with no issues, c/o pain, discomfort from resident. Yellow/light yellow urine flowing from the tube. (Size of catheter not documented).

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2 910	Continued From page 25	2 910		

During interview on 7/30/18, at 12:47 p.m. R14 stated I have had a catheter for a while now, and it had to be replaced before it was supposed to.

During interview on 7/31/18, at 12:45 p.m. R14 stated, I had to have a new catheter put in last night, it just wasn't working right.

During observation and interview on 8/1/18, at 7:25 a.m. R14 is lying in bed, dressed in facility night gown and nursing assistant (NA)-B is assisting R14 with catheter care. NA-B verified the catheter in place is an 18 French catheter with a 30 milliliter (ml) balloon.

During interview on 8/1/18, at 8:53 a.m. licensed practical nurse (LPN)-A verified R14 currently has an 18 French 30 cc Foley catheter in at this time and the only physicians order for R14's catheter was a size 16 French, 10 ml balloon, signed on 2/12/18. LPN-A further verified one of the nurses changed the order of the catheter in the electronic medical record to an 18 French 30 ml balloon without a signed order from the physician on 7/8/18.

During interview on 8/1/18, at 9:05 a.m. registered nurse (RN)-A verified R14 currently has a size 18 French 30 ml balloon catheter in place, with no current signed physician order for that size. RN-A further verified R14 has had her catheter changed 5 times in the last month with no documentation to notify the doctor. RN-A stated the more you change a catheter the more at risk you are for an infection, with R14's history of infection the doctor should have been updated.

During interview on 8/1/18, at 9:39 a.m. interim director of nursing (IDON) verified R14 currently has a size 18 French 30 ml balloon catheter in

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2 910	Continued From page 26 place, with no current signed physician order for that size. IDON further verified R14 has had her catheter changed 5 times in the month of July, 2018, with various sizes of catheters, without notifying the physician. IDON stated, my expectation would be the doctor should be notified of that many catheter changes, especially with her history of urinary tract infections, and that the nursing staff should be following the physician's orders as written. SUGGESTED METHOD OF CORRECTION: The administrator, director of nursing (DON) or designee could review and revise policies for following physician orders for a Foley catheter change according to evidence based practices/procedures. Nursing staff could be educated as necessary to the importance of following the physician orders prior to inserting a Foley catheter to ensure correct size. The DON or designee, should audit Foley catheter placement by all nursing staff assigned to residents effected and take that information to QAPI to ensure compliance and determine the need for further education/monitoring/compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 910		
21300	MN Rule 4658.0710 Subp. 4 A-C Admission Orders and Physician Evaluations Subp. 4. Physician visits. At each visit, a physician or physician's designee must: A. review the resident's comprehensive plan of care, including medications and treatments, and progress notes; B. write, sign, and date physician progress notes; and	21300		9/10/18

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21300	Continued From page 27 C. sign and date all orders. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure the physician reviewed treatments and auxiliary orders during routine visits for 16 of 16 residents (R17, R22, R43, R45, R9, R10, R31, R40, R2, R6, R13, R14, R18, R20 and R42) reviewed for signed physician orders. Findings include: R17's Face Sheet, dated 8/1/18, included diagnoses of Alzheimer's disease, chronic pulmonary embolism, obstructive sleep apnea, hypertension, nutritional deficiency, anxiety disorder, combined systolic and diastolic heart failure and obesity. R17's Physician Order Sheet, signed by a certified nurse practitioner, dated 7/26/18, included review of medications and care plan. The order sheets lacked documentation of review of R17's treatments and auxiliary orders. R22's Face Sheet, dated 8/1/18, included diagnoses of chronic obstructive pulmonary disease, chronic diastolic heart failure, chronic atrial fibrillation, anemia, malignant neoplasm of prostate, nutritional deficiency and sleep apnea. During observation and interview, on 7/30/18, at 3:18 p.m., R22 stated he had a catheter in place. A catheter drainage bag was observed to be hanging under R22's wheelchair. R22's Physician Order Sheet, signed by a	21300	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 signed 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 the 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 by the DON/designee 3x's/week for 4 weeks and then 2 audits monthly thereafter to ensure ongoing compliance. Audit results will be brought to the QAPI committee for review and further recommendations.	

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certified nurse practitioner, dated 7/9/18, included review of medications and care plan. The order sheets lacked documentation of review of R22's treatments and auxiliary orders.

R43's Face Sheet, dated 8/1/18, included diagnoses of chronic pain, kyphosis, peripheral vascular disease, osteoarthritis and dementia.

R43's Physician Order Sheet, signed by a certified nurse practitioner, dated 6/21/18, included review of medications and care plan. The order sheets lacked documentation of review of R43's treatments and auxiliary orders.

R45's Face Sheet, dated 8/1/18, included diagnoses of chronic pain, kyphosis, peripheral vascular disease, osteoarthritis and dementia.

R45's Physician Order Sheet, signed by the physician, dated 7/10/18, included review of medications and care plan. The order sheets lacked documentation of review of R45's treatments and auxiliary orders.

During interview on 7/31/18, at 12:09 p.m., the IDON stated Physician (P)-F preference was to print out the medications for residents only and he wanted to address the treatments in his narrative notes. However, the progress notes related to R17, R22, R43, & R45, lacked to include a review of treatment and auxiliary orders. The IDON stated she would guess all residents included the same and P-F was physician for every resident except one resident.

R9's Face sheet indicated, R9 admitted on 11/3/17, with diagnoses that included, non-pressure chronic ulcer of left calf, venous insufficiency (peripheral), atrial fib, heart failure

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and hypertension.

R9's most recent signed ordered for medications dated 7/9/18, showed medications only.

R9's most recent nurse practitioner progress note from visit dated 7/9/18, indicated review of medications orders, review of systems and was noted to have order to continue dressing changes to left lower leg ulcer twice daily.

However, no other documentation indicated treatment, dietary, or ancillary orders were reviewed and signed by nurse practitioner during this visit.

R10's face sheet indicated, R10 admitted on 2/1/18, with diagnoses that included stroke, heart disease, congestive heart failure and hypertenstion.

R10's most recent signed ordered for medications dated 6/7/18, showed medications only.

R10's most recent nurse practitioner progress note from visit dated 6/7/18, indicated review of medications orders and review of systems.

However, no other documentation indicated treatment, dietary, or ancillary orders were reviewed and signed by nurse practitioner during this visit.

R31's face sheet indicated, R31 admitted on 11/4/16, with diagnoses that include heart attack, difficulty swallowing, urinary retention and hearing loss.

R31's most recent signed ordered for

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medications dated 6/4/18, showed medications only.

R31's most recent nurse practitioner progress note from visit dated 6/4/2018, indicated review of medications orders and review of systems.

However, no other documentation indicated treatment, dietary, or ancillary orders were reviewed and signed by nurse practitioner during this visit.

R40's face sheet indicated, R40 admitted on 12/29/17, with diagnoses that include progress supranuclear opthalmoplegia (neurodegenerative condition that causes problems with balance, vision, speech, movement and swallowing), anxiety disorder, urinary retention, major depressive disorder and delusional disorder.

R40's most recent physician's progress note from visit dated 6/26/18, indicated review of medications orders and review of systems and was electronically signed by the physician on 6/26/18.

However, no other documentation indicated treatment, dietary, or ancillary orders were reviewed and signed by physician during this visit.

R2's Face Sheet, dated 8/1/18, included diagnoses of dementia with behavioral disturbance, major depressive disorder, anxiety disorder, presence of cardiac pacemaker, and insomnia.

R2's Physician Order Sheet, signed by the physician, dated 7/24/18, included review of medications and care plan. The order sheets lacked documentation of review of R2's

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treatments and auxiliary orders.

R6's Face Sheet, dated 8/1/18, included diagnoses of diabetes mellitus, hypertension, major depressive disorder, anemia, dizziness and giddiness, legal blindness, and insomnia.

R6's Physician Order Sheet, signed by the physician, dated 7/17/18, included review of medications and care plan. The order sheets lacked documentation of review of R6's treatments and auxiliary orders.

R13's Face Sheet, dated 8/1/18, included diagnoses of type 2 diabetes mellitus, obesity, major depressive disorder, contracture of the knee, cerebral infarct with hemiplegia of the right side, and heart failure.

R13's Physician Order Sheet, signed by a physician, dated 6/19/18, included review of medications and care plan. The order sheets lacked documentation of review of R13's treatments and auxiliary orders.

R14's Face Sheet, dated 8/1/18, included diagnoses of type diabetes mellitus with diabetic neuropathy, urinary retention, pulmonary edema, insomnia, anxiety, morbid obesity, diastolic heart failure, presence of cardiac pacemaker, and asthma.

R14's Physician Order Sheet, signed by the physician, dated 7/10/18, included review of medications and care plan. The order sheets lacked documentation of review of R14's treatments and auxiliary orders, to include Foley catheter orders, when R14 utilized a Foley catheter.

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R18's Face Sheet, dated 8/1/18, included diagnoses of anxiety disorder, low back pain, constipation, gastritis, and unstageable pressure ulcer.

R18's Physician Order Sheet, signed by a physician, dated 6/12/18, included review of medications and care plan. The order sheets lacked documentation of review of R18's treatments and auxiliary orders.

R20's Face Sheet, dated 8/1/18, included diagnoses of type 2 diabetes mellitus, anemia, chronic diastolic heart failure, hypertension, atrial fibrillation, phantom limb pain, chronic respiratory failure with hypoxia, dementia, insomnia, anemia, and stage 3 kidney disease.

R20's Physician Order Sheet, signed by certified nurse practitioner, dated 6/25/18, included review of medications and care plan. The order sheets lacked documentation of review of R20's treatments and auxiliary orders.

R42's Face Sheet, dated 8/1/18, included diagnoses of toxic encephalopathy, hemiplegia following a stroke on left side, congestive heart failure, cardiomegaly, hypertension, urinary retention, major depressive disorder, anemia, insomnia, chronic obstructive pulmonary disease, seizures, sleep apnea and chronic kidney disease stage 5.

R42's Physician Order Sheet, signed by a physician, dated 6/19/18, included review of medications and care plan. The order sheets lacked documentation of review of R42's treatments and auxiliary orders.

During interview on 8/1/18, at 1:09 p.m.

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21300	Continued From page 33 registered nurse (RN)-B said, "I can't tell a lie, the reason why our doctor quit signing the treatments and just signs the md [medication] orders now, is because he thought he had to sign every page." We have alerted him that he only has to sign the last page, so now that we are aware of this problem, we are going to fix that. Facility policy, "Physician visits" reviewed/amended 10/20/17, indicated each regulated physician visit will minimally consist of actual face to face contact with the resident, reviewing the residents total plan of care, including medications and treatments, writing a progress note which is signed and dated as well as signing all new orders. Suggested Method of Correction: The DON or designee could work with the medical director and administrator to ensure the physician had signed and dated all orders. The administrator, DON or designee could also perform audits of resident records to determine if the physician services had been provided. Time Period for Correction: Twenty-one (21) days.	21300		
21375	MN Rule 4658.0800 Subp. 1 Infection Control; Program Subpart 1. Infection control program. A nursing home must establish and maintain an infection control program designed to provide a safe and sanitary environment. This MN Requirement is not met as evidenced by:	21375		9/10/18

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21375	Continued From page 34 Based on observation, interview and document review, the facility failed to ensure current standards of practice for infection control when providing peri cares for 1 of 1 resident (R3), who was observed during morning cares. Findings include: During observation of morning cares on 8/1/18, at 7:16 a.m., nursing assistant (NA)-C applied gloves, cleansed R43's peri area, removed wet (urine) incontinent product, cleansed R43's buttocks (gloves remained on), applied a clean incontinent product, pulled up R43's pants, pulled down R43's shirt, touched a comb, rolled R43 towards her and removed gloves. NA-C held a walkie-talkie in her hand to communicate with staff, put R43's lotion bottle away, placed dirty linens in a bag and applied heel protectors to R43's feet. The interim director of nursing (IDON) walked into R43's room to assist with transferring R43 into a Broda chair. NA-C stated I am going to wash my hands now. During interview with NA-C after providing R43's morning care, NA-C verified she had not removed her gloves and washed hands after providing peri cares for R43. On 8/1/18, at 1:21 p.m., the IDON stated she would expect gloves to be removed and hands washed after providing peri cares. On 8/2/18, at 11:05 a.m., the assistant director of nursing stated she would expect when gloves are contaminated, staff should remove the gloves before touching other surfaces and perform hand hygiene. The Hand Hygiene policy, reviewed 8/2011, indicated Procedure: A. All staff will practice hand hygiene: 2. Before applying and after removing	21375	Staff caring for R#43 were re-educated on proper handwashing. All residents must have cares provided that ensure current standards of practice 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 brought to the QAPI committee for review and further recommendations.	

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21375	Continued From page 35 gloves. A policy for glove use was requested, but not provided. SUGGESTED METHOD OF CORRECTION: The director of nursing could in-service all staff on the need to follow infection control practices to eliminate the spread of infection from resident to resident, also visitors and staff. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21375		
21426	MN St. Statute 144A.04 Subd. 3 Tuberculosis Prevention And Control (a) A nursing home provider must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in CDC's Morbidity and Mortality Weekly Report (MMWR). This program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, residents, and volunteers. The Department of Health shall provide technical assistance regarding implementation of the guidelines. (b) Written compliance with this subdivision must be maintained by the nursing home.	21426		9/10/18

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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.

During interview on 8/2/18, at 8:58 a.m., human resources (HR)-C stated the facility had nothing on file for E-A's TB screen and first and second step TST's. HR-C stated I must have missed filed or shredded the information.

RESIDENT SCREEN:
R40 was admitted on 12/29/17, and R10 was admitted on 2/1/18. The resident records lacked a TB symptom screen.

During interview on 8/2/18, at 1:08 p.m., registered nurse (RN)-A stated I could not find a TB symptom screen for R40 and R10.

RESIDENT TST:
R45 was admitted on 1/17/18. R45 had a first step TST on 12/19/17, with read results on 12/21/17 of 0 millimeters and negative. R45's second step TST was given on 1/2/17, however

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00917	A. BUILDING: ______ B. WING ______	08/02/2018

NAME OF 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)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE 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.

The facility policy Resident Tuberculosis Prevention and Control, dated reviewed/revised 6/5/17, indicated Procedure: B. b. Each resident admitted to (care center) will be required to have a written assessment of the resident's risk factors for TB along with any current TB symptoms. A IGRA or a standard tow step TST will be initiated within 72 hours after admission to the care center.

SUGGESTED METHOD OF CORRECTION: The director of nursing could review tuberculosis policies and procedures to ensure compliance. The director of nursing could monitor compliance for screening and TST for employees and residents.

TIME PERIOD FOR CORRECTION: Twenty-one (21) days.

Minnesota Department of Health

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