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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: 8SC0

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00578N

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245616**
2.STATE VENDOR OR MEDICAID NO.
(L2) **850026600**

3. NAME AND ADDRESS OF FACILITY
(L3) **LIFECARE GREENBUSH MANOR**
(L4) **19120 200TH STREET**
(L5) **GREENBUSH, MN** (L6) **56726**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **10/30/2013** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY **03** (L7)

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

12.Total Facility Beds **40** (L18)

13.Total Certified Beds **40** (L17)

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

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

B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: **A*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	20	20		
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

See Attached Remarks

17. SURVEYOR SIGNATURE — Date :
Lyla Burkman, Unit Supervisor — 01/22/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Shellae Dietrich, Program Specialist — 02/07/2014 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
04/13/2009
(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
09/18/2013
(L33)

DETERMINATION APPROVAL

C&T REMARKS - CMS 1539 FORM STATE AGENCY REMARKS

CCN: 24-5616

A standard OTC survey was completed at this facility on July 26, 2013. The most serious deficiencies were cited at a S/S level of D.

In addition, on August 13, 2013, a Life Safety Code FMS was completed and deficiencies were found, the most serious at a S/S level of F. On August 30, 2013, CMS RO notified the facility of the following:

- Mandatory Denial of Payment for New Medicare and Medicaid admissions effective October 26, 2013.
- A Loss of NATCEP for a two year period beginning October 26, 2013 if DOPNA were to go into effect.

A PCR of the health deficiencies was completed by review of the plan of correction on September 10, 2013. A PCR of the FMS deficiencies was completed October 30, 2013. As a result, we recommended the following action to the CMS RO and CMS concurred:

- Mandatory Denial of Payment for New Medicare and Medicaid admissions effective October 26, 2013 be rescinded. This would also mean that the facility would not be subject to a loss of NATCEP.

See attached CMS-2567B from these revisits and the Fire Safety Evaluation System (FSES) results.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

CCN 24-5616

February 7, 2014

Ms. Susan Lisell, Administrator
Lifecare Greenbush Manor
19120 200th Street
Greenbush, Minnesota 56726

Dear Ms. Lisell:

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

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

Effective October 20, 2013 the above facility is certified for:

20 Skilled Nursing Facility/Nursing Facility Beds

20 Nursing Facility I Beds

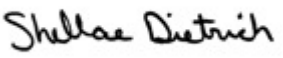
Your facility's Medicare approved area consists of all 20 skilled nursing facility beds.

You should advise our office of any changes in staffing, services, or organization, which might affect your certification status.

If, at the time of your next survey, we find your facility to not be in substantial compliance your Medicare and Medicaid provider agreement may be subject to non-renewal or termination.

Please contact me if you have any questions.

Sincerely,



Shellae Dietrich, Program Specialist
Program Assurance Unit
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
P.O. Box 64900
St. Paul, MN 55164-0900
Telephone #: (651) 201-4106 Fax #: (651) 215-9697

cc: Licensing and Certification File

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

January 22, 2014

Ms. Susan Lisell, Administrator
Lifecare Greenbush Manor
19120 200th Street
Greenbush, Minnesota 56726

RE: Project Number S5616005 and F5616007

Dear Ms. Lisell:

On August 13, 2013, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on July 26 , 2013. This survey found the most serious deficiencies to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D), whereby corrections were required.

In addition, on August 13, 2013, A surveyor representing the Region V Office of the Centers for Medicare and Medicaid Services (CMS) completed a Life Safety Code (LSC) Federal Monitoring Survey (FMS) of your facility. As you were informed during the exit conference the FMS revealed that your facility continues to not be in substantial compliance. The most serious deficiencies in your facility were found to be widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), whereby corrections were required.

On August 30, 2013, CMS forwarded the results of the FMS to you and informed you that the following enforcement remedy was being imposed:

- Mandatory denial of payment for new Medicare and Medicaid admissions effective October 26, 2013 (42 CFR 488.417(b))

On September 10, 2013, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on October 30, 2013 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on July 26, 2013 and an FMS completed on August 13, 2013. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of October 20, 2013. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on July 26, 2013 and the FMS completed on August 13, 2013, effective October 20, 2013.

As a result of the PCR findings, this Department recommended to the Region V Office of CMS the following actions related to the remedies in their letter of September 12, 2013. CMS concurs and has authorized this Department to notify you of these actions:

- Mandatory denial of payment for new Medicare and Medicaid admissions effective October 26, 2013 is rescinded. (42 CFR 488.417(b))

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

Enclosed is a copy of the Post Certification Revisit Form, (CMS-2567B) from this visit.

Feel free to contact me if you have questions related to this letter.

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Division of Compliance Monitoring
P.O. Box 64900
St. Paul, Minnesota 55164-0900
Telephone: (651) 201-4118 Fax: (651) 215-9697
Email: mark.meath@state.mn.us
Enclosure

cc: Licensing and Certification File 5616r14.rtf

Post-Certification Revisit Report

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D.C. 20503.

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245616	A. Building B. Wing	9/10/2013

Name of Facility	Street Address, City, State, Zip Code
LIFECARE GREENBUSH MANOR	19120 200TH STREET GREENBUSH, MN 56726

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/ or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **F0282** Reg. # **483.20(k)(3)(ii)** LSC	Correction Completed **08/26/2013**	ID Prefix **F0311** Reg. # **483.25(a)(2)** LSC	Correction Completed **08/26/2013**	ID Prefix **F0314** Reg. # **483.25(c)** LSC	Correction Completed **08/26/2013**
ID Prefix **F0371** Reg. # **483.35(i)** LSC	Correction Completed **08/26/2013**	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	MM/LB	01/22/2014	28035	10/30/2013
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
7/26/2013			

Post-Certification Revisit Report

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D.C. 20503.

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245616	A. Building B. Wing **02 - GREENBUSH MANOR**	10/30/2013

Name of Facility	Street Address, City, State, Zip Code
LIFECARE GREENBUSH MANOR	19120 200TH STREET GREENBUSH, MN 56726

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/ or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix	Correction Completed **08/29/2013**	ID Prefix	Correction Completed **10/01/2013**	ID Prefix	Correction Completed **09/04/2013**
Reg. # **NFPA 101** LSC K0011		Reg. # **NFPA 101** LSC K0020		Reg. # **NFPA 101** LSC K0022	
ID Prefix	Correction Completed **10/23/2013**	ID Prefix	Correction Completed **09/04/2013**	ID Prefix	Correction Completed **08/21/2013**
Reg. # **NFPA 101** LSC K0025		Reg. # **NFPA 101** LSC K0038		Reg. # **NFPA 101** LSC K0050	
ID Prefix	Correction Completed **10/20/2013**	ID Prefix	Correction Completed **10/10/2013**	ID Prefix	Correction Completed **10/20/2013**
Reg. # **NFPA 101** LSC K0051		Reg. # **NFPA 101** LSC K0062		Reg. # **NFPA 101** LSC K0066	
ID Prefix	Correction Completed **09/30/2013**	ID Prefix	Correction Completed **08/22/2013**	ID Prefix	Correction Completed **09/16/2013**
Reg. # **NFPA 101** LSC K0070		Reg. # **NFPA 101** LSC K0074		Reg. # **NFPA 101** LSC K0144	
ID Prefix	Correction Completed **09/03/2013**	ID Prefix	Correction Completed	ID Prefix	Correction Completed
Reg. # **NFPA 101** LSC K0147		Reg. # LSC		Reg. # LSC	

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	MM/PS	01/22/2014	03006	10/30/2013
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on: 8/21/2013

Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? YES NO

Loveland, Jim (MDH)

From:	Suzuki, Jan M. (CMS/CQISCO) <Jan.Suzuki@cms.hhs.gov>
Sent:	Friday, October 18, 2013 12:04 PM
To:	Loveland, Jim (MDH)
Cc:	Absolon, Mary (MDH); Kerssen, Pam (MDH); King, Maria (MDH)
Subject:	Acceptable POC for Lifecare Greenbush Manor, #245616
Attachments:	Scanned_document_18-10-2013_12-43-00.pdf; Scanned_document_18-10-2013_12-39-18.pdf; Scanned_document_18-10-2013_12-50-22.pdf

Please see the attachments for acceptable POC for the LSC FMS deficiencies. (Sorry about the attachments, the scanner kept skipping pages.) K25 resolved by FSES with corrections to be done by 10/23/13.
Please conduct a revisit per CMS policy.

Thanks,

Jan Suzuki
Principal Program Representative
Centers for Medicare & Medicaid Services
RO V, Chicago
Midwest Division of Survey and Certification
LTC Certification and Enforcement Branch
(P) 312-886-5209
(F) 443-380-6602
jan.suzuki@cms.hhs.gov

INFORMATION NOT RELEASABLE TO THE PUBLIC UNLESS AUTHORIZED BY LAW: This information has not been publicly disclosed and may be privileged and confidential. It is for internal government use only and must not be disseminated, distributed, or copied to persons not authorized to receive the information. Unauthorized disclosure may result in prosecution to the full extent of the law. If you receive email that is deemed inappropriate, defaces the federal government or offensive in any way, please report it immediately to 312.886.6432.

RECEIVED
OCT 17 2013
CMS-V-DS&C

LifeCare
MEDICAL CENTER
caring for generations

10/07/13

Enclosed is the Plan of Correction with revisions and FSES report for LifeCare Greenbush Manor.

Sue Lisell
Administrator

LifeCare
GREENBUSH MANOR

19120 200th Street, Greenbush, Minnesota 56726
Telephone: (218) 782-2131 Fax: (218) 463-4005
www.lifecaremedicalcenter.org

FAX to: Number of Pages: 53

CCN: 245616 DPNA Date: 10/26/2013

Name: Lifecare Greenbush Manor Termination Date: 01/26/2014

City, State: Greenbush, MN

FMS Survey Date: 08/21/2013

Fed Surveyor: BWW

Contr Surveyor:

S/S	Tag	POC Date or Temporary Waiver ("TW") Date or Waiver ("AW")
E	K11	POC 8/29/13
B	K20	POC 10/1/13
E	K22	POC 9/4/13
F	K25	**FSES with corrections to be done by 10/23/13**
E	K38	POC 9/4/13
C	K50	POC 8/21/13
F	K51	POC 10/20/13
F	K62	POC 10/10/13
F	K66	POC 10/20/13
F	K70	POC 9/30/13
D	K74	POC 8/22/13
F	K144	POC 9/16/13
D	K147	POC 9/3/13
		Bruce W. Wexelberg

Approved: YES By: Bruce W. Wexelberg Date: 10/18/2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245616	A. BUILDING 02 - GREENBUSH MANOR B. WING	08/21/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFECARE GREENBUSH MANOR	19120 200TH STREET GREENBUSH, MN 56726

(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 A Life Safety Code Comparative Federal Monitoring Survey was conducted by the Centers for Medicare & Medicaid Services (CMS) on 8/21/13 following a Minnesota Department of Health survey on 7/24/13. At this Comparative Federal Monitoring Survey, Lifecare Greenbush Manor was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR Subpart 483.70(a), Life Safety from Fire, and the related National Fire Protection Association (NFPA) standard 101 - 2000 edition. Lifecare Greenbush Manor is a one story building with four mechanical mezzanines located in the attic space that was constructed in 2010. The building is fully sprinklered and there is supervised smoke detection in the corridors, spaces open to the corridors and resident rooms. The facility has 40 certified beds. All 40 beds are dually certified for Medicare and Medicaid. At the time of the survey the census was 40. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000	RECEIVED SEP 17 2013 CMS-V-DS&C	
K 011 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD 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. 18.1.1.4.1, 18.1.1.4.2	K 011	Adjustments were made to the door closure and the brushes that cover the gap between the two doors in the E126 hallway. The work was completed by the maintenance staff of Greenbush Manor 8/29/13. The doors will be inspected on quarterly safety rounds by Brett Dallager, Maintenance Supervisor.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Susan C. Kissell — TITLE: Administrator — (X6) DATE: 9-12-13

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245616	A. BUILDING 02 - GREENBUSH MANOR B. WING _____	08/21/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFECARE GREENBUSH MANOR	19120 200TH STREET GREENBUSH, MN 56726

(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 011	Continued From page 1 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to maintain a two-hour fire rated separation between the skilled nursing unit and the non-long term care hospital facility in accordance with NFPA 101 - 2000 edition, sections 18.1.1.4.4, 8.2.2.2, 8.2.3.1 and 8.2.3.2.3. This deficient practice could affect approximately 20 of the 40 residents. Findings include: On 8/21/13 at 3:07pm, observation revealed that the 90-minute rated cross-corridor doors in the two hour rated building separation wall in the E126 Hall did not close completely three out of three times when tested by the surveyor. This deficient practice was confirmed by the Maintenance Supervisor at the time of discovery.	K 011		
K 020 SS=B	NFPA 101 LIFE SAFETY CODE STANDARD 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 two hours connecting four stories or more. (One hour for single story building and sprinklered buildings up to three stories in height.) 18.3.1.1. An atrium may be used in accordance with 8.2.2.3.5. This STANDARD is not met as evidenced by:	K 020	60-minute rated door ordered to replace 20-minute rated door. 60-minute door received and installed October 1, 2013 by maintenance staff.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245616	A. BUILDING 02 - GREENBUSH MANOR B. WING _____	08/21/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFECARE GREENBUSH MANOR	19120 200TH STREET GREENBUSH, MN 56726

(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 020	Continued From page 2 Based on observation and interview the facility failed to maintain vertical opening protection as required by NFPA 101 - 2000 edition, section 18.3.1, 18.3.1.1, 8.2.3, 8.2.3.2.3.1 and 8.2.5, as well as NFPA 90A - 1999 section 3-4.7. This deficient practice could affect approximately 20 of the 40 residents. Finding include: On 8/21/13 at 3:16pm, observation revealed that the door to the stair to the mechanical mezzanine by the public men's rest room had a 20-minute rated door and not a 60-minute rated door. This deficient practice was confirmed by the Maintenance Supervisor at the time of discovery.	K 020		
K 022 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Access to exits is marked by approved, readily visible signs in all cases where the exit or way to reach exit is not readily apparent to the occupants. 7.10.1.4 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to provide adequate marking of means of egress in accordance with the requirements of NFPA 101 - 2000 edition, Section 18.2.10.1, 7.10 and 7.10.8.1. This deficient practice could affect approximately 20 of the 40 residents.	K 022	Signs were placed on the doors to the Center Courtyard that state, "This Is Not An Exit" by Brett Dallager, Maintenance Supervisor, on 9/04/13. The signs will be checked on the quarterly safety rounds by Brett Dallager, Safety Officer.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245616	A. BUILDING **02 - GREENBUSH MANOR** B. WING _____	**08/21/2013**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFECARE GREENBUSH MANOR	**19120 200TH STREET GREENBUSH, MN 56726**

(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 022	Continued From page 3 Findings include: 1. On 8/21/13 at 2:15pm, observation revealed that the exterior door, by room B141, to the enclosed courtyard was not an exit or a way to an exit. The door could be confused with an exit and the door did not have a "NO Exit" sign. 2. On 8/21/13 at 2:35pm, observation revealed that the exterior door, by room A136, to the enclosed courtyard was not an exit or a way to an exit. The door could be confused with an exit and the door did not have a "NO Exit" sign. 3. On 8/21/13 at 3:45pm, observation revealed that the exterior door, by the coffee shop, to the enclosed courtyard was not an exit or a way to an exit. The door could be confused with an exit and the door did not have a "NO Exit" sign. These deficient practices were confirmed by the Director of Facilities and the Maintenance Supervisor at the time of discovery.	K 022		
K 025 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers are constructed to provide at least a one-hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels in approved frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 18.3.7.3, 18.3.7.5, 18.1.6.3	K 025		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245616	A. BUILDING 02 - GREENBUSH MANOR B. WING _____	08/21/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 025	Continued From page 4 This STANDARD is not met as evidenced by: Based on record review, observation and interview, the facility failed to maintain smoke barrier walls in accordance with the requirements of NFPA 101 - 2000 edition, Sections 18.3.7, 18.3.7.1, 18.3.7.3, 8.3.2 and 8.3.6. This deficient practice could affect all 40 residents. Findings include: 1. On 8/21/13 at 1:47pm, review of the building plans titled "Code" showed the locations of the smoke barriers on the first floor. Building plans sheet A127 showed the locations of the walls in the attic space. Sheet A127 showed the walls around the mechanical rooms but did not show that the smoke barrier walls continued through the attic space to the underside of the roof deck. An interview with the Maintenance Supervisor at the time of the plan observation revealed that he was not aware if the smoke barrier walls continued through the attic space. When asked if the smoke barrier walls continue through the attic space the Maintenance Supervisor replied, "I don't know." Access to the attic space was limited and the attic space where the smoke barrier walls should be located was not accessible. 2. On 8/21/13 at 2:00pm, observation revealed that above the ceiling at the smoke barrier by the entrance to the Rosewood unit there were penetrations of a bundle of 10-20 cables and a flexible metal conduit that were not properly firestopped.	K 025	An Informal Dispute Resolution (IDR) was requested 9/12/13. The IDR was unsuccessful. A consultant certified in the Fire Safety Evaluation System (FSES) completed a survey 10/01/13. The facility did not pass the category People Movement Safety. However, with the installation of additional smoke detection in Rooms A120, B120, and B137 the facility would achieve a passing score of the FSES. Note location on enclosed floor plans. See enclosed completed FSES survey report. Completion of installation of the three aforementioned sensors will be done by October 23. Brett Dallager, Maintenance Supervisor, will be responsible for maintaining the on-going compliance with the conditions necessary to maintain a passing FSES score.	

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	245616	A. BUILDING 02 - GREENBUSH MANOR B. WING _____	08/21/2013

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K 025	Continued From page 5 3. On 8/21/13 at 2:04pm, observation revealed that above the ceiling at the smoke barrier in the soiled utility room A129 there were penetrations of a copper pipe and three insulated pipes that were not properly firestopped. 4. On 8/21/13 at 2:05pm, observation revealed that above the ceiling at the smoke barrier at the entrance to room A129 there was a 10" by 17" opening in the smoke barrier wall. 5. On 8/21/13 at 3:00pm, observation revealed that above the ceiling at the smoke barrier by room 133 there were penetrations of five conduits that had open ends that were not properly firestopped. These deficient practices were confirmed by the Director of Facilities and the Maintenance Supervisor at the time of discovery.	K 025	2. Firestop was installed on all penetrations above the Rosewood entrance by Brett Dallager, Maintenance Supervisor, on 8/28/13. 3. Penetrations will be covered with the proper firestop by 10/01/13 by Brett Dallager, Maintenance Supervisor. 4. The 10"x17" opening above A129 was covered up with sheetrock and plaster by the Greenbush Manor Maintenance Dept. on 9/04/13. Brett Dallager, Maintenance Supervisor, oversaw the completion. 5. The penetrations will be covered with the proper firestop by 10/01/13 by Brett Dallager, Maintenance Supervisor.	
K 038 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 18.2.1 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to provide exit access doors and exit discharge paths in the means of egress in accordance with the requirements of NFPA 101 - 2000 edition, Sections 18.2.1, 18.2.2, 18.2.2.2.3, 18.2.2.2.4, 3.3.121, 7.1.10, 7.2.1.6, 7.2.1.6.1, 7.7 and 7.7.1. This deficient practice could affect	K 038	The code for the front entrance was posted in reverse at the keypad by Brett Dallager, Maintenance Supervisor, on 9/04/13. The codes to all exit doors will be inspected on quarterly safety rounds by Brett Dallager, Maintenance Supervisor/Safety Officer.	

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245616	A. BUILDING 02 - GREENBUSH MANOR B. WING _____	08/21/2013

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K 038	Continued From page 6 approximately 15 of the 40 residents. Findings include: On 8/21/13 at 1:21pm, observation revealed that the exit door at the main entrance had magnetic locks on the door. An interview with the Maintenance Supervisor at the time of observation revealed that the doors were locked part of the day. The Maintenance Supervisor stated, "The doors are locked with the magnetic locks at 10:00pm." When asked how a person would exit the doors when the magnetic lock was on the Maintenance Supervisor said that "You can exit the door by entering a code in the keypad that is adjacent to the door." The code to exit the door was not posted at the key pad and the facility did not have an effective means to educate all occupants of the building, who did not have a clinical need to be locked in, what the code was to exit the door.	K 038		
K 050 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD Fire drills are held at 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. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 18.7.1.2 This STANDARD is not met as evidenced by: Based on record review and interview, the facility	K 050	Fire drills will be conducted at more various times of the day by the Safety Officer, Brett Dallager. Date implemented 8/21/13	

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	245616	A. BUILDING 02 - GREENBUSH MANOR B. WING _____	08/21/2013

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K 050	Continued From page 7 failed to conduct fire drills in accordance with the requirements of NFPA 101 - 2000 edition, Section 18.7.1.2. This deficient practice could affect all 40 residents. Findings included: On 8/21/13 at 10:58am, review of the documents titled "Fire Drill Report" for the last 12 months revealed that the fire drills were not conducted at varied times. Three of four fire drills on the first shift were conducted between 10:10am and 10:46am. Three of four fire dills on the third shift were conducted between 11:10pm and 11:30pm. This deficient practice was confirmed by the Maintenance Supervisor at the time of discovery.	K 050		
K 051 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system with approved components, devices or equipment is installed according to NFPA 72, to provide effective warning of fire in any part of the building. Activation of the complete fire alarm system is by manual fire alarm initiation, automatic detection, or extinguishing system operation. Pull stations are located in the path of egress. Electronic or written records of tests are available. A reliable second source of power is provided. Fire alarm systems are maintained in accordance with NFPA 72, National Fire Alarm Code, and records of maintenance are kept readily available. There is remote annunciation of the fire alarm system to an approved central station. 18.3.4, 9.6	K 051	The said smoke detectors will be moved 36" away from ventilation or exhaust vents by 10/20/13 by the maintenance staff of Greenbush Manor and Brett Dallager, Maintenance Supervisor.	

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	245616	A. BUILDING **02 - GREENBUSH MANOR** B. WING _____	**08/21/2013**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 051	Continued From page 8 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to install the fire alarm system in accordance with the requirements of NFPA 101 - 2000 edition, Sections 18.3.4 and 9.6 and NFPA 72 - 1999 edition, Sections 1-5.5.6.1 and 2-3.5.1. This deficient practice could affect all 40 residents. Findings include: 1. On 8/21/13 at 1:19pm, observation revealed that the smoke detector located in the main lobby was installed within the airflow of the adjacent air supply outlet. 2. On 8/21/13 at 1:20pm, observation revealed that the smoke detector located in conference room C118 was installed within the airflow of the adjacent air supply outlet. 3. On 8/21/13 at 1:24pm, observation revealed that the smoke detector located in the reception area copy room was installed within the airflow of the adjacent air supply outlet. 4. On 8/21/13 at 1:30pm, observation revealed that the smoke detector located in the medical records room C107 was installed within the airflow of the adjacent air supply outlet. 5. On 8/21/13 at 1:59pm, observation revealed that the smoke detector located in the corridor by the entry to the Rosewood unit was installed within the airflow of the adjacent air supply outlet. 6. On 8/21/13 at 2:11pm, observation revealed that the smoke detector located in the Beauty/Barber shop room B138 was installed	K 051		

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	245616	A. BUILDING **02 - GREENBUSH MANOR** B. WING _____	**08/21/2013**

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K 051	Continued From page 9 within the airflow of the adjacent air supply outlet. 7. On 8/21/13 at 2:12pm, observation revealed that the smoke detector located in soiled utility room B129 was installed within the airflow of the adjacent air supply outlet. 8. On 8/21/13 at 2:14pm, observation revealed that the smoke detector located in office room B139 was installed within the airflow of the adjacent air supply outlet. 9. On 8/21/13 at 2:13pm, observation revealed that the smoke detector located in the Director of Nursing's office room B140 was installed within the airflow of the adjacent air supply outlet. 10. On 8/21/13 at 2:50pm, observation revealed that the smoke detector located in soiled utility room B129 was installed within the airflow of the adjacent air supply outlet. 11. On 8/21/13 at 2:58pm, observation revealed that the smoke detector located in the clean utility room A121 was installed within the airflow of the adjacent air supply outlet. These deficient practices were confirmed by the Director of Facilities and the Maintenance Supervisor at the time of discovery.	K 051		
K 062 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 18.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5	K 062		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245616	A. BUILDING 02 - GREENBUSH MANOR B. WING _____	08/21/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 062	Continued From page 10 This STANDARD is not met as evidenced by: Based on record review, observation and interview the facility failed to maintain its automatic sprinkler system in accordance with NFPA 101 - 2000 edition, Sections 18.3.5 and 9.7 and NFPA 25 - 1998 edition, Sections 2-2, 2.2.1.1, 2-3.3 and Table 2-1. This deficient practice could affect all 40 residents. Findings include: 1. On 8/21/13 at 11:25am, review of the documents titled "Annual Sprinkler Report of Inspection" dated 9/24/12 and the untitled tag that the Maintenance Supervisor said was on the sprinkler system showing when the waterflow tests were completed revealed that only two water flow tests were conducted within the last 12 months. The untitled tag shows that waterflow tests were conducted on 9/24/12 and 7/22/13. 2. On 8/21/13 at 2:38pm, observation revealed that in room A118 the sprinkler escutcheon cover was extended 1/2" down from the ceiling and was not completely installed flush with the ceiling. These deficient practices were confirmed by the Facility Administrator, the Director of Facilities and the Maintenance Supervisor at the time of discovery.	K 062	The valve tamper switches and water flow devices will be tested and documented quarterly by the maintenance staff. Effective 8/21/13 Sprinkler heads will be set back into place so they are flush with the ceiling tile by the maintenance staff and Brett Dallager, Maintenance Supervisor, by 10/20/13.	
K 066 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Smoking regulations are adopted and include no less than the following provisions: (1) Smoking is prohibited in any room, ward, or	K 066	The smoking policy will be revised by 10/20/13 stating that smoking will not be allowed for residents on the buildings and grounds.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245616	A. BUILDING **02 - GREENBUSH MANOR** B. WING _____	**08/21/2013**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 066	Continued From page 11 compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area is posted with signs that read NO SMOKING or with the international symbol for no smoking. (2) Smoking by patients classified as not responsible is prohibited, except when under direct supervision. (3) Ashtrays of noncombustible material and safe design are provided in all areas where smoking is permitted. (4) Metal containers with self-closing cover devices into which ashtrays can be emptied are readily available to all areas where smoking is permitted. 18.7.4 This STANDARD is not met as evidenced by: Based on record review and interview the facility failed to have a smoking policy in accordance with the requirements of NFPA 101 - 2000 edition, Section 18.7.4 and 18.7.4 (c). This deficient practice could affect all 40 residents. Findings include: On 8/21/13 at 10:40am, review of the document titled "Lifecare Medical Center Policy & Procedure Smoking Policy" dated "Environmental Safety Committee 4/09" revealed that the policy the facility had that addressed smoking allows nursing home residents to smoke. The policy states, "Nursing home residents do not apply to this policy." The facility did not have a policy that	K 066		

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	245616	A. BUILDING 02 - GREENBUSH MANOR B. WING _____	08/21/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 066	Continued From page 12 addressed how residents were assessed to be safe smokers and it did not have a policy addressing how someone who was assessed to be an unsafe smoker would be allowed to smoke under direct staff supervision. This deficient practice was confirmed by the Facility Administrator, the Director of Facilities and the Maintenance Supervisor at the time of discovery.	K 066		
K 070 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Portable space heating devices are prohibited in all health care occupancies, except in non-sleeping staff and employee areas where the heating elements of such devices do not exceed 212 degrees F. (100 degrees C) 18.7.8 This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to prohibit the use of portable space heaters in accordance with the requirements of NFPA 101 - 2000 edition, Sections 18.7.8. This deficient practice could affect all 40 residents. Findings include: On 8/21/13 at 11:40am, review of the document titled "LifeCare Medical Center Policy & Procedure, Decorations, Receptacles & Heating Devices." dated "Revised 03/12" revealed that the policy the facility had only prohibited the use of portable space heaters in the hospital and did not prohibit the use of portable space heaters in the nursing home.	K 070	The policy on space heaters was revised to include that LifeCare Medical Center prohibits space heating devices in all health care occupancies. (Exception for portable space heating devices may be used only in nonsleeping staff/employee areas, with proper documentation that heating element does not exceed 212 degrees Fahrenheit.) (For full text and any exceptions, refer to NFPA 101-2000: 18/19.7.8) Completed 9/30/13	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245616	A. BUILDING **02 - GREENBUSH MANOR** B. WING _____	**08/21/2013**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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
K 070	Continued From page 13 This deficient practice was confirmed by the Facility Administrator, the Director of Facilities and the Maintenance Supervisor at the time of discovery.	K 070		
K 074 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Draperies, curtains, including cubicle curtains, and other loosely hanging fabrics and films serving as furnishings or decorations in health care occupancies are in accordance with provisions of 10.3.1 and NFPA 13, Standards for the Installation of Sprinkler Systems. Shower curtains are in accordance with NFPA 701. Newly introduced upholstered furniture within health care occupancies meets the criteria specified when tested in accordance with the methods cited in 10.3.2 (2) and 10.3.3. 18.7.5.1, 1, NFPA 13 Newly introduced mattresses meet the criteria specified when tested in accordance with the method cited in 10.3.2 (3) , 10.3.4, 18.7.5.3 This STANDARD is not met as evidenced by: Based on observation and interview the facility failed to provide flame retardant drapery material in accordance with the requirements of NFPA 101 - 2000 edition, sections 18.7.5.1 and 10.3.1. This deficient practice could affect approximately 2 of the 40 residents.	K 074	Documentation was found on the divider curtains after the survey on 8/22/13 by Brett Dallager, Maintenance Supervisor. See Attachment #1.	

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

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	245616	A. BUILDING 02 - GREENBUSH MANOR B. WING _____	08/21/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 074	Continued From page 14 Findings include: On 8/21/13 at 2:09pm, observation revealed that in the central bath there were two cubicle curtains that did not have a label indicating that they were fire retardant. When asked if the facility had any documentation indicating that the cubicle curtains were fire retardant the Maintenance Supervisor replied, "No."	K 074		
K 144 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to inspect and test the emergency generator in accordance with the requirements of NFPA 101 - 2000 edition, section 18.5.1 and 9.1.3; NFPA 110 - 1999 edition, Section 6-4.1 and 6-4.2. This deficient practice could affect all 40 residents. Findings include: On 8/21/13 at 12:01pm, review of the document titled "Ziegler Power Systems Monthly Testing Log" for the last 12 months revealed that the monthly load test of the emergency generator was not at 30% of the name plate rating for 30 minutes. Review of the document titled Load	K 144	Annual load bank test will be completed week of 9/16/13 by Ziegler Power Systems. A service agreement is in place with Ziegler Power Systems for annual load bank test. Monthly testing which includes transfer of load to the generator will continue to be done by maintenance staff.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245616	A. BUILDING 02 - GREENBUSH MANOR B. WING _____	08/21/2013

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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
K 144	Continued From page 15 Bank = Engine/Generator Test dated 6/14/12 revealed that the last annual two hour load bank test was conducted more than 12 months ago. This deficient practice was confirmed by the Facility Administrator, the Director of Facilities and the Maintenance Supervisor at the time of discovery.	K 144		
K 147 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to utilize electrical equipment in accordance with the requirements of NFPA 101 - 2000 edition, Sections 18.5.1 and 9.1.2, as well as, NFPA 70 - 1999 edition. This deficient practice could affect approximately one of the 40 residents. Findings include: On 8/21/13 at 2:45pm, observation revealed that in room A103 a refrigerator was plugged into an electrical powerstrip and not into an electrical outlet installed in accordance with the National Electric Code. This deficient practice was confirmed by the Director of Facilities and the Maintenance Supervisor at the time of discovery.	K 147	The said refrigerator has been unplugged from the said power-strip and into a wall receptacle by Brett Dallager, Maintenance Supervisor. Done 9/03/13	

DUPLICATE

For cubicle curtains

Fantagraph

The Fabric & Design Division of Standard Textile Company, Inc.
One Knollcrest Drive Cincinnati, Ohio 45237

AFFIDAVIT OF FLAMEPROOFING

STATE OF OHIO
COUNTY OF HAMILTON } ss · JUNE 23, 1994

ROSEAU AREA HOSPITAL
715 DELMORE AVENUE
ROSEAU, MN 56751

GREENBUSH HOMES
152 5TH STREET
GREENBUSH, MN 56726

Date	Material	Order #	Invoice #
06/22/94	CM708801L	2696	550591
06/22/94	CM708802L	2696	550591

This certifies the above fabric passes the required NFPA 701 fire test for flame resistant textiles and complies with the NFPA 101 Life Safety Code Chapter 31, Section 31-1-4.1. The fabric will need no further treatment to maintain its flame resistant quality.

State of Ohio
County of Hamilton
Sworn and Subscribed to before me

This 23RD day of JUNE 19 94

NOTARIAL SEAL STATE OF OHIO

Fantagraph,™

Division Manager

MARK A. SPIEGEL Attorney at Law
NOTARY PUBLIC - STATE OF OHIO
My commission has no expiration
date. Section 147.03 O.R.C.

REPORT OF CONSULTANT FSES FINDINGS

LifeCare Greenbush Manor

19120 – 200th Street

Greenbush, MN 56726

Provider No. 245616

Date of Survey: October 1, 2013

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

Fire Safety Resources, LLC
Consulting, Education & Inspection Services

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

October 4, 2013

Ms. Susan Lisell
Administrator
LifeCare Greenbush Manor
19120 – 200th Street
Greenbush, Minnesota 56726

RE: FSES at LifeCare Greenbush Manor

Dear Ms. Lisell:

Enclosed please find the survey information relating to the fire safety evaluation of LifeCare Greenbush Manor, 19120 – 200th Street, Greenbush, MN conducted on 10/01/13. This evaluation was conducted in accordance with the Fire Safety Evaluation System (FSES) specified in Chapter 4 of NFPA 101A(01), *Guide to Alternative Approaches to Life Safety*.

As you're aware, the FSES is a rating system designed to evaluate the level of fire/life safety in health care facilities and serves as a method to demonstrate alternative compliance with the 2000 edition of the *Life Safety Code*® (NFPA 101). An FSES was made necessary in this case because of a smoke barrier wall (K025) deficiency cited during a Life Safety Code Comparative Federal Monitoring Survey conducted on 08/21/13.

The following factors served as the basis for this evaluation:

- Because the building was constructed after 03/11/03, LifeCare Greenbush Manor was considered a new building.
- LifeCare Greenbush Manor is one story in height and has no basement. For purposes of this FSES, the building was divided into four (4) separate smoke zones.

Calculations show that LifeCare Greenbush Manor comes very close, but does **not** pass the FSES in its current state.

In accordance with NFPA 101A(01), Sec. 4.2.3, a building must be able to achieve a score of zero (0) or better in all zones evaluated and in all four of the following categories in Table 7 of the FSES worksheets (Form CMS-2786T), ZONE FIRE SAFETY EQUIVALENCY EVALUATION:

- Containment Safety,
- Extinguishment Safety,
- People Movement Safety, and
- General Safety.

Based on conditions found during the on-site visit to the facility on 10/01/13, calculations show a negative score in the category People Movement Safety in two (2) of the four (4) zones evaluated. This occurred because it could not be confirmed that the construction design of the roof/ceiling assembly at which the smoke barrier walls terminate meets the exception to NFPA 101(00), Sec. 8.3.2 and the requirements of NFPA 101(00), Sec. 18.3.7.3. As a result, the score for Parameter 9, *Smoke Control*, in Table 4 of the FSES worksheets for Zones 1 and 2 was assigned a score of -5, "No Control".

Again, because of the negative score assigned to Parameter 9 in Table 4 of the Worksheets, LifeCare Greenbush Manor has currently **not** achieved a passing FSES score. It must be noted, however, that a score of zero (0) or better **can** be achieved in all four zones evaluated and in all four of the categories in Table 7 of the FSES worksheets provided that, at a minimum, the following correction is made:

> If system-connected automatic smoke detectors were installed in all habitable rooms not already so equipped (i.e. Family/Conference Room A120 in Zone 1, Rosewood, and Family/Conference Room B120 and MDS Nurse Room B137 in Zone 2, Edgewood) the smoke detection system in those zones would meet the criteria of NFPA 101A(01), Sec. 4.6.12.4 for "Corridor and Habitable Spaces" smoke detection and the score for Parameter 12, *Smoke Detection and Alarm*, in Table 4 of the FSES worksheets for Zones 1 and 2 would change from +3 to +4.

As shown in the Table of Alternates attached to the FSES worksheets for Zones 1 and 2, this scoring change will result in LifeCare Greenbush Manor achieving a passing score of zero (0) or better in all four categories in Table 7 of the FSES worksheets.

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

Wishing you a safe day!

Robert L. Imholte
President
Fire Safety Resources, LLC

Enclosures

RLI/rli

FIRE SAFETY EVALUATION

Name of Facility: LifeCare Greenbush Manor
Address: 19120 – 200th Street, Greenbush, MN 56726
Phone: 218-782-2131
Licensed capacity: 40
Census at time of survey: 39

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

What follows is a report on the findings of a fire safety evaluation of the above-named facility that was conducted during an on-site visit to the facility between 0845 hours and 1530 hours on 10/01/13. This evaluation was conducted in accordance with the Fire Safety Evaluation System (FSES) specified in Chapter 4 of NFPA 101A(01), *Guide to Alternative Approaches to Life Safety*. Based on this evaluation, LifeCare Greenbush Manor does not achieve a passing score on the FSES.

In addition to the 10/01/13 on-site visit the findings outlined herein are based on:

- Information provided by Mr. Brian Grafstrom, Director of Facilities; Mr. Brett Dallager, Maintenance Supervisor; and Ms. Kristi Gustafson, Director of Nursing; and
- A review of the Statement of Deficiencies (Form CMS-2567) from a Life Safety Code Comparative Federal Monitoring Survey conducted on 08/21/13.

Initial Comments:
The building housing LifeCare Greenbush Manor was constructed in 2010. Because the building was constructed after 03/11/03, it is considered a new building for federal certification purposes and was, therefore, treated as such for assigning values on the FSES worksheets.

The building is one story in height and has no basement. There are four fully enclosed mechanical spaces located in the building attic space. Because the spaces were found to be used exclusively for mechanical equipment rooms and the occupant load of the aggregate area of the enclosed spaces does not exceed 10, the spaces were treated as mezzanines in accordance with NFPA 101(00), Sec. 8.2.6 and were not considered a factor in the determination of building height.

Based on observation, staff interview and review of the Code Summary attached to the building construction drawings, the building's wood frame structural members (exterior walls and roof/ceiling assembly) are protected with materials providing a fire resistance rating of one hour. As a result, the building was assigned a Type V(111) construction type in accordance with NFPA 220(99), Sec. 3-5 and Table 3-1.

At the northeast corner of the building, the nursing home is connected to a medical clinic. At the southeast corner of the building, the nursing home is connected to a senior assisted living facility. Because neither the clinic nor the assisted living building are used for purposes of housing, treatment or customary access by the facility's residents and because they are both separated from the nursing home by a 2-hour-rated fire barrier, these buildings were not included in this evaluation.

The facility has an addressable manual fire alarm system with automatic smoke detection in the corridors, spaces open to corridors and most habitable rooms. The fire alarm system is monitored for automatic fire department notification. Documentation review revealed that the fire alarm system underwent a complete annual check by Fire Protection Systems, Inc. on 09/04/13.

A review of the Statement of Deficiencies from the 08/21/13 Federal Monitoring Survey revealed that the facility was cited for smoke detectors found located within the airflow of adjacent air supply outlets (see data tag K051). At the time of this FSES survey, it was observed that the smoke detectors at all 11 locations cited have been relocated a minimum of 36 inches away from the air supply outlets.

The facility is protected throughout by a supervised, wet-pipe automatic fire sprinkler system. A dry-pipe automatic fire sprinkler system, however, protects the attic space and combustible exterior canopy at the main entrance. It was found that the following sprinkler system deficiencies observed during the 08/21/13 Federal Monitoring Survey and cited under data tag K062 have been corrected as follows:

- A quarterly flow test of the building fire sprinkler system was conducted, satisfactorily completed and documented by Advanced Fire Protection during the course of this FSES survey.
- The fire sprinkler escutcheon covers found extending ½ in. down from the ceiling at Room A118 were found to have been installed flush with the ceiling.

Based on staff interview and review of building floor plan drawings, the building is divided into four (4) zones designated as Areas A, B, C and E on the building construction plan drawings:

- Area A houses a resident "neighborhood" called Rosewood. This zone consists of two wings containing resident sleeping rooms, one called Lady Slipper Drive, the other called Cedar Boulevard. The two wings share a common resident dining space.
- Area B houses a resident "neighborhood" called Edgewood. This zone, too, consists of two wings containing resident sleeping rooms, one called Whitetail Trail, the other called Eagle's Nest. The two wings share a common resident dining space.
- Area C houses offices, administrative areas, the facility barber/beauty salon, community room/chapel and wellness center. The medical clinic is attached to this zone.
- Area E houses facility support services. The assisted living building is attached to this zone.

A review of the Statement of Deficiencies from the 08/21/13 Federal Monitoring Survey revealed that the facility was issued a smoke barrier wall deficiency because it could not be confirmed that the smoke barrier walls continue through the attic space to the underside of the roof deck (see data tag K025, Item 1). Based on staff interview conducted during this FSES survey, it was confirmed that the smoke barrier walls do not continue through the attic space to the underside of the roof deck, but that efforts are being made to confirm that the roof/ceiling assembly meets the exception to NFPA 101(00), Sec. 8.3.2 and the exception to Sec. 709.4 of the 2007 Minnesota State Building Code to allow the smoke barrier walls to terminate at the bottom of the roof/ceiling assembly.

Documentation was provided showing that the roof/ceiling assembly is a 1-hour fire-rated assembly per UL Design P522. It was determined that the construction assembly forming the bottom of the roof/ceiling assembly consists of one layer of 5/8-in.-thick gypsum board attached to metal furring channels secured to the underside of the roof trusses. While it remains to be determined whether or not the construction design meets the exception to NFPA 101(00), Sec. 8.3.2 and the requirements of NFPA 101(00), Sec. 18.3.7.3, observations revealed that the ceiling assembly provides at least some degree of smoke and fire resistance. As a result for purposes of this FSES, the building was divided into four (4) separate smoke zones as follows:

Zone 1 – Rosewood
Zone 2 – Edgewood
Zone 3 – Administrative/Community Room Wing
Zone 4 – Support Services Wing

This report is intended to serve as an explanation of the scores entered on Tables 1, 4 and 8 of the FSES worksheets (i.e. Forms CMS-2786T) for the facility as it was found on 10/01/13. The score assigned to each item is noted in brackets ([ ]). It must be noted that numbers were rounded to the nearest tenth of a point and that measurements of over one-half inch were rounded to the nearest inch. To ensure that the FSES addresses the "worst-case scenario", the product of the multiplication in Table 3A (i.e. value of "R") was rounded up to the nearest whole number. Code references are provided where appropriate. Codes referenced include the 2001 edition of NFPA 101A and the 2000 edition of the *Life Safety Code*® (NFPA 101).

With the exception of Table 8, which applies to all zones, this narrative will address each of the four (4) zones separately.

All Zones – TABLE 8. FACILITY FIRE SAFETY REQUIREMENTS WORKSHEET

In accordance with NFPA 101A(01), Sec. 4.7, Step 8, only one copy of this table is required to be filled out for each building. For convenience, however, this table was filled out on the worksheets for all zones evaluated. All items in Table 8 could be checked 'Met' with the exception of Item L. Because LifeCare Greenbush Manor does not meet the definition of a high rise, Item L was checked 'Not Applicable'.

The remaining items in Table 8 were identified as 'Met' based on the following:

- Building utilities and heating and air conditioning systems appeared to be in conformance with applicable requirements.

  Surveyor Note: A review of the Statement of Deficiencies from the 08/21/13 Federal Monitoring Survey revealed that the facility was cited because the last annual 2-hour load bank test of the diesel-operated emergency generator was conducted more than 12 months ago (see data tag K144). Staff interview and documentation review conducted during this FSES survey revealed that Ziegler Power Systems conducted the required load bank test on 09/18/13.

  This review revealed that the facility was also cited for a refrigerator found plugged into an electrical power strip instead of an approved electrical outlet at Resident Room A103 (see data tag K147). Staff interview revealed that the resident who owned the refrigerator has since moved from the facility. Based on observation during this FSES survey, no refrigerator or electrical power strip were found in Resident Room A103.
- Alarms, emergency communication systems and illumination of generator set locations appeared to be powered as prescribed by NFPA 101(00), Sec. 18.5.1.2. It was reported that there are no residents on life support at LifeCare Greenbush Manor.
- No incinerator or space heaters were found.

  Surveyor Note: A review of the Statement of Deficiencies from the 08/21/13 Federal Monitoring Survey revealed that the facility was cited for failure to prohibit the use of portable space heaters in the nursing home in accordance with the requirements of NFPA 101(00), Sec. 18.7.8 (see data tag K070). Based on staff interview and documentation review conducted during this FSES survey, LifeCare Medical Center has amended this policy to reflect that space-heating devices are prohibited in all its health care occupancies except for portable space-heating devices in nonsleeping staff and employee areas as allowed by and in conformance with the exception to NFPA 101(00), Sec. 18.7.8.

- The facility's evacuation plan and fire drill records were reviewed and appeared to be in order.
  Surveyor Note: A review of the Statement of Deficiencies from the 08/21/13 Federal Monitoring Survey revealed that the facility was cited for failure to sufficiently vary the times that fire drills were conducted on the first and third shifts (see data tag K050). Documentation review conducted during this FSES survey revealed that the facility has subsequently submitted a Plan of Correction stating that fire drills will be conducted at more varied times.
- The facility's smoking regulations were reviewed and appeared to be in order. LifeCare Greenbush Manor is a smoke-free campus.
  Surveyor Note: A review of the Statement of Deficiencies from the 08/21/13 Federal Monitoring Survey revealed that the facility was cited for failure to have a smoking policy in accordance with the requirements of NFPA 101(00), Sec. 18.7.4 (see data tag K066). Based on staff interview and documentation review conducted during this FSES survey, LifeCare Medical Center has subsequently developed a policy prohibiting smoking on its property. It was found that the facility's admissions policy also states that LifeCare Greenbush Manor is a smoke-free campus.
- Documentation review showed all draperies, cubicle curtains, upholstered furniture, mattresses and decorations to be in accordance with NFPA 101(00), Sec. 18.7.5.
  Surveyor Note: A review of the Statement of Deficiencies from the 08/21/13 Federal Monitoring Survey revealed that the facility was cited because two cubicle curtains were found in the central bath that did not have a label indicating that they were fire retardant (see data tag K074). At the time of this FSES survey, it was observed that the cubicle curtains in the central bath now have a label indicating that they are fire retardant.
- Portable fire extinguishers, EXIT signage and emergency lighting appeared to be provided in accordance with applicable requirements.
  Surveyor Note: A review of the Statement of Deficiencies from the 08/21/13 Federal Monitoring Survey revealed that the facility was cited because the doors into the enclosed courtyard, which does not have an exit or serve as a way to an exit, could be confused with an exit and did not have a "NO EXIT" sign (see data tag K022). At the time of this FSES survey, it was observed that signage has been placed on the doors at all three (3) locations cited, as well as some additional locations, indicating that the doors are not an exit.

Zone 1 – Rosewood:

TABLE 1. OCCUPANY RISK PARAMETER FACTORS

1. Resident Mobility (*M*) [Value assigned = 3.2]: It was reported that some residents in this zone may need assistance with evacuation.
2. Patient Density (*D*) [Value assigned = 1.5]: There is bed capacity for up to 20 residents in this zone.
3. Zone Location (*L*) [Value assigned = 1.1]: This zone is less than one-half floor height above grade.
4. Ratio of Patients to Attendants (*T*) [Value assigned = 1.2]: It was reported that there are two (2) staff persons on duty in this zone on the night shift.
5. Patient Average Age (*A*) [Value assigned = 1.2]: Residents housed in this zone average over 65 years of age.

TABLE 4. SAFETY PARAMETERS and SAFETY PARAMETER VALUES

1. Construction [Score: 0]:
   The building was assigned a Type V(111) construction type.

2. Interior Finish (Corridors and Exits) [Score: +3]:
   A rigid material approximately 8 inches in width and identified as "Acrovyn 4000 Rub Strips" was found mounted behind the handrails and extending the full length of the corridors. Documentation was provided certifying that this material as well as the acoustical ceiling tile carry a Class A (25 or less) flame spread rating.
3. Interior Finish (Rooms) [Score: +3]:
   Documentation was provided certifying that approximately 8-in. wide "Acrovyn 4000 Rub Strips" installed as a wainscot in some rooms and the acoustical ceiling tile carry a Class A (25 or less) flame spread rating.
4. Corridor Partitions/Walls [Score: 0]:
   A 31-in. x 47-in. tempered glass vision panel was found in the corridor wall at Family/Conference Room A120. As a result, the corridor walls were graded as "<½ hour". Corridor walls were determined to be constructed of 5/8-inch-thick gypsum wallboard installed on both sides of wood studs and extend up through the suspended ceiling to the bottom of a roof/ceiling assembly consisting of one layer of 5/8-in.-thick gypsum board attached to metal furring channels secured to the underside of the roof trusses. Pass-through openings between the serving kitchen and the adjacent dining/lounge spaces in this zone were found to be protected with listed and labeled fire shutter assemblies that carry a 90-minute fire protection rating and are automatic-closing upon detection of smoke.
5. Doors to Corridor [Score: +1]:
   Corridor doors in this zone were found to be a mixture of 1¾-inch-thick solid wood construction and 60-minute and 90-minute fire-rated doors, all in steel frames.
6. Zone Dimensions [Score: 0]:
   Based on review of construction plan drawings, this zone was found to measure a maximum of approximately 125 ft in length and has no dead ends over 30 ft.
7. Vertical Openings [Score: 0]:
   This score was assigned per Footnote *e* to this Table – Parameter 1 is based on a first floor zone. The building has no basement. It was observed that the vertical opening deficiency cited in the adjacent zone (i.e. Zone 3 – Administrative/Community Room Wing) during the 08/21/13 Federal Monitoring Survey has been corrected.
8. Hazardous Areas [Score: 0]:
   No hazardous area deficiencies were found in this zone.
9. Smoke Control [Score: -5]:
   This score was assigned because it could not be confirmed that the construction design of the roof/ceiling assembly at which the smoke barrier walls terminate meets the exception to NFPA 101(00), Sec. 8.3.2 and the requirements of NFPA 101(00), Sec. 18.3.7.3.
   Surveyor Note: It was found that the following smoke barrier wall deficiencies observed during the 08/21/13 Federal Monitoring Survey and cited under data tag K025 have been corrected as follows:
   - The penetrations above the ceiling at the smoke barrier in Soiled Utility A129 were found to have been sealed and made smoketight with a UL Classified firestop material.
   - The 10-in. x 17-in. opening above the ceiling in the smoke barrier wall at the entrance to Soiled Utility A129 was found to have been sealed and made smoketight with 5/8-in.-thick gypsum wallboard.
10. Emergency Movement Routes [Score: 0]:
    There are multiple emergency movement routes from this zone.
11. Manual Fire Alarm [Score: +2]:
    Manual fire alarm pull stations are provided in accordance with NFPA 101(00), Sec. 18.3.4.2. The fire alarm system is monitored by Rapid Response.

12. Smoke Detection and Alarm [Score: +3]:
    This score was assigned per instruction in Footnote *g* to this Table. The zone is protected with quick-response sprinklers. System-connected smoke detectors were found in the egress corridor, spaces open to the corridor and in all habitable rooms except Family/Conference Room A120. Because this condition does not meet the criteria specified in NFPA 101A(01), Sections 4.6.12.3 and 4.6.12.4, this parameter was required to be scored as "Corridor Only".
    See Table of Alternates: *If a system-connected automatic smoke detector were installed in Family/Conference Room A120, the building smoke detection system would meet the criteria of NFPA 101A(01), Sec. 4.6.12.4 for "Corridor and Habitable Spaces" smoke detection and the score for this Parameter would change to +4.*
13. Automatic Sprinklers [Score: +10]:
    The building is protected throughout by a supervised automatic fire sprinkler system.

Zone 2 – Edgewood:

TABLE 1. OCCUPANY RISK PARAMETER FACTORS

1. Resident Mobility (*M*) [Value assigned = 3.2]: It was reported that some residents in this zone may need assistance with evacuation.
2. Patient Density (*D*) [Value assigned = 1.5]: There is bed capacity for up to 20 residents in this zone.
3. Zone Location (*L*) [Value assigned = 1.1]: This zone is less than one-half floor height above grade.
4. Ratio of Patients to Attendants (*T*) [Value assigned = 1.2]: It was reported that there are two (2) staff persons on duty in this zone on the night shift.
5. Patient Average Age (*A*) [Value assigned = 1.2]: Residents housed in this zone average over 65 years of age.

TABLE 4. SAFETY PARAMETERS and SAFETY PARAMETER VALUES

1. Construction [Score: 0]:
   The building was assigned a Type V(111) construction type.
2. Interior Finish (Corridors and Exits) [Score: +3]:
   A rigid material approximately 8 inches in width and identified as "Acrovyn 4000 Rub Strips" was found mounted behind the handrails and extending the full length of the corridors. Documentation was provided certifying that this material as well as the acoustical ceiling tile carry a Class A (25 or less) flame spread rating.
3. Interior Finish (Rooms) [Score: +3]:
   Documentation was provided certifying that approximately 8-in. wide "Acrovyn 4000 Rub Strips" installed as a wainscot in some rooms and the acoustical ceiling tile carry a Class A (25 or less) flame spread rating.
4. Corridor Partitions/Walls [Score: 0]:
   A 31-in. x 47-in. tempered glass vision panel was found in the corridor wall at Family/Conference Room B120. As a result, the corridor walls were graded as "<½ hour". Corridor walls were determined to be constructed of 5/8-inch-thick gypsum wallboard installed on both sides of wood studs and extend up through the suspended ceiling to the bottom of a roof/ceiling assembly consisting of one layer of 5/8-in.-thick gypsum board attached to metal furring channels secured to the underside of the roof trusses. Pass-through openings between the serving kitchen and the adjacent dining/lounge spaces in this zone were found to be protected with listed and labeled fire shutter assemblies that carry a 90-minute fire protection rating and are automatic-closing upon detection of smoke.

5. Doors to Corridor [Score: +1]:
   Corridor doors in this zone were found to be a mixture of 1¾-inch-thick solid wood construction and 60-minute and 90-minute fire-rated doors, all in steel frames.
6. Zone Dimensions [Score: 0]:
   Based on review of construction plan drawings, this zone was found to measure a maximum of approximately 125 ft in length and has no dead ends over 30 ft.
7. Vertical Openings [Score: 0]:
   This score was assigned per Footnote *e* to this Table – Parameter 1 is based on a first floor zone. The building has no basement. It was observed that the vertical opening deficiency cited in the adjacent zone (i.e. Zone 3 – Administrative/Community Room Wing) during the 08/21/13 Federal Monitoring Survey has been corrected.
8. Hazardous Areas [Score: 0]:
   No hazardous area deficiencies were found in this zone.
9. Smoke Control [Score: -5]:
   This score was assigned because it could not be confirmed that the construction design of the roof/ceiling assembly at which the smoke barrier walls terminate meets the exception to NFPA 101(00), Sec. 8.3.2 and the requirements of NFPA 101(00), Sec. 18.3.7.3.
10. Emergency Movement Routes [Score: 0]:
    There are multiple emergency movement routes from this zone.
11. Manual Fire Alarm [Score: +2]:
    Manual fire alarm pull stations are provided in accordance with NFPA 101(00), Sec. 18.3.4.2. The fire alarm system is monitored by Rapid Response.
12. Smoke Detection and Alarm [Score: +3]:
    This score was assigned per instruction in Footnote *g* to this Table. The zone is protected with quick-response sprinklers. System-connected smoke detectors were found in the egress corridor, spaces open to the corridor and in all habitable rooms except Family/Conference Room B120 and MDS Nurse Room B137. Because this condition does not meet the criteria specified in NFPA 101A(01), Sections 4.6.12.3 and 4.6.12.4, this parameter was required to be scored as "Corridor Only".
    See Table of Alternates: *If system-connected automatic smoke detectors were installed in Family/Conference Room B120 and MDS Nurse Room B137, the building smoke detection system would meet the criteria of NFPA 101A(01), Sec. 4.6.12.4 for "Corridor and Habitable Spaces" smoke detection and the score for this Parameter would change to +4.*
13. Automatic Sprinklers [Score: +10]:
    The building is protected throughout by a supervised automatic fire sprinkler system.

Zone 3 – Administrative/Community Room Wing:

TABLE 1. OCCUPANY RISK PARAMETER FACTORS

1. Resident Mobility (*M*) [Value assigned = 3.2]: It was reported that some residents in this zone may need assistance with evacuation.
2. Patient Density (*D*) [Value assigned = 2.0]: This score was assigned to ensure that the FSES addresses the "worst-case scenario". There are no sleeping rooms in this zone, but it contains the facility's Community Room/Chapel, Wellness Center and therapy spaces, barber/beauty salon, and staff and administrative offices, which are available for use by all residents.
3. Zone Location (*L*) [Value assigned = 1.1]: This zone is less than one-half floor height above grade.

4. Ratio of Patients to Attendants (*T*) [Value assigned = 1.2]: This score was assigned to ensure that the FSES addresses the "worst-case scenario". It was reported that when the Community Room/Chapel area is occupied by all 40 residents, sufficient staff is present to maintain a resident/staff ratio of not more than seven (7) to one (1).
5. Patient Average Age (*A*) [Value assigned = 1.2]: Residents housed in this zone average over 65 years of age.

TABLE 4. SAFETY PARAMETERS and SAFETY PARAMETER VALUES

1. Construction [Score: 0]:
   The building was assigned a Type V(111) construction type.
2. Interior Finish (Corridors and Exits) [Score: +3]:
   A rigid material approximately 8 inches in width and identified as "Acrovyn 4000 Rub Strips" was found mounted behind the handrails and extending the full length of the corridors. Documentation was provided certifying that this material as well as the acoustical ceiling tile carry a Class A (25 or less) flame spread rating.
3. Interior Finish (Rooms) [Score: +3]:
   Documentation was provided certifying that the acoustical ceiling tile carries a Class A (25 or less) flame spread rating.
4. Corridor Partitions/Walls [Score: +1]:
   Corridor walls were determined to be constructed of 5/8-inch-thick gypsum wallboard installed on both sides of wood studs and extend up through the suspended ceiling to the bottom of a roof/ceiling assembly consisting of one layer of 5/8-in.-thick gypsum board attached to metal furring channels secured to the underside of the roof trusses. Because it could not be confirmed that this assembly provides a fire resistance rating of 1-hour or better, they were graded as "≥½ hour to <1 hour" in accordance with NFPA 101A(01), Sec. 4.6.4.2. A pass-through opening between the administrative office and the adjacent corridor in this zone was found to be protected with a listed and labeled fire shutter assembly that carries a 90-minute fire protection rating and is automatic-closing upon detection of smoke.
5. Doors to Corridor [Score: +1]:
   Corridor doors in this zone were found to be a mixture of 1¾-inch-thick solid wood construction and 60-minute and 90-minute fire-rated doors, all in steel frames.
6. Zone Dimensions [Score: -2]:
   Based on review of construction plan drawings, this zone was found to measure over 150 ft in length and has no dead ends.
7. Vertical Openings [Score: 0]:
   This score was assigned per Footnote *e* to this Table – Parameter 1 is based on a first floor zone. The building has no basement.

   Surveyor Note: A review of the Statement of Deficiencies from the 08/21/13 Federal Monitoring Survey revealed that the facility was cited because the door to the stair to the mechanical mezzanine located by the public men's rest room carried a 20-minute fire protection rating instead of a 60-minute fire protection rating (see data tag K020). During the course of this FSES survey, the facility received and installed a replacement door. Observation confirmed that the replacement door carries a 60-minute fire protection rating.
8. Hazardous Areas [Score: 0]:
   No hazardous area deficiencies were found in this zone.

9. Smoke Control [Score: -5]:
   This score was assigned because it could not be confirmed that the construction design of the roof/ceiling assembly at which the smoke barrier walls terminate meets the exception to NFPA 101(00), Sec. 8.3.2 and the requirements of NFPA 101(00), Sec. 18.3.7.3.
   Surveyor Note: A review of the Statement of Deficiencies from the 08/21/13 Federal Monitoring Survey revealed that the facility was cited because of unprotected penetrations above the ceiling at the smoke barrier wall by the entrance to the Rosewood unit and at the smoke barrier by Room A133 (see data tag K025). At the time of this FSES survey, it was observed that the penetrations have been sealed and made smoketight with a UL Classified firestop material.
   This review also revealed that the facility was cited because the 90-minute-rated cross-corridor doors in the 2-hour fire-rated separation wall in the E126 Hall, which also serves as part of the smoke separation between this zone and the adjacent zone (Zone 4 – Support Services Wing) did not close completely when tested (see data tag K011). Based on testing conducted during this FSES survey, the doors were found to fully close and latch when released from the open position.
10. Emergency Movement Routes [Score: 0]:
    There are multiple emergency movement routes from this zone.
    Surveyor Note: A review of the Statement of Deficiencies from the 08/21/13 Federal Monitoring Survey revealed that the facility was cited because the code to release the magnetic locks on the main entrance/exit doors was not posted for use by building occupants who did not have a clinical need to be locked in the building (see data tag K038). At the time of this FSES survey, it was observed that the code to release the locks was posted at the door.
11. Manual Fire Alarm [Score: +2]:
    Manual fire alarm pull stations are provided in accordance with NFPA 101(00), Sec. 18.3.4.2. The fire alarm system is monitored by Rapid Response.
12. Smoke Detection and Alarm [Score: +3]:
    This score was assigned per instruction in Footnote *g* to this Table. The zone is protected with quick-response sprinklers. System-connected smoke detectors were found in the egress corridor, spaces open to the corridor and in all habitable rooms except the Wellness Center treatment rooms and Home Health Room C110. Because this condition does not meet the criteria specified in NFPA 101A(01), Sections 4.6.12.3 and 4.6.12.4, this parameter was required to be scored as "Corridor Only".
13. Automatic Sprinklers [Score: +10]:
    The building is protected throughout by a supervised automatic fire sprinkler system.

<u>Zone 4 – Support Services Wing</u>:

TABLE 1. OCCUPANY RISK PARAMETER FACTORS

1. Resident Mobility (*M*) [Value assigned = 3.2]: It was reported that some residents in this zone may need assistance with evacuation.
2. Patient Density (*D*) [Value assigned = 1.2]: There are no sleeping rooms in this zone. The zone houses the facility's main kitchen, laundry, maintenance and mechanical spaces, and the employee lounge. It was reported that facility residents use the main corridor that surrounds the enclosed courtyard as a "walking path" as part of the facility's physical fitness program. It was reported that there are a maximum of eight (8) residents in this zone at any one time.
3. Zone Location (*L*) [Value assigned = 1.1]: This zone is less than one-half floor height above grade.
4. Ratio of Patients to Attendants (*T*) [Value assigned = 1.2]: It was reported that when residents are present, sufficient staff is present to maintain a resident/staff ratio of not more than eight (8) to one (1).
5. Patient Average Age (*A*) [Value assigned = 1.2]: Residents housed in this zone average over 65 years of age.

TABLE 4. SAFETY PARAMETERS and SAFETY PARAMETER VALUES

1. Construction [Score: 0]:
   The building was assigned a Type V(111) construction type.
2. Interior Finish (Corridors and Exits) [Score: +3]:
   A rigid material approximately 8 inches in width and identified as "Acrovyn 4000 Rub Strips" was found mounted behind the handrails and extending the full length of the corridors. Documentation was provided certifying that this material as well as the acoustical ceiling tile carry a Class A (25 or less) flame spread rating.
3. Interior Finish (Rooms) [Score: +3]:
   Documentation was provided certifying that the acoustical ceiling tile carries a Class A (25 or less) flame spread rating.
4. Corridor Partitions/Walls [Score: +1]:
   Corridor walls were determined to be constructed of 5/8-inch-thick gypsum wallboard installed on both sides of wood studs and extend up through the suspended ceiling to the bottom of a roof/ceiling assembly consisting of one layer of 5/8-in.-thick gypsum board attached to metal furring channels secured to the underside of the roof trusses. Because it could not be confirmed that this assembly provides a fire resistance rating of 1-hour or better, they were graded as "≥½ hour to <1 hour" in accordance with NFPA 101A(01), Sec. 4.6.4.2. The two pass-through openings between the main kitchen and the adjacent corridor in this zone were found to be protected with listed and labeled fire shutter assemblies that carry a 90-minute fire protection rating and are automatic-closing upon detection of smoke.
5. Doors to Corridor [Score: +1]:
   Corridor doors in this zone were found to be a mixture of 1¾-inch-thick solid wood construction and 60-minute and 90-minute fire-rated doors, all in steel frames.
6. Zone Dimensions [Score: -2]:
   Based on review of construction plan drawings, this zone was found to measure over 150 ft in length and has no dead ends.
7. Vertical Openings [Score: 0]:
   This score was assigned per Footnote *e* to this Table – Parameter 1 is based on a first floor zone. The building has no basement. It was observed that the vertical opening deficiency cited in the adjacent zone (i.e. Zone 3 – Administrative/Community Room Wing) during the 08/21/13 Federal Monitoring Survey has been corrected.
8. Hazardous Areas [Score: 0]:
   No hazardous area deficiencies were found in this zone.
9. Smoke Control [Score: -5]:
   This score was assigned because it could not be confirmed that the construction design of the roof/ceiling assembly at which the smoke barrier walls terminate meets the exception to NFPA 101(00), Sec. 8.3.2 and the requirements of NFPA 101(00), Sec. 18.3.7.3.
   Surveyor Note: A review of the Statement of Deficiencies from the 08/21/13 Federal Monitoring Survey revealed that the facility was cited because the 90-minute-rated cross-corridor doors in the 2-hour fire-rated separation wall in the E126 Hall, which also serves as part of the smoke separation between this zone and the adjacent zone (Zone 3 – Administrative/Community Room Wing) did not close completely when tested (see data tag K011). Based on testing conducted during this FSES survey, the doors were found to fully close and latch when released from the open position.
10. Emergency Movement Routes [Score: 0]:
    There are multiple emergency movement routes from this zone.

11. Manual Fire Alarm [Score: +2]:
    Manual fire alarm pull stations are provided in accordance with NFPA 101(00), Sec. 18.3.4.2. The fire alarm system is monitored by Rapid Response.
12. Smoke Detection and Alarm [Score: +4]:
    System-connected smoke detectors were found in the egress corridor, spaces open to the corridor and in all habitable spaces.
13. Automatic Sprinklers [Score: +10]:
    The building is protected throughout by a supervised automatic fire sprinkler system.

* * * * * * * * * * * * *

It must be noted that the scores and values assigned to the parameters in the tables on the FSES worksheets are based on conditions found between 0845 hours and 1530 hours on 10/01/13. Any changes in those conditions after this date could affect those scores and values, either positively or negatively. Again, based on this evaluation, LifeCare Greenbush Manor **has not** achieved a passing score on the FSES. No other assessment of the level of safety in this facility is either intended or implied by *Fire Safety Resources, LLC.*

CODE SUMMARY

PROJECT NAME: [illegible]	PROJECT DESCRIPTION: [illegible]
APPLICABLE CODES: [illegible]	JURISDICTION: [illegible]

ASSISTED LIVING	Yes	No	SERVICES	Yes	No	SKILLED CARE/CHAPEL	Yes	No
Sprinkled	X		Sprinkled	X		Sprinkled	X	
Sprinkled for One Hour Construction ?		X	Sprinkled for One Hour Construction ?		X	Sprinkled for One Hour Construction ?		X
Occupancy Classifications: [illegible]			Occupancy Classifications: [illegible]			Occupancy Classifications: [illegible]		
Type of Construction: [illegible]			Type of Construction: [illegible]			Type of Construction: [illegible]		
Number of Stories: [illegible]			Number of Stories: [illegible]			Number of Stories: [illegible]		

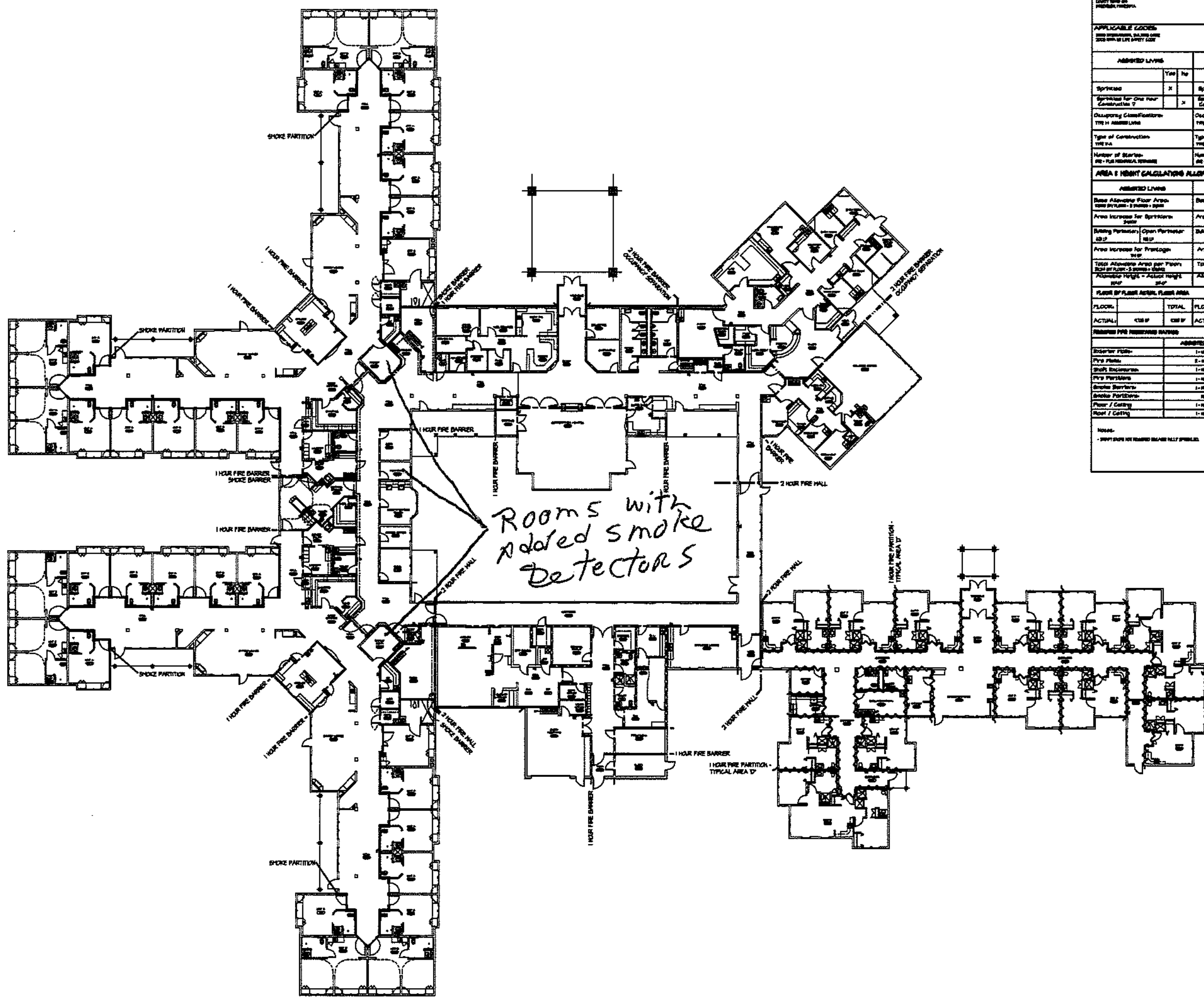
AREA & HEIGHT CALCULATIONS ALLOWABLE FOR SELECTED CONSTRUCTION TYPE.

ASSISTED LIVING	SERVICES	SKILLED CARE
Base Allowable Floor Area: [illegible]	Base Allowable Floor Area: [illegible]	Base Allowable Floor Area: [illegible]
Area Increase for Sprinklers: [illegible]	Area Increase for Sprinklers: [illegible]	Area Increase for Sprinklers: [illegible]
Building Perimeter / Open Perimeter: [illegible]	Building Perimeter / Open Perimeter: [illegible]	Building Perimeter / Open Perimeter: [illegible]
Area Increase for Frontage: [illegible]	Area Increase for Frontage: [illegible]	Area Increase for Frontage: [illegible]
Total Allowable Area per Floor: [illegible]	Total Allowable Area per Floor: [illegible]	Total Allowable Area per Floor: [illegible]
Allowable Height - Actual Height: [illegible]	Allowable Height - Actual Height: [illegible]	Allowable Height - Actual Height: [illegible]

FLOOR:		TOTAL	FLOOR:		TOTAL	FLOOR:		TOTAL
ACTUAL:	[illegible]	[illegible]	ACTUAL:	[illegible]	[illegible]	ACTUAL:	[illegible]	[illegible]

	ASSISTED LIVING	[illegible]	SKILLED CARE
Exterior Walls:	1-HOUR	1-HOUR	1-HOUR
Fire Walls:	2-HOUR	2-HOUR	2-HOUR
Shaft Enclosures:	1-HOUR	1-HOUR	1-HOUR
Fire Partitions:	1-HOUR	[illegible]	NO
Smoke Barriers:	1-HOUR	1-HOUR	1-HOUR
Smoke Partitions:	NO	[illegible]	[illegible]
Floor / Ceiling	1-HOUR	1-HOUR	1-HOUR
Roof / Ceiling	1-HOUR	1-HOUR	1-HOUR

Notes:
- [illegible]



CODE PLAN - MAIN FLOOR

LIFE CARE GREENBUSH MANOR

GREENBUSH, MINNESOTA

KEYNOTES:

FIRE RATING LEGEND

- SMOKE PARTITION
- SMOKE BARRIER
- ONE HOUR WALL - FIRE PARTITION
- ONE HOUR WALL - FIRE BARRIER
- ONE HOUR WALL - FIRE BARRIER OCCUPANCY SEPARATION
- TWO HOUR RATED FIRE WALL

ALL FIRE WALL SEPARATIONS TO SUBSTRATE ABOVE, UNLESS OTHERWISE NOTED.

GENERAL NOTES

I hereby certify that this plan, specification or report was prepared by me or under my direct supervision and that I am a duly Licensed Architect under the laws of the State of Minnesota.

Print Name: Julie Rokke

Signature:

Date: February 2009 License #: 2591

YHR PARTNERS
ARCHITECTURE PLANNING
420 Main Ave, Box 818
Moorhead, MN 56560
P: 218-233-7988 F: 218-233-4422

Project Number: 0717-3

File Name: 0717-3_CODE_SHEET_REVISED_04-23-09.dwg 5-24-09

Sheet No. CODE - R

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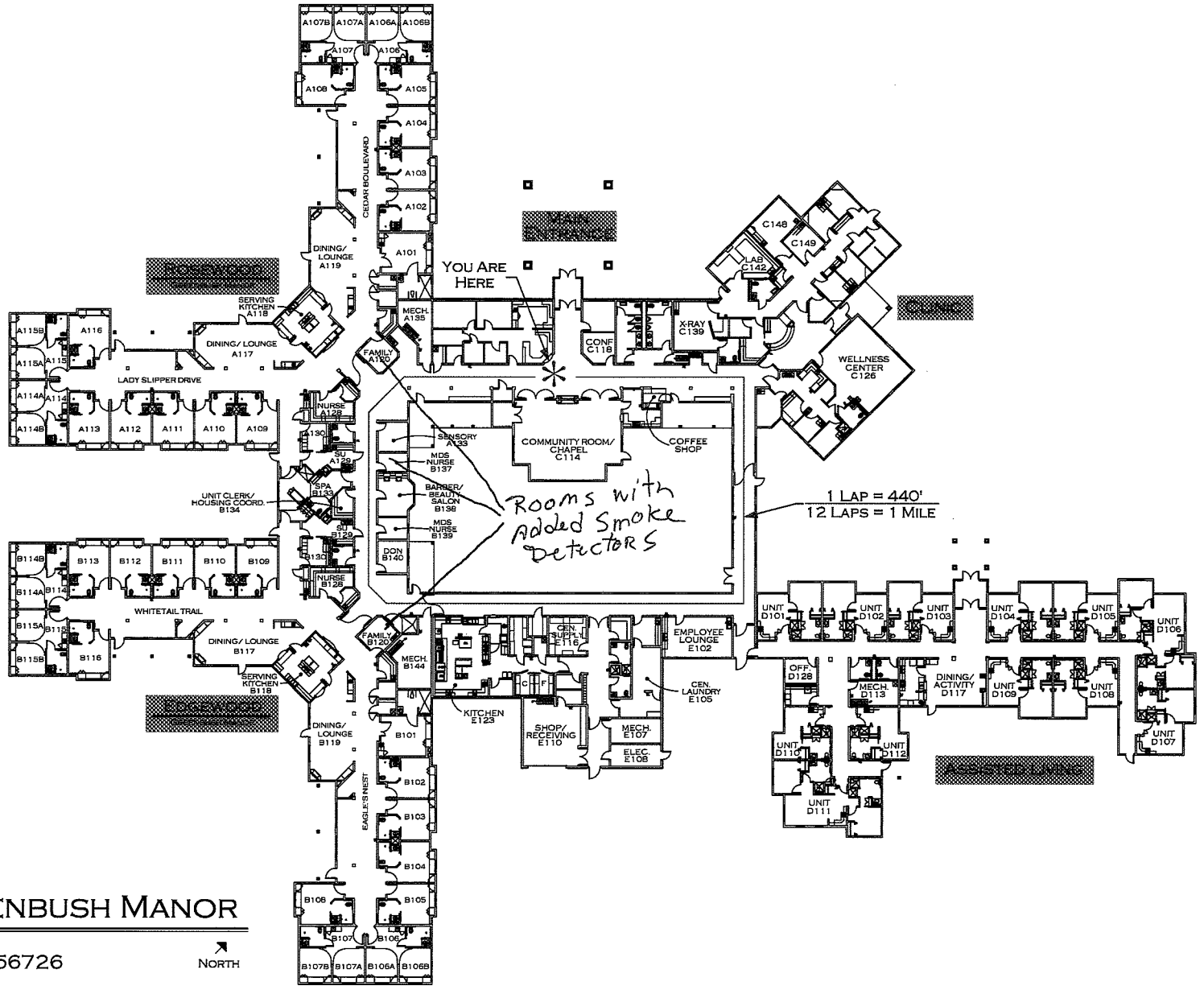

LIFE CARE GREENBUSH MANOR

19120 200TH STREET
GREENBUSH, MINNESOTA 56726

NORTH

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

Form Approved
OMB Exempt

ZONE 1 OF 4 ZONES

FIRE/SMOKE ZONE* EVALUATION WORKSHEET FOR HEALTH CARE FACILITIES

2000 LIFE SAFETY CODE

FACILITY	BUILDING
LIFECARE GREENBUSH MANOR	02 - GREENBUSH MANOR
ZONE(S) EVALUATED: ROSEWOOD	
PROVIDER/VENDOR NO.: 245616	DATE OF SURVEY: 10/01/13

COMPLETE THIS WORKSHEET FOR EACH ZONE. WHERE CONDITIONS ARE THE SAME IN SEVERAL ZONES, ONE WORKSHEET CAN BE USED FOR THOSE ZONES.

Step 1: Determine Occupancy Risk Parameter Factors - Use Table 1.
A. For each Risk Parameter in Table 1, select and circle the appropriate risk factor value. Choose only one for each of the five Risk Parameters.

TABLE 1. OCCUPANCY RISK PARAMETER FACTORS

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

Step 2: Compute Occupancy Risk Factor (F) - Use Table 2.
A. Transfer the circled risk factor values from Table 1 to the corresponding blocks in Table 2.
B. Compute F by multiplying the risk factor values as indicated in Table 2.

TABLE 2. OCCUPANCY RISK FACTOR CALCULATION

	M		D		L		T		A		F
OCCUPANCY RISK	3.2	X	1.5	X	1.1	X	1.2	X	1.2	=	7.6

Step 3: Compute Adjusted Building Status (R) - Use Table 2.
A. If building is classified as "NEW" use Table 3A. If building is classified as "Existing" use Table 3B.
B. Transfer the value of F from Table 2 to Table 3A or Table 3B as appropriate. Calculate R.
C. Transfer R to the block labeled R in Table 7 on page 4 of the work sheet.

TABLE 3A. (NEW BUILDINGS)

	F		R
1.0 X	7.6	=	7.6 = 8

TABLE 3B. (EXISTING BUILDINGS)

	F		R
0.6 X		=	

*** FIRE/SMOKE ZONE is a space separated from all other spaces by floors, horizontal exits, or smoke barriers.**

SURVEYOR SIGNATURE	TITLE	DATE
Robert P. Imbalzano, FIRE SAFETY RESOURCES, LLC	PRESIDENT	10/04/13
FIRE AUTHORITY SIGNATURE	TITLE	DATE

Step 4: Determine Safety Parameter Values - Use Table 4.

A. Select and circle the safety value for each safety parameter in Table 4 that best describes the conditions in the zone. Choose only one value for each of the 13 parameters. If two or more appear to apply, choose the one with the lowest point value.

TABLE 4.

Safety Parameters	Safety Parameters Values						
1. Construction	Combustible Types III, IV, and V				NonCombustible Types I and II		
Floor or Zone	000	111	200	211 + 2HH	000	111	222, 332, 433
First	-2	(0)	-2	0	0	2	2
Second	-7	-2	-4	-2	-2	2	4
Third	-9	-7	-9	-7	-7	2	4
4th and Above	-13	-7	-13	-7	-9	-7	4

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

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

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

8. Hazardous Areas	Double Deficiency		Single Deficiency		No Deficiencies
	In Zone	Outside Zone	In Zone	In Adjacent Zone	
	-11	-5	-6	-2	(0)

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

10. Emergency Movement Routes	<2 Routes	Multiple Routes			
		Deficient	W/O Horizontal Exit(s)	Horizontal Exit(s)	Direct Exit(s)
	-8	-2	(0)	1	5

11. Manual Fire Alarm	No Manual Fire Alarm	Manual Fire Alarm	
		W/O F.D. Conn.	W/F.D. Conn
	-4	1	(2)

12. Smoke Detection and Alarm	None	Corridor Only	Rooms Only	Corridor and Habit. Spaces	Total Spaces In Zone
	0(3)[g]	(2)(3)[g]	3(3)[g]	4	5

13. Automatic Sprinklers	None	Corridor and Habit. Space	Entire Building		
	0	8	(10)		

NOTE:

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

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

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

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

For SI units: 1 ft = 0.3048 m

[e] Use (0) where Parameter 1 is based on first floor zone or on an unprotected type of construction (columns marked "000" or "200")

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

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

Step 5: Compute Individual Safety Evaluations – Use Table 5.

A. Transfer each of the 13 circled Safety Parameter Values from Table 4 to every unshaded block in the line with the corresponding Safety Parameter in Table 5. For Safety Parameter 13 (Sprinklers) the value entered in the People Movement Safety column is recorded in Table 5 as ½ the corresponding value circled in Table 4.

B. Add the four columns, keeping in mind that any negative numbers deduct.

C. Transfer the resulting total values for S_1, S_2, S_3, S_G to blocks labeled S_1, S_2, S_3, S_G in Table 7 on page 4 of this sheet.

TABLE 5. INDIVIDUAL SAFETY EVALUATIONS

Safety Parameters	Containment Safety (S_1)	Extinguishment Safety (S_2)	People Movement Safety (S_3)	General Safety (S_4)
1. Construction	0	0		0
2. Interior Finish (Corr. and Exit)	3		3	3
3. Interior Finish (Rooms)	3			3
4. Corridor Partitions/Walls	0			0
5. Doors to Corridor	1		1	1
6. Zone Dimensions			0	0
7. Vertical Openings	0		0	0
8. Hazardous Areas	0	0		0
9. Smoke Control			-5	-5
10. Emergency Movement Routes			0	0
11. Manual Fire Alarm		2		2
12. Smoke Detection and Alarm		3	3	3
13. Automatic Sprinklers	10	10	10 ÷ 2 = 5	10
Total Value	S_1= 17	S_2= 15	S_3= 7	S_4= 17

TABLE 6.
MANDATORY SAFETY REQUIREMENTS (FOR USE IN HOSPITALS OR NURSING HOMES)

Zone Location	Containment (S_a)		Extinguishment (S_b)		People Movement (S_c)	
	New	Exist.	New	Exist.	New	Exist.
1st story	(11)	5	(15)(12)[a]	4	(8)(5)[a]	1
2nd or 3rd story[b]	15	9	17(14)[a]	6	10(7)[a]	3
4th story or higher	18	9	19(16)[a]	6	11(8)[a]	3

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

b. For a 2nd story zone location in a sprinklered EXISTING facility, as an alternative to the mandatory safety requirement values set specified in the table, the following mandatory values *set* shall be permitted to be used: S_a=7, S_b=10, and S_c=7

Step 6: Determine Mandatory Safety Requirement Values - Use Table 6.

A. Using the classification of the building (i.e., New or Existing) and the floor where the zone is located circle the appropriate value in each of the three columns in Table 6.

B. Transfer the three circled values from Table 6 to the blocks marked S_a, S_b, and S_c in Table 7.

C. For each row check "Yes" if the value in the answer block is zero or greater. Check "No" if the value in the answer block is a negative number.

TABLE 7. ZONE FIRE SAFETY EQUIVALENCY EVALUATION								Yes	No
Containment Safety (S_1)	minus	Mandatory Containment (S_a)	≥ 0	S_1 17	−	S_a 11	= C 6	✓	
Extinguishment Safety (S_2)	minus	Mandatory Extinguishment (S_b)	≥ 0	S_2 15	−	S_b 15	= E 0	✓	
People Movement Safety (S_3)	minus	Mandatory People Movement (S_c)	≥ 0	S_3 7	−	S_c 8	= P -1		✓
General Safety (S_4)	minus	Occupancy Risk (R)	≥ 0	S_4 17	−	R 8	= G 9	✓	

TABLE 8. FACILITY FIRE SAFETY REQUIREMENTS WORKSHEET				
Complete one copy of this worksheet for each facility. For each consideration, select and mark the appropriate column.		Met	Not Met	Not Applic.
A.	Building utilities conform to the requirements of Section 9.1.	✓		
B.	In new facilities only, life-support systems, alarms, emergency communication systems, and illumination of generator set locations are powered as prescribed by 18.5.1.2 and 18.5.1.3.	✓		
C.	Heating and air conditioning systems conform with the air conditioning, heating, and ventilating systems requirements within Section 9.2, except for enclosure of vertical openings, which have been considered in Safety Parameter 7 of Worksheet 4.7.6.	✓		
D.	Fuel-burning space heaters and portable electrical space heaters are not used.	✓		
E.	There are no flue-fed incinerators.	✓		
F.	An evacuation plan is provided and fire drills conducted in accordance with 18.7.1/18.7.2 and 19.7.1/19.7.2.	✓		
G.	Smoking regulations have been adopted and implemented in accordance with 18.7.4 and 19.7.4.	✓		
H.	Draperies, upholstered furniture, mattresses, furnishings, and decoration combustibility is limited in accordance with 18.7.5 and 19.7.5.	✓		
I.	Fire extinguishers are provided in accordance with the requirements of 18.3.5.4 and 19.3.5.6.	✓		
J.	Exit signs are provided in accordance with the requirements of 18.2.10.1 and 19.2.10.	✓		
K.	Emergency lighting is provided in accordance with 18.2.9.1 or 19.2.9.	✓		
L.	Standpipes are provided in all new high rise buildings as required by 18.4.2.			✓

CONCLUSIONS

1. ☐ All of the checks in Table 7 are in the "Yes" column. The level of fire safety is at least equivalent to that prescribed by the *Life Safety Code*.*

2. ☒ One of more of the checks in Table 7 are in the "No" column. The level of fire safety is not shown by this system to be equivalent to that prescribed by the *Life Safety Code*.*

*The equivalency covered by this worksheet includes the majority of considerations covered by the *Life Safety Code*. There are a few considerations that are not evaluated by this method. These must be considered separately. These additional considerations are covered in Table 8, the "Facility Fire Safety Requirements Worksheet." One copy of this separate worksheet is to be completed for each facility.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0242. The time required to complete this information collection is estimated to average 5 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, Attn: PRA Reports Clearance Officer, 7500 Security Boulevard, Baltimore, Maryland 21244-1850.

Table 5 Alternate Facility LIFECARE GREENBUSH MANOR - #245616 Zone # 1 Date: 10/01/13

Safety Parameters	As Is				Alt. 1				Alt. 2				Alt. 3			
	Containment (S_1)	Extinguishment (S_2)	People Movement (S_3)	General Safety (S_G)	Containment (S_1)	Extinguishment (S_2)	People Movement (S_3)	General Safety (S_G)	Containment (S_1)	Extinguishment (S_2)	People Movement (S_3)	General Safety (S_G)	Containment (S_1)	Extinguishment (S_2)	People Movement (S_3)	General Safety (S_G)
1. Construction	0	0		0	0	0		0								
2. Interior Finish (Corr.& Exit)	3		3	3	3		3	3								
3. Interior Finish (Rooms)	3			3	3			3								
4. Corridor Partitions/Walls	0			0	0			0								
5. Doors to Corridor	1		1	1	1		1	1								
6. Zone Dimensions			0	0			0	0								
7. Vertical Openings	0		0	0	0		0	0								
8. Hazardous Areas	0	0		0	0	0		0								
9. Smoke Control			-5	-5			-5	-5								
10. Emergency Movement Routes			0	0			0	0								
11. Manual Fire Alarm		2		2		2		2								
12. Smoke Detection & Alarm		3	3	3		4	4	4								
13. Automatic Sprinklers	10	10	5 ½	10	10	10	5 ½	10			½				½	
A. Total Value	17	15	7	17	17	16	8	18								
B. Mandatory Values	11	15	8	8	11	15	8	8								
C. Difference Between A & B	6	0	-1	9	6	1	0	10								
D. If C is 0 or more. check box	✓	✓		✓	✓	✓	✓	✓								

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

Form Approved
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ZONE 2 OF 4 ZONES

FIRE/SMOKE ZONE* EVALUATION WORKSHEET FOR HEALTH CARE FACILITIES

2000 LIFE SAFETY CODE

FACILITY	BUILDING
LIFECARE GREENBUSH MANOR	02-GREENBUSH MANOR
ZONE(S) EVALUATED: EDGEWOOD	
PROVIDER/VENDOR NO.: 245616	DATE OF SURVEY: 10/01/13

COMPLETE THIS WORKSHEET FOR EACH ZONE. WHERE CONDITIONS ARE THE SAME IN SEVERAL ZONES, ONE WORKSHEET CAN BE USED FOR THOSE ZONES.

Step 1: Determine Occupancy Risk Parameter Factors - Use Table 1.
A. For each Risk Parameter in Table 1, select and circle the appropriate risk factor value. Choose only one for each of the five Risk Parameters.

TABLE 1. OCCUPANCY RISK PARAMETER FACTORS

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

Step 2: Compute Occupancy Risk Factor (F) - Use Table 2.
A. Transfer the circled risk factor values from Table 1 to the corresponding blocks in Table 2.
B. Compute F by multiplying the risk factor values as indicated in Table 2.

TABLE 2. OCCUPANCY RISK FACTOR CALCULATION

	M		D		L		T		A		F
OCCUPANCY RISK	3.2	X	1.5	X	1.1	X	1.2	X	1.2	=	7.6

Step 3: Compute Adjusted Building Status (R) - Use Table 2.
A. If building is classified as "NEW" use Table 3A. If building is classified as "Existing" use Table 3B.
B. Transfer the value of F from Table 2 to Table 3A or Table 3B as appropriate. Calculate R.
C. Transfer R to the block labeled R in Table 7 on page 4 of the work sheet.

TABLE 3A. (NEW BUILDINGS)

	F		R
1.0 X	7.6	=	7.6 = 8

TABLE 3B. (EXISTING BUILDINGS)

	F		R
0.6 X		=	

*** FIRE/SMOKE ZONE is a space separated from all other spaces by floors, horizontal exits, or smoke barriers.**

SURVEYOR SIGNATURE	TITLE	DATE
Robert V. Imbalzano — FIRE SAFETY RESOURCES, LLC	PRESIDENT	10/04/13
FIRE AUTHORITY SIGNATURE	TITLE	DATE

Step 4: Determine Safety Parameter Values - Use Table 4.

A. Select and circle the safety value for each safety parameter in Table 4 that best describes the conditions in the zone. Choose only one value for each of the 13 parameters. If two or more appear to apply, choose the one with the lowest point value.

TABLE 4.

Safety Parameters	Safety Parameters Values						
1. Construction	Combustible Types III, IV, and V				NonCombustible Types I and II		
Floor or Zone	000	111	200	211 + 2HH	000	111	222, 332, 433
First	-2	(0)	-2	0	0	2	2
Second	-7	-2	-4	-2	-2	2	4
Third	-9	-7	-9	-7	-7	2	4
4th and Above	-13	-7	-13	-7	-9	-7	4

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

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

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

8. Hazardous Areas	Double Deficiency		Single Deficiency		No Deficiencies
	In Zone	Outside Zone	In Zone	In Adjacent Zone	
	-11	-5	-6	-2	(0)

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

10. Emergency Movement Routes	<2 Routes	Multiple Routes			
		Deficient	W/O Horizontal Exit(s)	Horizontal Exit(s)	Direct Exit(s)
	-8	-2	(0)	1	5

11. Manual Fire Alarm	No Manual Fire Alarm	Manual Fire Alarm	
		W/O F.D. Conn.	W/F.D. Conn
	-4	1	(2)

12. Smoke Detection and Alarm	None	Corridor Only	Rooms Only	Corridor and Habit. Spaces	Total Spaces In Zone
	0(3)[g]	2(3)[g]	3(3)[g]	4	5

13. Automatic Sprinklers	None	Corridor and Habit. Space	Entire Building		
	0	8	(10)		

NOTE:

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

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

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

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

For SI units: 1 ft = 0.3048 m

[e] Use (0) where Parameter 1 is based on first floor zone or on an unprotected type of construction (columns marked "000" or "200")

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

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

Step 5: Compute Individual Safety Evaluations – Use Table 5.

A. Transfer each of the 13 circled Safety Parameter Values from Table 4 to every unshaded block in the line with the corresponding Safety Parameter in Table 5. For Safety Parameter 13 (Sprinklers) the value entered in the People Movement Safety column is recorded in Table 5 as ½ the corresponding value circled in Table 4.

B. Add the four columns, keeping in mind that any negative numbers deduct.

C. Transfer the resulting total values for S_1, S_2, S_3, S_G to blocks labeled S_1, S_2, S_3, S_G in Table 7 on page 4 of this sheet.

TABLE 5. INDIVIDUAL SAFETY EVALUATIONS

Safety Parameters	Containment Safety (S_1)	Extinguishment Safety (S_2)	People Movement Safety (S_3)	General Safety (S_4)
1. Construction	0	0		0
2. Interior Finish (Corr. and Exit)	3		3	3
3. Interior Finish (Rooms)	3			3
4. Corridor Partitions/Walls	0			0
5. Doors to Corridor	1		1	1
6. Zone Dimensions			0	0
7. Vertical Openings	0		0	0
8. Hazardous Areas	0	0		0
9. Smoke Control			-5	-5
10. Emergency Movement Routes			0	0
11. Manual Fire Alarm		2		2
12. Smoke Detection and Alarm		3	3	3
13. Automatic Sprinklers	10	10	10 ÷ 2 = 5	10
Total Value	S_1= 17	S_2= 15	S_3= 7	S_4= 17

TABLE 6.
MANDATORY SAFETY REQUIREMENTS (FOR USE IN HOSPITALS OR NURSING HOMES)

Zone Location	Containment (S_a)		Extinguishment (S_b)		People Movement (S_c)	
	New	Exist.	New	Exist.	New	Exist.
1st story	(11)	5	15(12)[a]	4	8(5)[a]	1
2nd or 3rd story[b]	15	9	17(14)[a]	6	10(7)[a]	3
4th story or higher	18	9	19(16)[a]	6	11(8)[a]	3

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

b. For a 2nd story zone location in a sprinklered EXISTING facility, as an alternative to the mandatory safety requirement values set specified in the table, the following mandatory values *set* shall be permitted to be used: S_a=7, S_b=10, and S_c=7

Step 6: Determine Mandatory Safety Requirement Values - Use Table 6.

A. Using the classification of the building (i.e., New or Existing) and the floor where the zone is located circle the appropriate value in each of the three columns in Table 6.

B. Transfer the three circled values from Table 6 to the blocks marked S_a, S_b, and S_c in Table 7.

C. For each row check "Yes" if the value in the answer block is zero or greater. Check "No" if the value in the answer block is a negative number.

TABLE 7. ZONE FIRE SAFETY EQUIVALENCY EVALUATION								Yes	No
Containment Safety (S_1)	minus	Mandatory Containment (S_a)	≥ 0	S_1 17	−	S_a 11	= C 6	✓	
Extinguishment Safety (S_2)	minus	Mandatory Extinguishment (S_b)	≥ 0	S_2 15	−	S_b 15	= E 0	✓	
People Movement Safety (S_3)	minus	Mandatory People Movement (S_c)	≥ 0	S_3 7	−	S_c 8	= P -1		✓
General Safety (S_4)	minus	Occupancy Risk (R)	≥ 0	S_4 17	−	R 8	= G 9	✓	

TABLE 8. FACILITY FIRE SAFETY REQUIREMENTS WORKSHEET				
Complete one copy of this worksheet for each facility. For each consideration, select and mark the appropriate column.		Met	Not Met	Not Applic.
A.	Building utilities conform to the requirements of Section 9.1.	✓		
B.	In new facilities only, life-support systems, alarms, emergency communication systems, and illumination of generator set locations are powered as prescribed by 18.5.1.2 and 18.5.1.3.	✓		
C.	Heating and air conditioning systems conform with the air conditioning, heating, and ventilating systems requirements within Section 9.2, except for enclosure of vertical openings, which have been considered in Safety Parameter 7 of Worksheet 4.7.6.	✓		
D.	Fuel-burning space heaters and portable electrical space heaters are not used.	✓		
E.	There are no flue-fed incinerators.	✓		
F.	An evacuation plan is provided and fire drills conducted in accordance with 18.7.1/18.7.2 and 19.7.1/19.7.2.	✓		
G.	Smoking regulations have been adopted and implemented in accordance with 18.7.4 and 19.7.4.	✓		
H.	Draperies, upholstered furniture, mattresses, furnishings, and decoration combustibility is limited in accordance with 18.7.5 and 19.7.5.	✓		
I.	Fire extinguishers are provided in accordance with the requirements of 18.3.5.4 and 19.3.5.6.	✓		
J.	Exit signs are provided in accordance with the requirements of 18.2.10.1 and 19.2.10.	✓		
K.	Emergency lighting is provided in accordance with 18.2.9.1 or 19.2.9.	✓		
L.	Standpipes are provided in all new high rise buildings as required by 18.4.2.			✓

CONCLUSIONS

1. ☐ All of the checks in Table 7 are in the "Yes" column. The level of fire safety is at least equivalent to that prescribed by the *Life Safety Code*.*

2. ☒ One of more of the checks in Table 7 are in the "No" column. The level of fire safety is not shown by this system to be equivalent to that prescribed by the *Life Safety Code*.*

*The equivalency covered by this worksheet includes the majority of considerations covered by the *Life Safety Code*. There are a few considerations that are not evaluated by this method. These must be considered separately. These additional considerations are covered in Table 8, the "Facility Fire Safety Requirements Worksheet." One copy of this separate worksheet is to be completed for each facility.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0242. The time required to complete this information collection is estimated to average 5 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, Attn: PRA Reports Clearance Officer, 7500 Security Boulevard, Baltimore, Maryland 21244-1850.

Table 5 Alternate Facility LIFECARE GREENBUSH MANOR – #245616 Zone # 2 Date: 10/01/13

Safety Parameters	As Is				Alt. 1				Alt. 2				Alt. 3			
	Containment (S_1)	Extinguishment (S_2)	People Movement (S_3)	General Safety (S_G)	Containment (S_1)	Extinguishment (S_2)	People Movement (S_3)	General Safety (S_G)	Containment (S_1)	Extinguishment (S_2)	People Movement (S_3)	General Safety (S_G)	Containment (S_1)	Extinguishment (S_2)	People Movement (S_3)	General Safety (S_G)
1. Construction	0	0		0	0	0		0								
2. Interior Finish (Corr.& Exit)	3		3	3	3		3	3								
3. Interior Finish (Rooms)	3			3	3			3								
4. Corridor Partitions/Walls	0			0	0			0								
5. Doors to Corridor	1		1	1	1		1	1								
6. Zone Dimensions			0	0			0	0								
7. Vertical Openings	0		0	0	0		0	0								
8. Hazardous Areas	0	0		0	0	0		0								
9. Smoke Control			-5	-5			-5	-5								
10. Emergency Movement Routes			0	0			0	0								
11. Manual Fire Alarm		2		2		2		2								
12. Smoke Detection & Alarm		3	3	3		4	4	4								
13. Automatic Sprinklers	10	10	5 ½	10	10	10	5 ½	10			½				½	
A. Total Value	17	15	7	17	17	16	8	18								
B. Mandatory Values	11	15	8	8	11	15	8	8								
C. Difference Between A & B	6	0	-1	9	6	1	0	10								
D. If C is 0 or more, check box	✓	✓		✓	✓	✓	✓	✓								

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

Form Approved
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ZONE 3 OF 4 ZONES

FIRE/SMOKE ZONE* EVALUATION WORKSHEET FOR HEALTH CARE FACILITIES

2000 LIFE SAFETY CODE

FACILITY	BUILDING
LIFECARE GREENBUSH MANOR	02-GREENBUSH MANOR
ZONE(S) EVALUATED	
ADMINISTRATIVE/COMMUNITY ROOM WING	
PROVIDER/VENDOR NO.	DATE OF SURVEY
245616	10/01/13

COMPLETE THIS WORKSHEET FOR EACH ZONE. WHERE CONDITIONS ARE THE SAME IN SEVERAL ZONES, ONE WORKSHEET CAN BE USED FOR THOSE ZONES.

Step 1: Determine Occupancy Risk Parameter Factors - Use Table 1.
A. For each Risk Parameter in Table 1, select and circle the appropriate risk factor value. Choose only one for each of the five Risk Parameters.

TABLE 1. OCCUPANCY RISK PARAMETER FACTORS

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

Step 2: Compute Occupancy Risk Factor (F) - Use Table 2.
A. Transfer the circled risk factor values from Table 1 to the corresponding blocks in Table 2.
B. Compute F by multiplying the risk factor values as indicated in Table 2.

TABLE 2. OCCUPANCY RISK FACTOR CALCULATION

	M		D		L		T		A		F
OCCUPANCY RISK	3.2	X	2.0	X	1.1	X	1.2	X	1.2	=	10.1

Step 3: Compute Adjusted Building Status (R) - Use Table 2.
A. If building is classified as "NEW" use Table 3A. If building is classified as "Existing" use Table 3B.
B. Transfer the value of F from Table 2 to Table 3A or Table 3B as appropriate. Calculate R.
C. Transfer R to the block labeled R in Table 7 on page 4 of the work sheet.

TABLE 3A. (NEW BUILDINGS)

	F		R
1.0 X	10.1	=	10.1 = 11

TABLE 3B. (EXISTING BUILDINGS)

	F		R
0.6 X		=	

*** FIRE/SMOKE ZONE is a space separated from all other spaces by floors, horizontal exits, or smoke barriers.**

SURVEYOR SIGNATURE	TITLE	DATE
Robert J. Umholtz, FIRE SAFETY RESOURCES, LLC	PRESIDENT	10/04/13
FIRE AUTHORITY SIGNATURE	TITLE	DATE

Step 4: Determine Safety Parameter Values - Use Table 4.

A. Select and circle the safety value for each safety parameter in Table 4 that best describes the conditions in the zone. Choose only one value for each of the 13 parameters. If two or more appear to apply, choose the one with the lowest point value.

TABLE 4.

Safety Parameters	Safety Parameters Values						
1. Construction	Combustible Types III, IV, and V				NonCombustible Types I and II		
Floor or Zone	000	111	200	211 + 2HH	000	111	222, 332, 433
First	-2	(0)	-2	0	0	2	2
Second	-7	-2	-4	-2	-2	2	4
Third	-9	-7	-9	-7	-7	2	4
4th and Above	-13	-7	-13	-7	-9	-7	4

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

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

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

8. Hazardous Areas	Double Deficiency		Single Deficiency		No Deficiencies
	In Zone	Outside Zone	In Zone	In Adjacent Zone	
	-11	-5	-6	-2	(0)

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

10. Emergency Movement Routes	<2 Routes	Multiple Routes			
		Deficient	W/O Horizontal Exit(s)	Horizontal Exit(s)	Direct Exit(s)
	-8	-2	(0)	1	5

11. Manual Fire Alarm	No Manual Fire Alarm	Manual Fire Alarm	
		W/O F.D. Conn.	W/F.D. Conn
	-4	1	(2)

12. Smoke Detection and Alarm	None	Corridor Only	Rooms Only	Corridor and Habit. Spaces	Total Spaces In Zone
	0(3)[g]	(2)(3)[g]	3(3)[g]	4	5

13. Automatic Sprinklers	None	Corridor and Habit. Space	Entire Building	
	0	8	(10)	

NOTE:

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

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

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

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

For SI units: 1 ft = 0.3048 m

[e] Use (0) where Parameter 1 is based on first floor zone or on an unprotected type of construction (columns marked "000" or "200")

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

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

Step 5: Compute Individual Safety Evaluations – Use Table 5.

A. Transfer each of the 13 circled Safety Parameter Values from Table 4 to every unshaded block in the line with the corresponding Safety Parameter in Table 5. For Safety Parameter 13 (Sprinklers) the value entered in the People Movement Safety column is recorded in Table 5 as ½ the corresponding value circled in Table 4.

B. Add the four columns, keeping in mind that any negative numbers deduct.

C. Transfer the resulting total values for S_1, S_2, S_3, S_G to blocks labeled S_1, S_2, S_3, S_G in Table 7 on page 4 of this sheet.

TABLE 5. INDIVIDUAL SAFETY EVALUATIONS

Safety Parameters	Containment Safety (S_1)	Extinguishment Safety (S_2)	People Movement Safety (S_3)	General Safety (S_4)
1. Construction	0	0		0
2. Interior Finish (Corr. and Exit)	3		3	3
3. Interior Finish (Rooms)	3			3
4. Corridor Partitions/Walls	1			1
5. Doors to Corridor	1		1	1
6. Zone Dimensions			-2	-2
7. Vertical Openings	0		0	0
8. Hazardous Areas	0	0		0
9. Smoke Control			-5	-5
10. Emergency Movement Routes			0	0
11. Manual Fire Alarm		2		2
12. Smoke Detection and Alarm		3	3	3
13. Automatic Sprinklers	10	10	10 ÷ 2 = 5	10
Total Value	S_1= 18	S_2= 15	S_3= 5	S_4= 16

TABLE 6.
MANDATORY SAFETY REQUIREMENTS (FOR USE IN HOSPITALS OR NURSING HOMES)

Zone Location	Containment (S_a)		Extinguishment (S_b)		People Movement (S_c)	
	New	Exist.	New	Exist.	New	Exist.
1st story	(11)	5	15(12)[a]	4	8(5)[a]	1
2nd or 3rd story[b]	15	9	17(14)[a]	6	10(7)[a]	3
4th story or higher	18	9	19(16)[a]	6	11(8)[a]	3

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

b. For a 2nd story zone location in a sprinklered EXISTING facility, as an alternative to the mandatory safety requirement values set specified in the table, the following mandatory values *set* shall be permitted to be used: S_a=7, S_b=10, and S_c=7

Step 6: Determine Mandatory Safety Requirement Values - Use Table 6.

A. Using the classification of the building (i.e., New or Existing) and the floor where the zone is located circle the appropriate value in each of the three columns in Table 6.

B. Transfer the three circled values from Table 6 to the blocks marked S_a, S_b, and S_c in Table 7.

C. For each row check "Yes" if the value in the answer block is zero or greater. Check "No" if the value in the answer block is a negative number.

TABLE 7. ZONE FIRE SAFETY EQUIVALENCY EVALUATION								Yes	No
Containment Safety (S_1)	minus	Mandatory Containment (S_a)	≥ 0	S_1 18	−	S_a 11	= C 7	✓	
Extinguishment Safety (S_2)	minus	Mandatory Extinguishment (S_b)	≥ 0	S_2 15	−	S_b 12	= E 3	✓	
People Movement Safety (S_3)	minus	Mandatory People Movement (S_c)	≥ 0	S_3 5	−	S_c 5	= P 0	✓	
General Safety (S_4)	minus	Occupancy Risk (R)	≥ 0	S_4 16	−	R 11	= G 5	✓	

TABLE 8. FACILITY FIRE SAFETY REQUIREMENTS WORKSHEET				
Complete one copy of this worksheet for each facility. For each consideration, select and mark the appropriate column.		Met	Not Met	Not Applic.
A.	Building utilities conform to the requirements of Section 9.1.	✓		
B.	In new facilities only, life-support systems, alarms, emergency communication systems, and illumination of generator set locations are powered as prescribed by 18.5.1.2 and 18.5.1.3.	✓		
C.	Heating and air conditioning systems conform with the air conditioning, heating, and ventilating systems requirements within Section 9.2, except for enclosure of vertical openings, which have been considered in Safety Parameter 7 of Worksheet 4.7.6.	✓		
D.	Fuel-burning space heaters and portable electrical space heaters are not used.	✓		
E.	There are no flue-fed incinerators.	✓		
F.	An evacuation plan is provided and fire drills conducted in accordance with 18.7.1/18.7.2 and 19.7.1/19.7.2.	✓		
G.	Smoking regulations have been adopted and implemented in accordance with 18.7.4 and 19.7.4.	✓		
H.	Draperies, upholstered furniture, mattresses, furnishings, and decoration combustibility is limited in accordance with 18.7.5 and 19.7.5.	✓		
I.	Fire extinguishers are provided in accordance with the requirements of 18.3.5.4 and 19.3.5.6.	✓		
J.	Exit signs are provided in accordance with the requirements of 18.2.10.1 and 19.2.10.	✓		
K.	Emergency lighting is provided in accordance with 18.2.9.1 or 19.2.9.	✓		
L.	Standpipes are provided in all new high rise buildings as required by 18.4.2.			✓

CONCLUSIONS

1. ☒ All of the checks in Table 7 are in the "Yes" column. The level of fire safety is at least equivalent to that prescribed by the *Life Safety Code*.*

2. ☐ One of more of the checks in Table 7 are in the "No" column. The level of fire safety is not shown by this system to be equivalent to that prescribed by the *Life Safety Code*.*

*The equivalency covered by this worksheet includes the majority of considerations covered by the *Life Safety Code*. There are a few considerations that are not evaluated by this method. These must be considered separately. These additional considerations are covered in Table 8, the "Facility Fire Safety Requirements Worksheet." One copy of this separate worksheet is to be completed for each facility.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0242. The time required to complete this information collection is estimated to average 5 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, Attn: PRA Reports Clearance Officer, 7500 Security Boulevard, Baltimore, Maryland 21244-1850.

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

Form Approved
OMB Exempt

ZONE 4 OF 4 ZONES

FIRE/SMOKE ZONE* EVALUATION WORKSHEET FOR HEALTH CARE FACILITIES

2000 LIFE SAFETY CODE

FACILITY	BUILDING
LIFECARE GREENBUSH MANOR	02-GREENBUSH MANOR
ZONE(S) EVALUATED: SUPPORT SERVICES WING	
PROVIDER/VENDOR NO.: 245616	DATE OF SURVEY: 10/01/13

COMPLETE THIS WORKSHEET FOR EACH ZONE. WHERE CONDITIONS ARE THE SAME IN SEVERAL ZONES, ONE WORKSHEET CAN BE USED FOR THOSE ZONES.

Step 1: Determine Occupancy Risk Parameter Factors - Use Table 1.
A. For each Risk Parameter in Table 1, select and circle the appropriate risk factor value. Choose only one for each of the five Risk Parameters.

TABLE 1. OCCUPANCY RISK PARAMETER FACTORS

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

Step 2: Compute Occupancy Risk Factor (F) - Use Table 2.
A. Transfer the circled risk factor values from Table 1 to the corresponding blocks in Table 2.
B. Compute F by multiplying the risk factor values as indicated in Table 2.

TABLE 2. OCCUPANCY RISK FACTOR CALCULATION

	M		D		L		T		A		F
OCCUPANCY RISK	3.2	X	1.2	X	1.1	X	1.2	X	1.2	=	6.1

Step 3: Compute Adjusted Building Status (R) - Use Table 2.
A. If building is classified as "NEW" use Table 3A. If building is classified as "Existing" use Table 3B.
B. Transfer the value of F from Table 2 to Table 3A or Table 3B as appropriate. Calculate R.
C. Transfer R to the block labeled R in Table 7 on page 4 of the work sheet.

TABLE 3A. (NEW BUILDINGS)

	F		R
1.0 X	6.1	=	6.1 = 7

TABLE 3B. (EXISTING BUILDINGS)

	F		R
0.6 X		=	

*** FIRE/SMOKE ZONE is a space separated from all other spaces by floors, horizontal exits, or smoke barriers.**

SURVEYOR SIGNATURE	TITLE	DATE
Robert V. Imbalzano, FIRE SAFETY RESOURCES, LLC	PRESIDENT	10/04/13
FIRE AUTHORITY SIGNATURE	TITLE	DATE

Step 4: Determine Safety Parameter Values - Use Table 4.

A. Select and circle the safety value for each safety parameter in Table 4 that best describes the conditions in the zone. Choose only one value for each of the 13 parameters. If two or more appear to apply, choose the one with the lowest point value.

TABLE 4.

Safety Parameters	Safety Parameters Values						
1. Construction	Combustible Types III, IV, and V				NonCombustible Types I and II		
Floor or Zone	000	111	200	211 + 2HH	000	111	222, 332, 433
First	-2	(0)	-2	0	0	2	2
Second	-7	-2	-4	-2	-2	2	4
Third	-9	-7	-9	-7	-7	2	4
4th and Above	-13	-7	-13	-7	-9	-7	4

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

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

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

8. Hazardous Areas	Double Deficiency		Single Deficiency		No Deficiencies
	In Zone	Outside Zone	In Zone	In Adjacent Zone	
	-11	-5	-6	-2	(0)

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

10. Emergency Movement Routes	<2 Routes	Multiple Routes			
		Deficient	W/O Horizontal Exit(s)	Horizontal Exit(s)	Direct Exit(s)
	-8	-2	(0)	1	5

11. Manual Fire Alarm	No Manual Fire Alarm	Manual Fire Alarm	
		W/O F.D. Conn.	W/F.D. Conn
	-4	1	(2)

12. Smoke Detection and Alarm	None	Corridor Only	Rooms Only	Corridor and Habit. Spaces	Total Spaces In Zone
	0(3)[g]	2(3)[g]	3(3)[g]	(4)	5

13. Automatic Sprinklers	None	Corridor and Habit. Space	Entire Building	
	0	8	(10)	

NOTE:

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

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

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

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

For SI units: 1 ft = 0.3048 m

[e] Use (0) where Parameter 1 is based on first floor zone or on an unprotected type of construction (columns marked "000" or "200")

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

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

Step 5: Compute Individual Safety Evaluations – Use Table 5.

A. Transfer each of the 13 circled Safety Parameter Values from Table 4 to every unshaded block in the line with the corresponding Safety Parameter in Table 5. For Safety Parameter 13 (Sprinklers) the value entered in the People Movement Safety column is recorded in Table 5 as ½ the corresponding value circled in Table 4.

B. Add the four columns, keeping in mind that any negative numbers deduct.

C. Transfer the resulting total values for S_1, S_2, S_3, S_G to blocks labeled S_1, S_2, S_3, S_G in Table 7 on page 4 of this sheet.

TABLE 5. INDIVIDUAL SAFETY EVALUATIONS

Safety Parameters	Containment Safety (S_1)	Extinguishment Safety (S_2)	People Movement Safety (S_3)	General Safety (S_4)
1. Construction	0	0		0
2. Interior Finish (Corr. and Exit)	3		3	3
3. Interior Finish (Rooms)	3			3
4. Corridor Partitions/Walls	1			1
5. Doors to Corridor	1		1	1
6. Zone Dimensions			-2	-2
7. Vertical Openings	0		0	0
8. Hazardous Areas	0	0		0
9. Smoke Control			-5	-5
10. Emergency Movement Routes			0	0
11. Manual Fire Alarm		2		2
12. Smoke Detection and Alarm		4	4	4
13. Automatic Sprinklers	10	10	10 ÷ 2 = 5	10
Total Value	S_1= 18	S_2= 16	S_3= 6	S_4= 17

TABLE 6.
MANDATORY SAFETY REQUIREMENTS (FOR USE IN HOSPITALS OR NURSING HOMES)

Zone Location	Containment (S_a)		Extinguishment (S_b)		People Movement (S_c)	
	New	Exist.	New	Exist.	New	Exist.
1st story	(11)	5	15(12)[a]	4	8(5)[a]	1
2nd or 3rd story[b]	15	9	17(14)[a]	6	10(7)[a]	3
4th story or higher	18	9	19(16)[a]	6	11(8)[a]	3

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

b. For a 2nd story zone location in a sprinklered EXISTING facility, as an alternative to the mandatory safety requirement values set specified in the table, the following mandatory values *set* shall be permitted to be used: S_a=7, S_b=10, and S_c=7

Step 6: Determine Mandatory Safety Requirement Values - Use Table 6.

A. Using the classification of the building (i.e., New or Existing) and the floor where the zone is located circle the appropriate value in each of the three columns in Table 6.

B. Transfer the three circled values from Table 6 to the blocks marked S_a, S_b, and S_c in Table 7.

C. For each row check "Yes" if the value in the answer block is zero or greater. Check "No" if the value in the answer block is a negative number.

TABLE 7. ZONE FIRE SAFETY EQUIVALENCY EVALUATION								Yes	No
Containment Safety (S_1)	minus	Mandatory Containment (S_a)	≥ 0	S_1 18	−	S_a 11	= C 7	✓	
Extinguishment Safety (S_2)	minus	Mandatory Extinguishment (S_b)	≥ 0	S_2 16	−	S_b 12	= E 4	✓	
People Movement Safety (S_3)	minus	Mandatory People Movement (S_c)	≥ 0	S_3 6	−	S_c 5	= P 1	✓	
General Safety (S_4)	minus	Occupancy Risk (R)	≥ 0	S_4 17	−	R 7	= G 10	✓	

TABLE 8. FACILITY FIRE SAFETY REQUIREMENTS WORKSHEET				
Complete one copy of this worksheet for each facility. For each consideration, select and mark the appropriate column.		Met	Not Met	Not Applic.
A.	Building utilities conform to the requirements of Section 9.1.	✓		
B.	In new facilities only, life-support systems, alarms, emergency communication systems, and illumination of generator set locations are powered as prescribed by 18.5.1.2 and 18.5.1.3.	✓		
C.	Heating and air conditioning systems conform with the air conditioning, heating, and ventilating systems requirements within Section 9.2, except for enclosure of vertical openings, which have been considered in Safety Parameter 7 of Worksheet 4.7.6.	✓		
D.	Fuel-burning space heaters and portable electrical space heaters are not used.	✓		
E.	There are no flue-fed incinerators.	✓		
F.	An evacuation plan is provided and fire drills conducted in accordance with 18.7.1/18.7.2 and 19.7.1/19.7.2.	✓		
G.	Smoking regulations have been adopted and implemented in accordance with 18.7.4 and 19.7.4.	✓		
H.	Draperies, upholstered furniture, mattresses, furnishings, and decoration combustibility is limited in accordance with 18.7.5 and 19.7.5.	✓		
I.	Fire extinguishers are provided in accordance with the requirements of 18.3.5.4 and 19.3.5.6.	✓		
J.	Exit signs are provided in accordance with the requirements of 18.2.10.1 and 19.2.10.	✓		
K.	Emergency lighting is provided in accordance with 18.2.9.1 or 19.2.9.	✓		
L.	Standpipes are provided in all new high rise buildings as required by 18.4.2.			✓

CONCLUSIONS

1. ☒ All of the checks in Table 7 are in the "Yes" column. The level of fire safety is at least equivalent to that prescribed by the *Life Safety Code*.*

2. ☐ One of more of the checks in Table 7 are in the "No" column. The level of fire safety is not shown by this system to be equivalent to that prescribed by the *Life Safety Code*.*

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 8SC0

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00578N

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245616**
2.STATE VENDOR OR MEDICAID NO.
(L2) **850026600**

3. NAME AND ADDRESS OF FACILITY
(L3) **LIFECARE GREENBUSH MANOR**
(L4) **19120 200TH STREET**
(L5) **GREENBUSH, MN** (L6) **56726**

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 **07/26/2013** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 03 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

12.Total Facility Beds **40** (L18)

13.Total Certified Beds **40** (L17)

10.THE FACILITY IS CERTIFIED AS:

A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC

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

X B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	20	20		
(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):
At the time of the Standard survey completed July 19, 2013, the facility was not in substantial compliance with Federal certification regulations. Please refer to the CMS 2567 along with the facility's plan of correction. Post Certification Revisit to follow.

17. SURVEYOR SIGNATURE Date :
Sharron Williams, HFE NEII 08/21/2013 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath, Program Specialist 09/17/2013 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
04/13/2009
(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
Posted 9/18/2013 ML

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7011 2000 0002 5143 5223

August 13, 2013

Ms. Susan Lisell, Administrator
Lifecare Greenbush Manor
19120 200th Street
Greenbush, Minnesota 56726

RE: Project Number S5616005

Dear Ms. Lisell:

On July 26, 2013, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs. This survey found the most serious deficiencies in your facility to be isolated deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level D), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed. I

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

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

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

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

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

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

Informal Dispute Resolution - your right to request an informal reconsideration to dispute the attached deficiencies.

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

DEPARTMENT CONTACT

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

Lyla Burkman
Minnesota Department of Health
705 5th Street Northwest
Bemidji, Minnesota 56601

Telephone: (218) 308-2104
Fax: (218) 308-2122

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by September 4, 2013, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

PLAN OF CORRECTION (PoC)

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

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;

- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;

- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;

- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;

- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,

- Include signature of provider and date.

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

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

- Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));

- Per day civil money penalty (42 CFR 488.430 through 488.444).

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's PoC will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. In order for your allegation of compliance to be acceptable to the Department, the PoC 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 PoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable PoC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. A Post Certification Revisit (PCR) will occur after the date you identified that compliance was achieved in your plan of correction.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved PoC, unless it is determined that either correction actually occurred between the latest correction date on the PoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the PoC.

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by October 26, 2013 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by January 26, 2014 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

This request must be sent within the same ten days you have for submitting a PoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_idr.cfm

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

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

Feel free to contact me if you have questions related to this letter.

Sincerely,

Mark Meath

Mark Meath, Program Specialist
Program Assurance Unit
Licensing and Certification Program
Division of Compliance Monitoring
P.O. Box 64900
St. Paul, Minnesota 55164-0900
Telephone: (651) 201-4118 Fax: (651) 215-9697
Email: mark.meath@state.mn.us

Enclosure

cc: Licensing and Certification File 5616s13.rtf

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245616	A. BUILDING _____ B. WING _____ RECEIVED AUG 29 2013	07/26/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFECARE GREENBUSH MANOR	19120 200TH STREET GREENBUSH, MN 56726

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. Upon receipt of an acceptable POC an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000	POC DK 8/29/13 SB	
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide a wheelchair pressure redistribution cushion as the plan of care (POC) directed for 1 of 2 residents (R1) reviewed for the risk of pressure ulcer development. Findings include: R1's current POC printed 7/25/13, indicated R1 was to have a pressure redistribution cushion in his wheelchair.	F 282	1. (R1) Plan of care indicates that resident uses manual wheelchair. Resident is independent for wheelchair use on unit, and propels self. R1 does not use any foot rests and staff ensures footwear is worn. 2. Braden scale performed quarterly to assess for skin problems or irritation. 3. Following Plan of Care to reposition every 2 to 3 hours to prevent any skin breakdown. 4. Memory foam cushion placed in wheel chair to enhance resident's skin integrity and prevent any risk for pressure development. 5. Residents that are care planned to have a wheel chair cushion added to nurse aide daily care sheet. A yellow dot applied to all wheel chairs on the back in the right upper corner that are care planned to have wheel chair cushion. Continued on page 2	

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

Susan C. Rissell | Administrator | 8/26/13

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 282	Continued From page 1 On 7/24/13, at 9:06 a.m. R1 was observed in his wheelchair with no cushion present. At 12:23 p.m. R1 was observed in his wheelchair with no cushion in his wheelchair. At 1:00 p.m. R1 was observed in his wheelchair in his room with no cushion present. On 7/25/13, during continuous observation from 7:11 a.m. until 9:36 a.m. R1 was observed up in the wheelchair without a cushion in the wheelchair. On 7/25/13, at 11:08 a.m. registered nurse (RN) -A verified the POC was not followed.	F 282	6. Educational meetings regarding the importance of following Plan of Care to be held August 20th and 22nd, 2013 for all direct care and nursing staff. Communicated through weekly communication sheet to all staff. 7. Care plans are now printed when MDS is opened by MDS nurse, and given to assessment nurse to review, and note changes on paper copy. Care plan then returned to MDS nurse to review changes and make adjustments. 8. Ongoing random positioning/pressure relieving device audits, including direct observation, will continue x 1 month, and then monthly x 3 months. Results reported to Quality Assurance Committee and Medical Director. At this time the QA Committee will make the decision/recommendation regarding any necessary follow-up studies. Date of completion: August 26, 2013	
F 311 SS=D	483.25(a)(2) TREATMENT/SERVICES TO IMPROVE/MAINTAIN ADLS A resident is given the appropriate treatment and services to maintain or improve his or her abilities specified in paragraph (a)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide assistance with eating for 1 of 1 resident (R34) during 1 of 3 meal time observations. Findings include: R34 was diagnosed with multiple sclerosis (a chronic disabling disease that attacks the brain,	F 311	1. (R34) Screening done by occupational therapy on August 2, 2013 to screen for any adaptive wear to be used at meals. 2. (F34) Wheelchair company has ordered parts and adjustments made on August 22, 2013 to help make the wheelchair more adaptable to resident. 3. Screenings by OT to be done annually and as needed on any resident with MS. 4. (R34) Staff instructed to offer assistance at every meal and snack. Offer alternative food to enhance dining experience. Continued on page 3	

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F 311	Continued From page 2 spinal cord, and optic nerves). The quarterly MDS dated 6/2/13, indicated R34 had intact cognition and required limited assistance of one staff to eat. The Nutrition Care Area Assessment (CAA) dated 12/13/12, indicated on some days, R34 required staff assistance to eat. The CAA also indicated it took R34 quite awhile to finish a meal. The current plan of care (POC) printed 7/25/13, indicated R34 was independent with meals after set-up. In addition, the POC indicated R34 was soft spoken and directed staff to listen closely and request R34 to repeat himself as needed for understanding. On 7/25/13, at 8:20 a.m. nursing assistant (NA)-B was observed to serve R34 breakfast in the dining room. The meal included: a slice of toast, scrambled eggs, half of a banana, orange pieces, cold cereal, water, juice and coffee. At 8:30 a.m. R34 was observed to independently take a bite of cold cereal with his spoon. At 8:47 a.m. R34 was observed to have a straw in his mouth and attempted to hold the cereal bowl up towards his mouth to drink the remaining milk from the bowl. At 8:48 a.m. NA-B was observed to hold the bowl for R34 and he was able to finish the milk. At 8:55 a.m. NA-B was observed to move the plate of scrambled eggs and toast in front of R34 and walk away. R34 was observed to poke a fork into the half slice of toast.	F 311	Encourage independent eating with adaptive wear first, and then offer assistance. 5. Observation audit to be completed by Dietary Manager or designee weekly on observing dining experience. To be completed weekly x 4 weeks, then monthly x 3 months. Results forwarded to Quality Assurance Committee. At this time the QA Committee will make the decision/re-recommendation regarding any necessary follow-up studies. 6. Date of completion: August 26, 2013	

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F 311	Continued From page 3 At 8:57 a.m. R34 was observed to put down the fork and attempted to pick up the half of piece of toast with his right hand. At 9:00 a.m. R34 was observed to take the first bite of toast. (40 minutes after the toast was served to him). At 9:04 a.m. R34 was observed to pick up his spoon and place it into the scrambled eggs and take his first bite of the eggs (45 minutes after the eggs were served to him). In doing so, some of the scrambled eggs was observed to fall into the right side of R34's wheelchair and also onto the floor. At 9:09 a.m. R34 was observed to pick up some more of the scrambled eggs with his right hand and then watched as most of them fell onto his wheelchair and the floor. R34 picked up an empty spoon and placed it into his mouth. R34 was heard using profanity when referring to the eggs. R34 was then observed to push part of the scrambled eggs off the right side of his wheelchair with the spoon and then use his napkin to clean that side of his wheelchair off. R34 used profanity again. R34 was then observed to pick up a wet wipe off the table and attempt to clean the right side of his wheelchair where where the scrambled eggs had fallen.	F 311		
	At 9:11 a.m. R34 was observed to pick up his coffee cup and drink without the use of a straw. R34 was heard using profanity again. At 9:12 a.m. R34 was observed to reach for the last half of the piece of toast and take a bite. (52 minutes after the toast was served to him).			

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F 311	Continued From page 4 At 9:17 a.m. R34 was observed to put the empty spoon to his mouth. At 9:21 a.m. NA-A was observed to approach R34 and state, "Do you want some help?" NA-A was observed to stand next to R34 while she fed him the eggs until they were gone. At 9:23 a.m. NA-A stated to R34, "How are the eggs this morning?" and was observed to remain standing while giving R34 a drink of coffee. At 9:24 a.m. NA-A stated to R34, "You just need to ask if you need help." NA-A observed to hold up R34's plate so he was able to pick up the half of banana. At 9:30 a.m. in a very low and quiet tone of voice, R34 stated he usually fed himself, however, was feeling kind of tired this morning. R34 verified sometimes the staff needed to help him eat, depending on how tired he was. On 7/25/13, at 10:54 a.m. NA-A stated R34 was a slow eater. At 11:09 a.m. registered nurse (RN)-A verified R34 took a long time to eat. RN-A stated although R34 liked to be as independent as possible the nursing staff should be approaching and offering him assistance to eat at all meals. At 11:17 a.m. RN-A stated any staff walking through the dining room should ask R34 if he needed help to eat. RN-A verified it was hard for R34 to ask staff for help because he was	F 311		

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F 311	Continued From page 5 positioned in the dining room his back towards the staff as they walked by him. At 11:28 a.m. NA-B stated either herself or another staff member should assist R34 as needed during breakfast. A policy was requested and none was provided.	F 311		
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide a pressure redistribution cushion in the wheelchair for 1 of 2 residents (R1) reviewed for the risk of pressure ulcer (PU) development. Findings include: R1 was diagnosed with cerebral palsy and anxiety. The quarterly Minimum Data Set (MDS) dated 5/11/13, indicated R1 had severe cognitive impairment, was at risk for the development of PU's and required the use of pressure reducing device in the wheelchair.	F 314	1. (R1) Plan of care indicates that resident uses manual wheelchair. Resident is independent for wheelchair use on unit, and propels self. R1 does not use any foot rests and staff ensures footwear is worn. 2. Braden scales performed quarterly to assess for skin problems or irritation. 3. Following Plan of care to reposition every 2 to 3 hours to prevent any skin breakdown. 4. Added to nurse aide daily care sheet of residents that are care planned to have a wheelchair cushion, and a yellow dot applied to all wheelchairs on the back in the right upper corner that are care planned to have wheelchair cushion. 5. Educational meetings regarding the importance of following Plan of Care to be held on August 20th and 22nd, 2013 for all direct care and nursing staff. Communicated through weekly communication sheet to all staff. 6. Plan of Care to be reviewed by opposite MDS Coordinator and overseen by Director of Nursing, weekly x 4 weeks, then monthly x 3 months. Results reported to Quality Assurance Committee and Medical Director. Continued on page 7	

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F 314	Continued From page 6 The Braden Scale (a tool for predicting the risk of pressure ulcer development) dated 5/5/13, indicated R1 was at risk for PU development. The current plan of care (POC) printed 7/25/13, indicated R1 was to have a pressure relief cushion in his wheelchair and directed staff to toilet and reposition R1 every two to three hours. On 7/24/13, at 9:06 a.m. R1 was observed in the wheelchair with no cushion present. At 12:23 p.m. R1 was observed in the wheelchair with no cushion in his wheelchair. At 1:00 p.m. R1 was observed in the wheelchair, in his room with no cushion present. On 7/25/13, during continuous observations from 7:11 a.m. until 9:36 a.m. R1 was observed seated in the wheelchair with no cushion present. At 9:38 a.m. NA-A stated she had worked here for the past 7 months, and had never noticed a cushion in R1's wheelchair. NA-E added, the nurses go around and complete safety checks on residents which would include looking at their bed rails and possibly checking for wheelchair cushion placement. At 10:49 a.m. NA-E stated registered nurse (RN) -A had just informed her R1's POC indicated he was to have a cushion in his wheelchair. At 10:56 a.m. RN-A stated R1 spent most of his	F 314	At this time the QA Committee will make the decision/re-recommendation regarding any necessary follow-up studies. 7. Date of completion: August 26, 2013	

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F 314	Continued From page 7 time in the wheelchair and was at risk for the development of PU's. Additionally, RN-A confirmed the NAs should be checking to see if the cushion was in the wheelchair. At 11:04 RN-B verified R1 sat in his wheelchair a lot, therefore, we do want him to have a cushion in the chair. RN-B stated the NAs should have reported if the wheelchair cushion was not in place. At 11:08 a.m. RN-A verified the POC was not followed.	F 314		
F 371 SS=D	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure staff did not use their bare hands when touching bread in order to prevent food borne illness for 1 of 1 resident (R34) which affected 2 of 3 meals observed. Findings include:	F 371	1. LifeCare Greenbush Manor will store, prepare, distribute and serve food under sanitary conditions. 2. Educational meetings regarding sanitary handling of food will be held on August 20th and 22nd. Additional sessions to be held on August 26th and 28th, 2013. Communication also given through weekly communication sheet. 3. Education provided by Dietary Manager and Director of Nursing. Education will consist of the importance of no bare hand contact with resident food by staff. Staff will either cut up resident's food with utensils, napkin or wearing gloves to handle any resident food item. 4. Bi-weekly audits to ensure compliance regarding no bare hand contact with food will be done by charge nurse. When compliance is maintained at 100% for one month, formal auditing will be discontinued. Random visual audits for compliance will be done by charge nurses on an ongoing basis. Continued on page 9	

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F 371	Continued From page 8 On 7/23/13, at 6:16 p.m. nursing assistant (NA)-C was observed seated next to R34 to assist him with his meal. The meal consisted of a hamburger, potato salad and applesauce. At 6:25 p.m. NA-C was observed to pick up the hamburger with her right bare hand and held it up to R34's mouth. This action was repeated at 6:26 p.m., and 6:27 p.m. At 6:28 p.m. NA-C was observed to use a fork to feed R34 a bite of the hamburger. This action was repeated at 6:30 p.m. At 6:34 p.m. NA-C was observed to apply hand sanitizer and then with bare hands, took the top bun off the hamburger, place pickles on it, pick up the hamburger with her right bare hand and held it up to R34's mouth. With the same bare hands, NA-C was observed to place the hamburger in R34's mouth four additional times. At 7:26 p.m. NA-C stated she used the fork to feed the hamburger to R34 when the pieces got smaller. NA-C also stated she may have been told not to touch bread with bare hands and had probably forgot. On 7/24/13, at 12:32 p.m. NA-D was observed to pick up a slice of buttered bread with her bare hand, and hold it up to R34's mouth. This action was repeated three times until the bread was gone. At 1:16 p.m. NA-D stated normally she would use a fork to feed R34 his bread. However, stated she had probably just picked up a "bad habit."	F 371	5. Monitoring and compliance will be reported to Medical Director/Quality Assurance Committee. At this time the QA Committee will make the decisions/re-recommendation regarding any necessary follow-up studies. 6. Date of completion: August 26, 2013	

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F 371	Continued From page 9 On 7/25/13, at 11:09 a.m. registered nurse (RN) -A verified staff should not touch food with bare hands. RN-A stated staff should have used tongs or gloves when dealing with the bread. At 11:42 a.m. the food service supervisor (FSS) stated at the all staff monthly meetings staff were instructed not to have bare hand contact with food. The FSS also stated the NA's should have used a napkin to pick up the bread or a fork for the hamburger. A policy was requested and none was provided.	F 371		

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K 000	INITIAL COMMENTS Surveyor: 03006 FIRE SAFETY A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety. At the time of this survey, Lifecare Greenbush Manor was found in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 18 New Health Care. Lifecare Greenbush Manor was built in 2010, is a 1-story building without a basement and was determined to be Type V(111) construction, A clinic and an assisted living building are attached and separated with 2-hour fire barriers between the Manor and the clinic, and the Manor and the assisted living building. The facility is divided into 4 smoke compartments with 1-hour and 2-hour fire barriers. The facility is fully protected with an automatic sprinkler system installed in accordance with NFPA 13 The Standard for the Installation of Sprinkler Systems 1999 edition. The facility has a fire alarm system which includes corridor smoke detection throughout and in all common areas, installed in accordance with NFPA 72 "The National Fire Alarm Code" 1999 edition. All sleeping rooms have smoke detection and hazardous areas have automatic fire detection in accordance with the Minnesota State Fire Code 2007 edition. The fire alarm system is monitored for automatic fire department notification.	K 000		

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

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K 000	Continued From page 1 The facility has a capacity of 40 beds and had a census of 39 at the time of the survey. The facility was surveyed as one building. The requirement at 42 CFR, Subpart 483.70(a) is MET.	K 000		