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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: ENQT

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00168

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **24E166**

2.STATE VENDOR OR MEDICAID NO.
(L2) **458995500**

3. NAME AND ADDRESS OF FACILITY
(L3) **BIRCHWOOD CARE HOME**
(L4) **715 WEST 31ST STREET**
(L5) **MINNEAPOLIS, MN** (L6) **55408**

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) **01/01/2004**

6. DATE OF SURVEY **02/10/2017** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY **10** (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 **60** (L18)

13.Total Certified Beds **60** (L17)

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

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

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

* Code: **A** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
		60		
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Gloria Derfus, Unit Supervisor 03/28/2017 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Anne Peterson, Enforcement Specialist 08/04/2017 (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
03/31/1974
(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.
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
03/14/2017
(L33)

DETERMINATION APPROVAL

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

CMS Certification Number (CCN): 24E166

March 28, 2017

Mr. Randal Hagemeyer, Administrator
Birchwood Care Home
715 West 31st Street
Minneapolis, MN 55408

Dear Mr. Hagemeyer:

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 Medicaid program.

Effective February 2, 2017 the above facility is certified for:

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

Please contact me if you have any questions.

Sincerely,

Kamala Fiske-Downing

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

Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
March 28, 2017

Mr. Randal Hagemeyer, Administrator
Birchwood Care Home
715 West 31st Street
Minneapolis, MN 55408

RE: Project Number SE166026

Dear Mr. Hagemeyer:

On January 26, 2017, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on January 10, 2017. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required.

On February 10, 2017, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on February 14, 2017 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 January 10, 2017. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of February 2, 2017. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on January 10, 2017, effective February 2, 2017 and therefore remedies outlined in our letter to you dated January 26, 2017, will not be imposed.

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

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

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

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: ENQT

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00168

1. MEDICARE/MEDICAID PROVIDER NO.(L1) **24E166**

2. STATE VENDOR OR MEDICAID NO. (L2) **458995500**

3. NAME AND ADDRESS OF FACILITY
(L3) **BIRCHWOOD CARE HOME**
(L4) **715 WEST 31ST STREET**
(L5) **MINNEAPOLIS, MN** (L6) **55408**

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) **01/01/2004**

6. DATE OF SURVEY **01/10/2017** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 10 (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 **60** (L18)

13.Total Certified Beds **60** (L17)

10.THE FACILITY IS CERTIFIED AS:

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

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
		60		
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Amy Charais, HFE NE II 02/09/2017 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 03/13/2017 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION **03/31/1974** (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. (L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE (L33)

DETERMINATION APPROVAL

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: ENQT

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00168

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5. Validation 6. Complaint
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5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9) **01/01/2004**

6. DATE OF SURVEY **01/10/2017** (L34)

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FISCAL YEAR ENDING DATE: (L35) **09/30**

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And/Or Approved Waivers Of The Following Requirements:
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___3. 24 Hour RN
___4. 7-Day RN (Rural SNF)
___5. Life Safety Code
___6. Scope of Services Limit
___7. Medical Director
___8. Patient Room Size
___9. Beds/Room

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
		60		
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE — Date :
Amy Charais, HFE NE II — 02/09/2017 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Kamala Fiske-Downing, Enforcement Specialist 03/13/2017 (L20)

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26. TERMINATION ACTION: (L30)
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01-Merger, Closure
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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. (L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE
3-14-17 (L33)

DETERMINATION APPROVAL

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

020499

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
January 26, 2017

Mr. Randal Hagemeyer, Administrator
Birchwood Care Home
715 West 31st Street
Minneapolis, MN 55408

RE: Project Number SE166026

Dear Mr. Hagemeyer:

On January 10, 2017, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

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

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

> **Opportunity to Correct - the facility is allowed an opportunity to correct identified deficiencies before remedies are imposed;**
>
> **Electronic Plan of Correction - when a plan of correction will be due and the information to be contained in that document;**
>
> **Remedies - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS) if substantial compliance is not attained at the time of a revisit;**

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

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:

Gloria Derfus, Unit Supervisor
Minnesota Department of Health
P.O. Box 64900
St. Paul, Minnesota 55164-0900
gloria.derfus@state.mn.us
Telephone: (651) 201-3792 Fax: (651) 215-9697

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 February 21, 2017, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by February 21, 2017 the following remedy will be imposed:

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

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

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

- Submit electronically to acknowledge your receipt of the electronic 2567, your review and your ePoC submission.

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by April 10, 2017 (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 July 10, 2017 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

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

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

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

Feel free to contact me if you have questions.

Sincerely,

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24E166	A. BUILDING _____ B. WING _____	01/10/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BIRCHWOOD CARE HOME	715 WEST 31ST STREET MINNEAPOLIS, MN 55408

(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 is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Electronic submission of the POC 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		
F 225 SS=D	483.12(a)(3)(4)(c)(1)-(4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS (a) The facility must- (3) Not employ or otherwise engage individuals who- (i) Have been found guilty of abuse, neglect, exploitation, misappropriation of property, or mistreatment by a court of law; (ii) Have had a finding entered into the State nurse aide registry concerning abuse, neglect, exploitation, mistreatment of residents or misappropriation of their property; or (iii) Have a disciplinary action in effect against his or her professional license by a state licensure body as a result of a finding of abuse, neglect, exploitation, mistreatment of residents or misappropriation of resident property. (4) Report to the State nurse aide registry or licensing authorities any knowledge it has of actions by a court of law against an employee,	F 225		2/1/17

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

Electronically Signed | 02/03/2017

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
	24E166	A. BUILDING _____ B. WING _____	01/10/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BIRCHWOOD CARE HOME	**715 WEST 31ST STREET MINNEAPOLIS, MN 55408**

(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 225	Continued From page 1 which would indicate unfitness for service as a nurse aide or other facility staff. (c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: (1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. (2) Have evidence that all alleged violations are thoroughly investigated. (3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. (4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by:	F 225		

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F 225	Continued From page 2 Based on observation, interview and document review, the facility failed to operationalize their policy related to conducting background checks for 3 of 5 employees reviewed. Findings include: A review of a facility document titled Anniversary List By D/M/Y (date, month, year) identified E1, E2, E3, E4, and E5 were all hired between the dates of 9/21/16 through 12/6/16. A review of E2's employee file indicated she was employed at the facility beginning on 9/27/16. The employment file did not include any record of reference checks for E2. A review of E3's employee file indicated she was employed at the facility beginning on 10/111/16. The employment file did not contain evidence of a reference check. A review of E5's employment file indicated he was employed at the facility beginning on 12/6/16. E5's employment record did not contain evidence of a reference check. During an interview on 1/10/17, at 4:00 p.m. the business office manager (BOM) stated the director of nutritional services (DNS) was responsible for completing the reference checks for E1 and E5. She stated the DNS was not available and verified no reference checks were in the employee files. During an interview on 1/10/17, at 4:33 p.m., the director of nursing (DON) stated she did not complete a reference check for E3. She stated she had worked with E3 in the past. The DON	F 225	See attached document labeled #1A and 1B: A new reference check policy was written and all employees involved in the hiring process have been educated on this policy. All potential new hires will have documentation of reference checks on the Reference check verification form which will be attached to the application. All managers who are involved in the hiring process will be responsible. Business Office Manager will monitor to be sure reference check form is filled out before filing new employee file in Business Office. All managers and Business office Director responsible for compliance.	

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F 225	Continued From page 3 stated she had not worked with E3 for ten years and stated she did not know her work history for the last 10 years. A facility policy titled Birchwood Care Home Vulnerable Adult Policy, dated July 16, 2015, indicated the facility maintains policies and procedures geared toward abuse prevention which include: Screening all applicants for employment in the facility. Screening to include at a minimum: reference checks from current and/or past employer. The facility did not check for information from previous and/or current employers in effort to uncover any potential information about any past criminal prosecutions.	F 225		
F 226 SS=D	483.12(b)(1)-(3), 483.95(c)(1)-(3) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES 483.12 (b) The facility must develop and implement written policies and procedures that: (1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, (2) Establish policies and procedures to investigate any such allegations, and (3) Include training as required at paragraph §483.95, 483.95 (c) Abuse, neglect, and exploitation. In addition to the freedom from abuse, neglect, and exploitation requirements in § 483.12, facilities must also provide training to their staff that at a minimum	F 226		2/1/17

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F 226	Continued From page 4 educates staff on- (c)(1) Activities that constitute abuse, neglect, exploitation, and misappropriation of resident property as set forth at § 483.12. (c)(2) Procedures for reporting incidents of abuse, neglect, exploitation, or the misappropriation of resident property (c)(3) Dementia management and resident abuse prevention. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, In addition, the facility failed to operationalize their policy related to conducting background checks for 3 of 5 employees reviewed. Findings include: A facility policy titled Birchwood Care Home Vulnerable Adult Policy, dated July 16, 2015, indicated the facility maintains policies and procedures geared toward abuse prevention which include: Screening all applicants for employment in the facility. Screening to include at a minimum: reference checks from current and/or past employer. A review of a facility document titled Anniversary List By D/M/Y (date, month, year) identified E1, E2, E3, E4, and E5 were all hired between the dates of 9/21/16 through 12/6/16. A review of E2's employee file indicated she was employed at the facility beginning on 9/27/16. The employment file did not include any record of	F 226	See attached document labeled #1A and 1B: A new reference check policy was written and all employees involved in the hiring process have been educated on this policy. All potential new hires will have documentation of reference checks on the Reference check verification form which will be attached to the application. All managers who are involved in the hiring process will be responsible. Business Office Manager will monitor to be sure reference check form is filled out before filing new employee file in Business Office. All managers and Business office manager are responsible.	

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F 226	Continued From page 5 reference checks for E2. A review of E3's employee file indicated she was employed at the facility beginning on 10/111/16. The employment file did not contain evidence of a reference check. A review of E5's employment file indicated he was employed at the facility beginning on 12/6/16. E5's employment record did not contain evidence of a reference check. During an interview on 1/10/17, at 4:00 p.m. the business office manager (BOM) stated the director of nutritional services (DNS) was responsible for completing the reference checks for E1 and E5. She stated the DNS was not available and verified no reference checks were in the employee files. During an interview on 1/10/17, at 4:33 p.m., the Director of Nursing (DON) stated she did not complete a reference check for E3. She stated she had worked with E3 in the past. The DON stated she had not worked with E3 for ten years and stated she did not know her work history for the last 10 years. The facility did not check for information from previous and/or current employers in effort to uncover any potential information about any past criminal prosecutions.	F 226		
F 279 SS=D	483.20(d);483.21(b)(1) DEVELOP COMPREHENSIVE CARE PLANS 483.20 (d) Use. A facility must maintain all resident assessments completed within the previous 15 months in the resident's active record and use the results of the assessments to develop, review	F 279		2/2/17

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F 279	Continued From page 6 and revise the resident's comprehensive care plan. 483.21 (b) Comprehensive Care Plans (1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative (s)-	F 279		

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F 279	Continued From page 7 (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to reassess for and implement interventions to prevent falls for 1 of 1 residents (R29) reviewed for falls. Findings include: R29's care plan dated 8/5/16 indicated a risk for falls and directed staff to remind her to change position slowly, reminders to slow down, reminders to seek help in community during icy condition, and wear proper and non-slip foot wear. The care plan further identified psychotropic drug use, diuretic use, alteration in comfort and episodes of incontinence. R29's quarterly Minimum Data Set (MDS) dated 11/23/16, indicated she was moderately cognitively impaired and displayed memory problems and inattention. The MDS further indicated R29 was independent with transfers, ambulation, dressing, grooming and bed mobility, but required supervision for toileting. A fall risk	F 279	Birchwood Care Home IDT discusses any falls every day in morning meeting including causal factors and necessary interventions. R29 was receiving PT, is currently going to pool therapy and ambulates with a walker. Her care plan was reviewed and revised. The falls risk assessment policy was reviewed and updated, see attachment #1E. See also form 2E and 3E, we have revised our tracking and documentation of falls for use during our morning meeting to assist with watching for patterns and improved tracking of interventions including adding to the careplan. Any falls will be documented on the communication page for a period of 2 weeks to be sure all staff are aware of recent falls. Audit of past 6 months of falls was done to assure all care plans are up to date. Education has been initiated for nursing staff. Remainder of nursing staff will be educated on updated policy and new	

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F 279	Continued From page 8 assessment dated 11/23/16, indicated R29 sustained multiple falls in the last six months, used assistive devices and ambulated with short of shuffling steps. The assessment further indicated she had a steady gait and good balance while using her walker and continued to be reminded of safety measures including rising slowly, using her cane and asking for help as needed. A review of R29's Birchwood Care Home Progress Notes along with Birchwood Care Home Incident Report Forms indicated the following falls: 12/17/16, another resident came to nursing station and reported R29 fell. Staff responded to find R29 on the floor, and incident report dated 12/17/16, indicated R29 was reaching for her walker and fell backward. On 12/13/16, R29 sat on floor at the end of her bed. No injury noted, denies hitting head. An incident report form dated 12/13/16, indicated she sat on the floor and was advised to be more careful. On 6/25/16, R29 called for help to get up from the floor. R29 told staff she woke up to use the bathroom but lost balance when standing. An incident report form dated 6/25/16 indicated R29 fell backward onto her bed. A Progress Note dated 6/27/16, indicated an interdisciplinary team (IDT) review of fall was completed and indicated R29 felt her fall was related to her new slippers and not using her walker. On 5/13/16, writer called to R29's room. The resident was lying on her back at the end of her bed, stated she tripped coming around the bed. On 5/4/16, R29 had a fall at 1:50 a.m. while trying to use the bathroom. At 1:38 p.m., on 1/10/17, R29 approached surveyor. She was ambulating independently with a walker. She ambulated to the dining room and	F 279	forms at a mandatory nursing meeting February 19th. The falls logs will be brought to quarterly QAPI meetings for review and discussion. Director of Nursing and Resident Care Coordinator will be responsible for compliance.	

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F 279	Continued From page 9	F 279		

sat at a table. R29 appeared steady while ambulating and when lowering herself into the chair. During the interview, R29 stated she had a lot of falls. She stated she sometimes has "dizzy spells" and stated, "It's a project getting up from my bed." R29 stated no one had discussed her recent falls with her.

During an interview on 1/10/17, at 3:49 p.m., the assistant director of nursing (ADON) stated when a resident falls, the floor nurse assessed the resident and fills out an incident report. She stated the incident report is given to the director of nursing (DON). The ADON stated after a fall, interventions should be implemented and added to the care plan.

During an interview on 1/10/17, at 3:50 p.m., the DON stated falls were discussed daily in the morning meeting. She stated they look for potential causes, look at the environment, discuss physical therapy, or talk to the pharmacist to look at medication. During a subsequent interview at 4:50 p.m., the DON stated a fall risk assessment was completed with each MDS. She stated if there were multiple falls in a period of time an extra one would be done but stated they "probably had not reviewed any of the December falls for R29." She further stated she felt R29 was doing "super good" and had not done an analysis of her most recent falls.

During an interview on 1/10/17, at 5:13 p.m., registered nurse (RN)-A stated R29 had not fallen in about a year and half that she was aware of but stated she was a high risk for falls. RN-A stated, if she has fallen, it was not on her shift and she did not get a report. During the interview LPN-A stated R29 misjudged her seating a lot. She

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F 279	Continued From page 10 stated she had heard R29 talk about her falls but was not aware of any specific interventions for preventions. While R29 had a history of falls in the facility, two of which occurred in the past 30 days, there was no evidence the facility reviewed the falls in an effort to determine a root cause or implement any new interventions to minimize potential injury from further falls.	F 279		
F 323 SS=D	483.25(d)(1)(2)(n)(1)-(3) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES (d) Accidents. The facility must ensure that - (1) The resident environment remains as free from accident hazards as is possible; and (2) Each resident receives adequate supervision and assistance devices to prevent accidents. (n) - Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. (1) Assess the resident for risk of entrapment from bed rails prior to installation. (2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. (3) Ensure that the bed's dimensions are appropriate for the resident's size and weight.	F 323		2/1/17

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F 323	Continued From page 11 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to implement interventions to prevent falls for 1 of 1 resident (R29) reviewed for falls. Findings include: R29's care plan dated 8/5/16 indicated a risk for falls and directed staff to remind her to change position slowly, reminders to slow down, reminders to seek help in community during icy condition, and wear proper and non-slip foot wear. The care plan further identified psychotropic drug use, diuretic use, alteration in comfort and episodes of incontinence. R29's quarterly Minimum Data Set (MDS) dated 11/23/16, indicated she was moderately cognitively impaired and displayed memory problems and inattention. The MDS further indicated R29 was independent with transfers, ambulation, dressing, grooming and bed mobility, but required supervision for toileting. A fall risk assessment dated 11/23/16, indicated R29 sustained multiple falls in the last six months, used assistive devices and ambulated with short of shuffling steps. The assessment further indicated she had a steady gait and good balance while using her walker and continued to be reminded of safety measures including rising slowly, using her cane and asking for help as needed. A review of R29's Birchwood Care Home Progress Notes along with Birchwood Care Home Incident Report Forms indicated the following: -12/17/16, another resident came to nursing	F 323	Birchwood Care Home IDT discusses any falls every day in morning meeting including causal factors and necessary interventions. R29 was receiving PT, is currently going to pool therapy and ambulates with a walker. Her care plan was reviewed and revised. The falls risk assessment policy was reviewed and updated, see attachment #1E. See also form 2E and 3E, we have revised our tracking and documentation of falls for use during our morning meeting to assist with watching for patterns and improved tracking of interventions. Any falls will be documented on the communication page for a period of 2 weeks to be sure all staff are aware of recent falls. An audit was done of the past 6 months of falls to be sure interventions were implemented to prevent falls. Education has been initiated for nursing staff. Remainder of nursing staff will be educated on updated policy and new forms at a mandatory nursing meeting February 19th. The falls logs will be brought to quarterly QAPI meetings for review and discussion. Director of Nursing and Resident Care Coordinator will be responsible for compliance.	

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F 323	Continued From page 12	F 323		

station and reported R29 fell. Staff responded to find R29 on the floor, and incident report dated 12/17/16, indicated R29 was reaching for her walker and fell backward.
-12/16/16, R29 has bruising on bilateral lower extremities right shin and left knee and left inner thigh.
-12/13/16, R29 sat on floor at the end of her bed. No injury noted, denies hitting head. An incident report form dated 12/13/16, indicated she sat on the floor and was advised to be more careful.
-12/7/16, care conference note- Fall risk due to meds and history of falls, rolling walker. Gait is good, balance is steady. Independent in all areas of mobility.
-6/25/16, R29 called for help to get up from the floor. R29 told staff she woke up to use the bathroom but lost balance when standing. An incident report form dated 6/25/16, indicated R29 fell backward onto her bed. A Progress Note dated 6/27/16, indicated an interdisciplinary team (IDT) review of fall was completed and indicated R29 felt her fall was related to her new slippers and not using her walker.
-5/13/16, writer called to R29's room. Resident lying on her back at the end of her bed, stated she tripped coming around the bed. A 5/19/16, progress noted indicated IDT reviewed fall and determined fall resulted from hurrying. Reminder given to slow down. The Progress Note further indicated a note was sent to the consultant pharmacist to review medications. The review identified no new recommendations.
-5/4/16, R29 had a fall at 1:50 a.m. while trying to use the bathroom. On assessment a "big" bruise 8 centimeters (cm) x 8 cm was noted to left knee and a 3 cm x 4 cm bruise on the back of her left arm.
-5/5/16, IDT discussed the residents fall that

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F 323	Continued From page 13	F 323		

morning. R29 stated she woke up and had to use the bathroom, lost her balance and fell. Resident encouraged to slow down and continue to monitor.
-2/23/16, Writer interviewed R29 and analyzed recent fall while getting in and out of van during an outing. Reviewed falls risk assessment with no changes necessary.

At 1:38 p.m., on 1/10/17, R29 approached surveyor. She was ambulating independently with a walker. She ambulated to the dining room and sat at a table. R29 appeared steady while ambulating and when lowering herself into the chair. During the interview, R29 stated she had a lot of falls. She stated she sometimes has "dizzy spells" and stated, "It's a project getting up from my bed." R29 stated no one had discussed her recent falls with her.

During an interview on 1/10/17, at 3:49 p.m., the assistant director of nursing (ADON) stated when a resident falls, the floor nurse assessed the resident and fills out an incident report. She stated the incident report is given to the director of nursing (DON). She stated she felt R29's falls were related to changing positions too fast or sliding down in bed. The ADON stated interventions should be implemented and added to the care plan.

During an interview on 1/10/17, at 3:50 p.m., the DON stated falls were discussed daily in the morning meeting. She stated they look for potential causes, look at the environment, discuss physical therapy, or talk to the pharmacist to look at medications. The DON stated she felt R29's falls were related to not keeping the walker close enough to her. She stated any tracking and

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	24E166	A. BUILDING _____ B. WING _____	01/10/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BIRCHWOOD CARE HOME	715 WEST 31ST STREET MINNEAPOLIS, MN 55408

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F 323	Continued From page 14 trending of falls is documented on the incident report. During a subsequent interview at 4:50 p.m., the DON stated a fall risk assessment was completed with each MDS. She stated if there were multiple falls in a period of time an extra one would be done but stated they "probably hadn't done one in December for R29." She further stated she felt R29 was doing "super good" and had not done an analysis of her most recent falls. During an interview on 1/10/17, at 5:13 p.m., registered nurse (RN)-A stated R29 had not fallen in about a year and half that she was aware of but stated she was a high risk for falls. RN-A stated, if she has fallen, it was not on her shift and she did not get a report. During the interview LPN-A stated R29 misjudged her seating a lot. She stated she had heard R29 talk about her falls. While R29 had a history of falls in the facility, two of which occurred in the past 30 days, there was no evidence the facility reviewed the falls in an effort to determine a root cause. Furthermore, the facility continued to implement reminders as an intervention for falls, even though R29's assessments indicated she had a memory problem. A policy regarding falls assessment was requested but not received.	F 323		
F 334 SS=E	483.80(d)(1)(2) INFLUENZA AND PNEUMOCOCCAL IMMUNIZATIONS (d) Influenza and pneumococcal immunizations (1) Influenza. The facility must develop policies and procedures to ensure that-	F 334		2/2/17

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F 334	Continued From page 15 (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. (2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal	F 334		

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F 334	Continued From page 16 immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to implement the current standards of immunization for pneumonia for 3 of 5 residents (R17, R18, R37), over 65 years old, whose vaccination histories were reviewed. Additionally, the facility had not implemented their process to ensure immunizations for pneumonia were offered to 21 of 23 residents of the facility who were over the age of 65. Findings include: The Center for Disease Control and Prevention identified "Adults 65 years of age or older who have not previously received PCV13 and who have previously received one or more doses of PPSV23 (pneumococcal polysaccharide vaccine	F 334	The immunization policy and procedure was reviewed and updated to reflect the current guidelines. A letter outlining the new guidelines and requesting physicians to administer the pneumovax injections has been sent to all primary care Dr. appointments. Goal is to have every resident assessed by their MD for vaccination with the PCV 13 within the next 90 days unless it is contraindicated or they have previously received one. See attachment 1F and 2F for the physician letter and updated policy. Our new admission immunization form will be updated to reflect current guidelines as well for any new admissions coming into the facility. Director of Nursing, Resident	

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F 334	Continued From page 17 23) should receive a dose of pneumococcal 13-valent Conjugate Vaccine (PCV13). The dose of PCV13 should be administered at least one year after the most recent PPSV23 dose." R17's record indicated the resident had resided at the facility since January 2016, there was no documentation to indicate a PCV13 had been offered or administered. R18's record indicated the resident had resided at the facility since October 2015, there was no documentation to indicate a PCV13 had been offered or administered. R37's record indicated the resident had resided at the facility since January 2007, there was no documentation to indicate a PCV13 had been offered or administered. During an interview with the director of nursing (DON) and assistant director of nursing (ADON) on 1/10/17, at 2:54 p.m., The DON stated the facility process for pneumonia immunizations had not been implemented. The DON and ADON confirmed 21 of 23 residents over the age of 65 had not had the immunization offered or administered. A facility policy entitled Influenza and Pneumococcal Immunizations dated 5/2/2007, indicated "all residents and their legal representatives will be offered the opportunity for the resident to receive the Pneumococcal Vaccine and will also be made available to each resident."	F 334	Care Coordinator, Director of Medical Records are responsible for compliance.	
F 371 SS=F	483.60(i)(1)-(3) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY	F 371		2/1/17

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F 371	Continued From page 18 (i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. (i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. (i)(3) Have a policy regarding use and storage of foods brought to residents by family and other visitors to ensure safe and sanitary storage, handling, and consumption. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to maintain safe dishwashing temperatures to prevent the potential spread of food borne illness which had the potential to affect all 57 residents in the facility, staff and visitors who ate out of the kitchen. Findings include: During the initial kitchen tour on 1/09/17, at 1:21 p.m. the facility's director of nutrition services	F 371	The dishwashing temperature was immediately corrected by Ecolab. All Dietary staff were immediately re-educated regarding appropriate temperatures of the dish machine, an all Dietary training will be conducted within 2 weeks. See attachment 1D, dishmachine temperature log. Dietary manager will be responsible for supervising, Assistant Dietary manager will monitor log and spot check temperature a minimum of 3 times per week. See attachment 2D for	

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F 371	Continued From page 19 (DNS) stated they used a high temperature, one compartment dish machine. This was verified by the manufacturer identification plate which indicated a minimum wash of 150 degrees Fahrenheit (F) and rinse of 180F. The January, 2017 dishwashing temperature log was reviewed indicating all temperatures were below 144F for the wash cycle and below 177 degrees F for the rinse cycle. The DNS then ran three loads of dishes through the dishwasher. The digital temperature gauge on the outside of the dishwasher read: #1 156F wash, 177F rinse #2 149F wash, 174F rinse #3 168F wash, 179F rinse During interview on 1/9/17, at 1:21 p.m. Cook (C)-A stated he was "not sure" how long it has been running below 180 degrees F. The DNS stated the dishwasher temperatures are checked three times a day, that he was not aware of the low recorded temperatures, and verified he had not been monitoring the temperatures, "I have no excuse." DNS stated he did not have a thermometer to run through the dishwasher to check it. The registered dietitian (RD) stated the rinse cycle should be 180F and stated she was not aware of the low temperatures. Review of the Dish machine Temperature Logs indicated: December 2016 - 45 of 93 opportunities were recorded, all 142F for wash and 172F for rinse November 2016 - 54 of 90 opportunities were recorded, all below 143F for wash and at 172F for rinse October 2016 - 84 of 93 opportunities were recorded, 52 of which were 142F for wash and below 174 for rinse	F 371	Assistant manager checklist. Dietician and Infection Control nurse will also do audits for compliance.	

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F 371	Continued From page 20 September 2016 - 58 of 90 opportunities were recorded, 54 of which were 142F for wash and below 174F for rinse August 2016- 80 of 93 opportunities were recorded, 51 of which were below 145F for wash and 178F for rinse July 2016 - not provided June 2016- 76 of 90 opportunities were recorded, 60 of which were below 145F for wash and 176F for rinse During an interview on 1/9/17, at 1:45 p.m., the DNS stated he called Ecolab, they would use paper products because they did not have chemical test strips nor a policy for using the three compartment sink to wash dishes and stated "sometimes I monitor the temperatures, but not lately though." DNS verified the staff did not tell him about the continuous low temperatures for the wash and rinse cycles. During an interview on 1/9/17, at 2:30 p.m., an Ecolab representative (ER) stated he was not contacted before today about low wash and rinse temperatures and although he had replaced a contractor a couple months prior stated that it "had nothing to do with the temperatures of the machine." ER stated the internal board had been set to 178F, he did not know why, but turned it up now. Three more dish load were observed to be: wash 168F, rinse 188F wash 173F, rinse 191F wash 174F, rinse 196F During an interview on 1/9/17, at 2:32 p.m. Cook-A stated he thought the rinse should be 179F, "I didn't know what it should be, I take a lot of the temperatures, I didn't report it."	F 371		

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F 371	Continued From page 21 During follow-up tour on 1/10/17, at 12:40 p.m. two dishwashing cycles were observed to be: wash 156F, rinse 182F wash 166F, rinse 184F Review of undated Dish machine Temperature Log instructions indicated "run the dishwasher through an entire wash-rinse cycle and record the temperature before use, dishwasher temperature should be Wash 150 F or above and Rinse should be 180 F and above." Review of the facility infection control logs from February 2016 through January 9, 2017 indicated no identifiable gastrointestinal illness outbreak in the facility.	F 371		
F 465 SS=F	483.90(h)(5) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON (h) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. (h)(5) Establish policies, in accordance with applicable Federal, State, and local laws and regulations, regarding smoking, smoking areas, and smoking safety that also take into account non-smoking residents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure a sanitary and clean environment in the kitchen. This had the potential to affect all 57 residents in the facility and visitors who ate out of the facility kitchen. In	F 465	The dish room area has been cleaned including walls, dishwasher, doorway entering the kitchen. See attachment 1C, 2C and 3C for updated policies. The Dietary Manager will be responsible for	2/1/17

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F 465	Continued From page 22 addition, the facility failed to maintain a sanitary, orderly and comfortable interior throughout the second and third floors of the facility which included resident rooms. Findings include: On 1/9/17, at 1:21 p.m. during the initial kitchen tour with the facility's director of nutrition services (DNS) the following was observed and verified by the DNS: - The dish room area approximately 10 feet (ft) X 6 ft X 6 ft: on and around all stainless steel table legs and where the wall meets the floor there was a grimy, brown/black thick buildup of food debris. - The walls around entire dish room above the stainless steel tables to the right and left (clean dish area) of the one compartment dishwasher had food splatter going up the wall approximately 2-3 feet. - The lower half of the one compartment dishwasher was covered with heavy lime, food splatter, debris and greasy film over the entire unit. - Both sides of the doorway entering the kitchen was splattered with food debris. Paint was chipped off both sides of the door frame. On 1/10/17, at 12:40 p.m. during a second tour of the kitchen the following was observed and verified by the DNS: - The plastic corner protector on wall entering the dish room was cracked and missing pieces rendering the wall/doorway uncleanable.	F 465	supervision. The Assistant Dietary Manager will monitor at least 3 times per week to be sure cleaning log is up to date and that appropriate cleaning has been done. The plastic corner protectors have been ordered and will be replaced as soon as they are received but no greater than 30 days. The door frame was painted. The Formica counter top under the ice machine and cabinet doors have been cleaned so surface soil has been removed but these cabinets will be replaced within 60 days. All environmental issues listed will be repaired or painted within 90 days. Director of maintenance is responsible for compliance.	

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F 465	Continued From page 23 - There were dark, brown stains on the Formica under the ice machine and brown stains with brown specks imbedded in the stain area to the left of the coffee maker. The center seam in the Formica was lifted up and coming apart. Wall to the left of ice machine and the front of all the lower cabinet doors was splattered with food and coffee stains. - To the right of the kitchen entry the wall behind the dirty dish plastic bin container was heavily splattered with food debris. The wallpaper was ripped and coming apart at a seam approximately three feet in length. During interview on 1/10/17, at 12:40 p.m., the DNS verified the entire dish room area needed to be cleaned and stated the floors should be cleaned everyday by the overnight maintenance, "I need to talk to them." the DNS stated the top of the dishwasher is cleaned, "but not the bottom." During interview on 1/10/17, at 1:25 p.m., the DNS verified the walls, cabinets and doorways needed to be cleaned and stated although he did request a supply company to address the Formica cabinet in the beverage area in November, he was waiting on staff meetings regarding the redesign of the dining room, "we need to see where we are getting the money." Review of undated Birchwood Care Home policies: - "Sanitation of Dietary Department" - directed staff to maintain the kitchen in a sanitary condition. It indicated that a cleaning schedule will be posted for all cleaning tasks, staff will initial after completion of tasks, the DNS will monitor	F 465		

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F 465	Continued From page 24	F 465		

cleaning checklists weekly to ensure completion and the RD will monitor kitchen sanitation monthly.
- "Cleaning Walls" - indicated the walls will be free from food particles and dirt and they should be cleaned at least once a month and as needed.
- "Maintenance of Dish Machine" - indicated the dish machine will be properly maintained to assure proper functioning, would be regularly cleaned, de-limed as needed and the outside of the machine be cleaned with soap and water.
- "Cleaning Floors" - indicated the kitchen and dining room floors will be kept clean and sanitary, kitchen floors will be swept and cleaned daily and a thorough cleaning using a disinfectant will be done at least twice a week.

During an environmental tour with the director of maintenance (DM) on 1/10/17, at 3:50 p.m. the following observations were confirmed.

-Room 202 had six bathroom tiles missing from the bathroom floor.

-Room 203 had a toilet bolt cover missing.

-Room 206 had the ceiling above the toilet patched but not painted to match the ceiling.

-Room 212 had stains on the carpet in front of the closet and inside the doorway of the room. The area above the toilet had a brown area on the ceiling that had been repaired and not painted to match the ceiling.

-Room 309 had an air conditioner unit in the wall that did not include a frame.

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F 465	Continued From page 25 Throughout the second and third floor the wallpaper was peeling away from the wall and several baseboards and trim were missing from the walls. The DM confirmed this was from a treatment provided to the facility related to pests and there were plans in place to repair the wallpaper, paint the walls and ceiling and repair the trim and baseboards in the hallways and resident rooms. The DM stated there were no official bids for this work to be completed. During an interview with the Administrator on 1/10/17, at 4:17 p.m., he confirmed he had no bids for maintenance work to be completed by outside companies. The administrator stated the facility would complete the work due to the cost. A policy regarding falls assessment was requested but not received.	F 465		

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	24E166	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	01/10/2017

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K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on January 10, 2017. At the time of this survey, Birchwood Care Home was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, the Health Care Facilities Code. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		02/03/2017

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
	24E166	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**01/10/2017**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BIRCHWOOD CARE HOME	**715 WEST 31ST STREET** **MINNEAPOLIS, MN 55408**

(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	Continued From page 1 St. Paul, MN 55101-5145, OR By email to: Marian.Whitney@state.mn.us and Angela.Kappenman@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. Birchwood Care Home is a 2-story building with a full basement. The building was constructed at 3 different times. The original 2 story building was constructed in 1966 and was determined to be of Type II(222) construction. In 1971, a 20 bed addition was constructed and was determined to be of Type II(222) construction. In 2000, an addition was constructed to add an elevator as well as dry and cold storage to the East that was determined to be of Type II(222) construction. Because the original building and the 2 additions are of the same type of construction, the facility was surveyed as one building. This building is fully fire sprinklered. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors that is monitored for automatic fire department notification. The facility has a capacity of 60 beds and had a census of 57 at the time of the survey.	K 000		

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K 000	Continued From page 2	K 000		
	The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:			
K 163 SS=E	NFPA 101 Interior Nonbearing Wall Construction Interior Nonbearing Wall Construction Interior nonbearing walls in Type I or II construction are constructed of noncombustible or limited-combustible materials. Interior nonbearing walls required to have a minimum 2-hour fire resistance rating are fire-retardant-treated wood enclosed within noncombustible or limited-combustible materials, provided they are not used as shaft enclosures. 18.1.6.4, 18.1.6.5, 19.1.6.4, 19.1.6.5 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility did not maintain a minimum 2-hour fire resistance rating on interior walls. 19.1.6.4, 19.1.6.5. This deficient practice could affect all residents within the smoke compartment. Findings Include: On a facility tour between the hours of 0900 and 1730 on January 10, 2017, observation revealed that the two hour fire rated roof had an access panel constructed of wood and unprotected metal. This deficient practice was verified by the maintenance director at the time of discovery.	K 163	After correspondence with the Fire Marshall, the following corrective action will be taken within 30 days: Chemically treat the wood panel with fire retardant chemical. Director of Maintenance will be responsible.	2/1/17
K 211 SS=D	NFPA 101 Means of Egress - General Means of Egress - General Aisles, passageways, corridors, exit discharges,	K 211		2/1/17

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K 211	Continued From page 3 exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility did not maintain a continuous means of egress that was free from obstructions. 19.2.2, 19.2.11, 19.2.1, 7.1.10.1. This deficient practice could effect staff within the room. Findings include: On a facility tour between the hours of 0900 and 1730 on January 10, 2017, observation revealed that the boiler room egress stairs were obstructed by storage. This deficient practice was verified by the maintenance director at the time of discovery.	K 211	Stairs and surrounding areas have been cleaned to maximize egress. A sign was posted to remind staff to keep stairway area clear. Director of Maintenance is responsible for supervision and compliance with this area.	
K 223 SS=E	NFPA 101 Doors with Self-Closing Devices Doors with Self-Closing Devices Doors in an exit passageway, stairway enclosure, or horizontal exit, smoke barrier, or hazardous area enclosure are self-closing and kept in the closed position, unless held open by a release device complying with 7.2.1.8.2 that automatically closes all such doors throughout the smoke compartment or entire facility upon activation of: * Required manual fire alarm system; and * Local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system; and * Automatic sprinkler system, if installed; and	K 223		2/1/17

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K 223	Continued From page 4 * Loss of power. 18.2.2.2.7, 18.2.2.2.8, 19.2.2.2.7, 19.2.2.2.8 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility did not maintain self-closing doors in exit passageways, stairway enclosures, horizontal exits, smoke barriers, or hazardous areas. 19.2.2.2.7, 19.2.2.2.8. This deficient practice could affect residents in the smoke compartment. Findings include: On a facility tour between the hours of 0900 and 1730 on January 10, 2017, observation revealed that the North exit stairway door in the second floor corridor, did not self-close and positively latch. This deficient practice was verified by the maintenance director at the time of discovery.	K 223	Second floor door North was adjusted 1/27/17 and tested x 10 times, door positively latched 10 times. Director of Maintenance is responsible for supervision and compliance with this area.	
K 225 SS=F	NFPA 101 Stairways and Smokeproof Enclosures Stairways and Smokeproof Enclosures Stairways and Smokeproof enclosures used as exits are in accordance with 7.2. 18.2.2.3, 18.2.2.4, 19.2.2.3, 19.2.2.4, 7.2 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility did not properly enclose stairways used for exits. 19.2.2.3, 19.2.2.4, 7.2. This deficient practice could affect all 57 residents. Findings include:	K 225	First floor North exit fire- rated door was ordered on 1/9/17. Technician from fire door company stated it would be roughly 4 weeks until door can be delivered. Door will be installed immediately upon arrival. Maintenance staff will check all fire doors	2/1/17

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K 225	Continued From page 5 1. On a facility tour between the hours of 0900 and 1730 on January 10, 2017, observation revealed that there were combustible decorations in the exit stairways. 2. On a facility tour between the hours of 0900 and 1730 on January 10, 2017, observation revealed that the first floor, North exit stairway fire-rated door was cracked. This deficient practice was verified by the maintenance director at the time of discovery.	K 225	at least monthly when they are doing their monthly fire detector checks. Director of Maintenance is responsible for compliance.	
K 321 SS=E	NFPA 101 Hazardous Areas - Enclosure Hazardous Areas - Enclosure 2012 EXISTING Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4-hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet)	K 321		2/1/17

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K 321	Continued From page 6 c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility did not properly separate and protect hazardous areas. 19.3.2.1. This deficient practice could affect all residents within the smoke compartment. Findings include: 1. On a facility tour between the hours of 0900 and 1730 on January 10, 2017, observation revealed that the laundry room door was held open with a door wedge. 2. On a facility tour between the hours of 0900 and 1730 on January 10, 2017, observation revealed that the medical records room is over 100 square feet and contains combustible storage but does not have and automatic door closer. This deficient practice was verified by the maintenance director at the time of discovery.	K 321	Laundry room door was immediately closed, wedge was removed from laundry room and staff was educated on potential dangers. Medical Records door will have an automatic closing door installed within 30 days. Director of Maintenance is responsible for compliance.	
K 341 SS=E	NFPA 101 Fire Alarm System - Installation Fire Alarm System - Installation A fire alarm system is installed with systems and components approved for the purpose in accordance with NFPA 70, National Electric Code,	K 341		2/1/17

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K 341	Continued From page 7 and NFPA 72, National Fire Alarm Code to provide effective warning of fire in any part of the building. In areas not continuously occupied, detection is installed at each fire alarm control unit. In new occupancy, detection is also installed at notification appliance circuit power extenders, and supervising station transmitting equipment. Fire alarm system wiring or other transmission paths are monitored for integrity. 18.3.4.1, 19.3.4.1, 9.6, 9.6.1.8 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility did not properly install components of the fire alarm system in accordance with NFPA 72. 19.3.4.1, 9.6.1.8. This deficient practice could affect all residents in the smoke compartment. Findings include: On a facility tour between the hours of 0900 and 1730 on January 10, 2017, observation revealed that there was a manual switch installed in the main fire alarm panel that can disable the automatic fire shutter door in the kitchen. This deficient practice was verified by the maintenance director at the time of discovery.	K 341	Test switch in fire panel will be removed and direct wired with fire panel. This will be done within 30 days. Director of Maintenance will be responsible.	
K 346 SS=C	NFPA 101 Fire Alarm System - Out of Service Fire Alarm - Out of Service Where required fire alarm system is out of services for more than 4 hours in a 24-hour period, the authority having jurisdiction shall be	K 346		2/1/17

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K 346	Continued From page 8 notified, and the building shall be evacuated or an approved fire watch shall be provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service. 9.6.1.6 This STANDARD is not met as evidenced by: Based on observation and document review, the facility did not properly implement a fire watch protocol for when the fire alarm system is out of service for more than 4 hours in 24-hour period. 9.6.1.6. This deficient practice could affect all 57 residents. Findings include: On a facility tour between the hours of 0900 and 1730 on January 10, 2017, observation revealed that the facility could not provide a fire watch tour log sheet in the event of a fire alarm system outage. This deficient practice was verified by the director of environmental services at the time of inspection.	K 346	Birchwood Care Home has developed a fire watch tour log sheet in the event of a fire alarm system outage. See attachment 3 and 4. Director of Maintenance will be responsible for this.	
K 353 SS=F	NFPA 101 Sprinkler System - Maintenance and Testing Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked	K 353		2/1/17

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K 353	Continued From page 9 b) Who provided system test c) Water system supply source Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This STANDARD is not met as evidenced by: Based on observation and document review, the facility did not maintain and test their automatic fire sprinkler system in accordance with NFPA 25 and the 2012 LSC NFPA 101. 9.7.5, 9.7.7, 9.7.8. This deficient practice could effect all 57 residents. Findings include: On a facility tour between the hours of 0900 and 1730 on January 10, 2017, observation revealed that the five year, automatic fire sprinkler system internal obstruction investigation was due but was not performed. The last internal obstruction investigation was conducted on September 19, 2011 This deficient practice was verified by the director of environmental services at the time of inspection.	K 353	Internal obstruction Investigation is scheduled to be completed on 2/8/17. We will reschedule for every 5 years with Viking Sprinkler. Director of Maintenance will be responsible for monitoring and compliance in this area.	
K 354 SS=C	NFPA 101 Sprinkler System - Out of Service Sprinkler System - Out of Service Where the sprinkler system is impaired, the extent and duration of the impairment has been determined, areas or buildings involved are inspected and risks are determined,	K 354		2/1/17

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K 354	Continued From page 10 recommendations are submitted to management or designated representative, and the fire department and other authorities having jurisdiction have been notified. Where the sprinkler system is out of service for more than 10 hours in a 24-hour period, the building or portion of the building affected are evacuated or an approved fire watch is provided until the sprinkler system has been returned to service. 18.3.5.1, 19.3.5.1, 9.7.5, 15.5.2 (NFPA 25) This STANDARD is not met as evidenced by: Based on observation and document review, the facility did not properly implement a fire watch protocol for when the automatic fire sprinkler system is out of service for more than 10 hours in 24-hour period. 19.3.5.1, 9.7.5, 15.5.2 (NFPA 25). This deficient practice could affect all 57 residents. Findings include: On a facility tour between the hours of 0900 and 1730 on January 10, 2017, observation revealed that the facility could not provide a fire watch tour log sheet in the event of a fire alarm system outage. This deficient practice was verified by the director of environmental services at the time of inspection.	K 354	Birchwood Care Home has developed a 10 hour fire watch tour log sheet in case of sprinkler system outage. See attachment 3 and 4. Director of Maintenance will be responsible for compliance in this area.	
K 521 SS=F	NFPA 101 HVAC HVAC Heating, ventilation, and air conditioning shall comply with 9.2 and shall be installed in accordance with the manufacturer's specifications.	K 521		2/2/17

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K 521	Continued From page 11 18.5.2.1, 19.5.2.1, 9.2 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility's heating, ventilation, and air conditioning in not in compliance with the 2012 LSC NFPA 101 9.2, 19.5.2.1 and NFPA 90A. This deficient practice could effect all residents on the second and third floor. Findings include: On a facility tour between the hours of 0900 and 1730 on January 10, 2017, observation revealed that the facility is using the second and third floor corridors as an exhaust plenum. This deficient practice was verified by the director of environmental services at the time of inspection.	K 521	An HVAC worker came and assessed our facility, they will be contacting us next week with a plan. Once we have direction, we will resolve the matter within 120 days. Director of Maintenance and Administrator will be responsible for compliance.	
K 712 SS=C	NFPA 101 Fire Drills Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. 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 9:00 PM and 6:00 AM, a coded announcement may be used	K 712		2/1/17

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K 712	Continued From page 12 instead of audible alarms. 18.7.1.4 through 18.7.1.7, 19.7.1.4 through 19.7.1.7 This STANDARD is not met as evidenced by: Based on documentation review and staff interview, the facility could not provide documentation that fire drills were conducted once per shift per quarter for all staff under varying times and conditions as required by 2012 NFPA 101, Section 19.7.1.4. through 19.7.1.7. This deficient practice could affect all 57 residents. Findings include: On a facility tour between the hours of 0900 and 1730 on January 10, 2017, observation revealed that the facility could not provide documentation for receiving a verified alarm signal from the central monitoring company. This deficient practice was verified by the director of environmental services at the time of inspection.	K 712	Birchwood Care Home does Fire drills as per regulation. On the December fire drill log the Alarm verification from the monitoring company was not logged, this was a clerical error. The monitoring company was notified but an entry was omitted. In review of previous 2 years of fire drills, all other verifications were documented. This is corrected immediately through staff education, an extra reminder will be in place in fire drill log. Director of Maintenance will be responsible for supervision.	
K 781 SS=F	NFPA 101 Portable Space Heaters Portable Space Heaters Portable space heating devices shall be prohibited in all health care occupancies, except, unless used in nonsleeping staff and employee areas where the heating elements do not exceed 212 degrees Fahrenheit (100 degrees Celsius). 18.7.8, 19.7.8 This STANDARD is not met as evidenced by: Based on observation and document review, The facility did not properly implement a portable space heater policy. 19.7.8. This deficient	K 781	A space heater Policy has been developed (see attachment #1). All staff have been educated and the policy is	2/1/17

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K 781	Continued From page 13 practice could affect all 57 residents. Findings include: On a facility tour between the hours of 0900 and 1730 on January 10, 2017, observation revealed that the facility could not initially provide documentation for a space heater policy. Later in the survey a policy was produced but was dated as of the date of survey. This deficient practice was verified by the director of environmental services at the time of inspection.	K 781	readily available. Director of Maintenance is responsible for supervision.	
K 901 SS=F	NFPA 101 Fundamentals - Building System Categories Fundamentals - Building System Categories Building systems are designed to meet Category 1 through 4 requirements as detailed in NFPA 99. Categories are determined by a formal and documented risk assessment procedure performed by qualified personnel. Chapter 4 (NFPA 99) This STANDARD is not met as evidenced by: Based on observation and document review, the facility did not implement a risk assessment procedure for building systems designed to meet Category 1 through 4 in accordance with NFPA 99, Chapter 4. This deficient practice could affect all 57 residents. Findings include:	K 901	We will be contacting an expert to do this evaluation within 120 days. Director of Maintenance and Administrator will be responsible for compliance.	2/2/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24E166	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**01/10/2017**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BIRCHWOOD CARE HOME	**715 WEST 31ST STREET** **MINNEAPOLIS, MN 55408**

(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 901	Continued From page 14 On a facility tour between the hours of 0900 and 1730 on January 10, 2017, observation revealed that the facility could not provide a risk assessment planned for building systems. This deficient practice was verified by the director of environmental services at the time of inspection.	K 901		
K 918 SS=F	NFPA 101 Electrical Systems - Essential Electric Syste Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of	K 918		2/1/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24E166	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**01/10/2017**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BIRCHWOOD CARE HOME	**715 WEST 31ST STREET** **MINNEAPOLIS, MN 55408**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 918	Continued From page 15 maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked and readily identifiable. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This STANDARD is not met as evidenced by: Based on observation and document review, the facility did not maintain the emergency back-up generator in accordance with the 2012 NFPA 99. 6.4.4, 6.5.4, 6.6.4. These deficient practices could effect all 57 residents. Findings include: 1. On a facility tour between the hours of 0900 and 1730 on January 10, 2017, observation revealed that the facility did not document the 30 minute generator load test separately from the minimum five minute cool-down period. 2. On a facility tour between the hours of 0900 and 1730 on January 10, 2017, observation revealed that the facility could not provide evidence that the generator was tested monthly under at least 30 percent load capacity. These deficient practices were verified by the director of maintenance at the time of inspection.	K 918	Birchwood Care Home tests the generator on a monthly basis. The cool down period was not logged, this has been corrected immediately. See attachment #2 for Inspection sheet which has been updated to include cool down period. See attachment #3 and #4 for Monthly testing including documentation of it being at least 30 percent load capacity. Director of Maintenance is responsible.	
K 923 SS=D	NFPA 101 Gas Equipment - Cylinder and Container Storag Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and	K 923		2/2/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24E166	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**01/10/2017**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BIRCHWOOD CARE HOME	**715 WEST 31ST STREET** **MINNEAPOLIS, MN 55408**

(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 923	Continued From page 16 ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited- combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99) This STANDARD is not met as evidenced by: Based on observation and staff interview, that facility did not properly store oxygen cylinders in accordance with NFPA 99. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5. This deficient practice could affect all residents with the room.	K 923	We will be purchasing a Securall polyurethane green gas cylinder cabinet which will add additional fire prevention. This will be purchased and oxygen placed in cabinet within 30 days. Director of	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24E166	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**01/10/2017**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BIRCHWOOD CARE HOME	**715 WEST 31ST STREET** **MINNEAPOLIS, MN 55408**

(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 923	Continued From page 17 Findings include: On a facility tour between the hours of 0900 and 1730 on January 10, 2017, observation revealed that oxygen was being stored within five feet of combustible storage in the central nursing storage room. This deficient practice was verified by the director of environmental services at the time of inspection.	K 923	Nursing and Director of Maintenance will be responsible.	

Minnesota Department of Health
Protecting, maintaining and improving the health of all Minnesotans

MINNESOTA MDH DEPARTMENT of HEALTH

Confirmation page! Thank you for using the data entry system.
If you have comments please send to:
monica.larson@health.state.mn.us

Please print this page and give it to your state survey team. A page for both the CMS-671 and CMS-672 will be required to complete the process.	Print this Page
Would you like to go to the CMS-672 form for data entry?	Go to CMS-672
I'm finished and would like to exit the application.	Exit

Standard Survey Date Format: mm/dd/yy From F1: **01/09/16** To F2: **01/10/16**	Extended Survey Date Format: mm/dd/yy From F3: To F4:	
Name of Facility: **BIRCHWOOD CARE HOME**	Provider Number: **24E166**	Fiscal Year ending:
Address: **715 WEST 31ST STREET, MINNEAPOLIS, HENNEPIN, MN 55408**		
Telephone Number: F6 **612-823-7286**	State/County Code: **MN / HENNEPIN**	State/Region Code: **MN / 05**
A. F9 **02 - Nursing Facility (NF) - Medicaid** Participation B. Is this facility hospital based? F10 **No** If yes, indicate Hopsital Provider Number: F11		
Ownership: F12 03 - For Profit - Corporation		
Owned or leased by Multi-Facility Organization: F13 **No** Name of Multi-Facility Organization: F14		
Dedicated Special Care Units (show number of beds for all that apply)		
AIDS F15 **0** Dialysis F17 **0** Head Trama F19 **0**	Alzheimer's Disease F16 **0** Disabled Child Young Adult F18 **0** Hospice F20 **0**	

Huntington's Disease F21 **0** Ventilator/Respiratory Care F22 **0**
Other Spec Rehab. F23 **0**

Does the facility currently have an organized resident group? F24	**Yes**
Does the facility currently have an organized group of family members of residents? F25	**Yes**
Does the facility conduct experimental research? F26	**No**
Is the facility part of a continuing care retirement community (CCRC)? F27	**No**

If the facility currently has a staffing waiver, indicate the type(s) of waiver(s) by writing in the date(s) of the last approval. Indicate the number of hours waived for each type of waiver granted. If the facility does not have a waiver, write NA in the blanks.

Waiver of seven day RN requirement.	Date: mm/dd/yy F28	Hours waived per week: F29
Waiver of 24 hr licensed nursing requirement.	Date: mm/dd/yy F30	Hours waived per week: F31

Does the facility currently have an approved nurse aide training and competency program? F32	**No**

The following three questions are to be completed by the survey team.

1) Was this a staggered Survey?	**No - Not Staggered**
2) If staggered, day of the week starting?	**Surveyor to Complete**
3) If staggered, starting time?	**Surveyor to complete AM**

FACILITY STAFFING

		A	B	C	D
	Tag #	Services Provided 1 2 3	Full-Time Staff (hours)	Part-Time Staff (hours)	Contract (hours)
Administration	F33		**160**	**80**	
Physician Services	F34	**No No Yes**			
Medical Director	F35		**0**		**2**
Other Physician	F36		**0**	**0**	**0**
Physician Extender	F37	**No No No**	**0**	**0**	**0**

Nursing Services	F38	Yes No No			
RN Director of Nursing	F39		72	0	0
Nurses with Admin Duties	F40		72	53	0
Registered Nurses	F41		40	31	0
Licensed Practical/ Vocational Nurses	F42		80	166	0
Certified Nurse Aides	F43		72	167	0
Nurse Aides in Training	F44		0	0	0
Medication	F45		0	247	0
Pharmacists	F46	Yes No No	0	0	2
Dietary Services	F47	Yes No No			
Dietitian	F48		0	0	16
Food Service Workers	F49		148	271	0
Therapeutic Services	F50				
Occupational Therapist	F51	No No No	0	0	0
Occupational Therapy Assistant	F52		0	0	0
Occupational Therapy Aides	F53		0	0	0
Physical Therapist	F54	No No No	0	0	0
Physical Therapy Assist	F55		0	0	0
Physical Therapy Aides	F56		0	0	0
Speech/Language	F57	No No No	0	0	0
Therapeutic Recreation Spec.	F58	No No No	0	0	0
Qualified Activities Prof.	F59	No No No	0	0	0
Other Activities Staff	F60	Yes No No	233	0	0
Qualified Social Workers	F61	Yes No No	80	0	0

Other Social Services Staff	F62	Yes No No	0	80	0
Dentists	F63	No No No	0	0	0
Podiatrists	F64	No No No	0	0	0
Mental Health Services	F65	Yes No No	0	0	0
Vocational Services	F66	No No No			
Clinical Laboratory Services	F67	Yes No No			
Diagnostic X-ray Services	F68	No No No			
Administration Storage of Blood	F69	No No No			
Housekeeping Services	F70	Yes No No	185	110	0
Other	F71		0	0	0
Name of Person Completing Form: **Kathryn Herbert**					Date: **01/12/17**

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Spotlight

Minnesota eLicensing

Questions?

Please contact our Health Regulation Division: health.fpc-web@state.mn.us or 651-201-4101.

See also > Health Regulation

- Certificates & Records
- Data & Statistics
- Diseases & Conditions
- Emergency Preparedness
- Environments & Your Health
- Facilities & Professions
- Health Care & Coverage
- Injury, Violence & Safety
- Life Stages & Populations
- Policy, Economics & Legislation

Minnesota Department of Health
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Would you like to go to the CMS-671 form for data entry?	Go to CMS-671
I'm finished and would like to exit the application.	Exit

BIRCHWOOD CARE HOME				
Provider No. **24E166**	Medicare F75 **0**	Medicaid F76 **51**	Other F77 **6**	Total Residents F78 **57**

ADL	Independent	Assist of One Two Staff	Dependent
Bathing	F79 **55**	F80 **2**	F81 **0**
Dressing	F82 **57**	F83 **0**	F84 **0**
Transferring	F85 **57**	F86 **0**	F87 **0**
Toilet Use	F88 **57**	F89 **0**	F90 **0**
Eating	F91 **57**	F92 **0**	F93 **0**

A. Bowel/Bladder Status	**B. Mobility**
F94 **0** With indwelling or external catheter.	F100 **0** Bedfast all or most of time..
F95 Of total number of residents with catheters, **0** were present on admission.	F101 **0** In chair all or most of time.
	F102 **49** Independently ambulatory.

F96 **1** Occasionally or frequently incontinent of bladder.

F97 **1** Occasionally or frequently incontinent of bowel.

F98 **0** On individually written bladder training program.

F99 **0** On individually written bowel training program.

F103 **8** Ambulation with assistance or assistive device.

F104 **0** Physically restrained.

F105 Of total number of residents with restrained, **0** were admitted with orders for restraints.

F106 **0** With contractures.

F107 Of total number of residents with contractures, **0** had contractures on admission.

C. Mental Status

F108 **3** With mental retardation.

F109 **28** With documentation signs and symptoms of depression.

F110 **54** With documentation psychiatric diagnosis (excluding dementias and depression).

F111 **3** Dementia: multi-infarct, senile, Alzheimer's type, or other than Alzheimer's type.

F112 **38** With behavioral symptoms.

F113 **38** Of the total number of residents with behavioral symptoms, the total number receiving a behavior management prpgram.

F114 **35** Receiving health rehabilitative services for MI/MR.

D. Skin Integrity

F115 **0** With pressure sores (exclude stage I).

F116 **0** Of the total number of residents with pressure sores excluding stage I, how many residents had pressure sores on admission?

F117 **20** Receiving preventive skin care.

F118 **0** With rashes.

E. Special Care

F119 **0** Receiving hospice care benefit.

F120 **0** Receiving radiation therapy.

F121 **1** Receiving chemotherapy.

F127 **0** Receiving suction.

F128 **13** Receiving injections (exclude vitamin B12 injections)

F129 **0** Receiving tube feedings.

F122 **0** Receiving dialysis.	F130 **5** Receiving mechanically altered diets including pureed and all chopped food (not only meat).
F123 **0** Receiving intravenous therapy, parenteral nutrition, and/or blood transfusion.	F131 **0** Receiving specialized rehabilitative services (Physical therapy, speech-language therapy, occupational therapy).
F124 **2** Receiving respiratory treatment.	F132 **0** Assistive devices while eating.
F125 **0** Receiving tracheostomy care.	
F126 **0** Receiving ostomy care.	

F. Medication	**G. Other**
F133 **55** Receiving any psychoactive medication.	F140 **4** With unplanned significant weight loss/gain.
F134 **55** Receiving antipsychotic medications.	F141 **0** Who do not communicate in the dominant language of the facility (includes those who use sign language).
F135 **18** Receiving antianxiety medications.	F142 **0** Who use non-oral communicationdevices.
F136 **30** Receiving antidepressant medications.	F143 **8** With advance directives.
F137 **5** Receiving hypnotic medication.	F144 **43** Received influenza immunization.
F138 **6** Receiving antibiotics.	F145 **39** Received pneumococcal vaccine.
F139 **12** On pain management program.	

I certify that this Information is accurate to the best of my knowledge.		
Name of Person Completing	Title	Date
Bernice Ngwa	**RN**	**01/13/2017**

To be completed by MDH survey team.
F146 Was ombudsman office notified prior to survey? **Yes**
F147 Was ombudsman present during any portion of the survey? **No**
F148 Medication error rate **0%**

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Spotlight

Minnesota eLicensing

Questions?

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See also > Health Regulation

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Information on this website is available in alternative formats upon request.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINSTRATION

FORM APPROVED
OMB No. 0938-0391

SURVEY TEAM COMPOSITION AND WORKLOAD REPORT

Provider/Supplier Number	Provider/Supplier Name
24E166	BIRCHWOOD CARE HOME

Type of Survey (select all that apply):

I					

A Complaint Investigation
B Dumping Investigation
C Federal Monitoring
D Follow-up Visit
E Initial Certification
F Inspection of Care
G Validation
H Life safety Code
I Recertification
J Sanction/Hearing
K State License
L Chow

Extent of Survey (Select all that apply):

A					

A Routine/Standard (all providers/suppliers)
B Extended Survey (HHA or long term care facility)
C Partial Extended Survey (HHA)
D Other Survey

SURVEY TEAM AND WORKLOAD DATA

Please enter the workload information for each surveyor. Use the surveyor's information number.

Surveyor Id Number (A)	First Date Arrived (B)	Last Date Departed (C)	Pre-Survey Preparation Hours (D)	On-Site Hours 12am-8am (E)	On-Site Hours 8am-6pm (F)	On-Site Hours 6pm-12am (G)	Travel Hours (H)	Off-Site Report Preparation Hours (I)
1. 19692	01-09-2017	01-10-2017	0.00	0.00	15.50	2.00	0.00	0.00
2. 31223	01-09-2017	01-10-2017	0.00	0.00	16.00	2.00	0.00	9.50
3. Team Leader 35569	01-09-2017	01-10-2017	1.50	2.00	16.00	0.00	0.00	8.50
4.								
5.								
6.								
7.								
8.								
9.								
10.								

Total Supervisory Review Hours 2.75

Total Clerical/Data Entry Hours..... 3.25

Was Statement of Deficiencies given to the provider on-site at completion of the survey? ..... N

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINSTRATION

FORM APPROVED
OMB No. 0938-0391

SURVEY TEAM COMPOSITION AND WORKLOAD REPORT

Provider/Supplier Number	Provider/Supplier Name
24E166	BIRCHWOOD CARE HOME

Type of Survey (select all that apply):

H	I				

A Complaint Investigation E Initial Certification I Recertification
B Dumping Investigation F Inspection of Care J Sanction/Hearing
C Federal Monitoring G Validation K State License
D Follow-up Visit H Life safety Code L Chow

Extent of Survey (Select all that apply):

A					

A Routine/Standard (all providers/suppliers)
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SURVEY TEAM AND WORKLOAD DATA

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1. Team Leader 37009	01-10-2017	01-10-2017	1.00	0.00	9.00	0.00	3.00	4.50
2.								
3.								
4.								
5.								
6.								
7.								
8.								
9.								
10.								

Total Supervisory Review Hours 0.25

Total Clerical/Data Entry Hours..... 0.25

Was Statement of Deficiencies given to the provider on-site at completion of the survey? .....

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

PROVIDER NUMBER	FACILITY NAME	SURVEY DATE
K1 24E166	**BIRCHWOOD CARE HOME**	*K4 **01/10/2017**

K6 DATE OF PLAN APPROVAL

K3 : MULTIPLE CONSTRUCTION

TOTAL NUMBER OF BUILDINGS 1

NUMBER OF THIS BUILDING 01

[A]

A BUILDING
B WING
C FLOOR
D APARTMENT UNIT

LSC FORM INDICATOR

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

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

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

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

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

K321: [3] K351: [3]

COMPLETE IF ICF/MR IS SURVEYED UNDER CHAPTER 21

SMALL (16 BEDS OR LESS)

K8: [ ]

1 PROMPT
2 SLOW
3 IMPRACTICAL

LARGE

K8: [ ]

4 PROMPT
5 SLOW
6 IMPRACTICAL

APARTMENT HOUSE

K8: [ ]

7 PROMPT
8 SLOW
9 IMPRACTICAL

ENTER E-SCORE HERE

K5: [ ] e.g 2.5

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

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

FACILITY DOES NOT MEET LSC:

B. [ ]

K180:

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

*MANDATORY

FIRE SAFETY SURVEY REPORT 2012 CODE – HEALTH CARE
Medicare – Medicaid

1. (A) PROVIDER NUMBER	1. (B) MEDICAID I.D. NO.
24E166 K1	K2

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

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

2. NAME OF FACILITY	2. (A) MULTIPLE CONSTRUCTION (BLDGS)	2. (B) ADDRESS OF FACILITY (STREET, CITY, STATE, ZIP CODE)	
Birchwood Care Home	A. BUILDING 1 B. WING C. FLOOR K3	715 West 31st Street Minneapolis, MN 55408	A. (●) Fully Sprinklered (All required areas are sprinklered) B. ( ) Partially Sprinklered (Not all required areas are sprinklered) C. ( ) None (No sprinkler system) K0180

3. SURVEY FOR	4. DATE OF SURVEY	DATE OF PLAN APPROVAL	SURVEY UNDER
[ ] MEDICARE [✔] MEDICAID	01/10/2017 K4	K6	5. (●) 2012 EXISTING 6. ( ) 2012 NEW K7

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

IF "2" OR "5" ABOVE IS MARKED, CHECK APPROPRIATE ITEM(S) BELOW
1. [✔] ENTIRE FACILITY 2. [ ] DISTINCT PART OF (SPECIFY) _____

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

6. BED COMPOSITION a. TOTAL NO. OF BEDS IN THE FACILITY	b. NUMBER OF HOSPITAL BEDS CERTIFIED FOR MEDICARE	c. NUMBER OF SKILLED BEDS CERTIFIED FOR MEDICARE	d. NUMBER OF SKILLED BEDS CERTIFIED FOR MEDICAID	e. NUMBER OF NF or ICF/IID BEDS CERTIFIED FOR MEDICAID
60			60	

7. A. (●) THE FACILITY MEETS THE STANDARD, BASED UPON (CHECK ALL APPROPRIATE BOXES)
1. [ ] COMPLIANCE WITH ALL PROVISIONS 2. [✔] ACCEPTANCE OF A PLAN OF CORRECTION 3. [✔] RECOMMENDED WAIVERS 4. [ ] FSES 5. [ ] PERFORMANCE BASED DESIGN
B. ( ) THE FACILITY DOES NOT MEET THE STANDARD
K9

SURVEYOR *(Signature)*	TITLE	OFFICE	DATE
William Abderhalden 999 SURVEYOR ID 37009 K10	Deputy State Fire Marshal	State Fire Marshal Division	01/20/2017
FIRE AUTHORITY OFFICIAL *(Signature)* Thomas Linhoff12424	TITLE Fire Safety Supervisor	OFFICE State Fire Marshal Division	DATE 01-24-2017

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

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

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

ID PREFIX		MET	NOT MET	N/A	REMARKS
K133	**Multiple Occupancies – Construction Type** Where separated occupancies are in accordance with 18/19.1.3.2 or 18/19.1.3.4, the most stringent construction type is provided throughout the building, unless a two hour separation is provided in accordance with 8.2.1.3, in which case the construction type is determined as follows: • The construction type and supporting construction of the health care occupancy is based on the story in which it is located in the building in accordance with 18/19.1.6 and Tables 18/19.1.6.1. • The construction type of the areas of the building enclosing the other occupancies shall be based on the applicable occupancy chapters. 18.1.3.5, 19.1.3.5, 8.2.1.3	○	○	◉	
K161	**Building Construction Type and Height** 2012 EXISTING Building construction type and stories meets Table 19.1.6.1, unless otherwise permitted by 19.1.6.2 through 19.1.6.7 19.1.6.4, 19.1.6.5 *Sprinklered stories must be sprinklered throughout by an approved, supervised automatic system in accordance with section 9.7. (See 19.3.5)* *Give a brief description, in REMARKS, of the construction, the number of stories, including basements, floors on which patients are located, location of smoke or fire barriers and dates of approval. Complete sketch or attach small floor plan of the building as appropriate.*	◉	○	○	Birchwood Care Home is a 2-story building with a full basement. The building was constructed at 3 different times. The original 2 story building was constructed in 1966 and was determined to be of Type II(222) construction. In I971, a 20 bed addition was constructed and was determined to be of Type II(222) construction. In 2000, an addition was constructed to add an elevator as well as dry and cold storage to the East that was determined to be of Type II(222) construction. Because the original building and the 2 additions are of the same type of construction, the facility was surveyed as one building. This building is fully fire sprinklered. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors that is monitored for automatic fire department notification.

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

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

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

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

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

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

ID PREFIX		MET	NOT MET	N/A	REMARKS
K162	2012 NEW Buildings of Type I (442), Type I (332), Type II (222), Type II (111) having roof systems employing combustible roofing supports, decking or roofing meet the following: 1. roof covering meets Class A requirements. 2. roof is separated from occupied building portions with 2 hour fire resistive noncombustible floor assembly using not less than 2½ inches concrete or gypsum fill. 3. the structural elements supporting the rated floor assembly meet the required fire resistance rating of the building. 18.1.6.2, ASTM E108, ANSI/UL 790	○	○	○	
K163	**Interior Nonbearing Wall Construction** Interior nonbearing walls in Type I or II construction are constructed of noncombustible or limited-combustible materials. Interior nonbearing walls required to have a minimum 2 hour fire resistance rating are fire-retardant-treated wood enclosed within noncombustible or limited-combustible materials, provided they are not used as shaft enclosures. 18.1.6.4, 18.1.6.5, 19.1.6.4, 19.1.6.5	○	◉	○	Observation revealed that the two hour fire rated roof had an access panel constructed of wood and unprotected metal.
	SECTION 2 – MEANS OF EGRESS REQUIREMENTS				
K200	**Means of Egress Requirements – Other** List in the REMARKS section any LSC Section 18.2 and 19.2 Means of Egress requirements that are not addressed by the provided K-tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. 18.2, 19.2	◉	○	○	
K211	**Means of Egress – General** Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1	○	◉	○	Observation revealed that the boiler room egress stairs were obstructed by storage.

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

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

ID PREFIX		MET	NOT MET	N/A	REMARKS
K224	**Horizontal-Sliding Doors** Horizontal-sliding doors permitted by 7.2.1.14 that are not automatic-closing are limited to a single leaf and shall have a latch or other mechanism to ensure the door will not rebound. Horizontal-sliding doors serving an occupant load fewer than 10 shall be permitted, providing all of the following criteria are met: • Area served by the door has no hazards. • Door is operable from either side without special knowledge or effort. • Force required to operate the door in the direction of travel is ≤ 30 lbf to set the door in motion and ≤ 15 lbf to close or open to the required width. • Assembly is appropriately fire rated, and where rated, is self-or automatic-closing by smoke detection per 7.2.1.8, and installed per NFPA 80. • Where required to latch, the door has a latch or other mechanism to ensure the door will not rebound. 18.2.2.2.10, 19.2.2.2.10	○	○	◉	
K225	**Stairways and Smokeproof Enclosures** Stairways and Smokeproof enclosures used as exits are in accordance with 7.2. 18.2.2.3, 18.2.2.4, 19.2.2.3, 19.2.2.4, 7.2	○	◉	○	1. Observation revealed that there were combustible decorations in the exit stairways. 2. Observation revealed that the first floor, North exit stairway fire-rated door was cracked.
K226	**Horizontal Exits** Horizontal exits, if used, are in accordance with 7.2.4 and the provisions of 18.2.2.5.1 through 18.2.2.5.7, or 19.2.2.5.1 through 19.2.2.5.4. 18.2.2.5, 19.2.2.5	○	○	◉	
K227	**Ramps and Other Exits** Ramps, exit passageways, fire escape ladders, alternating tread devices, and areas of refuge are in accordance with the provisions 7.2.5 through 7.2.12. 18.2.2.6 to 18.2.2.10 or 19.2.2.6 to 19.2.2.10	◉	○	○	
K231	**Means of Egress Capacity** The capacity of required means of egress is in accordance with 7.3. 18.2.3.1, 19.2.3.1	◉	○	○	

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

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

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

ID PREFIX		MET	NOT MET	N/A	REMARKS
K261	**Travel Distance to Exits** Travel distance (excluding suites) to exits are measured in accordance with 7.6. • From any point in the room or suite to exit less than or equal to 150 feet (less than or equal to 200 feet if the building is fully sprinklered). • Point in a room to room door less than or equal to 50 feet. 18.2.6, 19.2.6	◉	○	○	
K271	**Discharge from Exits** Exit discharge is arranged in accordance with 7.7, provides a level walking surface meeting the provisions of 7.1.7 with respect to changes in elevation and shall be maintained free of obstructions. Additionally, the exit discharge shall be a hard packed all-weather travel surface in accordance with CMS Survey and Certification Letter 05-38. 18.2.7, 19.2.7, S&C 05-38	◉	○	○	
K281	**Illumination of Means of Egress** Illumination of means of egress, including exit discharge, is arranged in accordance with 7.8 and shall be either continuously in operation or capable of automatic operation without manual intervention. 18.2.8, 19.2.8	◉	○	○	
K291	**Emergency Lighting** Emergency lighting of at least 1-1/2 hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1	◉	○	○	
K292	**Life Support Means of Egress** 2012 NEW (INDICATE N/A FOR EXISTING) Buildings equipped with or requiring the use of life support systems (electro-mechanical or inhalation anesthetics) have illumination of means of egress, emergency lighting equipment, exit, and directional signs supplied by the life safety branch of the electrical system described in NFPA 99. (Indicate N/A if life support equipment is for emergency purposes only.) 18.2.9.2, 18.2.10.5	○	○	◉	

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

ID PREFIX		MET	NOT MET	N/A	REMARKS
K321	**Hazardous Areas – Enclosure** 2012 EXISTING Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with ¾ hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. *Describe the floor and zone locations of hazardous areas that are deficient in REMARKS.* 19.3.2.1		○	◉	○	1. Observation revealed that the laundry room door was held open with a door wedge. 2. Observation revealed that the medical records room is over 100 square feet and contains combustible storage but does not have and automatic door closer.

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

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

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

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

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

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

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

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

ID PREFIX		MET	NOT MET	N/A	REMARKS
K345	**Fire Alarm System – Testing and Maintenance** A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, *National Electric Code,* and NFPA 72, *National Fire Alarm and Signaling Code.* Records of system acceptance, maintenance and testing are readily available. 9.7.5, 9.7.7, 9.7.8, and NFPA 25	◉	○	○	
K346	**Fire Alarm – Out of Service** Where required fire alarm system is out of services for more than 4 hours in a 24 hour period, the authority having jurisdiction shall be notified, and the building shall be evacuated or an approved fire watch shall be provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service. 9.6.1.6	○	◉	○	Observation revealed that the facility could not provide a fire watch tour log sheet in the event of a fire alarm system outage.
K347	**Smoke Detection** 2012 EXISTING Smoke detection systems are provided in spaces open to corridors as required by 19.3.6.1. 19.3.4.5.2	◉	○	○	
	2012 NEW Smoke detection systems are provided in spaces open to corridors as required by 18.3.6.1 In nursing homes, an automatic smoke detection system is installed in the corridors of all smoke compartments containing resident sleeping rooms, unless the resident sleeping rooms have: • smoke detection, or • automatic door closing devices with integral smoke detectors on the room side that provide occupant notification. Such detectors are electrically interconnected to the fire alarm system. 18.3.4.5.2, 18.3.4.5.3	○	○	○	

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

ID PREFIX		MET	NOT MET	N/A	REMARKS
K353	**Sprinkler System – Maintenance and Testing** Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, *Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems.* Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked. 02/12/2016 b) Who provided system test. Viking c) Water system supply source. City Water *Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system.* 9.7.5, 9.7.7, 9.7.8, and NFPA 25	○	◉	○	1. Observation revealed that the facility could not provide evidence for a five year internal obstruction investigation of the automatic sprinkler system. 2. Observation revealed that the sprinkler head in the dish washing room had an excessive amount of debris covering the frangible bulb. 3. Observation revealed that the storage in the walk in freezer and kitchen pantry are piled in a manner that will block the pattern of the sprinkler head. 4. Observation revealed that the spare automatic sprinkler heads were stored outside of the sprinkler cabinet.
K354	**Sprinkler System – Out of Service** Where the sprinkler system is impaired, the extent and duration of the impairment has been determined, areas or buildings involved are inspected and risks are determined, recommendations are submitted to management or designated representative, and the fire department and other authorities having jurisdiction have been notified. Where the sprinkler system is out of service for more than 10 hours in a 24 hour period, the building or portion of the building affected are evacuated or an approved fire watch is provided until the sprinkler system has been returned to service. 18.3.5.1, 19.3.5.1, 9.7.5, 15.5.2 (NFPA 25)	○	◉	○	Observation revealed that the facility could not provide a fire watch tour log sheet in the event of an automatic sprinkler system outage.
K355	**Portable Fire Extinguishers** Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, *Standard for Portable Fire Extinguishers.* 18.3.5.12, 19.3.5.12, NFPA 10	◉	○	○	
K361	**Corridors – Areas Open to Corridor** Spaces (other than patient sleeping rooms, treatment rooms and hazardous areas), waiting areas, nurse's stations, gift shops, and cooking facilities, open to the corridor are in accordance with the criteria under 18.3.6.1 and 19.3.6.1. 18.3.6.1, 19.3.6.1	◉	○	○	

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

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

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

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

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

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

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

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

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

ID PREFIX		MET	NOT MET	N/A	REMARKS
K711	**Evacuation and Relocation Plan** There is a written plan for the protection of all patients and for their evacuation in the event of an emergency. Employees are periodically instructed and kept informed with their duties under the plan, and a copy of the plan is readily available with telephone operator or with security. The plan addresses the basic response required of staff per 18/19.7.2.1.2 and provides for all of the fire safety plan components per 18/19.7.2.2. 18.7.1.1 through 18.7.1.3, 18.7.2.1.2, 18.7.2.2, 18.7.2.3, 19.7.1.1 through 19.7.1.3, 19.7.2.1.2, 19.7.2.2, 19.7.2.3	◉	○	○	
K712	**Fire Drills** Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at 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 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 18.7.1.4 through 18.7.1.7, 19.7.1.4 through 19.7.1.7	○	◉	○	Observation revealed that the facility could not provide documentation for receiving a verified alarm signal from the central monitoring company.

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

ID PREFIX		MET	NOT MET	N/A	REMARKS
K752	**Upholstered Furniture and Mattresses** Newly introduced upholstered furniture meets Class I or char length, and heat release criteria in accordance with 10.3.2.1 and 10.3.3, unless the building is fully sprinklered. Newly introduced mattresses shall meet char length and heat release criteria in accordance with 10.3.2.2 and 10.3.4, unless the building is fully sprinklered. Upholstered furniture and mattresses belonging to nursing home residents do not have to meet these requirements as all nursing homes are required to be fully sprinklered. Newly introduced upholstered furniture and mattresses means purchased on or after the LSC final rule effective date. 18.7.5.2, 18.7.5.4, 19.7.5.2, 19.7.5.4	◉	○	○	
K753	**Combustible Decorations** Combustible decorations shall be prohibited unless one of the following is met: • Flame retardant or treated with approved fire-retardant coating that is listed and labeled for product. • Decorations meet NFPA 701. • Decorations exhibit heat release less than 100 kilowatts in accordance with NFPA 289. • Decorations, such as photographs, paintings and other art are attached to the walls, ceilings and non-fire-rated doors in accordance with 18.7.5.6 or 19.7.5.6. • The decorations in existing occupancies are in such limited quantities that a hazard of fire is not present. 18.7.5.6, 19.7.5.6	◉	○	○	

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

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

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

ID PREFIX		MET	NOT MET	N/A	REMARKS
K908	**Gas and Vacuum Piped Systems – Inspection and Testing Operations** The gas and vacuum systems are inspected and tested as part of a maintenance program and include the required elements. Records of the inspections and testing are maintained as required. 5.1.14.2.3, B.5.2, 5.2.13, 5.3.13, 5.3.13.4 (NFPA 99)	○	○	◉	
K909	**Gas and Vacuum Piped Systems – Information and Warning Signs** Piping is labeled by stencil or adhesive markers identifying the gas or vacuum system, including the name of system or chemical symbol, color code (Table 5.1.11), and operating pressure if other than standard. Labels are at intervals not more than 20 feet, are in every room, at both sides of wall penetrations, and on every story traversed by riser. Piping is not painted. Shutoff valves are identified with the name or chemical symbol of the gas or vacuum system, room or area served, and caution to not use the valve except in emergency. 5.1.14.3, 5.1.11.1, 5.1.11.2, 5.2.11, 5.3.13.3, 5.3.11 (NFPA 99)	○	○	◉	
K910	**Gas and Vacuum Piped Systems – Modifications** Whenever modifications are made that breach the pipeline, any necessary installer and verification test specified in 5.1.2 is conducted on the downstream portion of the medical gas piping system. Permanent records of all tests required by system verification tests are maintained. 5.1.14.4.1, 5.1.14.4.6, 5.2.13, 5.3.13.4.3 (NFPA 99)	○	○	◉	
K911	**Electrical Systems – Other** List in the REMARKS section any NFPA 99 Chapter 6 Electrical Systems requirements that are not addressed by the provided K-Tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. Chapter 6 (NFPA 99)	◉	○	○	
K912	**Electrical Systems – Receptacles** Power receptacles have at least one, separate, highly dependable grounding pole capable of maintaining low-contact resistance with its mating plug. In pediatric locations, receptacles in patient rooms, bathrooms, play rooms, and activity rooms, other than nurseries, are listed tamper-resistant or employ a listed cover. If used in patient care room, ground-fault circuit interrupters (GFCI) are listed. 6.3.2.2.6.2 (F), 6.3.2.4.2 (NFPA 99)	◉	○	○	

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

ID PREFIX		MET	NOT MET	N/A	REMARKS
K916	**Electrical Systems – Essential Electric System Alarm Annunciator** A remote annunciator that is storage battery powered is provided to operate outside of the generating room in a location readily observed by operating personnel. The annunciator is hard-wired to indicate alarm conditions of the emergency power source. A centralized computer system (e.g., building information system) is not to be substituted for the alarm annunciator. 6.4.1.1.17, 6.4.1.1.17.5 (NFPA 99)	◉	○	○	
K917	**Electrical Systems – Essential Electric System Receptacles** Electrical receptacles or cover plates supplied from the life safety and critical branches have a distinctive color or marking. 6.4.2.2.6, 6.5.2.2.4.2, 6.6.2.2.3.2 (NFPA 99)	◉	○	○	
K918	**Electrical Systems – Essential Electric System Maintenance and Testing** The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked and readily identifiable. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70)	○	◉	○	1. Observation revealed that the facility did not document the 30 minute generator load test separately from the minimum five minute cool-down period. 2. Observation revealed that the facility could not provide evidence that the generator was tested monthly under at least 30 percent load capacity.

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

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

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

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

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

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

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

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

PROVISION NUMBER(S)	JUSTIFICATION
K400	

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

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

Provider Number	Facility Name	Survey Date
K1		*K4

K6 DATE OF PLAN APPROVAL

K3 MULTIPLE CONSTRUCTION ☐

TOTAL NUMBER OF BUILDINGS _____

NUMBER OF THIS BUILDING _____

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

LSC FORM INDICATOR

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

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

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

*K7 ☐ SELECT NUMBER OF FORM USED FROM ABOVE

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

SMALL (16 BEDS OR LESS)

K8 ☐
1. PROMPT
2. SLOW
3. IMPRACTICAL

LARGE

K8 ☐
4. PROMPT
5. SLOW
6. IMPRACTICAL

APARTMENT HOUSE

K8 ☐
7. PROMPT
8. SLOW
9. IMPRACTICAL

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

K321: ☐ K351: ☐

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

ENTER E – SCORE

K5: ☐ e.g. 2.5

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

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

FACILITY DOES NOT MEET LSC

B. ☐

K0180

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

*MANDATORY

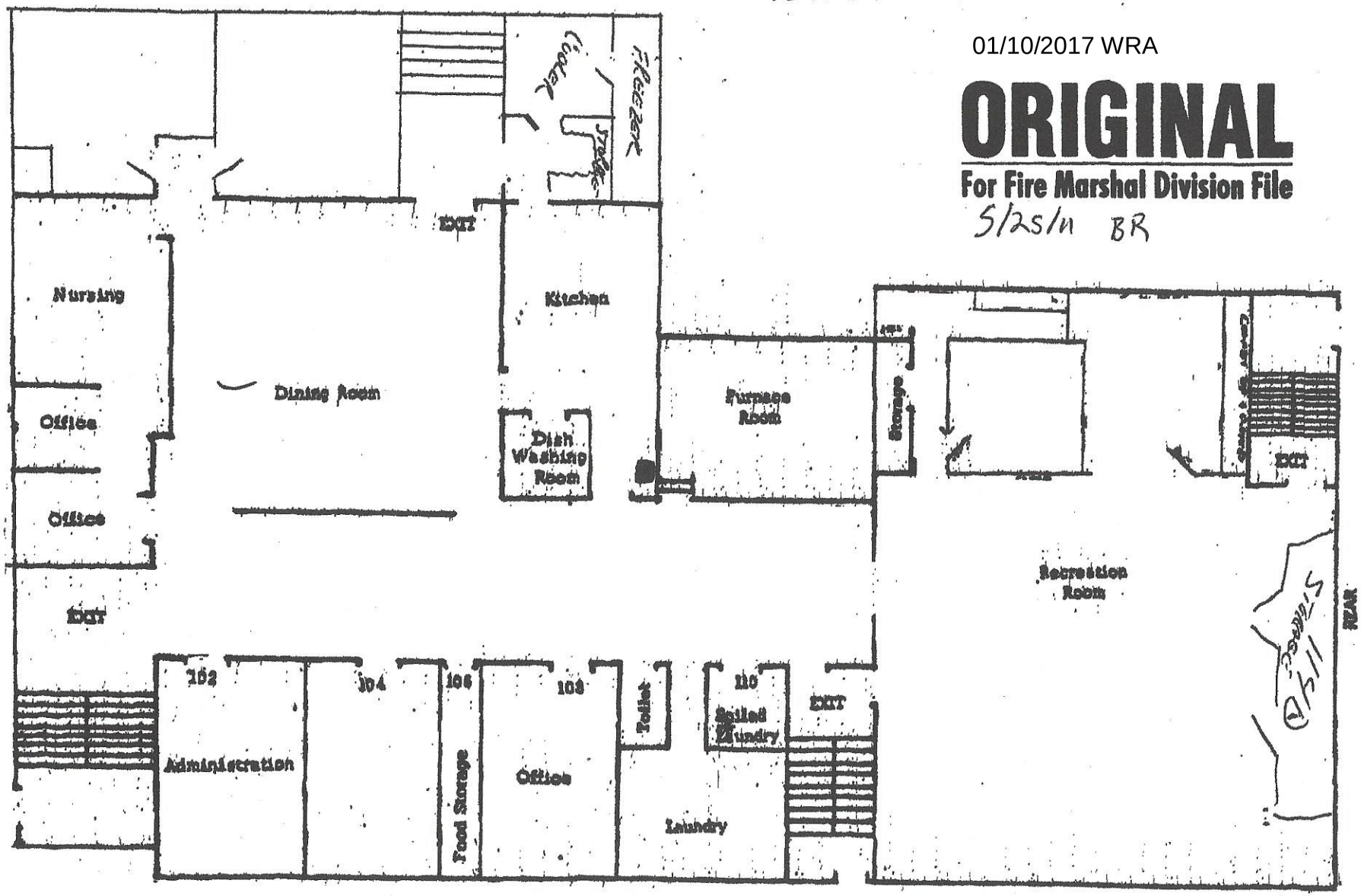
BIRCHWOOD CARE HOME

01/10/2017 WRA

ORIGINAL

For Fire Marshal Division File

5/25/11 BR



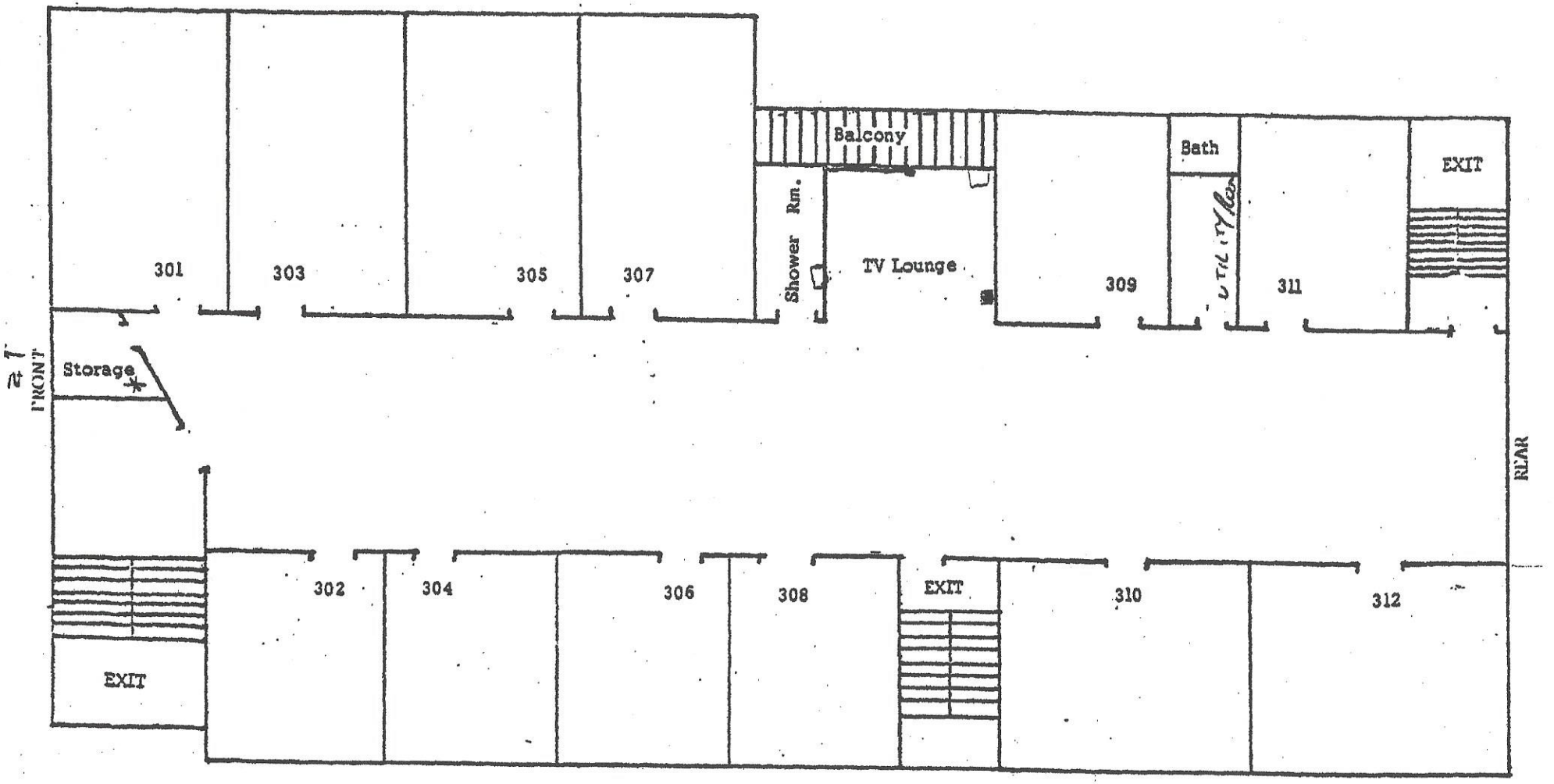
ORIGINAL

For Fire Marshal Division File

5/25/11 BR

BIRCHWOOD CARE HOME
715 W 31ST ST
MPLS, MN

01/10/2017 WRA



BIRCHWOOD CARE HOME

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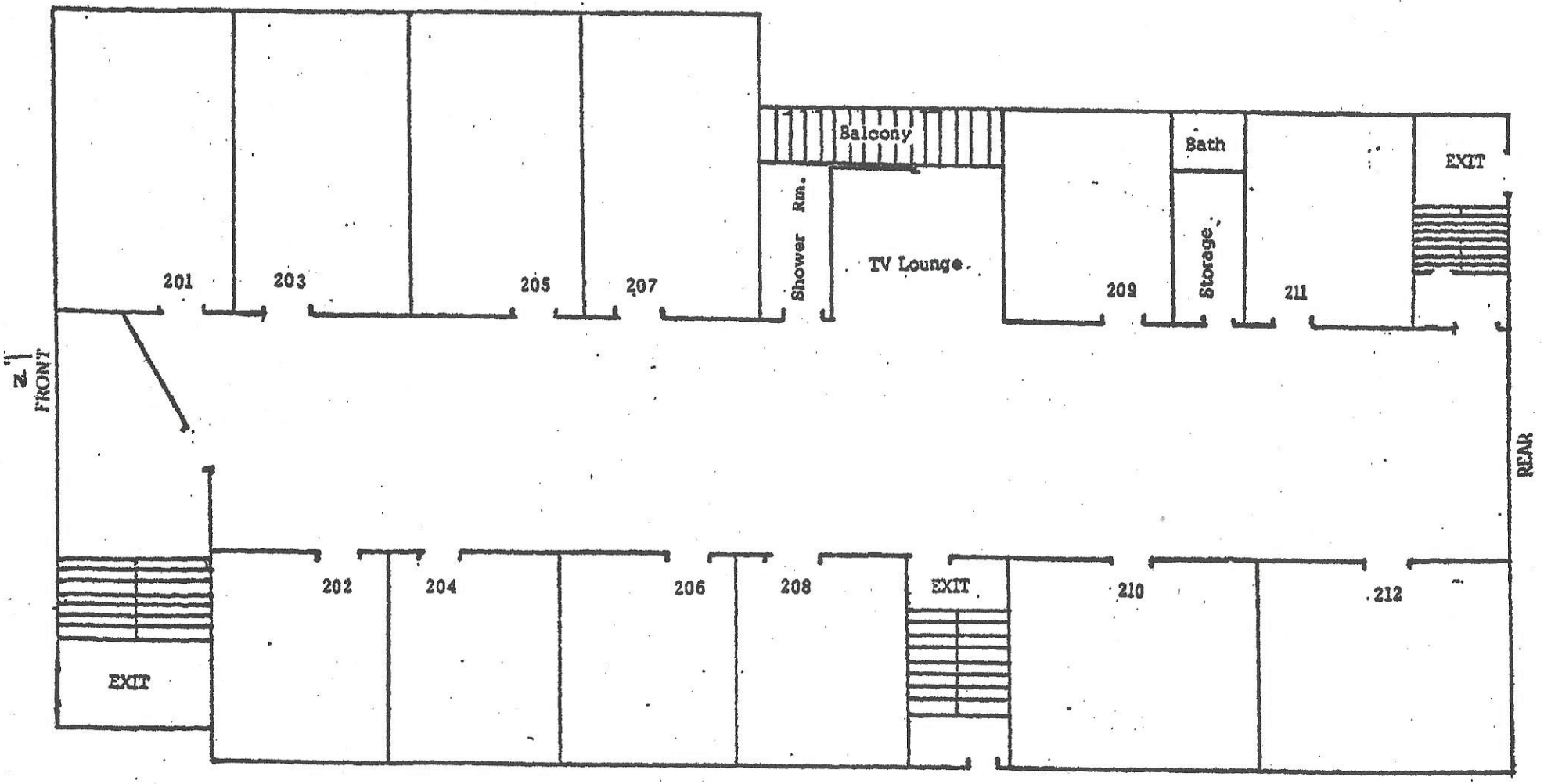

PROJECT NUMBER:	PROVIDER NAME	SURVEY DATE
FE166026	Birchwood Care Home	01/10/2017

Administrator: Randy Hagemeyer | Phone Number: (612) 823-7286

Email address: rand@birchwoodcare.com

State Fire Inspector: William Abderhalden, (507) 361-6204 william.abderhalden@state.mn.us

These are preliminary findings only. A complete and final Statement of Deficiencies 2567 report will be provided by US Mail.

○ **At the time of this inspection, this facility was found to comply with the requirements of the 2012 Life Safety Code applicable to:** ☑ **SNF/NF** ☐ **Hospital** ☐ **ICFMR** ☐ **ASC Facilities participating in the Medicare/Medicaid programs.**

◉ **The following fire/life safety deficiencies were found during this inspection:**

K TAG S& S	◉ **Draft Summary of Deficiency(ies)** ○ **Revisit** ○ **Clearance**
K918 S&S= F	1. Observation revealed that the facility did not document the 30 minute generator load test separately from the minimum five minute cool-down period. 2. Observation revealed that the facility could not provide evidence that the generator was tested monthly under at least 30 percent load capacity.
K923 S&S= D	Observation revealed that oxygen was being stored within five feet of combustible storage in the central nursing storage room.
	This was an annual federal recertification and state licensing inspection to the standards of the 2012 edition of the Life Safety Code NFPA 101 and the 2012 edition of the Health Care Facilities Code NFPA 99.

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SE166026

MINNESOTA DEPARTMENT OF HEALTH
Division of Health Policy, Information and Compliance Monitoring
85 East Seventh Place, Suite 300, P.O. Box 64900
St. Paul, Minnesota 55164-0900

Email for Administrator: randy@birchwoodcare.com

National Provider Identifier (NPI) Number: 1457355240
One facility may have multiple NPI Numbers. Please verify the NPI number associated with the provider type for this survey, i.e. for a nursing home survey, the NPI Number will be associated with the Nursing Home.

OWNERSHIP INFORMATION AT THE TIME OF SURVEY

Name of Facility: BIRCHWOOD CARE HOME City: MINNEAPOLIS

Name of Legal Entity Operating Provider: DYNAMIC HEALTH CONCEPTS, INC.

Name and Address of Governing Board President:

Name: RANDAL HAGEMEYER
Address: 5000 NOB HILL DR

City/State/Zip: EDINA, MN 55439

If legal entity or president of the governing board is different than what is noted above, please provide the information below.

Name of Facility: _____ City: _____

Name of Legal Entity Operating Provider: _____

Name and Address of Governing Board President:

Name: _____
Address: _____
City/State/Zip: _____

SIGNATURE

Completed by: Randal L. Hagemeyer
Title: President/Admin
Date: 1/10/17