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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL ID: 728P

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY Facility ID: 00189

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245556**
2.STATE VENDOR OR MEDICAID NO.
(L2) **376724800**

3. NAME AND ADDRESS OF FACILITY
(L3) **PRESBYTERIAN HOMES OF BLOOMINGTON**
(L4) **9889 PENN AVENUE SOUTH**
(L5) **BLOOMINGTON, MN** (L6) **55431**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **10/28/2021** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

12.Total Facility Beds **98** (L18)
13.Total Certified Beds **98** (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
	98			
(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 :
Haley Young, HFE NE II 12/01/2021 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 12/12/2021 (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
04/01/1991
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

Electronically delivered
November 18, 2021

Administrator
Presbyterian Homes Of Bloomington
9889 Penn Avenue South
Bloomington, MN 55431

RE: CCN: 245556
Cycle Start Date: October 28, 2021

Dear Administrator:

On October 28, 2021, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

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

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

DEPARTMENT CONTACT

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

Nicole Osterloh, RN, Unit Supervisor
Marshall District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
1400 East Lyon Street, Suite 102
Marshall, Minnesota 56258-2504
Email: nicole.osterloh@state.mn.us
Office: 507-476-4230
Mobile: (507) 251-6264 Mobile: (605) 881-6192

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

If substantial compliance has been achieved, certification of your facility in the Medicare and/or

Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

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

If substantial compliance with the regulations is not verified by January 28, 2022 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by April 28, 2022 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

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

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

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

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

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

Please note that the failure to complete the informal dispute resolution process will not delay the dates

specified for compliance or the imposition of remedies.

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

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

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245556	A. BUILDING _____ B. WING _____	C 10/28/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRESBYTERIAN HOMES OF BLOOMINGTON	**9889 PENN AVENUE SOUTH BLOOMINGTON, MN 55431**

(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 Recertification and Complaint Emergency Preparedness Survey was conducted by Healthcare Management Solutions, LLC on behalf of the Minnesota Department of Health on 10/25/21 through 10/28/21. The facility was found to be IN compliance with 42 CFR 483.73.	E 000		
F 000	INITIAL COMMENTS A standard recertification survey was conducted by Healthcare Management Solutions, LLC on behalf of the Minnesota Department of Health on 10/25/21 through 10/28/21. Complaints were also investigated. The facility was found to be NOT in substantial compliance with 42 CFR 483 subpart B. The following complaints were found to be UNSUBSTANTIATED: H5556073C (MN69862), H5556074C (MN60851), H5556075C (MN63158), H5556076C (MN70923), H5556079C (MN75014), and H5556082C (MN77674), The following complaints were found to be SUBSTANTIATED: H5556077C (MN64540 and MN63808) however NO deficiencies were cited due to actions taken by the facility prior to the survey. H5556081C (MN72231) was also SUBSTANTIATED with a deficiency cited at F770. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance.	F 000		

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

Electronically Signed | 11/26/2021

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

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F 000	Continued From page 1 Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulations has been attained.	F 000		
F 552 SS=D	Right to be Informed/Make Treatment Decisions CFR(s): 483.10(c)(1)(4)(5) §483.10(c) Planning and Implementing Care. The resident has the right to be informed of, and participate in, his or her treatment, including: §483.10(c)(1) The right to be fully informed in language that he or she can understand of his or her total health status, including but not limited to, his or her medical condition. §483.10(c)(4) The right to be informed, in advance, of the care to be furnished and the type of care giver or professional that will furnish care. §483.10(c)(5) The right to be informed in advance, by the physician or other practitioner or professional, of the risks and benefits of proposed care, of treatment and treatment alternatives or treatment options and to choose the alternative or option he or she prefers. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and interviews, the facility failed to treat 1 of 30 resident (R16) with dignity during administration of medications in the Pathway Unit Dining Room. Findings include: Review of the facility's policy titled "Dignity" dated December 2014 directs "that residents are cared for in a manner that and in an environment that	F 552	This Plan of Correction and the responses to each F-Tag are submitted to maintain certification in the Medicare and Medicaid programs and constitute a credible allegation of compliance. The written responses do not constitute an admission of noncompliance or agreement with any findings stated under the F-Tags. The facility reserves its right to dispute all findings and deficiencies in	12/7/21

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F 552	Continued From page 2 promotes maintenance and enhancement of a resident's quality of life. [Facility] is committed to an atmosphere that humanizes and individualizes each resident and their experiences." Review of the facility's policy titled "Medication Administration Procedures" dated 01/27/19 directs "Eye Drop Administration ...Provide for resident privacy." Review of the "Profile" tab in the electronic medical record (EMR) revealed that R16 was admitted to the facility on 11/17/20 for long term care. Review of the Quarterly "Minimum Data Set" (MDS) with an Assessment Reference Date (ARD of 08/11/21 revealed R16 had a Brief Interview for Mental Status (BIMS) score of 12 that indicated the resident had mild cognitive impairment. During an observation on 10/25/21 at 6:36 PM Licensed Practical Nurse (LPN) 36 approached R16 with medications and without asking administered a pill with a spoon and eye drops to R16, who was sitting in a wheelchair, in the Pathway Unit dining room; two other residents were still in the dining room. During an interview on 10/25/21 at 7:05 PM, R16 stated that she did not like receiving medication in a public area, she would rather get her medication in her room in private. She further revealed she often is given her medications in the dining room. During an interview on 10/25/21 at 7:17 PM LPN 36 acknowledged that he administered a Tylenol in applesauce using a spoon and eye drops to	F 552	any appropriate forum, including in an independent dispute resolution, or, if appealable remedies are subsequently imposed, by timely appeal to the Departmental Appeals Board. F552 Right to be Informed/Make Treatment Decisions Immediate Corrective Action: LPN-36 received coaching and re-education on Medication Administration Policy and Procedures. R-16 care plan and eMAR were updated to reflect residents' preference on receiving medications in private areas. Corrective Action as it Applies to Other Residents: All licensed nurses were reeducated on the Medication Administration Policy and Procedures. Reviewed all care plans for medication administration preferences. Reoccurrence will be Prevented By: The IDT will complete weekly medication administration audits on 10% of residents to ensure medication preferences are being followed according to the care plan. Will review care plans quarterly following resident preferences for medication administration. Audits will be reported by the Care Center Administrator or Clinical Administrator to the Quality Assurance Committee to determine ongoing need for audits. Date Certain: 12/7/21	

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F 552	Continued From page 3 R16 in the Pathway Unit dining room. LPN 36 stated he normally administers the resident's evening medications in the dining room because most of the residents take their medication in the dining room; R16 was waiting for them that's why she took them there. During an interview on 10/28/21 at 2:38 PM, with both the Director of Nursing (DON) and Campus Administrator revealed the policy would not allow administration of eye drops or an injection in the dining room. The Campus Administrator stated any medication administration in the dining room should be addressed in the resident's care plan.	F 552		
F 558 SS=D	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure accommodations were met when water was not accessible for 1 of 1 resident (R31). Findings included: R31's admission record dated 10/28/21, indicated R31 was admitted on 7/13/13 with diagnosis of multiple sclerosis. R31's quarterly Minimum Data Set (MDS) dated 9/7/21, indicated R31 was cognitively intact and	F 558	This Plan of Correction and the responses to each F-Tag are submitted to maintain certification in the Medicare and Medicaid programs and constitute a credible allegation of compliance. The written responses do not constitute an admission of noncompliance or agreement with any findings stated under the F-Tags. The facility reserves its right to dispute all findings and deficiencies in any appropriate forum, including in an independent dispute resolution, or, if appealable remedies are subsequently	12/7/21

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F 558	Continued From page 4 required extensive assistance of one person for eating and drinking. R31's care area assessment (CAA) for dehydration/fluid maintenance dated 6/15/21, indicated R31 was at risk for dehydration due to urinary tract infection (UTI) requiring an emergency room visit on 5/21/21,chronic catheter use, and required staff assist with eating. Staff were to monitor fluid intake to minimize the risk of decline/ and or complications. R31's care plan dated 6/22/21, indicated R31 had an activity of daily living (ADL) self-care performance deficit and need staff assistance due to limited mobility and multiple sclerosis with an intervention of requiring one assist with eating. Further, R31 had dehydration or potential fluid deficit related to decreased mobility and requires assistance with eating with a goal to continue to take fluids between and with meals through the review date on 11/30/21. Interventions included: ensure resident had access to fluids whenever possible and monitor/document intake and output. R31's care conference summary dated 9/27/21, indicated the staff and family discussed use of the new power chair and F-C requested that a cup holder be added to the chair. R31's progress note dated 9/28/21, indicated a care conference was held with family (F)-C. F-C requested that a cup holder be added to R31's power wheelchair for a way for R31 to use a water bottle independently. R31's progress notes dated from 9/28/21 through 10/27/21, lacked evidence of staff notifying Handi medical (the power chair company) regarding adding the cup holder.	F 558	imposed, by timely appeal to the Departmental Appeals Board. F558 Reasonable Accommodations Needs/Preferences Immediate Corrective Action: R31□s power chair was modified on 11/24/21 to include a cup holder to accommodate easy access to fluids at anytime to ensure hydration, and care plan was updated accordingly. Corrective Action as it Applies to Other Residents: The facility process has been and will continue to be to ask during care conferences if there are any changes in the residents plan of care as it relates to personal preferences. All current residents who have had their initial comprehensive care plan developed have been reviewed at a conference have been reviewed and the anyone indicating a request to update their plan of care based on a personal preference or need has been reviewed and determined if this can be accommodated into their plan of care. All licensed nurses and the Interdisciplinary Team was reeducated on the process to review the care plan at each care conference to ensure resident preferences are being met. Reoccurrence will be Prevented By: Resident care plan/preference audits will be completed weekly on 10% of residents to ensure that residents and families were interviewed for any unmet or accommodation of needs at each care	

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F 558	Continued From page 5 During observation on 10/25/21, at 4:27 p.m. R31's water jug was on the bedside table which was on the other side of the bed away from R31. During observation on 10/26/21, at 10:47 a.m. R31's water jug was on the bedside table which was on the other side of the bed away from R31. During observation on 10/27/21, at 2:47 p.m. R31's water jug was on the dresser by the television. R31 was in a manual wheelchair at this time and unable to propel to the dresser to reach the water jug. During observation on 10/28/21, at 7:46 a.m. R31's water jug was on the dresser by the television. R31 was in bed at the time. During an interview on 10/25/21, at 4:25 p.m. R31 stated, "I do feel dehydrated". Further, R31 stated, "I have to wait for someone to come in here and ask for a drink and I wouldn't mind having more water throughout the day". During an interview on 10/28/21, at 7:52 a.m. resident assistant (RA)-43 stated the staff assist R31 to eat and drink due to R31's "right hand doesn't work and the left hand is very weak". Further, RA-43 stated R31's old wheelchair use to have a place for a water bottle so R31 could reach it independently and the new power wheelchair doesn't have a water bottle holder. RA-43 verified the staff doesn't automatically go into R31's room and offer fluids. During an interview on 10/28/21, at 8:11 a.m. registered nurse (RN)-45 stated R31 was independent and can asked for water.	F 558	conference. Audits will be reported by the Care Center Administrator or Clinical Administrator to the Quality Assurance Committee to determine ongoing need for audits. Date Certain: 12/7/21	

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PRESBYTERIAN HOMES OF BLOOMINGTON	9889 PENN AVENUE SOUTH BLOOMINGTON, MN 55431

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F 558	Continued From page 6 During an interview on 10/28/21, at 8:15 a.m. clinical coordinator registered nurse (RN)-10 verified the power wheelchair company had not been notified regarding the water bottle holder since the care conference was held on 9/28/21. RN-10 verified R31 did not have access to water and staff should offer water each time they enter the room. RN-10 stated R31 not having enough water could cause UTI's and dehydration. During an interview on 10/28/21, at 8:31 a.m. resident services specialist (RSS)-15 stated R31 does not have a water bottle holder on the power chair and R31's family wanted the facility to contact the chair company. Further, RSS-15 verified no follow-up was made after the first call regarding the water bottle holder. During an interview on 10/28/21, at 8:48 a.m. the interim clinical administrator registered nurse (RN)-4 stated staff should have talked to the wheelchair company right away and if the company had not completed the work then the staff should have placed a protocol to make sure R31 was getting fluids. A request for an accommodations of needs policy was made but none provided.	F 558		
F 572 SS=E	Notice of Rights and Rules CFR(s): 483.10(g)(1)(16) §483.10(g) Information and Communication. §483.10(g)(1) The resident has the right to be informed of his or her rights and of all rules and regulations governing resident conduct and responsibilities during his or her stay in the facility.	F 572		12/7/21

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	245556	A. BUILDING _____ B. WING _____	C 10/28/2021

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F 572	Continued From page 7 §483.10(g)(16) The facility must provide a notice of rights and services to the resident prior to or upon admission and during the resident's stay. (i) The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. (ii) The facility must also provide the resident with the State-developed notice of Medicaid rights and obligations, if any. (iii) Receipt of such information, and any amendments to it, must be acknowledged in writing; This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and facility policy review, the facility failed to ensure information on resident rights was posted and provided during their stay for residents who lived on the second and third floors of the facility. This had the potential to affect 38 of 84 residents who resided on the second and third floor. Findings include: During the resident council interview on 10/27/21 at 10:35 AM Residents (R) 39, 61, 4 and 34 said they attended resident council meetings regularly and their resident rights were not always discussed. The residents said they did not know where the resident rights information was posted. The residents did not recall if they were given a copy of their rights upon admission. During on observation on 10/27/21 at 12:30 PM the resident rights information was posted in the first-floor lobby area. Residents on the first floor lived on a secured unit. Residents on the second	F 572	This Plan of Correction and the responses to each F-Tag are submitted to maintain certification in the Medicare and Medicaid programs and constitute a credible allegation of compliance. The written responses do not constitute an admission of noncompliance or agreement with any findings stated under the F-Tags. The facility reserves its right to dispute all findings and deficiencies in any appropriate forum, including in an independent dispute resolution, or, if appealable remedies are subsequently imposed, by timely appeal to the Departmental Appeals Board. F572 Notice of Rights and Rules Immediate Corrective Action: Facility has posted resident rights and rules on all floors. Corrective Action as it Applies to Other	

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F 572	Continued From page 8 and third floor must access the stairs or elevator to get to the first-floor lobby. Observations of the second and third floor revealed there were no postings of the resident rights information. During an interview on 10/27/21 at 12:46 PM the Administrator and Resident Services Specialists (RSS) 15 and 32 and Social Worker (SW) 31 and 33 were in attendance. RSS-15 said resident council meetings were held monthly with a staff person present and residents were verbally invited to attend. RSS-15 said the minutes from resident council meetings were not shared with residents who did not attend. The Administrator said one or two resident rights were reviewed before each resident council meeting. He also said the residents were not reeducated on their rights on a regular basis but could be if warranted. The Administrator said residents were given a copy of their resident rights upon admission, but he was unsure if residents retained those copies after years long stays at the facility. The Administrator said the resident rights were posted in the first-floor lobby and residents who went downstairs had access to them. RSS-15 said many residents were able to go down to the lobby and could see the resident rights posting. RSS-15 confirmed if residents were unable to go to the lobby and did not attend resident council, they would have no information regarding their rights unless they kept their admission packet. During an interview on 10/27/21 at 2:12 PM the Life Enrichment Coordinator (LEC) said the facility had no system in place to communicate information discussed in resident council with residents who were not able or did not attend. The LEC said one or two resident rights were	F 572	Residents: Staff responsible for running the resident council were reeducated on the process to inform residents of their rights at each monthly resident council meeting. Meeting minutes from the resident council meetings will be offered to residents who did not attend. Reoccurrence will be Prevented By: Notice of Rights and Rules Audit will be completed monthly on 10% of residents to ensure residents received notice of their rights upon admission, that postings remain in place on all floors of the facility, that rights are discussed at each resident council meeting, and that the residents that did not attend are offered a copy of the meeting minutes. Audits will be reported by the Care Center Administrator or Clinical Administrator to the Quality Assurance Committee to determine need for ongoing audits. Date Certain: 12/7/21	

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F 572	Continued From page 9 discussed at each resident council meeting. The LEC said the activities staff did not provide any ongoing information regarding resident rights to the residents. She said she was unsure where the resident rights were posted but if a resident asked, they could provide them a copy. The LEC said she was sure the residents were given a copy of their rights upon admission but did not know how residents were educated about their rights during their stay. The LEC said she thought the social services department would be responsible for that. Review of "Resident Council Minutes" dated 09/21/21 indicated four residents attended and no resident rights were read during the meeting. Review of "Resident Council Minutes" dated 09/28/21 indicated three residents attended and "Resident Rights Read: 1-2 Exercise of Rights 1-7" were covered during the meeting. Review of the "Resident Rights Policy" dated January 2020 indicated "the resident services department or designee informs the resident of Resident's Rights at the time of admission and at periodic intervals throughout the resident's care period".	F 572		
F 575 SS=E	Required Postings CFR(s): 483.10(g)(5)(i)(ii) §483.10(g)(5) The facility must post, in a form and manner accessible and understandable to residents, resident representatives: (i) A list of names, addresses (mailing and email), and telephone numbers of all pertinent State agencies and advocacy groups, such as the State Survey Agency, the State licensure office, adult	F 575		12/7/21

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F 575	Continued From page 10 protective services where state law provides for jurisdiction in long-term care facilities, the Office of the State Long-Term Care Ombudsman program, the protection and advocacy network, home and community based service programs, and the Medicaid Fraud Control Unit; and (ii) A statement that the resident may file a complaint with the State Survey Agency concerning any suspected violation of state or federal nursing facility regulation, including but not limited to resident abuse, neglect, exploitation, misappropriation of resident property in the facility, and non-compliance with the advanced directives requirements (42 CFR part 489 subpart I) and requests for information regarding returning to the community. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to post the list of pertinent state agencies, ombudsman information, and a statement on how to file a complaint with the State Survey Agency in a manner that was accessible to all residents of the facility. The posting was not readily available to 38 of 84 residents who resided on the second and third floor of the facility. Findings include: During the resident council interview on 10/27/21 at 10:35 AM Residents (R) 39, 61, 4 and 34 said they attended resident council meetings regularly. The residents said they did not know where the ombudsman and complaint information were located. The residents said if they had a complaint, they would have to fill out a grievance form with a facility staff person. The residents indicated they were unsure how to file a complaint	F 575	This Plan of Correction and the responses to each F-Tag are submitted to maintain certification in the Medicare and Medicaid programs and constitute a credible allegation of compliance. The written responses do not constitute an admission of noncompliance or agreement with any findings stated under the F-Tags. The facility reserves its right to dispute all findings and deficiencies in any appropriate forum, including in an independent dispute resolution, or, if appealable remedies are subsequently imposed, by timely appeal to the Departmental Appeals Board. F575 Required Postings Immediate Corrective Action: Facility has posted names, addresses, and telephone numbers of all pertinent state agencies	

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F 575	Continued From page 11 without notifying the staff. During on observation on 10/27/21 at 12:30 PM the state agency, complaint and ombudsman information was posted in the first-floor lobby area. Residents on the second and third floor must access the stairs or elevator to get to the first-floor lobby. Observations of the second and third floor revealed there were no postings of the state agency, complaint and ombudsman information. During an interview on 10/27/21 at 12:46 PM the Administrator and Resident Services Specialists (RSS) 15 and 32 and Social Worker (SW) 31 and 33 were in attendance. The Administrator confirmed the state agency, complaint and ombudsman information was posted in the lobby on the first floor but not on the second or third floor. RSS15 said many of the residents were able to access the first floor with and without staff assistance. Both the Administrator and RSS15 confirmed a resident who needed assistance would not be able to confidentially find the state agency, complaint, or ombudsman information without asking a staff person. During an interview on 10/28/21 at 10:47 AM R54 said someone came in a few years ago and told her how to report something but she did not remember how to do it. She said she would have a hard time finding out how to report if she wanted it to be private. R54's room was located on the third floor. During an interview 10/28/21 at 10:51 AM R279 said "I have no idea where the information is to report things to the state." R279's room was located on the third floor.	F 575	and advocacy groups on all floors. Corrective Action as it Applies to Other Residents: Staff responsible for running the resident council were reeducated on the process to inform residents of contact information for pertinent state agencies and to ensure residents and families understand their right to file a grievance. Reoccurrence will be Prevented By: Required Postings Audit will be completed weekly on 10% of residents to ensure that postings remain in place on all floors of the facility, and that residents and families understand their right to file a grievance. Audits will be reported by the Care Center Administrator or Clinical Administrator to the Quality Assurance Committee to determine need for ongoing audits. Date Certain: 12/7/21	

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F 575	Continued From page 12 During an interview 10/28/21 at 10:58 AM R34 said "I don't know where to find the information about how to call the state, but I guess if I felt comfortable, I could go get the information from [sic] Clinical Coordinator 10." R34's room was located on the third floor. During an interview 10/28/21 at 11:03 AM R67 said "I have no idea how to make a private complaint." R67's room was located on the third floor.	F 575		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2)	F 580		12/7/21

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F 580	Continued From page 13 is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on interview, and document review, the facility failed to ensure the responsible party was notified of medication changes for 2 of 2 residents (R58 and R29). Findings include: R58's facesheet dated 10/28/21, indicated resident responsible party to notify was family member (F)-A and F-B, the daughters of R58. R58's quarterly Minimum Data Set (MDS) dated 10/1/21, indicated R58 was moderately	F 580	This Plan of Correction and the responses to each F-Tag are submitted to maintain certification in the Medicare and Medicaid programs and constitute a credible allegation of compliance. The written responses do not constitute an admission of noncompliance or agreement with any findings stated under the F-Tags. The facility reserves its right to dispute all findings and deficiencies in any appropriate forum, including in an independent dispute resolution, or, if appealable remedies are subsequently	

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F 580	Continued From page 14 cognitively impaired and required extensive assistance to total dependence with two assist for all activities of daily living (ADL). R58's physician progress note dated 10/20/21, indicated R58's family requested "something stronger for pain...they are looking for a PRN (as needed) narcotic". R58's provider replied back on 10/20/21, and indicated R58's physician ordered Neurontin 100 mg TID (three times a day) for pain. R58's progress noted identified on: 1) 10/25/21, at 4:43 p.m. R58's F-A pulled staff aside and explained that resident "has been extremely confused today - yelling out, trying to get out of bed multiple times". 2) 10/26/21, at 1:19 p.m. [F-A] informed staff they refused the Neurontin medication for R58 as they noted it made her "drowsy...drugged just like in the past" when she had previously tried Neurontin. There was no indication F58's family was ever notified of the medication orders for Neurontin to make an informed choice to agree or disagree with treatment. R58's medication administration record (MAR) dated October 2021, indicated R58 was given 18 doses of Neurontin 100 mg prior to being discontinued on 10/26/21 at 2:38 p.m. During interview on 10/26/21, at 2:49 p.m. R58's F-B stated, "my mother has been confused and unresponsive since last night about 10:00 p.m. The clinical coordinator registered nurse (RN)-11 stated to us she was started on Neurontin five days ago for pain. We did ask for a PRN pain	F 580	imposed, by timely appeal to the Departmental Appeals Board. F580 Notify of Changes (Injury/Decline/Room) Immediate Corrective Action: R58□s Neurontin order was discontinued and review of the record reflects that the family/resident representative reviewed all current medications. R58 discharged from the facility on 11/25/21. R29 discharged from the facility on 11/15/21. Corrective Action as it Applies to Other Residents: : A review of all residents who have had a change in medication since survey entrance has occurred to verify that families/ resident representatives have documentation to reflect they have been updated on these changes. All Care Center nurses were re-educated on the Change of Condition Policy Family or Responsible Party Notification Policy. Reoccurrence will be Prevented By: Change in Medication Audits will be completed weekly on 10% of residents on random households to ensure communication with family is attempted and documented prior to administration of new medication or change in dosage. The Clinical Administrator or Care Center Administrator will be responsible for ensuring ongoing compliance and reporting to the Quality Assurance Committee. Date Certain: 12/7/21	

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F 580	Continued From page 15	F 580		

medication but didn't want something daily and they are supposed to contact F-A whenever they change medications."

During interview on 10/26/21, at 2:59 p.m. F-A stated, "I was not made aware of the Neurontin order".

During interview on 10/27/21, at 8:34 a.m. RN-12 stated when a family member is notified of any medication changes the nurses would document it in the progress notes. RN-12 verified the progress notes did not indicate the family was notified of the Neurontin medication order.

During interview on 10/27/21, at 8:40 a.m. RN-11 stated the expectation was the nurses would notify family members of new medication orders and document in the progress notes. RN-11 verified the progress notes did not indicate the family was notified of the Neurontin medication order.

During interview on 10/27/21, at 11:02 a.m. the interim clinical administrator registered nurse (RN)-4 stated the nurses should notify family members immediately prior to starting a new medication to make sure the family agrees to the change in medication. Further, RN-4 stated the nurses should document the family notification in the progress notes. RN-4 verified the progress notes did not indicate the family was notified of the Neurontin medication order.

Review of the facility's policy titled "Change of Condition Policy Family or Responsible Party Notification" modified February 2021, indicated "It is the policy to notify family and/or resident representative any time there is a change in

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F 580	Continued From page 16 medication and significant change in the plan of care." Review of the facility's policy titled "Change of Condition Policy Family or Responsible Party Notification" modified February 2021 directs that "It is the policy to notify family and/or resident representative any time there is a ...Change in Medication." Review of the facility's policy titled "Psychotropic and Unnecessary Medication Use Policy" modified September 2021 directs "Family/ Emergency contact will be notified of any change in dosage of psychotropic medication and new behaviors requiring intervention." Review of the "Profile" under the "Profile" tab in the electronic medical record (EMR) revealed that R29 was admitted to the facility in February 2019 for long term care. Review of the significant change "Minimum Data Set" (MDS) with an Assessment Reference Date (ARD of 09/10/21 revealed the resident had a Brief Interview for Mental Status (BIMS) score of 3 that indicated R29 had severe cognitive impairment. Review of the hospital discharge summary dated 09/03/21 documented R29 was treated with an antibiotic with for a urinary tract infection (UTI) and for having behavioral agitation which was worse in the evening and overnight. The	F 580		

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responsible party was in agreement with an increase Seroquel (antipsychotic) dosing and the addition of Ativan for unmanageable behaviors since the resident gets anxious and has a fear of falling. R29 was discharged from the hospital on 09/03/21 with plans for Ativan (anti-anxiety) 0.5 milligrams (mg) three times a day, Olanzapine (antipsychotic) 10 mg daily, Seroquel 50 mg three times a day, and Sertraline (antidepressant) 50 mg daily based on recommendations from a hospital psychiatric consultation.

Review of physician "orders" for R29 under the "Orders" tab dated 09/17/21 revealed a new order for Seroquel 100 mg by mouth two times a day and Seroquel 50 mg one time a day at noon.

Review of R29's "Progress Notes" under the "Progress Notes" tab in the EMR revealed there was no family notification for the change is dosage of the Seroquel.

During an interview on 10/28/21 at 3:12 PM, Family (F)-1 stated that when the resident was transferred to the hospital at the end of August he was transferred there for unmanageable behaviors. F1 stated she spoke to hospital staff regarding R29's psychoactive medication dosage, including the increased use of Seroquel, and was informed by hospital staff about R29's psychoactive medication regimen upon discharge from the hospital on 09/03/21; however, facility staff had not informed him of any changes in his psychoactive medications since he was readmitted.

During an interview on 10/27/21 at 11:56 AM Registered Nurse (RN)19 acknowledged on 09/17/21 the resident's Seroquel was increased

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 580	Continued From page 18 because he kept pinching staff and was combative during care, once the resident was cleaned up, he is calm. RN19 could not recall if the responsible party was informed of the increase in Seroquel on 09/17/21. The RN confirmed there was no documented evidence R29's family was notified of the increase in Seroquel. During an interview on 10/28/21 at 6:15 PM, the Director of Nursing (DON) acknowledged that when psychoactive medications are changed, the responsible party should be notified.	F 580		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will	F 656		12/7/21

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	245556	A. BUILDING _____ B. WING _____	C 10/28/2021

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F 656	Continued From page 19 provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on record review, review of hospital records, interview and review of the facility policy, the facility failed to ensure that one (Resident (R)129) of thirty residents reviewed for comprehensive care plans had a care plan that included shunt care for an arteriovenous (AV) access for hemodialysis (medical procedure to remove fluid and waste products from the blood and to correct electrolyte imbalances.) This deficient practice had the potential for R129 to experience shunt complications that would not be identified by facility staff in a timely manner. Findings include: Review of the facility's policy titled "Care Plan Policy and Procedure" modified October 2017 directs "It is the policy of Presbyterian Homes to initiate a baseline care plan within 48 hours of	F 656	This Plan of Correction and the responses to each F-Tag are submitted to maintain certification in the Medicare and Medicaid programs and constitute a credible allegation of compliance. The written responses do not constitute an admission of noncompliance or agreement with any findings stated under the F-Tags. The facility reserves its right to dispute all findings and deficiencies in any appropriate forum, including in an independent dispute resolution, or, if appealable remedies are subsequently imposed, by timely appeal to the Departmental Appeals Board. F656 Develop/Implement Comprehensive Care Plan	

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F 656	Continued From page 20 admission and complete and comprehensive care plan prior to the initial care conference. The care plan will ensure the resident has the appropriate care required to maintain or attain theres ident's highest practicable physical, mental, and psychosocial well-being." Review of the facility's policy titled "Dialysis Program Guidelines" modified January 2020 directs " The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical nursing and psychosocial ....The care plan should address the following: identify potential risks and complications of dialysis (CHF, pulmonary edema, drug toxicity, electrolyte imbalance) ... monitoring of shunt or access site for signs of infection ...potential for bleeding ...care of the access site." Review of R129's hospital records revealed the resident was admitted to the hospital on 09/16/21 for pneumonia and respiratory failure and was on chronic hemodialysis. The resident was dialyzed via a left AV fistula for dialysis care. R129 was discharged to the facility on 10/07/21 for rehabilitation therapy. Review of the "Profile" found in the "Profile Tab" in the electronic medical record (EMR) revealed that R129 was admitted to the facility on 10/07/21 for rehabilitation therapy. Review of the Admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 10/13/21 revealed R129 had a Brief Interview for Mental Status (BIMS) score of 14 that indicated the resident was cognitively intact.	F 656	Immediate Corrective Action: R129 discharged from the facility on 10/28/21. Corrective Action as it Applies to Other Residents: All other dialysis residents were audited to ensure a comprehensive care plan was developed according to the Dialysis Program Guidelines Policy. All nurses were re-educated on the Dialysis Program Guidelines Policy. All nurses were also re-educated on how to add the order set for PHS Dialysis Order Templates for all dialysis residents. Reoccurrence will be Prevented By: Dialysis audits will be completed weekly on all dialysis residents. The Clinical or Care Center Administrator will be responsible for reporting to the Quality Assurance Committee to determine ongoing need for audits. Date Certain: 12/7/21	

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F 656	Continued From page 21 The "MDS" further indicated the resident required dialysis. The Care Plan was signed for completion on 10/26/21 by Registered Nurse (RN) 42. Review the active "Care Plan" under the "Care Plan" tab in the EMR documented an identified problem on 10/07/21 of dialysis with planned interventions to "Follow facility policies and procedures for dialysis ...Dialysis M-W-F [Monday-Wednesday-Friday]." The care plan did not identify the type of dialysis access site the resident had nor include plans for monitoring the AV fistula for signs of infection, bleeding, and/or complications. During an interview on 10/28/21 at 7:25 AM, RN24 stated the admission nurse does the comprehensive care plan based on the Nursing Admission assessment and acknowledged that the Care plan did not have any inclusion for care of the resident's AV shunt care, and it should be included in the care plan. RN 24 acknowledged that she was not familiar with the facility's policy for dialysis and did not know the specific elements of nursing interventions required for care of the hemodialysis fistula. She confirmed the AV shunt was not monitored anywhere in the EMR. During an interview on 10/28/21 at 2:18 PM, the Director of Nursing (DON) acknowledged that she would expect the care plan to include care of the hemodialysis access, the fistula, as specified in the facility's dialysis policy.	F 656		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii)	F 686		12/7/21

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F 686	Continued From page 22 §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, record review, interview and review of facility policy, the facility failed to provide necessary treatment and services to promote healing, to potentially prevent infection and new pressure ulcers from developing. This affected 1 of 3 residents (R59) reviewed for pressure ulcers. Findings include: Review of the facility's policy titled "Skin Integrity Management Policy-Minnesota" modified June 2021 directs "guidelines for the treatment of pressure injuries to facilitate healing ....Procedure for dressing change ...Please note: when referencing hand washing below-this includes washing hands or use of alcohol based hand sanitizer per facility policy. Also any unplanned change of gloves will require hand washing as well ...Wash hands. Put on gloves. Loosen tape and remove dressing...16. Pull glove over dressing and discard into plastic bag... 17. Wash hands. Put on gloves... 26. If packing the	F 686	This Plan of Correction and the responses to each F-Tag are submitted to maintain certification in the Medicare and Medicaid programs and constitute a credible allegation of compliance. The written responses do not constitute an admission of noncompliance or agreement with any findings stated under the F-Tags. The facility reserves its right to dispute all findings and deficiencies in any appropriate forum, including in an independent dispute resolution, or, if appealable remedies are subsequently imposed, by timely appeal to the Departmental Appeals Board. F686 Treatment/Svcs to Prevent/Heal Pressure Ulcer Immediate Corrective Action: LPN 21 was re-educated on infection control policy as it relates to changing soiled gloves.	

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F 686	Continued From page 23 wound is the ordered treatment, loosely pack the wound... 27 -Use a no-touch technique. Use sterile tongue blades and applicators to remove ointments and creams from their containers...28. Pour liquid solutions directly on gauze sponges on their papers... 29. Dress the wound with the prescribed dressing." Review of the "Profile" under the "Profile" tab in the electronic medical record (EMR) revealed that R59 was admitted to the facility on 01/26/17 for long term care. Review of the quarterly "Minimum Data Set" (MDS) with an Assessment Reference Date (ARD) of 10/06/21 revealed R59 had severe cognitive impairment and had one unstageable pressure ulcer requiring pressure ulcer care. Review the active "Care Plan" found in the "Care Plan" tab in the EMR documented an identified focus for R59 on 01/11/19 for a pressure injury on the coccyx related to cognitive impairment and friction and shearing with planned interventions to complete treatments as ordered and monitor for effectiveness, update Nurse Practitioner (NP/Medical Doctor (MD)and follow facility policies/protocols for the prevention of skin breakdown. Review of active "Orders" found in the "Orders" tab in the EMR dated 10/11/21 directs "1. Clean with wound cleanser and pat dry. 2. Apply crushed Flagyl (antibiotic) to base. 3. Apply thin layer of Santyl (sterile enzymatic debriding ointment) ointment to slough (dead tissue)/base. 4. Apply moist 4x4 (NS-normal saline) to wound and Cover with foam dressing QD [daily]."	F 686	Corrective Action as it Applies to Other Residents: The facility has provided education to all licensed nurses on the policy for infection control and wound care dressing changes. Reoccurrence will be Prevented By: Audits on wound care will be completed weekly on 10% of residents with wounds to ensure compliance with principles of infection control and wound dressing changes. The Clinical or Care Center Administrator will be responsible for reporting to the Quality Assurance Committee to determine ongoing need for audits. Date Certain: 12/7/21	

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F 686	Continued From page 24	F 686		

On 10/16/21 the order revealed to "Continue current wound care orders to midline coccyx wound. Add Curity (non-adherent strip oil emulsion to left buttock pressure injury). Cut strip to cover wound only. Apply Cavilon (skin protectant) barrier film and composite dressing to cover both open areas."

During an observation on 10/27/21 at 7:35 AM Resident Assistant (RA) 26 and Licensed Practical Nurse (LPN) 21 entered R59's room for wound care. LPN 21 removed the dressing and the 4 X 4 packed in the main wound with gloved hands. LPN 21 did not change the soiled gloves and proceeded to spray wound cleanser in the wound, poured the Santyl in the open wound, crushed Flagyl and stirred the Flagyl with the gloves she had on and placed the Flagyl in the wound with a cotton tipped applicator. The LPN then got saline from a cupboard with same contaminated gloves and soaked a 2 x 2 in in saline and placed it in the wound with the contaminated gloves. When the task was done, LPN 21 removed the contaminated gloves, and donned clean gloves without handwashing or the use of any alcohol based hand rub (ABHR). LPN 21 then used Cavilar on perimeter of wound and applied the Mepilex dressing over both areas.

During an interview on 10/27/21 on 7:45 AM LPN 21 acknowledged that she used contaminated gloves to treat and dress the unstageable wound and stated she should have changed her gloves and washed her hands.

During an interview on 10/28/21 at 2:49 PM, the Director of Nursing (DON) acknowledged that after removing the soiled dressing the nurse was required to change her gloves for treatment and

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F 686	Continued From page 25 dressing of the pressure ulcer in accordance with facility policy.	F 686		
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 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	F 690		12/7/21

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F 690	Continued From page 26 possible. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview, the facility failed to ensure a resident with an indwelling catheter received appropriate treatment and services to potentially prevent urinary tract infections (UTIs). This affected 1 of 4 resident (R29) reviewed for urinary catheters. Findings include: Review of the facility's policy titled "Catheter-Care of Indwelling" modified June 2021 directs "Urine reflux can cause bladder distention or infection ....Keep the bag below bladder level to prevent urine reflux. If you can't avoid raising the bag during transfer or position change, briefly clamp the tubing near the catheter tubing junction just before you raise the bag. Lower it as soon as possible and unclamp the tubing... Never raise a catheter bag above the level of the bladder. This could increase the chance of a bladder infection." Review of the "Profile" under the "Profile" tab in the electronic medical record (EMR) revealed that R29 was admitted to the facility on 02/25/19 for long term care. Review the active "Care Plan" under the "Care Plan" tab in the EMR documented on 03/13/19 that R29 was at risk for infection due to a history of UTIs and chronic indwelling catheter use. Review of the significant change "Minimum Data Set" (MDS) with an Assessment Reference Date (ARD) of 09/10/21 revealed the resident had a Brief Interview for Mental Status (BIMS) score of 3 that indicated R29 had severe cognitive	F 690	This Plan of Correction and the responses to each F-Tag are submitted to maintain certification in the Medicare and Medicaid programs and constitute a credible allegation of compliance. The written responses do not constitute an admission of noncompliance or agreement with any findings stated under the F-Tags. The facility reserves its right to dispute all findings and deficiencies in any appropriate forum, including in an independent dispute resolution, or, if appealable remedies are subsequently imposed, by timely appeal to the Departmental Appeals Board. F690 Bowel/Bladder Incontinence, Catheter, UTI Immediate Corrective Action: RA22 was provided with coaching and re-education on the Cather □ Care of Indwelling Policy. R29 discharged from the facility on 11/15/21. Corrective Action as it Applies to Other Residents: All nursing staff were re-educated on the Catheter □ Care of Indwelling Policy. Reoccurrence will be Prevented By: Random catheter care audits will be completed on residents with indwelling catheters weekly. The Clinical or Care Center Administrator will be responsible for reporting to the Quality Assurance	

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F 690	Continued From page 27 impairment and documented R29 had an indwelling catheter. During an observation on 10/27/21 at 7:33 AM R29 was in bed with eyes closed; however, there was no foley bag hanging on the bed frame below the resident's body. During a subsequent observation on 10/27/21at 8:46 AM Registered Nurse (RN)19 entered R29's room with Resident Assistant (RA)22. When RA22 pulled down the resident's bed covers the resident's foley bag was laying on the bed and parallel to the resident's body. During the observation RA22 stated that that was how staff left the foley bag for the night. When RA22 emptied the Foley bag, he raised the bag up in the air above the resident's head to empty the bag. At 9:04 AM on 10/27/21 RA22 and RN19 performed pericare. RA22 dressed the resident in an incontinence brief. During the care there was a brown substance observed on the Foley leg strap on the resident's left leg that was stabilizing the Foley catheter. RN19 and RA22 began to dress the resident in sweatpants and were almost done when the surveyor intervened and asked if the leg strap should be changed if it was soiled. The staff lowered the resident's sweatpants, acknowledged that the leg strap was soiled with a brown substance and stated it should be changed. During an interview on 10/27/21 at 09:26 AM, RA22 acknowledged that when he emptied the Foley bag it should have been done below the level of the resident's body/bladder.	F 690	Committee to determine ongoing need for audits. Date Certain: 12/7/21	

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F 690	Continued From page 28 During an interview on 10/28/21 at 2:33 PM, the Director of Nursing (DON) acknowledged that the Foley bag need to remain below the level of the resident's bladder while sleeping and when emptying the Foley bag to prevent catheter associated infections. In addition, she would expect staff to keep the Foley leg strap clean and change it if it became soiled.	F 690		
F 698 SS=D	Dialysis CFR(s): 483.25(l) §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observation, record review, interview and review of facility policy, the facility failed to ensure 1 of 1 resident (R129) reviewed for dialysis received dialysis services consistent with professional standards of practice. Specifically, the facility failed to ensure ongoing communication and collaboration with the dialysis facility. This deficient practice had the potential for R129 to experience post dialysis and/or shunt complications that would not be identified by facility staff in a timely manner. Findings include: Review of the facility's policy titled "Dialysis Program Guidelines" modified January 2020 directs " a dialysis treatment record will be used by dialysis provider during treatment and given to	F 698	This Plan of Correction and the responses to each F-Tag are submitted to maintain certification in the Medicare and Medicaid programs and constitute a credible allegation of compliance. The written responses do not constitute an admission of noncompliance or agreement with any findings stated under the F-Tags. The facility reserves its right to dispute all findings and deficiencies in any appropriate forum, including in an independent dispute resolution, or, if appealable remedies are subsequently imposed, by timely appeal to the Departmental Appeals Board. F698 Dialysis	12/7/21

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F 698	Continued From page 29 SNF [Skilled Nursing Facility] staff after treatment as a summary and communication record ... The following information is a guide to assessing patient complications post dialysis therapy. Access Assessment: Internal Accesses - Fistulas and Grafts ...infection - warm, pain, redness, swelling, discharge, temperature, tenderness (assess daily). dressing - remove Band-Aids or gauze 4 hours after discharge from dialysis. patency - feel the access for a thrill, listen with a stethoscope for a bruit (assess daily) clotted access - notify the dialysis unit and/or nephrologists ...hematoma - apply ice to the site for 24 hours then apply warm packs ...avoid occlusive clothing on access arm - avoid watches ...avoid BP measurement on access arm. No blood draws. avoid sleeping with access arm flexed greater than 90 [degrees]." Review of the "Profile" found in the "Profile" tab in the electronic medical record (EMR) revealed that R129 was admitted to the facility on 10/07/21 for rehabilitation therapy. Review of the Admission "Minimum Data Set" (MDS) with an Assessment Reference Date (ARD) of 10/13/21 revealed R129 had a Brief Interview for Mental Status (BIMS) score of 14 indicating the resident was cognitively intact and required dialysis. Review the active "Care Plan" found in the "Care Plan" tab in the EMR documented an identified resident focus on 10/07/21 of dialysis with planned interventions to "Follow facility policies and procedures for dialysis ...Dialysis M-W-F [Monday-Wednesday-Friday]." The care plan did not identify that the resident had a Left Arteriovenous Fistula (LAVF) access site nor	F 698	Immediate Corrective Action: R129 discharged from the facility on 10/28/21. Corrective Action as it Applies to Other Residents: All other dialysis residents were audited to ensure a comprehensive care plan was developed according to the Dialysis Program Guidelines Policy. All nurses were re-educated on the Dialysis Program Guidelines Policy. All nurses were also re-educated on how to add the order set for PHS Dialysis Order Templates for all dialysis residents. Reoccurrence will be Prevented By: Dialysis audits will be completed weekly on all dialysis residents. The Clinical or Care Center Administrator will be responsible for reporting to the Quality Assurance Committee to determine ongoing need for audits. Date Certain: 12/7/21	

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include plans for monitoring the LAVF for signs of infection, bleeding, and/or complications.

During an interview on 10/26/21 at 4:21 PM, R129 stated she had dialysis on M-W- F via her LAVF. She revealed staff did not monitor her shunt post dialysis. R129 stated the LAVF is five years old with some prolonged post dialysis bleeding issues, "nothing out of the ordinary."

During an interview on 10/27/21 at 2:55 PM, Registered Nurse (RN) 35 stated when R129 came back from dialysis she did vital signs, got a blood glucose reading and administered hydralazine for an elevated blood pressure (BP); and stated R129 did not require any care for her LAVF. The RN stated the resident had no blood draws on the left arm and she performed the BP check on her right arm.

During an interview on 10/28/21 at 7:25 AM, RN24, who was the Unit Coordinator stated the admission nurse did the initial care plan based on the Nursing Admission assessment and acknowledged that the care plan did not include interventions for care of the resident's LAVF and interventions should be included in the care plan. RN24 admitted she was not familiar with the facility's policy for dialysis and did not know the elements of nursing interventions required for care of the hemodialysis fistula. When questioned what nursing staff documented for care of the LAVF, the RN replied there should be documentation in the skilled charting in the progress notes in the EMR. When none could be found during a review of R129's progress notes during the interview RN24 stated perhaps the nurses are charting by exception. RN24 stated the facility communicates with the dialysis center

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F 698	Continued From page 31 via communication forms that they send and receive when the resident returns from dialysis; however, a review of the dialysis communication forms during the interview revealed they contained no information regarding the resident's dialysis care. When questioned if she had communicated with the dialysis center, the RN acknowledged that she "overlooked it." During an interview on 10/28/21 at 9:43 AM, Nurse Practitioner (NP)7 acknowledged that R129 had a LAVF. When questioned about physician orders for the care and monitoring required by facility staff or the LAVF, NP7 stated there is nothing for facility staff to do because the dialysis center did everything. During an interview on 10/28/21 at 02:18 PM, the Director of Nursing (DON) acknowledged R129 had a LVAF for dialysis and the facility staff should follow the facility's policy, the dialysis centers communication, and physician orders for care of the resident's fistula. In addition, the DON stated if there were no physician orders for care of the fistula, she would expect staff to call the dialysis center and get them.	F 698		
F 757 SS=D	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or	F 757		12/7/21

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F 757	Continued From page 32 §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by: Based on interview, record review, facility policy review, review of the facility's "Infection Control-Antibiotic Stewardship Procedure," and review of the Centers for Disease Control (CDC), "Core Elements of Antibiotic Stewardship for Nursing Homes," the facility failed to ensure 1 of 5 resident (RR30) reviewed for unnecessary medications, were free from unnecessary medications regarding the use of an antibiotic in the absence of infection. Findings include: Review of the facility's policy titled, "Infection Control-Antibiotic Stewardship Procedure," approved April 2021 and modified April 2021, indicated " ...If it is determined that an antibiotic was ordered but is not clinically indicated, the Clinical Coordinator is responsible for working with the Infection Control & Prevention Specialist to contact the provider and request further clarification on indication for the use and/or request to have the antibiotic discontinued."	F 757	This Plan of Correction and the responses to each F-Tag are submitted to maintain certification in the Medicare and Medicaid programs and constitute a credible allegation of compliance. The written responses do not constitute an admission of noncompliance or agreement with any findings stated under the F-Tags. The facility reserves its right to dispute all findings and deficiencies in any appropriate forum, including in an independent dispute resolution, or, if appealable remedies are subsequently imposed, by timely appeal to the Departmental Appeals Board. F757 Drug Regimen is Free from Unnecessary Drugs Immediate Corrective Action: R30 discharged from the facility on 10/28/21. Corrective Action as it Applies to Other Residents: All residents in the facility	

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F 757	Continued From page 33 Review of the CDC, "Core Elements of Antibiotic Stewardship for Nursing Homes, dated 2015 located at https://www.cdc.gov/antibiotic-use/core-elements/nursing-homes.html, reported " Harms from antibiotic overuse are significant for the frail and older adults receiving care in nursing homes. These harms include risk of serious diarrhea infections from Clostridium difficile (C.Diff/inflammation of the colon often from antibiotics) ..." Review of R30's most recent "Minimum Data Set" (MDS), Admission Assessment dated 09/02/21 with an Assessment Reference Date (ARD) of 09/02/21, located in the resident's Electronic Medical Record (EMR) under the "MDS" tab, documented that R30 was admitted to the facility on 08/27/21 with diagnoses including benign prostate hyperplasia (BPH), urinary tract infection (UTI) in the previous 30 days, and surgical repair of hip fracture. Medications taken in the previous seven day look back period indicated antibiotics were used in the previous six days. Resident 30 utilized an indwelling catheter and had a Brief Interview for Mental Status (BIMS) score of 14, indicating the resident was cognitively intact. Review of the R30's physician orders, located in the EMR under "Orders" indicated the resident was prescribed Cefdinir 300 milligrams (mg) capsule, give one capsule by mouth in the morning for UTI prophylaxis, with start date of 08/27/21 and no end date indicated. A lab order C.Diff toxin was ordered on 09/29/21. There were no orders for a urinalysis to determine UTI status from the time of admission. Review of a laboratory result dated 10/01/21,	F 757	currently on a prophylactic antibiotic were reviewed to ensure Antibiotic Stewardship Program was followed. Facility licensed nurses including Clinical Coordinators were educated on the principles of antibiotic stewardship and to ensure future orders received for prophylactic antibiotic use are followed under our current PHS policy and documented in the medical record. Reoccurrence will be Prevented By: Audits will be completed weekly for all residents who have newly ordered antibiotics will be completed to ensure that there is a clinical rationale for the use. Audits will also include that Antibiotics without clinical reason have follow up to the primary physician for evaluation of ongoing need documented. The Clinical or Care Center Administrator will be responsible for reporting to the Quality Assurance Committee to determine ongoing need for audits. Date Certain: 12/7/21	

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F 757	Continued From page 34 indicated R30 was positive for C.Diff. During an interview on 10/27/21 at 1:08 PM, Nurse Practitioner (NP) 7 indicated Resident 30 was admitted to the facility on antibiotics that were prescribed by a urologist, and she did not typically communicate with physicians who prescribe medications that were not associated with the reason residents were in the facility. In this case the resident was in the facility for a hip fracture. NP7 revealed she made a recommendation to the family about the resident being on antibiotics because the resident had developed C.Diff, however the family wanted the resident to remain on prophylactic antibiotics. NP7 further stated she could certainly make a recommendation to the urologist but has not done so at this time. During an interview 10/28/21 at 1:44 PM, the Infection Prevention Specialist indicated R30 did not currently have a UTI but was taking an antibiotic for prophylactic use. The Infection Preventionist Specialist confirmed the resident has not had a urinalysis while a resident in the facility.	F 757		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and	F 758		12/7/21

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F 758	Continued From page 35 (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by:	F 758		

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F 758	Continued From page 36 Based on observation, interview, record review, and facility policy review, the facility failed to ensure that 1 of 5 resident (R36) who was prescribed an antipsychotic medication had an appropriate diagnosis. The facility also failed to monitor the resident for specific behaviors related to the indication of use for the medication. Findings include: Review of R36's undated "Face Sheet," located in the resident's electronic medical record (EMR), under the face sheet tab, revealed the resident was admitted to the facility on 03/06/15. Review of R36's "Diagnoses," located in the resident's EMR under the diagnoses/procedure tab revealed the resident's diagnoses included anxiety disorder and major depressive disorder. R36 was a bilateral leg amputee. Review of R36's "Care Plan", dated 01/07/21 located under the care plan tab in the EMR indicated she used an anti-psychotic medication for anxiety, sleep, behaviors, delusions and staff were to monitor occurrence for target behavior symptoms and document per facility protocol. Review of R36's quarterly "Minimum Data Set" (MDS), with an assessment reference date (ARD) of 09/16/21 and found under the "MDS" tab in the resident's EMR, revealed R36 had a Brief Interview for Mental Status (BIMS) score of 12/15, which indicated the resident was moderately cognitively impaired. The "MDS" also revealed the resident was assessed to not have exhibited any behaviors. The MDS revealed R36 did not have a psychotic disorder and had received antipsychotic medication for the last	F 758	This Plan of Correction and the responses to each F-Tag are submitted to maintain certification in the Medicare and Medicaid programs and constitute a credible allegation of compliance. The written responses do not constitute an admission of noncompliance or agreement with any findings stated under the F-Tags. The facility reserves its right to dispute all findings and deficiencies in any appropriate forum, including in an independent dispute resolution, or, if appealable remedies are subsequently imposed, by timely appeal to the Departmental Appeals Board. F758 Free from Unnecessary Psychotropic Meds/PRN Use Immediate Corrective Action: R36 was reassessed and care plan and medication are appropriate. Target behaviors for agitation and anxiety were added to tasks for care plan. Corrective Action as it Applies to Other Residents: All residents on psychotropics were reviewed to ensure that all had target behaviors identified and monitored and are reflected on the care plan. All facility nursing staff and Resident Services Specialists (RSS) were re-educated on the Psychotropic and Unnecessary Medication Use Policy. Reoccurrence will be Prevented By: Psychotropic drug audit will be completed weekly on 10% of residents with orders for psychotropic medications. The Clinical	

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F 758	Continued From page 37 seven days. Review of R36's "Physician's Order," dated 10/02/21, located under the orders tab in the resident's EMR, revealed the resident was ordered Seroquel (an antipsychotic medication) 12.5 milligrams (mg) by mouth at bedtime for anxiety/sleep. Additional "Physician's Orders" dated 10/05/21 revealed R36 was also ordered 25 mg Seroquel tablet by mouth, one time a day for agitation/anxiety. The physician's order did not include to monitor for behaviors related to agitation or anxiety. Review of R36's "Medication Administration Record (MAR)," dated October 2021 located under the orders tab in the EMR revealed R36 received the physician ordered Seroquel 12.5 mg at bedtime and 25 mg once daily from 10/05/21 to 10/28/21. The MAR did not indicate orders to monitor for target behaviors related to the antipsychotic use. The MAR did indicate to monitor for target behaviors related to R36's Major Depressive Disorder. Review of "Associated Clinic of Psychology" progress notes from August 2021 to October 2021 completed by Clinical Psychologist (CP)44 indicated R36 did not exhibit signs of psychosis. During an interview on 10/27/21 at 9:15 AM Registered Nurse (RN)12 said she had worked with R36 for several years. RN12 said R36's exhibited behaviors including saying she had not been changed by staff, making up stories and saying her legs are trapped or tied down. RN12 said R36 was prescribed as needed (PRN) Seroquel but it was recently changed to once daily. RN12 said she documented in the nursing	F 758	or Care Center Administrator will be responsible for reporting to the Quality Assurance Committee to determine the need for ongoing audits. Date Certain: 12/7/21	

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notes if R36 had behaviors but did not have a target behavior monitoring sheet on the MAR.

During an interview on 10/27/21 at 3:32 PM Clinical Psychologist (CP)44 said she had known R36 for many years and they were currently doing telehealth sessions. CP44 said she had noticed increased confusion and some delirium with R36 recently but no psychosis. CP44 said R36 did not have a history of psychosis or sleep disturbance. CP44 was aware the staff reported R36's increased agitation and anxiety. CP44 said when R36 had phantom pains or thought someone was strapping her legs to the bed, it was the result of her amputation, and she would not characterize it as a delusion. CP44 stated "I would not give her a diagnosis of psychosis and she did not have a history as a psychiatrically diagnosed person." CP44 also said she was not aware R36's Seroquel medication had been changed to 25 mg daily and "we do not like to see people treated for agitation with an antipsychotic."

During an interview on 10/28/21 9:28 AM Nurse Practitioner (NP)29 revealed she had worked with R36 for the past two or three years. NP29 revealed she was aware of the increased Seroquel from 12.5 mg to 25 mg at the beginning of October 2021 and "assumed it was because her behaviors were worse." NP29 said R36 did not have a diagnosis of psychosis but had some psychotic behaviors. NP29 said the staff should be monitoring for target behaviors such as "agitation/fighting/striking out" and documenting in the EMR.

During an interview on 10/28/21 at 11:10 AM Physician 18 said the Seroquel medication was prescribed to R36 due to anxiety, disruptive

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behaviors, sleep issues and distress. Physician 18 said R36's behaviors were verbal, and she had "wacky ideas." Physician 18 said they tried other medications for sleep disturbance including melatonin and trazadone, but they were ineffective. Physician 18 said R36 had a decline in functional status, and she was aware the resident did not have a diagnosis of psychosis. She said she expected the staff to monitor the target behaviors related to the antipsychotic medication.

During an interview on 10/28/21 at 2:10 PM the Consultant Pharmacist (CP) revealed according to the Food and Drug Administration (FDA) label, an antipsychotic medication like Seroquel could be used as an adjunct for depression. He said if an antidepressant medication was not working, the Physician could consider a dosage change or an alternate antidepressant or a second antidepressant as well. The CP said using an antipsychotic medication to treat symptoms like agitation, anxiety and sleep disturbance was not the first choice or used often but it was not inappropriate. He said the Physician could treat those symptoms with an anti-anxiety medication.

Review of the facility's policy titled, "Psychotropic and Unnecessary Medication Use Policy" dated September 2021 indicated "each resident's drug regimen must be free from unnecessary drugs. Unnecessary dugs are any drug when used ...without adequate monitoring and without adequate indication for its use." Under "Initiation of Psychotropic Medication" the staff should "initiate target behavior monitoring" and "any new psychotropic medication orders will be reviewed by the IDT [interdisciplinary team]." Additionally, under "Monitoring" the policy indicated "specific

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F 758	Continued From page 40 target behaviors will be monitored for psychotropic medications" and "the use of a psychotropic medication will be reviewed by Clinical Coordinator and Resident Services upon admission, quarterly, annually, with significant change and as needed by using the Psychotropic Medication assessment." The policy further indicated under "Antipsychotic Medications" that "antipsychotic medications may be prescribed for expressions or indications of distress, the IDT must first identify and address any medical, physical or psychological causes and/or social/environmental triggers."	F 758		
F 770 SS=D	Laboratory Services CFR(s): 483.50(a)(1)(i) §483.50(a) Laboratory Services. §483.50(a)(1) The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services. (i) If the facility provides its own laboratory services, the services must meet the applicable requirements for laboratories specified in part 493 of this chapter. This REQUIREMENT is not met as evidenced by: Based on interview, record review, and facility policy review, the facility failed to provide laboratory services in a timely manner to meet the needs of 1 of 5 resident (R79) reviewed for laboratory service. Findings include: Review of R79's quarterly "Minimum Data Set" (MDS) with an Assessment Reference Date (ARD) of 04/07/21, located in the resident's	F 770	This Plan of Correction and the responses to each F-Tag are submitted to maintain certification in the Medicare and Medicaid programs and constitute a credible allegation of compliance. The written responses do not constitute an admission of noncompliance or agreement with any findings stated under the F-Tags. The facility reserves its right to dispute all findings and deficiencies in any appropriate forum, including in an	12/7/21

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	245556	A. BUILDING _____ B. WING _____	C 10/28/2021

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PRESBYTERIAN HOMES OF BLOOMINGTON	**9889 PENN AVENUE SOUTH BLOOMINGTON, MN 55431**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 770	Continued From page 41 Electronic Medical Record (EMR) under the "MDS" tab, documented R79 had a Brief Interview for Mental Status (BIMS) score of 5, indicating severe cognitive impairment. Review of the R79's physician orders, located in the EMR under the "Orders" tab revealed an order dated 04/26/21 for UA/UC (urinalysis and culture and sensitivity) due to confusion. Review of R79's progress notes located under the "Progress Notes" tab in the resident's EMR revealed on 04/26/21 at 2:39 PM, "specimen was collected and called lab to pick up." At 5:13 PM, "because nurse sent lab slip for incorrect resident, with correctly labeled specimen in collection cup, lab would not accept." Attempts were made to straight cath [catheter/to collect urine] this afternoon, with daughter present, and were not successful, will try again tomorrow." On 04/27/21 at 10:47 AM, "specimen was collected by straight cath process. Specimen was sent to the lab. During an interview on 10/27/21 at 9:07 AM, Clinical Coordinator 10 confirmed Licensed Practical Nurse (LPN) 42 had correctly labeled the urine specimen container for R79, however included a lab slip with another resident's name. The lab would not accept the specimen, so R79 had to go through another specimen procedure. Clinical Coordinator10 indicated she and Registered Nurse (RN)13 were unable to get a urine return, so the collection was repeated again for the third time the next morning. Clinical Coordinator 10 reported she and LPN42 successfully collected the urine sample and submitted it to the lab for testing the following morning.	F 770	independent dispute resolution, or, if appealable remedies are subsequently imposed, by timely appeal to the Departmental Appeals Board. F770 Laboratory Services Immediate Corrective Action: R79 discharged from the facility on 7/25/21 prior to survey entrance. Corrective Action as it Applies to Other Residents: Facility□s process for laboratory slips has been modified. Facility will no longer be using master copies of lab slips for each resident, but rather, will use a sticker for the specimen as well as on the lab slip to ensure no discrepancies at the time of collection. Facility nurses educated on following the lab specimen collection process and verifying printed lab slip matches the name on the specimen. Reoccurrence will be Prevented By: Weekly audits of 10% of residents having labs completed will occur to ensure compliance with the revised process. The Care Center Administrator or Clinical Administrator will be responsible for reporting to the Quality Assurance Committee to determine ongoing need. Date Certain: 12/7/21	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245556	A. BUILDING _____ B. WING _____	C 10/28/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRESBYTERIAN HOMES OF BLOOMINGTON	**9889 PENN AVENUE SOUTH BLOOMINGTON, MN 55431**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 770	Continued From page 42 Review of the facility policy titled, "Sterile Specimen-Urine," approved December 2014 and reviewed 09/2015, indicated, " ...Send specimen to lab with the appropriate lab slips." This deficiency substantiates Intake: MN00072231	F 770		
F 881 SS=D	Antibiotic Stewardship Program CFR(s): 483.80(a)(3) §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)(3) An antibiotic stewardship program that includes antibiotic use protocols and a system to monitor antibiotic use. This REQUIREMENT is not met as evidenced by: Based on interview, record review, review of the Centers for Disease Control Prevention (CDC) guidelines, and review of facility policy, the facility failed to fully implement their antibiotic stewardship program regarding 1 of 6 resident (R30) reviewed for antibiotic stewardship. Findings include: Review of the facility's policy titled, "Infection Control-Antibiotic Stewardship Procedure," approved April 2021 and modified April 2021, indicated " ...If it is determined that an antibiotic was ordered but is not clinically indicated, the Clinical Coordinator is responsible for working with the Infection Control & Prevention Specialist	F 881	This Plan of Correction and the responses to each F-Tag are submitted to maintain certification in the Medicare and Medicaid programs and constitute a credible allegation of compliance. The written responses do not constitute an admission of noncompliance or agreement with any findings stated under the F-Tags. The facility reserves its right to dispute all findings and deficiencies in any appropriate forum, including in an independent dispute resolution, or, if appealable remedies are subsequently imposed, by timely appeal to the Departmental Appeals Board.	12/7/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245556	A. BUILDING _____ B. WING _____	C 10/28/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRESBYTERIAN HOMES OF BLOOMINGTON	9889 PENN AVENUE SOUTH BLOOMINGTON, MN 55431

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 881	Continued From page 43 to contact the provider and request further clarification on indication for the use and/or request to have the antibiotic discontinued. Document progress notes of steps taken during IDT [Interdisciplinary Team] process (i.e. reviewed infection report and contacted provider). Ensure all documentation related to symptoms, diagnosis and labs results are documented in PCC [Point Click Care (Electronic Medical Record)]. Ensure antibiotic orders include provider's diagnosis of infection." Review of R30's most recent "Minimum Data Set" (MDS), with an Assessment Reference Date (ARD) of 09/02/21, located in the resident's Electronic Medical Record (EMR) under the "MDS" tab, documented that R30 was admitted to the facility on 08/27/21 with diagnoses including benign prostate hyperplasia (BPH), urinary tract infection (UTI) in the previous 30 days, and surgical repair of hip fracture. Medications taken in the previous seven day look back period indicated antibiotics were used in the previous six days. R30 utilized a indwelling catheter and had a Brief Interview for Mental Status (BIMS) score of 14, indicating the resident was cognitively intact. Review of the R30's physician orders, located in the EMR under "Orders" tab indicated the resident was prescribed Cefdinir (antibiotic) 300 milligrams (mg) capsule, to give one capsule by mouth in the morning for UTI prophylaxis (for prevention), with start date of 08/27/21 and no end date indicated. There were no orders for urinalysis to determine UTI status from the time of admission. Review of the CDC's definition of Clostridium difficile, found at https://www.cdc.gov>cdiff,	F 881	F881 Antibiotic Stewardship Program Immediate Corrective Action: R30 discharged from the facility on 10/28/21. Corrective Action as it Applies to Other Residents: All residents in the facility currently on a prophylactic antibiotic were reviewed to ensure Antibiotic Stewardship Program was followed. Facility licensed nurses including Clinical Coordinators were educated on the principles of antibiotic stewardship and to ensure future orders received for prophylactic antibiotic use are followed under our current PHS policy and documented in the medical record. Reoccurrence will be Prevented By: Audits will be completed weekly for all residents who have newly ordered antibiotics will be completed to ensure that there is a clinical rationale for the use. Audits will also include that Antibiotics without clinical reason have follow up to the primary physician for evaluation of ongoing need documented. The Clinical or Care Center Administrator will be responsible for reporting to the Quality Assurance Committee to determine ongoing need for audits. Date Certain: 12/7/21	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245556	A. BUILDING _____ B. WING _____	C 10/28/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRESBYTERIAN HOMES OF BLOOMINGTON	**9889 PENN AVENUE SOUTH BLOOMINGTON, MN 55431**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 881	Continued From page 44	F 881		

reveals "C.Diff is a germ (bacterium) that causes sever diarrhea and colitis (an inflammation of the colon). Most cases of C. Diff infection occur while you're taking antibiotics or not long after you've finished taking antibiotics."

Review of a laboratory result dated 10/01/21, indicated R30 was positive for C.Diff.

During an interview on 10/27/21 at 1:08 PM, Nurse Practitioner (NP)7 indicated R30 was admitted to the facility on antibiotics that were prescribed by a urologist, and she did not typically communicate with physicians who prescribe medications that were not associated with the reason a resident is admitted to the facility. In this case the resident was in the facility for a hip fracture. NP7 revealed she made a recommendation to the family about being on antibiotics because the resident had developed C.Diff, however the family wanted the resident to remain on prophylactic antibiotics. NP7 further stated she could certainly make a recommendation the the urologist but has not done so at this time.

During an interview on 10/28/21 at 1:44 PM, the Infection Prevention Specialist indicated R30 did not currently have a UTI, however was taking an antibiotic for prophylactic use. The Infection Preventionist confirmed the resident has not had a urinalysis while a resident in the facility. The Infection Prevention Specialist confirmed she never contacted the physician to request further clarification on the indication for the use of the antibiotic and never requested to have the antibiotic discontinued.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245556	A. BUILDING **1N - NEW BUILDING** B. WING _____	**10/26/2021**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRESBYTERIAN HOMES OF BLOOMINGTON	**9889 PENN AVENUE SOUTH BLOOMINGTON, MN 55431**

(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 000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety Code survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 10/26/2021. At the time of this survey, Presbyterian Homes of Bloomington was found in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, the Health Care Facilities Code. Presbyterian Homes of Bloomington Care Center is a 3-story building with a full basement that was built in 2005 determined to be of Type II(222) construction. The facility is separated from an assisted living occupancy by 2-hour fire rated construction. The facility is fully protected throughout by an automatic fire sprinkler system and has a fire alarm system with smoke detection in resident rooms, corridors and spaces open to the corridor that is monitored for automatic fire department notification. The facility has a capacity of 98 beds and had a census of 85 at time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is MET.	K 000		

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

FIRE SAFETY SURVEY REPORT
CRUCIAL DATA EXTRACT
(TO BE USED WITH CMS-2786 FORMS)

PROVIDER NUMBER	FACILITY NAME	SURVEY DATE
K1 245556	**PRESBYTERIAN HOMES OF BLOOMINGTON**	*K4 **10/26/2021**

K6 DATE OF PLAN APPROVAL

K3 : MULTIPLE CONSTRUCTION

TOTAL NUMBER OF BUILDINGS 1

NUMBER OF THIS BUILDING 01

[A]

A BUILDING
B WING
C FLOOR
D APARTMENT UNIT

LSC FORM INDICATOR

Health Care Form		
12	2786 R	2012 EXISTING
13	2786 R	2012 NEW

ASC Form		
14	2786 U	2012 EXISTING
15	2786 U	2012 NEW

ICF/MR Form		
16	2786 V, W, X	2012 EXISTING
17	2786 V, W, X	2012 NEW

*K7 [12] SELECT NUMBER OF FORM USED FROM ABOVE

(Check if K321 or K351 are marked as not applicable in the 2786 M, R, T, U, V, W, X, Y and Z.)

K321: [3] K351: [3]

COMPLETE IF ICF/MR IS SURVEYED UNDER CHAPTER 21

SMALL (16 BEDS OR LESS)

K8: [ ]

1 PROMPT
2 SLOW
3 IMPRACTICAL

LARGE

K8: [ ]

4 PROMPT
5 SLOW
6 IMPRACTICAL

APARTMENT HOUSE

K8: [ ]

7 PROMPT
8 SLOW
9 IMPRACTICAL

ENTER E-SCORE HERE

K5: [ ] e.g 2.5

*K9 : FACILITY MEETS LSC BASED ON: (*Check all that apply*)

A1	A2	A3	A4	A5
[X]	[X]	[ ]	[ ]	[ ]
(COMP. WITH ALL PROVISIONS)	(ACCEPTABLE POC)	(WAIVERS)	(FSES)	(PERFORMANCE BASED DESIGN)

FACILITY DOES NOT MEET LSC:

B. [ ]

K180:

A.	B.	C.
[X]	[ ]	[ ]
FULLY SPRINKLERED (All required areas are sprinklered)	PARTIALLY SPRINKLERED (Not all required areas are sprinklered)	NONE (No sprinkler system)

*MANDATORY

FIRE SAFETY SURVEY REPORT - 2012 LIFE SAFETY CODE HEALTHCARE

1. (A) PROVIDER NUMBER	1. (B) MEDICAID I.D. NO.
K1 245556	K2

PART I — Life Safety Code, New and Existing
PART II — Health Care Facilities Code, New and Existing
PART III — Recommendation for Waiver
PART IV – Crucial Data Extract
OPTIONAL — Chapter 4 – NFPA 101A - Fire Safety Evaluation System for Health Care Occupancies – CMS-2786T

Identifying information as shown in applicable records. Enter changes, if any, alongside each item, giving date of change.

2. NAME OF FACILITY	2. (A) MULTIPLE CONSTRUCTION (BLDGS)	2. (B) ADDRESS OF FACILITY (STREET, CITY, STATE, ZIP CODE)	
Presbyterian Homes of Bloomington	A. BUILDING 01 B. WING C. FLOOR K3	9889 Penn Avenue South Bloomington, MN 55431	A. (●) Fully Sprinklered (All required areas are sprinklered) B. ( ) Partially Sprinklered (Not all required areas are sprinklered) C. ( ) None (No sprinkler system) K0180

3. SURVEY FOR	4. DATE OF SURVEY	DATE OF PLAN APPROVAL	SURVEY UNDER
[✔] MEDICARE [✔] MEDICAID	10/26/2021 K4	K6	5. (●) 2012 EXISTING 6. ( ) 2012 NEW K7

5. SURVEY FOR CERTIFICATION OF

1. ( ) HOSPITAL 2. (●) SKILLED/NURSING FACILITY 4. ( ) ICF/IID UNDER HEALTH CARE 5. ( ) HOSPICE

IF "2" OR "5" ABOVE IS MARKED, CHECK APPROPRIATE ITEM(S) BELOW

1. [✔] ENTIRE FACILITY 2. [ ] DISTINCT PART OF (SPECIFY) _____

3. [ ] IF DISTINCT PART OF HOSPITAL, IS HOSPITAL ACCREDITED?
a. [ ] YES b. [ ] NO

6. BED COMPOSITION a. TOTAL NO. OF BEDS IN THE FACILITY	b. NUMBER OF HOSPITAL BEDS CERTIFIED FOR MEDICARE	c. NUMBER OF SKILLED BEDS CERTIFIED FOR MEDICARE	d. NUMBER OF SKILLED BEDS CERTIFIED FOR MEDICAID	e. NUMBER OF NF or ICF/IID BEDS CERTIFIED FOR MEDICAID
98	____	98	98	____

7. A. (●) THE FACILITY MEETS THE STANDARD, BASED UPON (CHECK ALL APPROPRIATE BOXES)

1. (●) COMPLIANCE WITH ALL PROVISIONS 2. ( ) ACCEPTANCE OF A PLAN OF CORRECTION 3. [ ] RECOMMENDED WAIVERS 4. [ ] FSES 5. [ ] PERFORMANCE BASED DESIGN

B. ( ) THE FACILITY DOES NOT MEET THE STANDARD
K9

SURVEYOR *(Signature)*	TITLE	OFFICE	DATE
Roy M Kingsley	Deputy State Fire Marshal	Minnesota State Fire Marshal Division	11/2/2021
SURVEYOR ID 37008 K10			
FIRE AUTHORITY OFFICIAL (William Abderhalden 37009	TITLE Fire Safety Supervisor	OFFICE Minnesota State Fire Marshal Division	DATE 11/16/2021

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

ID PREFIX		MET	NOT MET	N/A	REMARKS
	PART I – NFPA 101 LSC REQUIREMENTS (Items in italics relate to the FSES)				
	SECTION 1 – GENERAL REQUIREMENTS				
K100	**General Requirements – Other** List in the REMARKS section any LSC Section 18.1 and 19.1 General Requirements that are not addressed by the provided K-tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567.	◉	○	○	
K111	**Building Rehabilitation** ***Repair, Renovation, Modification, or Reconstruction*** Any building undergoing repair, renovation, modification, or reconstruction complies with both of the following: • Requirements of Chapter 18 and 19. • Requirements of the applicable Sections 43.3, 43.4, 43.5, and 43.6. 18.1.1.4.3, 19.1.1.4.3, 43.1.2.1 ***Change of Use or Change of Occupancy*** Any building undergoing change of use or change of occupancy classification complies with the requirements of Section 43.7, unless permitted by 18.1.1.4.2 or 19.1.1.4.2. 18.1.1.4.2 (4.6.7 and 4.6.11), 19.1.1.4.2 (4.6.7 and 4.6.11), 43.1.2.2 (43.7) ***Additions*** Any building undergoing an addition shall comply with the requirements of Section 43.8. If the building has a common wall with a nonconforming building, the common wall is a fire barrier having at least a two hour fire resistance rating constructed of materials as required for the addition. Communicating openings occur only in corridors and are protected by approved self-closing fire doors with at least a 1-1/2 hour fire resistance rating. Additions comply with the requirements of Section 43.8. 18.1.1.4.1 (4.6.7 and 4.6.11), 18.1.1.4.1.1 (8.3), 18.1.1.4.1.2, 18.1.1.4.1.3, 19.1.1.4.1 (4.6.7 and 4.6.11), 19.1.1.4.1.1 (8.3), 19.1.1.4.1.2, 19.1.1.4.1.3, 43.1.2.3(43.8)	○	○	◉	

ID PREFIX		MET	NOT MET	N/A	REMARKS
K112	**Sprinkler Requirements for Major Rehabilitation** If a nonsprinklered smoke compartment has undergone major rehabilitation the automatic sprinkler requirements of 18.3.5 have been applied to the smoke compartment. In cases where the building is not protected throughout by a sprinkler system, the requirements of 18.4.3.2, 18.4.3.3, and 18.4.3.8 are also met. Note: Major rehabilitation involves the modification of more than 50 percent, or more than 4500 ft² of the area of the smoke compartment. 18.1.1.4.3.3, 19.1.1.4.3.3	○	○	◉	
K131	**Multiple Occupancies – Sections of Health Care Facilities** Sections of health care facilities classified as other occupancies meet all of the following: • They are not intended to serve four or more inpatients for purposes of housing, treatment, or customary access. • They are separated from areas of health care occupancies by construction having a minimum two hour fire resistance rating in accordance with Chapter 8. • The entire building is protected throughout by an approved, supervised automatic sprinkler system in accordance with Section 9.7. Hospital outpatient surgical departments are required to be classified as an Ambulatory Health Care Occupancy regardless of the number of patients served. 18.1.3.3, 19.1.3.3, 42 CFR 482.41, 42 CFR 485.623	○	○	◉	
K132	**Multiple Occupancies – Contiguous Non-Health Care Occupancies** Non-health care occupancies that are located immediately next to a Health Care Occupancy, but are primarily intended to provide outpatient services are permitted to be classified as Business or Ambulatory Health Care Occupancies, provided the facilities are separated by construction having not less than two hour fire resistance-rated construction, and are not intended to provide services simultaneously for four or more inpatients. Outpatient surgical departments must be classified as Ambulatory Health Care Occupancy regardless of the number of patients served. 18.1.3.4.1, 19.1.3.4.1	○	○	◉	

<table>
<tr><th>ID PREFIX</th><th></th><th>MET</th><th>NOT MET</th><th>N/A</th><th>REMARKS</th></tr>
<tr><td>K133</td><td>Multiple Occupancies – Construction Type
Where separated occupancies are in accordance with 18/19.1.3.2 or 18/19.1.3.4, the most stringent construction type is provided throughout the building, unless a two hour separation is provided in accordance with 8.2.1.3, in which case the construction type is determined as follows:
• The construction type and supporting construction of the health care occupancy is based on the story in which it is located in the building in accordance with 18/19.1.6 and Tables 18/19.1.6.1.
• The construction type of the areas of the building enclosing the other occupancies shall be based on the applicable occupancy chapters.
18.1.3.5, 19.1.3.5, 8.2.1.3</td><td>◉</td><td>○</td><td>○</td><td></td></tr>
<tr><td>K161</td><td>Building Construction Type and Height
2012 EXISTING
Building construction type and stories meets Table 19.1.6.1, unless otherwise permitted by 19.1.6.2 through 19.1.6.7
19.1.6.4, 19.1.6.5
<table>
<tr><th></th><th></th><th>Construction Type</th><th></th></tr>
<tr><td>1</td><td>◉</td><td>I (442), I (332), II (222)</td><td>Any number of stories non-sprinklered or sprinklered</td></tr>
<tr><td>2</td><td>○</td><td>II (111)</td><td>One story non-sprinklered
Maximum 3 stories sprinklered</td></tr>
<tr><td>3</td><td>○</td><td>II (000)</td><td rowspan="4">Not allowed non-sprinklered
Maximum 2 stories sprinklered</td></tr>
<tr><td>4</td><td>○</td><td>III (211)</td></tr>
<tr><td>5</td><td>○</td><td>IV (2HH)</td></tr>
<tr><td>6</td><td>○</td><td>V (111)</td></tr>
<tr><td>7</td><td>○</td><td>III (200)</td><td rowspan="2">Not allowed non-sprinklered
Maximum 1 story sprinklered</td></tr>
<tr><td>8</td><td>○</td><td>V (000)</td></tr>
</table>
Sprinklered stories must be sprinklered throughout by an approved, supervised automatic system in accordance with section 9.7. (See 19.3.5)
Give a brief description, in REMARKS, of the construction, the number of stories, including basements, floors on which patients are located, location of smoke or fire barriers and dates of approval. Complete sketch or attach small floor plan of the building as appropriate.</td><td>◉</td><td>○</td><td>○</td><td>Presbyterian Homes of Bloomington Care Center is a 3-story building with a full basement that was built in 2005 determined to be of Type II(222) construction. The facility is separated from an assisted living occupancy by 2-hour fire rated construction. The facility is fully protected throughout by an automatic fire sprinkler system and has a fire alarm system with smoke detection in resident rooms, corridors and spaces open to the corridor that is monitored for automatic fire department notification.</td></tr>
</table>

ID PREFIX		MET	NOT MET	N/A	REMARKS
K161	2012 NEW Building construction type and stories meets Table 18.1.6.1, unless otherwise permitted by 18.1.6.2 through 18.1.6.7 18.1.6.4, 18.1.6.5	○	○	◉	

		Construction Type	
1	○	I (442), I (332), II (222)	Not allowed non-sprinklered Any number of stories sprinklered
2	○	II (111)	Not allowed non-sprinklered Maximum 3 stories sprinklered
3	○	II (000)	Not allowed non-sprinklered Maximum 1 story sprinklered
4	○	III (211)	
5	○	IV (2HH)	
6	○	V (111)	
7	○	III (200)	Not allowed non-sprinklered
8	○	V (000)	

Sprinklered stories must be sprinklered throughout by an approved, supervised automatic system in accordance with section 9.7. (See 18.3.5)

Give a brief description, in REMARKS, of the construction, the number of stories, including basements, floors on which patients are located, location of smoke or fire barriers and dates of approval. Complete sketch or attach small floor plan of the building as appropriate.

K162	**Roofing Systems Involving Combustibles** 2012 EXISTING Buildings of Type I (442), Type I (332), Type II (222), or Type II (111) having roof systems employing combustible roofing supports, decking or roofing meet the following: 1. roof covering meets Class C requirements. 2. roof is separated from occupied building portions with a noncombustible floor assembly using not less than 2½ inches concrete or gypsum fill. 3. attic or other space is either unoccupied or protected throughout by an approved automatic sprinkler system. 19.1.6.2*, ASTM E108, ANSI/UL 790	◉	○	○	

ID PREFIX		MET	NOT MET	N/A	REMARKS
K162	2012 NEW Buildings of Type I (442), Type I (332), Type II (222), Type II (111) having roof systems employing combustible roofing supports, decking or roofing meet the following: 1. roof covering meets Class A requirements. 2. roof is separated from occupied building portions with 2 hour fire resistive noncombustible floor assembly using not less than 2½ inches concrete or gypsum fill. 3. the structural elements supporting the rated floor assembly meet the required fire resistance rating of the building. 18.1.6.2, ASTM E108, ANSI/UL 790	○	○	◉	
K163	**Interior Nonbearing Wall Construction** Interior nonbearing walls in Type I or II construction are constructed of noncombustible or limited-combustible materials. Interior nonbearing walls required to have a minimum 2 hour fire resistance rating are permitted to be fire-retardant-treated wood enclosed within noncombustible or limited-combustible materials, provided they are not used as shaft enclosures. 18.1.6.4, 18.1.6.5, 19.1.6.4, 19.1.6.5	◉	○	○	
	SECTION 2 – MEANS OF EGRESS REQUIREMENTS				
K200	**Means of Egress Requirements – Other** List in the REMARKS section any LSC Section 18.2 and 19.2 Means of Egress requirements that are not addressed by the provided K-tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. 18.2, 19.2	◉	○	○	
K211	**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	◉	○	○	

ID PREFIX		MET	NOT MET	N/A	REMARKS
K221	**Patient Sleeping Room Doors** Locks on patient sleeping room doors are not permitted unless the key-locking device that restricts access from the corridor does not restrict egress from the patient room, or the locking arrangement is permitted for patient clinical, security or safety needs in accordance with 18.2.2.2.5 or 19.2.2.2.5. 18.2.2.2, 19.2.2.2, TIA 12-4	◉	○	○	
K222	**Egress Doors** Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: ☐ CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 ☐ SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4	◉	○	○	

ID PREFIX		MET	NOT MET	N/A	REMARKS
K222	☐ DELAYED-EGRESS LOCKING ARRANGEMENTS Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 ☐ ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted. 18.2.2.2.4, 19.2.2.2.4 ☐ ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4	◉	○	○	
K223	**Doors with Self-Closing Devices** Doors in an exit passageway, stairway enclosure, or horizontal exit, smoke barrier, or hazardous area enclosure are self-closing and kept in the closed position, unless held open by a release device complying with 7.2.1.8.2 that automatically closes all such doors throughout the smoke compartment or entire facility upon activation of: • Required manual fire alarm system; and • Local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system; and • Automatic sprinkler system, if installed; and • Loss of power. 18.2.2.2.7, 18.2.2.2.8, 19.2.2.2.7, 19.2.2.2.8	◉	○	○	

ID PREFIX		MET	NOT MET	N/A	REMARKS
K224	**Horizontal-Sliding Doors** Horizontal-sliding doors permitted by 7.2.1.14 that are not automatic-closing are limited to a single leaf and shall have a latch or other mechanism to ensure the door will not rebound. Horizontal-sliding doors serving an occupant load fewer than 10 shall be permitted, providing all of the following criteria are met: • Area served by the door has no high hazard contents. • Door is operable from either side without special knowledge or effort. • Force required to operate the door in the direction of travel is ≤ 30 lbf to set the door in motion and ≤ 15 lbf to close or open to the required width. • Assembly is appropriately fire rated, and where rated, is self-or automatic-closing by smoke detection per 7.2.1.8, and installed per NFPA 80. • Where required to latch, the door has a latch or other mechanism to ensure the door will not rebound. 18.2.2.2.10, 19.2.2.2.10	○	○	◉	
K225	**Stairways and Smokeproof Enclosures** Stairways and Smokeproof enclosures used as exits are in accordance with 7.2. 18.2.2.3, 18.2.2.4, 19.2.2.3, 19.2.2.4, 7.2	◉	○	○	
K226	**Horizontal Exits** Horizontal exits, if used, are in accordance with 7.2.4 and the provisions of 18.2.2.5.1 through 18.2.2.5.7, or 19.2.2.5.1 through 19.2.2.5.4. 18.2.2.5, 19.2.2.5	◉	○	○	
K227	**Ramps and Other Exits** Ramps, exit passageways, fire and slide escapes, alternating tread devices, and areas of refuge are in accordance with the provisions 7.2.5 through 7.2.12. 18.2.2.6 to 18.2.2.10 or 19.2.2.6 to 19.2.2.10	◉	○	○	
K231	**Means of Egress Capacity** The capacity of required means of egress is in accordance with 7.3. 18.2.3.1, 19.2.3.1	◉	○	○	

ID PREFIX		MET	NOT MET	N/A	REMARKS
K232	**Aisle, Corridor or Ramp Width** 2012 EXISTING The width of aisles or corridors (clear or unobstructed) serving as exit access shall be at least 4 feet and maintained to provide the convenient removal of nonambulatory patients on stretchers, except as modified by 19.2.3.4, exceptions 1-5. 19.2.3.4, 19.2.3.5	◉	○	○	
	2012 NEW The width of aisles or corridors (clear and unobstructed) serving as exit access in hospitals and nursing homes shall be at least 8 feet. In limited care facility and psychiatric hospitals, width of aisles or corridors shall be at least 6 feet, except as modified by the 18.2.3.4 or 18.2.3.5 exceptions. 18.2.3.4, 18.2.3.5	○	○	◉	
K233	**Clear Width of Exit and Exit Access Doors** 2012 EXISTING Exit access doors and exit doors are of the swinging type and are at least 32 inches in clear width. Exceptions are provided for existing 34-inch doors and for existing 28-inch doors where the fire plan does not require evacuation by bed, gurney, or wheelchair. 19.2.3.6, 19.2.3.7	◉	○	○	
	2012 NEW Exit access doors and exit doors are of the swinging type and are at least 41.5 inches in clear width. In psychiatric hospitals or limited care facilities, doors are at least 32 inches wide. Doors not subject to patient use, in exit stairway enclosures, or serving newborn nurseries shall be no less than 32 inches in clear width. If using a pair of doors, the doors shall be provided with a rabbet, bevel, or astragal at the meeting edge, at least one of the doors shall provide 32 inches in clear width, and the inactive leaf of the pair shall be secured with automatic flush bolts. 18.2.3.6, 18.2.3.7	○	○	◉	
K241	**Number of Exits – Story and Compartment** Not less than two exits, remote from each other, and accessible from every part of every story are provided for each story. Each smoke compartment shall likewise be provided with two distinct egress paths to exits that do not require the entry into the same adjacent smoke compartment. 18.2.4.1-18.2.4.4, 19.2.4.1-19.2.4.4	◉	○	○	

ID PREFIX		MET	NOT MET	N/A	REMARKS
K251	**Dead-End Corridors and Common Path of Travel** 2012 EXISTING Dead-end corridors shall not exceed 30 feet. Existing dead-end corridors greater than 30 feet shall be permitted to be continued to be used if it is impractical and unfeasible to alter them. 19.2.5.2	◉	○	○	
K251	2012 NEW Dead-end corridors shall not exceed 30 feet. Common path of travel shall not exceed 100 feet. 18.2.5.2, 18.2.5.3	○	○	◉	
K252	**Number of Exits – Corridors** Every corridor shall provide access to not less than two approved exits in accordance with Sections 7.4 and 7.5 without passing through any intervening rooms or spaces other than corridors or lobbies. 18.2.5.4, 19.2.5.4	◉	○	○	
K253	**Number of Exits – Patient Sleeping and Non-Sleeping Rooms** Patient sleeping rooms of more than 1,000 square feet or nonsleeping rooms of more than 2,500 square feet have at least two exit access doors remotely located from each other. 18.2.5.5.1, 18.2.5.5.2, 19.2.5.5.1, 19.2.5.5.2	◉	○	○	
K254	**Corridor Access** All habitable rooms not within suites have a door leading directly outside to grade or have a door leading to an exit access corridor. Patient sleeping rooms with less than eight patient beds may have one room intervening to reach an exit access corridor provided the intervening room is equipped with an approved automatic smoke detection system. 18.2.5.6.1 through 18.2.5.6.4, 19.2.5.6.1 through 19.2.5.6.4	◉	○	○	
K255	**Suite Separation, Hazardous Content, and Subdivision** All suites are separated from the remainder of the building (including from other suites) by construction meeting the separation provisions for corridor construction (18.3.6.2-18.3.6.5 or 19.3.6.2-19.3.6.5). Existing approved barriers shall be allowed to continue to be used provided they limit the transfer of smoke. Intervening rooms have no hazardous areas and hazardous areas within suites comply with 18/19.2.5.7.1.3. Subdivision of suites shall be by noncombustible or limited-combustible construction. 18.2.5.7.1.2 through 18.2.5.7.1.4, 19.2.5.7.1.2, 19.2.5.7.1.3, 19.2.5.7.1.4	◉	○	○	

ID PREFIX		MET	NOT MET	N/A	REMARKS
K256	**Sleeping Suites** Occupants shall have exit access to a corridor or direct access to a horizontal exit. Where ≥ 2 exits are required, one exit access door may be to a stairway, passageway or to the exterior. Suites shall be provided with constant staff supervision. Staff shall have direct visual supervision of patient sleeping rooms, from a constantly attended location or the room shall be provided with an automatic smoke detection system. Suites more than 1,000 ft² shall have 2 or more remote exits. One means of egress from the suite shall be to a corridor and one may be into an adjacent suite separated in accordance with corridor requirements. Suites shall not exceed the following size limitations: • 5,000 square feet if the suite is not fully smoke detected or fully sprinklered. • 7,500 square feet if the suite is either fully smoke detected or fully sprinklered. • 10,000 square feet if the suite is both fully smoke detected and fully sprinklered and the sleeping rooms have direct supervision from a constantly attended location. Travel distance between any point in a suite to exit access shall not exceed 100 feet and distance to an exit shall not exceed 150 feet (200 feet if building is fully sprinklered). 18.2.5.7.2, 19.2.5.7.2	○	○	◉	
K257	**Non-Sleeping Suites** Occupants shall have exit access to a corridor or direct access to a horizontal exit. Where ≥ 2 exits are required, one exit access door may be to a stairway, passageway or to the exterior. Suites more than 2,500 ft² shall have 2 or more remote exits. One means of egress from the suite shall be to a corridor and one may be into an adjacent suite separated in accordance with corridor requirements. Suites shall not exceed 10,000 ft². Travel distance between any point in a suite to exit access shall not exceed 100 feet and distance to an exit shall not exceed 150 feet (200 feet if building is fully sprinklered). 18.2.5.7.3, 19.2.5.7.3	◉	○	○	

ID PREFIX		MET	NOT MET	N/A	REMARKS
K261	**Travel Distance to Exits** Travel distance (excluding suites) to exits are measured in accordance with 7.6. • From any point in the room or suite to exit less than or equal to 150 feet (less than or equal to 200 feet if the building is fully sprinklered). • Point in a room to room door less than or equal to 50 feet. 18.2.6, 19.2.6	◉	○	○	
K271	**Discharge from Exits** Exit discharge is arranged in accordance with 7.7, provides a level walking surface meeting the provisions of 7.1.7 with respect to changes in elevation and shall be maintained free of obstructions. Additionally, the exit discharge shall be a hard packed all-weather travel surface. 18.2.7, 19.2.7	◉	○	○	
K281	**Illumination of Means of Egress** Illumination of means of egress, including exit discharge, is arranged in accordance with 7.8 and shall be either continuously in operation or capable of automatic operation without manual intervention. 18.2.8, 19.2.8	◉	○	○	
K291	**Emergency Lighting** Emergency lighting of at least 1-1/2 hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1	◉	○	○	
K292	**Life Support Means of Egress** 2012 NEW (INDICATE N/A FOR EXISTING) Buildings equipped with or requiring the use of life support systems (electro-mechanical or inhalation anesthetics) have illumination of means of egress, emergency lighting equipment, exit, and directional signs supplied by the life safety branch of the electrical system described in NFPA 99. (Indicate N/A if life support equipment is for emergency purposes only.) 18.2.9.2, 18.2.10.5	○	○	◉	

ID PREFIX		MET	NOT MET	N/A	REMARKS
K293	**Exit Signage** 2012 EXISTING Exit and directional signs are displayed in accordance with 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1 (Indicate N/A in one-story existing occupancies with less than 30 occupants where the line of exit travel is obvious.)	◉	○	○	
	2012 NEW Exit and directional signs are displayed in accordance with 7.10 with continuous illumination also served by the emergency lighting system. 18.2.10.1	○	○	◉	
	SECTION 3 – PROTECTION				
K300	**Protection – Other** List in the REMARKS section any LSC Section 18.3 and 19.3 Protection requirements that are not addressed by the provided K-tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567.	◉	○	○	
K311	**Vertical Openings – Enclosure** 2012 EXISTING Stairways, elevator shafts, light and ventilation shafts, chutes, and other vertical openings between floors are enclosed with construction having a fire resistance rating of at least 1-hour. An atrium may be used in accordance with 8.6. 19.3.1.1 through 19.3.1.6 *If all vertical openings are properly enclosed with construction providing at least a 2 hour fire resistance rating, also check this box.* ☐	◉	○	○	
	2012 NEW Stairways, elevator shafts, light and ventilation shafts, chutes, and other vertical openings between floors are enclosed with construction having a fire resistance rating of at least 2 hours connecting four or more stories. (1-hour for single story building and buildings up to three stories in height.) An atrium may be used in accordance with 8.6.7. 18.3.1 through 18.3.1.5	○	○	◉	

ID PREFIX		MET	NOT MET	N/A	REMARKS
K321	**Hazardous Areas – Enclosure** 2012 EXISTING Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with ¾ hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. *Describe the floor and zone locations of hazardous areas that are deficient in REMARKS.* 19.3.2.1, 19.3.5.9	◉	○	○	

Area	Automatic Sprinkler	Separation	N/A
a. Boiler and Fuel-Fired Heater Rooms	✔	✔	
b. Laundries (larger than 100 sq. ft.)	✔	✔	
c. Repair, Maintenance, and Paint Shops	✔	✔	
d. Soiled Linen Rooms (exceeding 64 gal.)	✔	✔	
e. Trash Collection Rooms (exceeding 64 gal.)	✔	✔	
f. Combustible Storage Rooms/Spaces (over 50 sq. ft.)	✔	✔	
g. Laboratories (if classified as Severe Hazard - see K322)			✔

ID PREFIX		MET	NOT MET	N/A	REMARKS
K321	2012 NEW Hazardous areas are protected in accordance with 18.3.2.1. The areas shall be enclosed with a 1-hour fire-rated barrier, with a ¾ hour fire-rated door without windows (in accordance with 8.7.1.1). Doors shall be self-closing or automatic-closing in accordance with 7.2.1.8. Hazardous areas are protected by a sprinkler system in accordance with 9.7, 18.3.2.1, and 8.4. *Describe the floor and zone locations of hazardous areas that are deficient in REMARKS.* 18.3.2.1, 7.2.1.8, 8.4, 8.7, 9.7		○	○	◉	

Area	Automatic Sprinkler	Separation	N/A
a. Boiler and Fuel-Fired Heater Rooms	☐	☐	☐
b. Laundries (larger than 100 sq. ft.)	☐	☐	☐
c. Repair, Maintenance, and Paint Shops	☐	☐	☐
d. Soiled Linen Rooms (exceeding 64 gal.)	☐	☐	☐
e. Trash Collection Rooms (exceeding 64 gal.)	☐	☐	☐
f. Combustible Storage Rooms/Spaces (over 50 and less than 100 sq. ft.)	☐	☐	☐
g. Combustible Storage Rooms/Spaces (over 100 sq. ft.)	☐	☐	☐
h. Laboratories (if classified as Severe Hazard - see K322)	☐	☐	☐

ID PREFIX		MET	NOT MET	N/A	REMARKS
K322	**Laboratories** Laboratories employing quantities of flammable, combustible, or hazardous materials that are considered a severe hazard are protected by 1-hour fire resistance-rated separation, automatic sprinkler system, and are in accordance with 8.7 and with NFPA 99. Laboratories not considered a severe hazard are protected as hazardous areas (see K321). Laboratories using chemicals are in accordance with NFPA 45, *Standard on Fire Protection for Laboratories Using Chemicals*. Gas appliances are of appropriate design and installed in accordance with NFPA 54. Shutoff valves are marked to identify material they control. Devices requiring medical grade oxygen from the piped distribution system meet the requirements under 11.4.2.2 (NFPA 99). 18.3.2.2, 19.3.2.2, 8.7, 8.7.4.1 (LSC) 9.3.1.2, 11.4.3.2, 15.4 (NFPA 99)	○	○	◉	

ID PREFIX		MET	NOT MET	N/A	REMARKS
K323	**Anesthetizing Locations** Areas designated for administration of general anesthesia (i.e., inhalation anesthetics) are in accordance with 8.7 and NFPA 99. Zone valves are: located immediately outside each life-support, critical care, and anesthetizing location of moderate sedation, deep sedation, or general anesthesia for medical gas or vacuum; readily accessible in an emergency; and arranged so shutting off any one anesthetizing location will not affect others. Area alarm panels are provided to monitor all medical gas, medical-surgical vacuum, and piped WAGD systems. Panels are at locations that provide for surveillance, indicate medical gas pressure decreases of 20 percent and vacuum decreases of 12 inch gauge HgV, and provide visual and audible indication. Alarm sensors are installed either on the source side of individual room zone valve box assemblies or on the patient/use side of each of the individual zone box valve assemblies. The EES critical branch supplies power for task illumination, fixed equipment, select receptacles, and select power circuits, and EES equipment system supplies power to ventilation system. Heating, cooling, and ventilation are in accordance with ASHRAE 170. Medical supply and equipment manufacturer's instructions for use are considered before reducing humidity levels to those allowed by ASHRAE, per S&C 13-58. 18.3.2.3, 19.3.2.3 (LSC) 5.1.4.8.7, 5.1.4.8.7.2, 5.1.9.3, 5.1.9.3.4, 6.4.2.2.4.2 (NFPA 99)	○	○	◉	

ID PREFIX		MET	NOT MET	N/A	REMARKS
K324	**Cooking Facilities** Cooking equipment is protected in accordance with NFPA 96, *Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations*, unless: • residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2. • cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or • cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2	◉	○	○	
K325	**Alcohol Based Hand Rub Dispenser (ABHR)** ABHRs are protected in accordance with 8.7.3.1, unless all conditions are met: • Corridor is at least 6 feet wide. • Maximum individual dispenser capacity is 0.32 gallons (0.53 gallons in suites) of fluid and 18 ounces of Level 1 aerosols. • Dispensers shall have a minimum of four foot horizontal spacing. • Not more than an aggregate of 10 gallons of fluid or 1135 ounces of aerosol are used in a single smoke compartment outside a storage cabinet, excluding one individual dispenser per room. • Storage in a single smoke compartment greater than 5 gallons complies with NFPA 30. • Dispensers are not installed within 1 inch of an ignition source. • Dispensers over carpeted floors are in sprinklered smoke compartments. • ABHR does not exceed 95 percent alcohol. • Operation of the dispenser shall comply with Section 18.3.2.6(11) or 19.3.2.6(11). • ABHR is protected against inappropriate access. 18.3.2.6, 19.3.2.6, 42 CFR Parts 403, 418, 460, 482, 483, and 485	◉	○	○	

ID PREFIX		MET	NOT MET	N/A	REMARKS
K331	**Interior Wall and Ceiling Finish** 2012 EXISTING Interior wall and ceiling finishes, including exposed interior surfaces of buildings such as fixed or movable walls, partitions, columns, and have a flame spread rating of Class A or Class B. The reduction in class of interior finish for a sprinkler system as prescribed in 10.2.8.1 is permitted. 10.2, 19.3.3.1, 19.3.3.2 *Indicate flame spread rating(s).* B	◉	○	○	
	2012 NEW Interior wall and ceiling finishes, including exposed interior surfaces of buildings such as fixed or movable walls, partitions and columns have a flame spread rating of Class A. The reduction in class of interior finish for a sprinkler system as prescribed in 10.2.8.1 is permitted. Individual rooms not exceeding four persons may have a Class A or B finish. Lower half of corridor walls, not exceeding 4 feet in height, may have a Class A or B flame spread rating. 10.2, 18.3.3.1, 18.3.3.2 *Indicate flame spread rating(s).* _____	○	○	◉	
K332	**Interior Floor Finish** 2012 NEW (Indicate N/A for 2012 EXISTING) Interior finishes shall comply with 10.2. Floor finishes in exit enclosures and exit access corridors and spaces not separated by walls that resist the passage of smoke shall be Class I or II. 18.3.3.3.1, 18.3.3.3.2, 18.3.3.3.3, 10.2, 10.2.7.1, 10.2.7.2	◉	○	○	
K341	**Fire Alarm System – Installation** A fire alarm system is installed with systems and components approved for the purpose in accordance with NFPA 70, *National Electric Code,* and NFPA 72, *National Fire Alarm Code* to provide effective warning of fire in any part of the building. In areas not continuously occupied, detection is installed at each fire alarm control unit. In new occupancy, detection is also installed at notification appliance circuit power extenders, and supervising station transmitting equipment. Fire alarm system wiring or other transmission paths are monitored for integrity. 18.3.4.1, 19.3.4.1, 9.6, 9.6.1.8	◉	○	○	

ID PREFIX		MET	NOT MET	N/A	REMARKS
K342	**Fire Alarm System – Initiation** Initiation of the fire alarm system is by manual means and by any required sprinkler system alarm, detection device, or detection system. Manual alarm boxes are provided in the path of egress near each required exit. Manual alarm boxes in patient sleeping areas shall not be required at exits if manual alarm boxes are located at all nurse's stations or other continuously attended staff location, provided alarm boxes are visible, continuously accessible, and 200' travel distance is not exceeded. 18.3.4.2.1, 18.3.4.2.2, 19.3.4.2.1, 19.3.4.2.2, 9.6.2.5	◉	○	○	
K343	**Fire Alarm – Notification** 2012 EXISTING Positive alarm sequence in accordance with 9.6.3.4 are permitted in buildings protected throughout by a sprinkler system. Occupant notification is provided automatically in accordance with 9.6.3 by audible and visual signals. In critical care areas, visual alarms are sufficient. The fire alarm system transmits the alarm automatically to notify emergency forces in the event of a fire. 19.3.4.3, 19.3.4.3.1, 19.3.4.3.2, 9.6.4, 9.7.1.1(1)	◉	○	○	
	2012 NEW Positive alarm sequence in accordance with 9.6.3.4 are permitted. Occupant notification is provided automatically in accordance with 9.6.3 by audible and visual signals. In critical care areas, visual alarms are sufficient. The fire alarm system transmits the alarm automatically to notify emergency forces in the event of a fire. Annunciation and annunciation zoning for fire alarm and sprinklers shall be provided by audible and visual indicators and zones shall not be larger than 22,500 square feet per zone. 18.3.4.3 through 18.3.4.3.3, 9.6.4	○	○	◉	
K344	**Fire Alarm – Control Functions** The fire alarm automatically activates required control functions and is provided with an alternative power supply in accordance with NFPA 72. 18.3.4.4, 19.3.4.4, 9.6.1, 9.6.5, NFPA 72	◉	○	○	

ID PREFIX		MET	NOT MET	N/A	REMARKS
K345	**Fire Alarm System – Testing and Maintenance** A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, *National Electric Code,* and NFPA 72, *National Fire Alarm and Signaling Code.* Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72	◉	○	○	
K346	**Fire Alarm – Out of Service** Where required fire alarm system is out of services for more than 4 hours in a 24 hour period, the authority having jurisdiction shall be notified, and the building shall be evacuated or an approved fire watch shall be provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service. 9.6.1.6	◉	○	○	
K347	**Smoke Detection** 2012 EXISTING Smoke detection systems are provided in spaces open to corridors as required by 19.3.6.1. 19.3.4.5.2	◉	○	○	
	2012 NEW Smoke detection systems are provided in spaces open to corridors as required by 18.3.6.1 In nursing homes, an automatic smoke detection system is installed in the corridors of all smoke compartments containing resident sleeping rooms, unless the resident sleeping rooms have: • smoke detection, or • automatic door closing devices with integral smoke detectors on the room side that provide occupant notification. Such detectors are electrically interconnected to the fire alarm system. 18.3.4.5.2, 18.3.4.5.3	○	○	◉	

ID PREFIX		MET	NOT MET	N/A	REMARKS
K351	**Sprinkler System – Installation** 2012 EXISTING Nursing homes, and hospitals where required by construction type, are protected throughout by an approved automatic sprinkler system in accordance with NFPA 13, *Standard for the Installation of Sprinkler Systems.* In Type I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where state or local regulations prohibit sprinklers. In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area of the closet does not exceed 6 ft² and sprinkler coverage covers the closet footprint as required by NFPA 13, *Standard for Installation of Sprinkler Systems.* 19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1)	◉	○	○	
	2012 NEW Buildings are to be protected throughout by an approved automatic sprinkler system in accordance with NFPA 13, *Standard for the Installation of Sprinkler Systems.* In Type I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where State and local regulations prohibit sprinklers. Listed quick-response or listed residential sprinklers are used throughout smoke compartments with patient sleeping rooms. In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area of the closet does not exceed 6 ft² and sprinkler coverage covers the closet footprint as required by NFPA 13, *Standard for Installation of Sprinkler Systems.* 18.3.5.1, 18.3.5.4, 18.3.5.5, 18.3.5.6, 9.7, 9.7.1.1(1), 18.3.5.10	○	○	◉	
K352	**Sprinkler System – Supervisory Signals** Automatic sprinkler system supervisory attachments are installed and monitored for integrity in accordance with NFPA 72, *National Fire Alarm and Signaling Code,* and provide a signal that sounds and is displayed at a continuously attended location or approved remote facility when sprinkler operation is impaired. 9.7.2.1, NFPA 72	◉	○	○	

ID PREFIX		MET	NOT MET	N/A	REMARKS
K353	**Sprinkler System – Maintenance and Testing** Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, *Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems.* Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked. 03/11/2021 b) Who provided system test. Summit Fire Protection c) Water system supply source. City water *Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system.* 9.7.5, 9.7.7, 9.7.8, and NFPA 25	◉	○	○	
K354	**Sprinkler System – Out of Service** Where the sprinkler system is impaired, the extent and duration of the impairment has been determined, areas or buildings involved are inspected and risks are determined, recommendations are submitted to management or designated representative, and the fire department and other authorities having jurisdiction have been notified. Where the sprinkler system is out of service for more than 10 hours in a 24 hour period, the building or portion of the building affected are evacuated or an approved fire watch is provided until the sprinkler system has been returned to service. 18.3.5.1, 19.3.5.1, 9.7.5, 15.5.2 (NFPA 25)	◉	○	○	
K355	**Portable Fire Extinguishers** Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, *Standard for Portable Fire Extinguishers.* 18.3.5.12, 19.3.5.12, NFPA 10	◉	○	○	
K361	**Corridors – Areas Open to Corridor** Spaces (other than patient sleeping rooms, treatment rooms and hazardous areas), waiting areas, nurse's stations, gift shops, and cooking facilities, open to the corridor are in accordance with the criteria under 18.3.6.1 and 19.3.6.1. 18.3.6.1, 19.3.6.1	◉	○	○	

ID PREFIX		MET	NOT MET	N/A	REMARKS
K362	**Corridors – Construction of Walls** 2012 EXISTING Corridors are separated from use areas by walls constructed with at least ½ hour fire resistance rating. In fully sprinklered smoke compartments, partitions are only required to resist the transfer of smoke. In nonsprinklered buildings, walls extend to the underside of the floor or roof deck above the ceiling. Corridor walls may terminate at the underside of ceilings where specifically permitted by Code. Fixed fire window assemblies in corridor walls are in accordance with Section 8.3, but in sprinklered compartments there are no restrictions in area or fire resistance of glass or frames. *If the walls have a fire resistance rating, give the rating* Smoke *if the walls terminate at the underside of the ceiling, give brief description in REMARKS, describing the ceiling throughout the floor area.* 19.3.6.2, 19.3.6.2.7	◉	○	○	
	2012 NEW Corridor walls shall form a barrier to limit the transfer of smoke. Such walls shall be permitted to terminate at the ceiling where the ceiling is constructed to limit the transfer of smoke. No fire resistance rating is required for the corridor walls. 18.3.6.2	○	○	◉	

ID PREFIX		MET	NOT MET	N/A	REMARKS
K363	**Corridor – Doors** 2012 EXISTING Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1¾ inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5lbf is applied, whether or not power is applied. Clearance between bottom of door and floor covering is not exceeding 1 inch. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc.	◉	○	○	
	2012 NEW Doors protecting corridor openings shall be constructed to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have self-latching and positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5lbf is applied, whether or not power is applied. Clearance between bottom of door and floor covering is not exceeding 1 inch. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 18.3.6.3.6 are permitted. 18.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatic closing devices, etc.	○	○	◉	

ID PREFIX		MET	NOT MET	N/A	REMARKS
K364	**Corridor – Openings** Transfer grilles are not used in corridor walls or doors. Auxiliary spaces that do not contain flammable or combustible materials are permitted to have louvers or be undercut. In other than smoke compartments containing patient sleeping rooms, miscellaneous openings are permitted in vision panels or doors, provided the openings per room do not exceed 20 in² and are at or below half the distance from floor to ceiling. In sprinklered rooms, the openings per room do not exceed 80 in². Vision panels in corridor walls or doors shall be fixed window assemblies in approved frames. (In fully sprinklered smoke compartments, there are no restrictions in the area and fire resistance of glass and frames.) 18.3.6.5.1, 19.3.6.5.2, 8.3	◉	○	○	
K371	**Subdivision of Building Spaces – Smoke Compartments** 2012 EXISTING Smoke barriers shall be provided to form at least two smoke compartments on every sleeping floor with a 30 or more patient bed capacity. Size of compartments cannot exceed 22,500 square feet or a 200-foot travel distance from any point in the compartment to a door in the smoke barrier. 19.3.7.1, 19.3.7.2 *Detail in REMARKS zone dimensions including length of zones and dead-end corridors.*	◉	○	○	
	2012 NEW Smoke barriers shall be provided to form at least two smoke compartments on every floor used by inpatients for sleeping or treatment, and on every floor with an occupant load of 50 or more persons, regardless of use. Size of compartments cannot exceed 22,500 square feet or a 200-foot travel distance from any point in the compartment to a door in the smoke barrier. Smoke subdivision requirements do not apply to any of the stories or areas described in 18.3.7.2. 18.3.7.1, 18.3.7.2 *Detail in REMARKS zone dimensions including length of zones and dead-end corridors.*	○	○	◉	

ID PREFIX		MET	NOT MET	N/A	REMARKS
K372	**Subdivision of Building Spaces – Smoke Barrier Construction** 2012 EXISTING Smoke barriers shall be constructed to a ½ hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) *Describe any mechanical smoke control system in REMARKS.*	◉	○	○	
	2012 NEW Smoke barriers shall be constructed to provide at least a 1-hour fire resistance rating and constructed in accordance with 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations of fully ducted HVAC systems. 18.3.7.3, 18.3.7.4, 18.3.7.5, 8.3 *Describe any mechanical smoke control system in REMARKS.*	○	○	◉	
K373	**Subdivision of Building Spaces – Accumulation Space** Space shall be provided on each side of smoke barriers to adequately accommodate the total number of occupants in adjoining compartments. 18.3.7.5.1, 18.3.7.5.2, 19.3.7.5.1, 19.3.7.5.2	◉	○	○	
K374	**Subdivision of Building Spaces – Smoke Barrier Doors** 2012 EXISTING Doors in smoke barriers are 1¾-inch thick solid bonded wood-core doors or of construction that resists fire for 20 minutes. Nonrated protective plates of unlimited height are permitted. Doors are permitted to have fixed fire window assemblies per 8.5. Doors are self-closing or automatic-closing, do not require latching, and are not required to swing in the direction of egress travel. Door opening provides a minimum clear width of 32 in for swinging or horizontal doors. 19.3.7.6, 19.3.7.8, 19.3.7.9	◉	○	○	

ID PREFIX		MET	NOT MET	N/A	REMARKS
K374	2012 NEW Doors in smoke barriers have at least a 20-minute fire protection rating or are at least 1¾-inch thick solid bonded core wood. Required clear widths are provided per 18.3.7.6(4) and (5). Nonrated protective plates of unlimited height are permitted. Horizontal-sliding doors comply with 7.2.1.14. Swinging doors shall be arranged so that each door swings in an opposite direction. Doors shall be self-closing and rabbets, bevels, or astragals are required at the meeting edges. Positive latching is not required. 18.3.7.6, 18.3.7.7, 18.3.7.8	○	○	◉	
K379	**Smoke Barrier Door Glazing** 2012 EXISTING Openings in smoke barrier doors shall be fire-rated glazing or wired glass panels in steel frames. 19.3.7.6, 19.3.7.6.2, 8.5	◉	○	○	
	2012 NEW Windows in smoke barrier doors shall be installed in each cross corridor swinging or horizontal-sliding door protected by fire-rated glazing or by wired glass panels in approved frames. 18.3.7.9	○	○	◉	
K381	**Sleeping Room Outside Windows and Doors** Every patient sleeping room has an outside window or outside door. In new occupancies, sill height does not exceed 36 inches above the floor. Windows in atrium walls are considered outside windows. Newborn nurseries and rooms intended for occupancy less than 24 hours have no outside window or door requirements. Window sills in special nursing care areas (e.g., ICU, CCU, hemodialysis, neonatal) do not exceed 60 inches above the floor. 42 CFR 403, 418, 460, 482, 483, and 485	◉	○	○	
	SECTION 4 – SPECIAL PROVISIONS				
K400	**Special Provisions – Other** List in the REMARKS section any LSC Section 18.4 and 19.4 Special Provisions requirements that are not addressed by the provided K-tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567.	◉	○	○	

ID PREFIX		MET	NOT MET	N/A	REMARKS
K421	**High-Rise Buildings** 2012 EXISTING High-rise buildings are protected throughout by an approved, supervised automatic sprinkler system in accordance with Section 9.7 within 12 years of LSC final rule effective date. 19.4.2	○	○	◉	
	2012 NEW High-rise buildings comply with section 11.8. 18.4.2	○	○	◉	
	SECTION 5 – BUILDING SERVICES				
K500	**Building Services – Other** List in the REMARKS section any LSC Section 18.5 and 19.5 Building Services requirements that are not addressed by the provided K-tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567.	◉	○	○	
K511	**Utilities – Gas and Electric** Equipment using gas or related gas piping complies with NFPA 54, *National Fuel Gas Code*, electrical wiring and equipment complies with NFPA 70, *National Electric Code*. Existing installations can continue in service provided no hazard to life. 18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2	◉	○	○	
K521	**HVAC** Heating, ventilation, and air conditioning shall comply with 9.2 and shall be installed in accordance with the manufacturer's specifications. 18.5.2.1, 19.5.2.1, 9.2	◉	○	○	
K522	**HVAC – Any Heating Device** Any heating device, other than a central heating plant, is designed and installed so combustible materials cannot be ignited by device, and has a safety feature to stop fuel and shut down equipment if there is excessive temperature or ignition failure. If fuel fired, the device also: • is chimney or vent connected. • takes air for combustion from outside. • provides for a combustion system separate from occupied area atmosphere. 18.5.2.2, 19.5.2.2	◉	○	○	

ID PREFIX		MET	NOT MET	N/A	REMARKS
K523	**HVAC – Suspended Unit Heaters** Suspended unit heaters are permitted provided the following are met: • Not located in means of egress or in patient rooms. • Located high enough to be out of reach of people in the area. • Has a safety feature to stop fuel and shut down equipment if there is excessive temperature or ignition failure. 18.5.2.3(1), 19.5.2.3(1)	○	○	◉	
K524	**HVAC – Direct-Vent Gas Fireplaces** Direct-vent gas fireplaces, as defined in NFPA 54, inside of all smoke compartments containing patient sleeping areas comply with the requirements of 18.5.2.3(2), 19.5.2.3(2). 18.5.2.3(2), 19.5.2.3(2), NFPA 54	○	○	◉	
K525	**HVAC – Solid Fuel-Burning Fireplaces** Solid fuel-burning fireplaces are permitted in other than patient sleeping areas provided: • Areas are separated by 1-hour fire resistance construction. • Fireplace complies with 9.2.2. • Fireplace enclosure resists breakage up to 650°F and has heat-tempered glass. • Room has supervised CO detection per 9.8. 18.5.2.3(3) and 19.5.2.3(3)	○	○	◉	
K531	**Elevators** 2012 EXISTING Elevators comply with the provision of 9.4. Elevators are inspected and tested as specified in ASME A17.1, *Safety Code for Elevators and Escalators.* Firefighter's Service is operated monthly with a written record. Existing elevators conform to ASME/ANSI A17.3, *Safety Code for Existing Elevators and Escalators.* All existing elevators, having a travel distance of 25 feet or more above or below the level that best serves the needs of emergency personnel for firefighting purposes, conform with Firefighter's Service Requirements of ASME/ANSI A17.3. (Includes firefighter's service Phase I key recall and smoke detector automatic recall, firefighter's service Phase II emergency in-car key operation, machine room smoke detectors, and elevator lobby smoke detectors.) 19.5.3, 9.4.2, 9.4.3	◉	○	○	

ID PREFIX		MET	NOT MET	N/A	REMARKS
K531	2012 NEW Elevators comply with the provision of 9.4. Elevators are inspected and tested as specified in ASME A17.1, *Safety Code for Elevators and Escalators.* Firefighter's Service is operated monthly with a written record. New elevators conform to ASME/ANSI A17.1, *Safety Code for Elevators and Escalators,* including Firefighter's Service Requirements. (Includes firefighter's Phase I key recall and smoke detector automatic recall, firefighter's service Phase II emergency in-car key operation, machine room smoke detectors, and elevator lobby smoke detectors.) 18.5.3, 9.4.2, 9.4.3	○	○	◉	
K532	**Escalators, Dumbwaiters, and Moving Walks** 2012 EXISTING Escalators, dumbwaiters, and moving walks comply with the provisions of 9.4. All existing escalators, dumbwaiters, and moving walks conform to the requirements of ASME/ANSI A17.3, *Safety Code for Existing Elevators and Escalators.* (Includes escalator emergency stop buttons and automatic skirt obstruction stop. For power dumbwaiters, includes hoistway door locking to keep doors closed except for floor where car is being loaded or unloaded.) 19.5.3, 9.4.2.2	○	○	◉	
	2012 NEW Escalators, dumbwaiters, and moving walks comply with the provisions of 9.4. 18.5.3, 9.4.2.2	○	○	◉	

ID PREFIX		MET	NOT MET	N/A	REMARKS
K541	**Rubbish Chutes, Incinerators, and Laundry Chutes** 2012 EXISTING (1) Any existing linen and trash chute, including pneumatic rubbish and linen systems, that opens directly onto any corridor shall be sealed by fire resistive construction to prevent further use or shall be provided with a fire door assembly having a fire protection rating of 1-hour. All new chutes shall comply with 9.5. (2) Any rubbish chute or linen chute, including pneumatic rubbish and linen systems, shall be provided with automatic extinguishing protection in accordance with 9.7. (3) Any trash chute shall discharge into a trash collection room used for no other purpose and protected in accordance with 8.4. (Existing laundry chutes permitted to discharge into same room are protected by automatic sprinklers in accordance with 19.3.5.9 or 19.3.5.7.) (4) Existing fuel-fed incinerators shall be sealed by fire resistive construction to prevent further use. 19.5.4, 9.5, 8.4, NFPA 82	◉	○	○	
	2012 NEW Rubbish chutes, incinerators, and laundry chutes shall comply with the provisions of Section 9.5, unless otherwise specified in 18.5.4.2. • The fire resistance rating of chute charging room shall not be required to exceed 1-hour. • Any rubbish chute or linen chute shall be provided with automatic extinguishing protection in accordance with Section 9.7. • Chutes shall discharge into a trash collection room used for no other purpose and shall be protected in accordance with 8.7. 18.5.4.2, 8.7, 9.5, 9.7, NFPA 82	○	○	◉	
	SECTION 6 – RESERVED				
	SECTION 7 – OPERATING FEATURES				
K700	**Operating Features – Other** List in the REMARKS section any LSC Section 18.7 and 19.7 Operating Features requirements that are not addressed by the provided K-tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included in Form CMS-2567.	◉	○	○	

ID PREFIX		MET	NOT MET	N/A	REMARKS
K711	**Evacuation and Relocation Plan** There is a written plan for the protection of all patients and for their evacuation in the event of an emergency. Employees are periodically instructed and kept informed with their duties under the plan, and a copy of the plan is readily available with telephone operator or with security. The plan addresses the basic response required of staff per 18/19.7.2.1.2 and provides for all of the fire safety plan components per 18/19.7.2.2. 18.7.1.1 through 18.7.1.3, 18.7.2.1.2, 18.7.2.2, 18.7.2.3, 19.7.1.1 through 19.7.1.3, 19.7.2.1.2, 19.7.2.2, 19.7.2.3	◉	○	○	
K712	**Fire Drills** Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 18.7.1.4 through 18.7.1.7, 19.7.1.4 through 19.7.1.7	◉	○	○	

ID PREFIX		MET	NOT MET	N/A	REMARKS
K741	**Smoking Regulations** Smoking regulations shall be adopted and shall include not less than the following provisions: (1) Smoking shall be prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area shall be posted with signs that read NO SMOKING or shall be posted with the international symbol for no smoking. (2) In health care occupancies where smoking is prohibited and signs are prominently placed at all major entrances, secondary signs with language that prohibits smoking shall not be required. (3) Smoking by patients classified as not responsible shall be prohibited. (4) The requirement of 18.7.4(3) shall not apply where the patient is under direct supervision. (5) Ashtrays of noncombustible material and safe design shall be provided in all areas where smoking is permitted. (6) Metal containers with self-closing cover devices into which ashtrays can be emptied shall be readily available to all areas where smoking is permitted. 18.7.4, 19.7.4	◉	○	○	
K751	**Draperies, Curtains, and Loosely Hanging Fabrics** Draperies, curtains including cubicle curtains and loosely hanging fabric or films shall be in accordance with 10.3.1. Excluding curtains and draperies: at showers and baths; on windows in patient sleeping room located in sprinklered compartments; and in non-patient sleeping rooms in sprinklered compartments where individual drapery or curtain panels do not exceed 48 square feet or total area does not exceed 20 percent of the wall. 18.7.5.1, 18.3.5.11, 19.7.5.1, 19.3.5.11, 10.3.1	◉	○	○	

ID PREFIX		MET	NOT MET	N/A	REMARKS
K752	**Upholstered Furniture and Mattresses** Newly introduced upholstered furniture meets Class I or char length, and heat release criteria in accordance with 10.3.2.1 and 10.3.3, unless the building is fully sprinklered. Newly introduced mattresses shall meet char length and heat release criteria in accordance with 10.3.2.2 and 10.3.4, unless the building is fully sprinklered. Upholstered furniture and mattresses belonging to nursing home residents do not have to meet these requirements as all nursing homes are required to be fully sprinklered. Newly introduced upholstered furniture and mattresses means purchased on or after the LSC final rule effective date. 18.7.5.2, 18.7.5.4, 19.7.5.2, 19.7.5.4	◉	○	○	
K753	**Combustible Decorations** Combustible decorations shall be prohibited unless one of the following is met: • Flame retardant or treated with approved fire-retardant coating that is listed and labeled for product. • Decorations meet NFPA 701. • Decorations exhibit heat release less than 100 kilowatts in accordance with NFPA 289. • Decorations, such as photographs, paintings and other art are attached to the walls, ceilings and non-fire-rated doors in accordance with 18.7.5.6(4) or 19.7.5.6(4). • The decorations in existing occupancies are in such limited quantities that a hazard of fire development or spread is not present. 18.7.5.6, 19.7.5.6	◉	○	○	
K761	**Maintenance, Inspection & Testing - Doors** Fire doors assemblies are inspected and tested annually in accordance with NFPA 80 *Standard for Fire Doors and Other Opening Protectives*. Fire doors that are not located in required fire barriers, including corridor doors to patient rooms and smoke barrier doors, are routinely inspected as part of the facility maintenance program. Individuals performing the door inspection and testing have an understanding of the operating components of the doors. Written records of inspection and testing are maintained and are available for review. 18.7.6, 19.7.6, 8.3.3.1 (LSC), 5.2, 5.2.3 (NFPA 80)	◉	○	○	

ID PREFIX		MET	NOT MET	N/A	REMARKS
K754	**Soiled Linen and Trash Containers** Soiled linen or trash collection receptacles shall not exceed 32 gallons in capacity. The average density of container capacity in a room or space shall not exceed 0.5 gallons/square feet. A total container capacity of 32 gallons shall not be exceeded within any 64 square feet area. Mobile soiled linen or trash collection receptacles with capacities greater than 32 gallons shall be located in a room protected as a hazardous area when not attended. Containers used solely for recycling are permitted to be excluded from the above requirements where each container is ≤ 96 gal. unless attended, and containers for combustibles are labeled and listed as meeting FM Approval Standard 6921 or equivalent. 18.7.5.7, 19.7.5.7	◉	○	○	
K771	**Engineer Smoke Control Systems** 2012 EXISTING When installed, engineered smoke control systems are tested in accordance with established engineering principles. Test documentation is maintained on the premises. 19.7.7	○	○	◉	
	2012 NEW When installed, engineered smoke control systems are tested in accordance with NFPA 92, *Standard for Smoke Control Systems*. Test documentation is maintained on the premises. 18.7.7	○	○	◉	
K781	**Portable Space Heaters** Portable space heating devices shall be prohibited in all health care occupancies. Unless used in nonsleeping staff and employee areas where the heating elements do not exceed 212 degrees Fahrenheit (100 degrees Celsius). 18.7.8, 19.7.8	○	○	◉	
K791	**Construction, Repair, and Improvement Operations** Construction, repair, and improvement operations shall comply with 4.6.10. Any means of egress in any area undergoing construction, repair, or improvements shall be inspected daily to ensure its ability to be used instantly in case of emergency and compliance with NFPA 241. 18.7.9, 19.7.9, 4.6.10, 7.1.10.1	○	○	◉	

ID PREFIX		MET	NOT MET	N/A	REMARKS
	PART II – HEALTH CARE FACILITIES CODE REQUIREMENTS				
K900	**Health Care Facilities Code - Other** List in the REMARKS section any NFPA 99 requirements (excluding Chapter 7, 8, 12, and 13) that are not addressed by the provided K-Tags, but are deficient. This information, along with the applicable Health Care Facilities Code or NFPA standard citation, should be included on Form CMS-2567.	◉	○	○	
K901	**Fundamentals – Building System Categories** Building systems are designed to meet Category 1 through 4 requirements as detailed in NFPA 99. Categories are determined by a formal and documented risk assessment procedure performed by qualified personnel. Chapter 4 (NFPA 99)	◉	○	○	
K902	**Gas and Vacuum Piped Systems – Other** List in the REMARKS section any NFPA 99 Chapter 5 Gas and Vacuum Systems requirements that are not addressed by the provided K-Tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. Chapter 5 (NFPA 99)	○	○	◉	
K903	**Gas and Vacuum Piped Systems – Categories** Medical gas, medical air, surgical vacuum, WAGD, and air supply systems are designated: ☐ Category 1. Systems in which failure is likely to cause major injury or death. ☐ Category 2. Systems in which failure is likely to cause minor injury. ☐ Category 3. Systems in which failure is not likely to cause injury, but can cause discomfort. Deep sedation and general anesthesia are not to be administered using a Category 3 medical gas system. 5.1.1.1, 5.2.1, 5.3.1.1, 5.3.1.5 (NFPA 99)	○	○	◉	
K904	**Gas and Vacuum Piped Systems – Warning Systems** All master, area, and local alarm systems used for medical gas and vacuum systems comply with appropriate Category warning system requirements, as applicable. 5.1.9, 5.2.9, 5.3.6.2.2 (NFPA 99)	○	○	◉	

ID PREFIX		MET	NOT MET	N/A	REMARKS
K905	**Gas and Vacuum Piped Systems – Central Supply System Identification and Labeling** Containers, cylinders and tanks are designed, fabricated, tested, and marked in accordance with 5.1.3.1.1 through 5.1.3.1.7. Locations containing only oxygen or medical air have doors labeled with "Medical Gases, NO Smoking or Open Flame". Locations containing other gases have doors labeled "Positive Pressure Gases, NO Smoking or Open Flame, Room May Have Insufficient Oxygen, Open Door and Allow Room to Ventilate Before Opening." 5.1.3.1, 5.2.3.1, 5.3.10 (NFPA 99)	○	○	◉	
K906	**Gas and Vacuum Piped Systems – Central Supply System Operations** Adaptors or conversion fittings are prohibited. Cylinders are handled in accordance with 11.6.2. Only cylinders, reusable shipping containers, and their accessories are stored in rooms containing central supply systems or cylinders. No flammable materials are stored with cylinders. Cryogenic liquid storage units intended to supply the facility are not used to transfill. Cylinders are kept away from sources of heat. Valve protection caps are secured in place, if supplied, unless cylinder is in use. Cylinders are not stored in tightly closed spaces. Cylinders in use and storage are prevented from exceeding 130°F, and nitrous oxide and carbon dioxide cylinders are prevented from reaching temperatures lower than manufacture recommendations or 20°F. Full or empty cylinders, when not connected, are stored in locations complying with 5.1.3.3.2 through 5.1.3.3.3, and are not stored in enclosures containing motor-driven machinery, unless for instrument air reserve headers. 5.1.3.2, 5.1.3.3.17, 5.1.3.3.1.8, 5.1.3.3.4, 5.2.3.2, 5.2.3.3, 5.3.6.20.4, 5.6.20.5, 5.3.6.20.7, 5.3.6.20.8, 5.3.6.20.9 (NFPA 99)	○	○	◉	
K907	**Gas and Vacuum Piped Systems – Maintenance Program** Medical gas, vacuum, WAGD, or support gas systems have documented maintenance programs. The program includes an inventory of all source systems, control valves, alarms, manufactured assemblies, and outlets. Inspection and maintenance schedules are established through risk assessment considering manufacturer recommendations. Inspection procedures and testing methods are established through risk assessment. Persons maintaining systems are qualified as demonstrated by training and certification or credentialing to the requirements of AASE 6030 or 6040. 5.1.14.2.1, 5.1.14.2.2, 5.1.15, 5.2.14, 5.3.13.4.2 (NFPA 99)	○	○	◉	

ID PREFIX		MET	NOT MET	N/A	REMARKS
K908	**Gas and Vacuum Piped Systems – Inspection and Testing Operations** The gas and vacuum systems are inspected and tested as part of a maintenance program and include the required elements. Records of the inspections and testing are maintained as required. 5.1.14.2.3, B.5.2, 5.2.13, 5.3.13, 5.3.13.4 (NFPA 99)	○	○	◉	
K909	**Gas and Vacuum Piped Systems – Information and Warning Signs** Piping is labeled by stencil or adhesive markers identifying the gas or vacuum system, including the name of system or chemical symbol, color code (Table 5.1.11), and operating pressure if other than standard. Labels are at intervals not more than 20 feet, are in every room, at both sides of wall penetrations, and on every story traversed by riser. Piping is not painted. Shutoff valves are identified with the name or chemical symbol of the gas or vacuum system, room or area served, and caution to not use the valve except in emergency. 5.1.14.3, 5.1.11.1, 5.1.11.2, 5.2.11, 5.3.13.3, 5.3.11 (NFPA 99)	○	○	◉	
K910	**Gas and Vacuum Piped Systems – Modifications** Whenever modifications are made that breach the pipeline, any necessary installer and verification test specified in 5.1.2 is conducted on the downstream portion of the medical gas piping system. Permanent records of all tests required by system verification tests are maintained. 5.1.14.4.1, 5.1.14.4.6, 5.2.13, 5.3.13.4.3 (NFPA 99)	○	○	◉	
K911	**Electrical Systems – Other** List in the REMARKS section any NFPA 99 Chapter 6 Electrical Systems requirements that are not addressed by the provided K-Tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. Chapter 6 (NFPA 99)	◉	○	○	
K912	**Electrical Systems – Receptacles** Power receptacles have at least one, separate, highly dependable grounding pole capable of maintaining low-contact resistance with its mating plug. In pediatric locations, receptacles in patient rooms, bathrooms, play rooms, and activity rooms, other than nurseries, are listed tamper-resistant or employ a listed cover. If used in patient care room, ground-fault circuit interrupters (GFCI) are listed. 6.3.2.2.6.2 (F), 6.3.2.2.4.2 (NFPA 99)	◉	○	○	

ID PREFIX		MET	NOT MET	N/A	REMARKS
K913	**Electrical Systems – Wet Procedure Locations** Operating rooms are considered wet procedure locations, unless otherwise determined by a risk assessment conducted by the facility governing body. Operating rooms defined as wet locations are protected by either isolated power or ground-fault circuit interrupters. A written record of the risk assessment is maintained and available for inspection. 6.3.2.2.8.4, 6.3.2.2.8.7, 6.4.4.2	○	○	◉	
K914	**Electrical Systems – Maintenance and Testing** Hospital-grade receptacles at patient bed locations and where deep sedation or general anesthesia is administered, are tested after initial installation, replacement or servicing. Additional testing is performed at intervals defined by documented performance data. Receptacles not listed as hospital-grade at these locations are tested at intervals not exceeding 12 months. Line isolation monitors (LIM), if installed, are tested at intervals of ≤ 1 month by actuating the LIM test switch per 6.3.2.6.3.6, which activates both visual and audible alarm. For LIM circuits with automated self-testing, this manual test is performed at intervals ≤ 12 months. LIM circuits are tested per 6.3.3.3.2 after any repair or renovation to the electric distribution system. Records are maintained of required tests and associated repairs or modifications, containing date, room or area tested, and results. 6.3.4 (NFPA 99)	◉	○	○	
K915	**Electrical Systems – Essential Electric System Categories** ○ Critical care rooms (Category 1) in which electrical system failure is likely to cause major injury or death of patients, including all rooms where electric life support equipment is required, are served by a Type 1 EES. ◉ General care rooms (Category 2) in which electrical system failure is likely to cause minor injury to patients (Category 2) are served by a Type 1 or Type 2 EES. ○ Basic care rooms (Category 3) in which electrical system failure is not likely to cause injury to patients and rooms other than patient care rooms are not required to be served by an EES. Type 3 EES life safety branch has an alternate source of power that will be effective for 1 1/2 hours. 3.3.138, 6.3.2.2.10, 6.6.2.2.2, 6.6.3.1.1 (NFPA 99), TIA 12-3	◉	○	○	

ID PREFIX		MET	NOT MET	N/A	REMARKS
K916	**Electrical Systems – Essential Electric System Alarm Annunciator** A remote annunciator that is storage battery powered is provided to operate outside of the generating room in a location readily observed by operating personnel. The annunciator is hard-wired to indicate alarm conditions of the emergency power source. A centralized computer system (e.g., building information system) is not to be substituted for the alarm annunciator. 6.4.1.1.17, 6.4.1.1.17.5 (NFPA 99)	◉	○	○	
K917	**Electrical Systems – Essential Electric System Receptacles** Electrical receptacles or cover plates supplied from the life safety and critical branches have a distinctive color or marking. 6.4.2.2.6, 6.5.2.2.4.2, 6.6.2.2.3.2 (NFPA 99)	◉	○	○	
K918	**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)	◉	○	○	

ID PREFIX		MET	NOT MET	N/A	REMARKS
K919	**Electrical Equipment – Other** List in the REMARKS section any NFPA 99 Chapter 10, *Electrical Equipment*, requirements that are not addressed by the provided K-Tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. Chapter 10 (NFPA 99)	◉	○	○	
K920	**Electrical Equipment – Power Cords and Extension Cords** Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5	◉	○	○	

ID PREFIX		MET	NOT MET	N/A	REMARKS
K921	**Electrical Equipment – Testing and Maintenance Requirements** The physical integrity, resistance, leakage current, and touch current tests for fixed and portable patient-care related electrical equipment (PCREE) is performed as required in 10.3. Testing intervals are established with policies and protocols. All PCREE used in patient care rooms is tested in accordance with 10.3.5.4 or 10.3.6 before being put into service and after any repair or modification. Any system consisting of several electrical appliances demonstrates compliance with NFPA 99 as a complete system. Service manuals, instructions, and procedures provided by the manufacturer include information as required by 10.5.3.1.1 and are considered in the development of a program for electrical equipment maintenance. Electrical equipment instructions and maintenance manuals are readily available, and safety labels and condensed operating instructions on the appliance are legible. A record of electrical equipment tests, repairs, and modifications is maintained for a period of time to demonstrate compliance in accordance with the facility's policy. Personnel responsible for the testing, maintenance and use of electrical appliances receive continuing training. 10.3, 10.5.2.1, 10.5.2.1.2, 10.5.2.5, 10.5.3, 10.5.6, 10.5.8	◉	○	○	
K922	**Gas Equipment – Other** List in the REMARKS section any NFPA 99 Chapter 11 Gas Equipment requirements that are not addressed by the provided K-Tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. Chapter 11 (NFPA 99)	◉	○	○	

ID PREFIX		MET	NOT MET	N/A	REMARKS
K923	**Gas Equipment – Cylinder and Container Storage** **≥ 3,000 cubic feet** Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. **> 300 but <3,000 cubic feet** Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited- combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating. **≤ 300 cubic feet** In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of ≤ 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING". Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99)	◉	○	○	
K924	**Gas Equipment – Testing and Maintenance Requirements** Anesthesia apparatus are tested at the final path to patient after any adjustment, modification or repair. Before the apparatus is returned to service, each connection is checked to verify proper gas and an oxygen analyzer is used to verify oxygen concentration. Defective equipment is immediately removed from service. Areas designated for servicing of oxygen equipment are clean and free of oil, grease, or other flammables. Manufacturer service manuals are used to maintain equipment and a scheduled maintenance program is followed. 11.4.1.3, 11.5.1.3, 11.6.2.5, 11.6.2.6 (NFPA 99)	○	○	◉	

ID PREFIX		MET	NOT MET	N/A	REMARKS
K925	**Gas Equipment – Respiratory Therapy Sources of Ignition** Smoking materials are removed from patients receiving respiratory therapy. When a nasal cannula is delivering oxygen outside of a patient's room, no sources of ignition are within in the site of intentional expulsion (1-foot). When other oxygen deliver equipment is used or oxygen is delivered inside a patient's room, no sources of ignition are within the area are of administration (15-feet). Solid fuel-burning appliances is not in the area of administration. Nonmedical appliances with hot surfaces or sparking mechanisms are not within oxygen-delivery equipment or site of intentional expulsion. 11.5.1.1, TIA 12-6 (NFPA 99)	◉	○	○	
K926	**Gas Equipment – Qualifications and Training of Personnel** Personnel concerned with the application, maintenance and handling of medical gases and cylinders are trained on the risk. Facilities provide continuing education, including safety guidelines and usage requirements. Equipment is serviced only by personnel trained in the maintenance and operation of equipment. 11.5.2.1 (NFPA 99)	◉	○	○	
K927	**Gas Equipment – Transfilling Cylinders** Transfilling of oxygen from one cylinder to another is in accordance with CGA P-2.5, *Transfilling of High Pressure Gaseous Oxygen Used for Respiration*. Transfilling of any gas from one cylinder to another is prohibited in patient care rooms. Transfilling to liquid oxygen containers or to portable containers over 50 psi comply with conditions under 11.5.2.3.1 (NFPA 99). Transfilling to liquid oxygen containers or to portable containers under 50 psi comply with conditions under 11.5.2.3.2 (NFPA 99). 11.5.2.2 (NFPA 99)	◉	○	○	

ID PREFIX		MET	NOT MET	N/A	REMARKS
K928	**Gas Equipment – Labeling Equipment and Cylinders** Equipment listed for use in oxygen-enriched atmospheres are so labeled. Oxygen metering equipment and pressure reducing regulators are labeled "OXYGEN-USE NO OIL". Flowmeters, pressure reducing regulators, and oxygen-dispensing apparatus are clearly and permanently labeled designating the gases for which they are intended. Oxygen-metering equipment, pressure reducing regulators, humidifiers, and nebulizers are labeled with name of manufacturer or supplier. Cylinders and containers are labeled in accordance with CGA C-7. Color coding is not utilized as the primary method of determining cylinder or container contents. All labeling is durable and withstands cleaning or disinfecting. 11.5.3.1 (NFPA 99)	◉	○	○	
K929	**Gas Equipment – Precautions for Handling Oxygen Cylinders and Manifolds** Handling of oxygen cylinders and manifolds is based on CGA G-4, Oxygen. Oxygen cylinders, containers, and associated equipment are protected from contact with oil and grease, from contamination, protected from damage, and handled with care in accordance with precautions provided under 11.6.2.1 through 11.6.2.4 (NFPA 99). 11.6.2 (NFPA 99)	◉	○	○	
K930	**Gas Equipment – Liquid Oxygen Equipment** The storage and use of liquid oxygen in base reservoir containers and portable containers comply with sections 11.7.2 through 11.7.4 (NFPA 99). 11.7 (NFPA 99)	◉	○	○	
K931	**Hyperbaric Facilities** All occupancies containing hyperbaric facilities comply with construction, equipment, administration, and maintenance requirements of NFPA 99. Chapter 14 (NFPA 99)	○	○	◉	
K932	**Features of Fire Protection – Other** List in the REMARKS section any NFPA 99 Chapter 15 Features of Fire Protection requirements that are not addressed by the provided K-Tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. Chapter 15 (NFPA 99)	◉	○	○	

ID PREFIX		MET	NOT MET	N/A	REMARKS
K933	**Features of Fire Protection – Fire Loss Prevention in Operating Rooms** Periodic evaluations are made of hazards that could be encountered during surgical procedures, and fire prevention procedures are established. When flammable germicides or antiseptics are employed during surgeries utilizing electrosurgery, cautery or lasers: • packaging is non-flammable. • applicators are in unit doses. • Preoperative "time-out" is conducted prior the initiation of any surgical procedure to verify: o application site is dry prior to draping and use of surgical equipment. o pooling of solution has not occurred or has been corrected. o solution-soaked materials have been removed from the OR prior to draping and use of surgical devices. o policies and procedures are established outlining safety precautions related to the use of flammable germicide or antiseptic use. Procedures are established for operating room emergencies including alarm activation, evacuation, equipment shutdown, and control operations. Emergency procedures include the control of chemical spills, and extinguishment of drapery, clothing and equipment fires. Training is provided to new OR personnel (including surgeons), continuing education is provided, incidents are reviewed monthly, and procedures are reviewed annually. 15.13 (NFPA 99)	○	○	◉	

PART III – RECOMMENDATION FOR WAIVER OF SPECIFIC LIFE SAFETY CODE PROVISIONS

For each item of the Life Safety Code recommended for waiver, list the survey report form item number and state the reason for the conclusion that: (a) the specific provisions of the code, if rigidly applied, would result in unreasonable hardship on the facility, and (b) the waiver of such unmet provisions will not adversely affect the health and safety of the patients. If additional space is required, attach additional sheet(s).

PROVISION NUMBER(S)	JUSTIFICATION
K400	

Surveyor *(Signature)*	Title	Office	Date
Fire Authority Official *(Signature)*	Title	Office	Date

PART IV - FIRE SAFETY SURVEY REPORT
CRUCIAL DATA EXTRACT
(TO BE USED WITH CMS 2786 FORMS)

Provider Number	Facility Name	Survey Date
K1		*K4

K6 DATE OF PLAN APPROVAL

K3 MULTIPLE CONSTRUCTION ☐

TOTAL NUMBER OF BUILDINGS _____

NUMBER OF THIS BUILDING _____

A. BUILDING
B. WING
C. FLOOR
D. APARTMENT UNIT

LSC FORM INDICATOR

HEALTH CARE FORM		
12	2786R	2012 EXISTING
13	2786R	2012 NEW

AHCO FORM		
14	2786U	2012 EXISTING
15	2786U	2012 NEW

ICF/IID FORM		
16	2786V, W, X	2012 EXISTING
17	2786V, W, X	2012 NEW

*K7 ☐ SELECT NUMBER OF FORM USED FROM ABOVE

COMPLETE IF ICF/IID IS SURVEYED UNDER CHAPTER 33, EXISTING

SMALL (16 BEDS OR LESS)

K8 ☐
1. PROMPT
2. SLOW
3. IMPRACTICAL

LARGE

K8 ☐
4. PROMPT
5. SLOW
6. IMPRACTICAL

APARTMENT HOUSE

K8 ☐
7. PROMPT
8. SLOW
9. IMPRACTICAL

(Check if K321 or K351 are marked as not applicable in the 2786 M, R, T, U, V, W, X, and Y.)

K321: ☐ K351: ☐

COMPLETE IF ICF/IID IS SURVEYED UNDER CHAPTER 33, EXISTING

ENTER E – SCORE

K5: ☐ e.g. 2.5

*K9 FACILITY MEETS LSC BASED ON *(Check all that Apply)*

A1. ☐	A2. ☐	A3. ☐	A4. ☐	A5. ☐
(COMP. WITH ALL PROVISIONS)	(ACCEPTABLE POC)	(WAIVERS)	(FSES)	(PERFORMANCE BASED DESIGN)

FACILITY DOES NOT MEET LSC

B. ☐

K0180

A. ☐	B. ☐	C. ☐
FULLY SPRINKLERED (All required areas are sprinklered)	PARTIALLY SPRINKLERED (Not all required areas are sprinklered)	NONE (No sprinkler system)

*MANDATORY