

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL
PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: ENZN
Facility ID: 00887

1. MEDICARE/MEDICAID PROVIDER NO. (L1) 245496	3. NAME AND ADDRESS OF FACILITY (L3) MINNEOTA MANOR HEALTH CARE CENTER (L4) 700 NORTH MONROE STREET (L5) MINNEOTA, MN (L6) 56264	4. TYPE OF ACTION: <u>7</u> (L8) 1. Initial 3. Termination 5. Validation 7. On-Site Visit 2. Recertification 4. CHOW 6. Complaint 9. Other 8. Full Survey After Complaint
2.STATE VENDOR OR MEDICAID NO. (L2) 611042800	5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9)	FISCAL YEAR ENDING DATE: (L35) 09/30
6. DATE OF SURVEY 05/09/2014 (L34)	7. PROVIDER/SUPPLIER CATEGORY <u>02</u> (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	
8. ACCREDITATION STATUS: <u> </u> (L10) 0 Unaccredited 1 TJC 2 AOA 3 Other		

11. LTC PERIOD OF CERTIFICATION From (a) : To (b) :	10.THE FACILITY IS CERTIFIED AS: A. In Compliance With Program Requirements Compliance Based On: 1. Acceptable POC	And/Or Approved Waivers Of The Following Requirements: 2. Technical Personnel 3. 24 Hour RN 4. 7-Day RN (Rural SNF) 5. Life Safety Code 6. Scope of Services Limit 7. Medical Director 8. Patient Room Size 9. Beds/Room
12.Total Facility Beds 67 (L18)	B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: A5 (L12)	
13.Total Certified Beds 67 (L17)		

14. LTC CERTIFIED BED BREAKDOWN 18 SNF 18/19 SNF 19 SNF ICF IID 67 (L37) (L38) (L39) (L42) (L43)	15. FACILITY MEETS 1861 (e) (1) or 1861 (j) (1): (L15)
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16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):
See Attached Remarks

17. SURVEYOR SIGNATURE <u>Kathryn Serie, Unit Supervisor</u> (L19)	Date : 07/17/2014	18. STATE SURVEY AGENCY APPROVAL <u>Kamala Fiske-Downing, Enforcement Specialist</u> (L20)	Date: 07/18/2014
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PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY <input checked="" type="checkbox"/> 1. Facility is Eligible to Participate <input type="checkbox"/> 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 : <u> </u>
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22. ORIGINAL DATE OF PARTICIPATION 09/01/1987 (L24)	23. LTC AGREEMENT BEGINNING DATE (L41)	24. LTC AGREEMENT ENDING DATE (L25)	26. TERMINATION ACTION: (L30) <u>VOLUNTARY</u> <u>00</u> <u>INVOLUNTARY</u> 01-Merger, Closure 05-Fail to Meet Health/Safety 02-Dissatisfaction W/ Reimbursement 06-Fail to Meet Agreement 03-Risk of Involuntary Termination <u>OTHER</u> 04-Other Reason for Withdrawal 07-Provider Status Change 00-Active
25. LTC EXTENSION DATE: (L27)	27. ALTERNATIVE SANCTIONS A. Suspension of Admissions: (L44) B. Rescind Suspension Date: (L45)		

28. TERMINATION DATE: (L28)	29. INTERMEDIARY/CARRIER NO. 03001 (L31)	30. REMARKS
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31. RO RECEIPT OF CMS-1539 (L32)	32. DETERMINATION OF APPROVAL DATE 06/26/2014 (L33)	DETERMINATION APPROVAL
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C&T REMARKS - CMS 1539 FORM

STATE AGENCY REMARKS

CCN: 24-5496

Post certification revisit (PCR) of the Health survey was completed on May 9, 2014. Refer to CMS form 2567B. Documentation supporting the facility's request for a continuing waiver involving K67 has been approved by CMS.



Protecting, Maintaining and Improving the Health of Minnesotans

Medicare Provider # 245496

July 18, 2014

Ms. Kathy Johnson, Administrator
Minneota Manor Health Care Center
700 North Monroe Street
Minneota, MN 56264

Dear Ms. Johnson:

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

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

Effective June 5, 2014 the above facility is certified for:

67 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 67 skilled nursing facility beds.

We have recommended CMS approve the waivers that you requested for the following Life Safety Code Requirements: K67.

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

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

Minneota Manor Health Care Center

July 18, 2014

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Please contact me if you have any questions.

Sincerely,

A handwritten signature in cursive script that reads "Kamala Fiske-Downing".

Kamala Fiske-Downing, Program Specialist

Licensing and Certification Program

Division of Compliance Monitoring

Minnesota Department of Health

Telephone: (651) 201-4112

Fax: (651) 215-9697

cc: Licensing and Certification File



Protecting, Maintaining and Improving the Health of Minnesotans

July 17, 2014

Ms. Kathy Johnson, Administrator
Minneota Manor Health Care Center
700 North Monroe Street
Minneota, Minnesota 56264

RE: Project Number S5496025

Dear Ms. Johnson:

On May 23, 2014, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on May 9, 2014. 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 June 25, 2014, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on May 9, 2014. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of June 9, 2014. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on May 9, 2014, effective June 9, 2014 and therefore remedies outlined in our letter to you dated May 23, 2014, will not be imposed.

Your request for a continuing waiver involving the deficiency(ies) cited under K67 at the time of the May 9, 2014 standard survey has been forwarded to CMS for their review and determination. Your facility's compliance is based on pending CMS approval of your request for waiver.

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

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

Feel free to contact me if you have questions.

Sincerely,

A handwritten signature in black ink that reads "Kamala P. Downing". The signature is written in a cursive, flowing style.

Minneota Manor Health Care Center

July 17, 2014

Page 2

Kamala Fiske-Downing, Program Specialist

Licensing and Certification Program

Division of Compliance Monitoring

Minnesota Department of Health

Telephone: (651) 201-4112

Fax: (651) 215-9697

Enclosure

cc: Licensing and Certification File

Post-Certification Revisit Report

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

(Y1) Provider / Supplier / CLIA / Identification Number 245496	(Y2) Multiple Construction A. Building B. Wing	(Y3) Date of Revisit 6/25/2014
Name of Facility MINNEOTA MANOR HEALTH CARE CENTER	Street Address, City, State, Zip Code 700 NORTH MONROE STREET MINNEOTA, MN 56264	

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

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix F0248 Reg. # 483.15(f)(1) LSC _____	Correction Completed 06/05/2014	ID Prefix F0329 Reg. # 483.25(l) LSC _____	Correction Completed 06/05/2014	ID Prefix F0428 Reg. # 483.60(c) LSC _____	Correction Completed 06/05/2014
ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed
ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed
ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed
ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed

Reviewed By _____	Reviewed By KS/kfd	Date: 07/17/2014	Signature of Surveyor: 03048	Date: 06/25/2014
Reviewed By _____	Reviewed By	Date:	Signature of Surveyor:	Date:
CMS RO				

Followup to Survey Completed on: 5/9/2014	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? <table style="float: right; margin-left: 20px;"> <tr> <td>YES</td> <td>NO</td> </tr> </table>	YES	NO
YES	NO		

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL
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2.STATE VENDOR OR MEDICAID NO. (L2) 611042800	5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9)	FISCAL YEAR ENDING DATE: (L35) 09/30
6. DATE OF SURVEY 05/09/2014 (L34)	7. PROVIDER/SUPPLIER CATEGORY <u>02</u> (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	
8. ACCREDITATION STATUS: <u> </u> (L10) 0 Unaccredited 1 TJC 2 AOA 3 Other		

11. LTC PERIOD OF CERTIFICATION From (a) : To (b) :	10.THE FACILITY IS CERTIFIED AS: X A. In Compliance With Program Requirements Compliance Based On: X 1. Acceptable POC B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: B,5 (L12)	And/Or Approved Waivers Of The Following Requirements: <u> </u> 2. Technical Personnel <u> </u> 6. Scope of Services Limit <u> </u> 3. 24 Hour RN <u> </u> 7. Medical Director <u> </u> 4. 7-Day RN (Rural SNF) <u> </u> 8. Patient Room Size X 5. Life Safety Code <u> </u> 9. Beds/Room
12.Total Facility Beds 67 (L18)		
13.Total Certified Beds 67 (L17)		

14. LTC CERTIFIED BED BREAKDOWN 18 SNF 18/19 SNF 19 SNF ICF IID 67 (L37) (L38) (L39) (L42) (L43)	15. FACILITY MEETS 1861 (e) (1) or 1861 (j) (1): (L15)
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16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):
See Attached Remarks

17. SURVEYOR SIGNATURE <u>Pamela Manzke, HFE NE II</u> (L19)	Date : 06/05/2014	18. STATE SURVEY AGENCY APPROVAL <u>Kamala Fiske-Downing, Enforcement Specialist</u> (L20)	Date: 06/24/2014
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PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY <u> </u> 1. Facility is Eligible to Participate <u> </u> 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 : <u> </u>
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22. ORIGINAL DATE OF PARTICIPATION 09/01/1987 (L24)	23. LTC AGREEMENT BEGINNING DATE (L41)	24. LTC AGREEMENT ENDING DATE (L25)	26. TERMINATION ACTION: (L30) VOLUNTARY <u>00</u> INVOLUNTARY 01-Merger, Closure 05-Fail to Meet Health/Safety 02-Dissatisfaction W/ Reimbursement 06-Fail to Meet Agreement 03-Risk of Involuntary Termination OTHER 04-Other Reason for Withdrawal 07-Provider Status Change 00-Active
25. LTC EXTENSION DATE: (L27)	27. ALTERNATIVE SANCTIONS A. Suspension of Admissions: (L44) B. Rescind Suspension Date: (L45)		

28. TERMINATION DATE: (L28)	29. INTERMEDIARY/CARRIER NO. 03001 (L31)	30. REMARKS AW K67 PDF_ACO 06/26/2014 Emailed CMS 06/26/2014 Posted 06/26/2014 Co.
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31. RO RECEIPT OF CMS-1539 (L32)	32. DETERMINATION OF APPROVAL DATE (L33)	DETERMINATION APPROVAL
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C&T REMARKS - CMS 1539 FORM

STATE AGENCY REMARKS

CCN-24-5496

At the time of the Standard survey, the facility was not in substantial compliance with Federal Certification Regulations. This survey found the most serious deficiencies in the facility to widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), Post Certification Revisit to follow. Please refer to the CMS 2567 along with the facility's plan of correction.



Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7011 2000 0002 5143 4929

May 23, 2014

Ms. Kathy Johnson, Administrator
Minneota Manor Health Care Center
700 North Monroe Street
Minneota, Minnesota 56264

RE: Project Number S5496025

Dear Ms. Johnson:

On May 9, 2014, 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;

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:

**Gary Nederhoff, Unit Supervisor
Minnesota Department of Health
18 Wood Lake Drive Southeast
Rochester, Minnesota 55904-5506**

Telephone: (507) 206-2731

Fax: (507) 206-2711

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by June 8, 2014, 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 June 8, 2014 the following remedy will be imposed:

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

PLAN OF CORRECTION (PoC)

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

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

- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;
- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;

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

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

- Include signature of provider and date.

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

If new deficiencies are identified at the time of the revisit, those deficiencies may be disputed through the informal dispute resolution process. However, the remedies specified in this letter will be imposed for original deficiencies not corrected. If the deficiencies identified at the revisit require the imposition

of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed.

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by August 9, 2014 (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 November 9, 2014 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

Minneota Manor Health Care Center

May 23, 2014

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INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

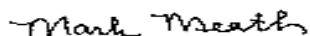
Questions regarding all documents submitted as a response to the Life Safety Code deficiencies (those preceded by a "K" tag), i.e., the plan of correction, request for waivers, should be directed to:

Mr. Patrick Sheehan, Supervisor
Health Care Fire Inspections
State Fire Marshal Division
444 Cedar Street, Suite 145
St. Paul, Minnesota 55101-5145

Telephone: (651) 201-7205
Fax: (651) 215-0541

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

Sincerely,



Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Division of Compliance Monitoring
mark.meath@state.mn.us
Telephone: (651) 201-4118 Fax: (651) 215-9697

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

PRINTED: 05/23/2014
FORM APPROVED
OMB NO. 0938-0391

JUN 9 2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245496	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>MN Dept of Health Rochester</u> B. WING _____	(X3) DATE SURVEY COMPLETED 05/09/2014
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NAME OF PROVIDER OR SUPPLIER MINNEOTA MANOR HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 700 NORTH MONROE STREET MINNEOTA, MN 56264
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. Upon receipt of an acceptable POC an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 248 SS=D	483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to provide an ongoing activity program for 2 of 3 residents (R57 & R22) reviewed for activity involvement and who resided in the memory care unit. Findings include: R57 resided in the memory care unit. The annual Minimum Data Set (MDS) dated 3/5/14 identified R57 as having diagnosis which included Alzheimer's Disease. R57 was identified as being rarely/never understood, severely cognitively impaired and rarely/never made decisions.	F 248	<i>approved Kmt 6/9/14</i>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *Kathy Johnson* TITLE *Administrator* (X6) DATE *6/6/14*

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.

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

PRINTED: 05/23/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245496	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/09/2014
NAME OF PROVIDER OR SUPPLIER MINNEOTA MANOR HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 700 NORTH MONROE STREET MINNEOTA, MN 56264		
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F 248	<p>Continued From page 1</p> <p>Section F - Preferences for Customary Routine identified it being very important for R57 to listen to music she likes and somewhat important to have books, newspapers and magazine to read, be around animals such as pets, to do things with groups of people, to go outside when the weather is good, and participate in religious services. The respondent to these questions was R57's spouse.</p> <p>The Care Area Assessment (CAA) dated 3/10/14 included CAA 2. Cognitive Loss/Dementia- "Resident has severe cognitive impairment related to diagnosis and health status. Resident is not able to communicated needs consistently and staff have learned residents care needs over time and learned resident cues to provide her cares. Resident may be at risk for further decline or withdrawal due to change in health status." CAA-4. Communication- "Resident triggers communication r/t [related to] difficulties with understanding others and making self understood. Resident has severe dementia and can't verbalize her thoughts. She doe not verbalize any longer; She may laugh when staff talk to her. Hearing appears adequate and resident does not wear hearing aids. Visual impairment is noted; she is at risk for isolation and further decline and inability to get her thoughts and needs expressed and met;".</p> <p>Review of the annual activities document in the medical record identified R57 liked country, 50's and 60's music, watch for interaction with others, take her hands and dance with her and would maybe like short stories read. An activity note dated 3/10/14 indicated the admission assessment (from 2011) was reviewed and that R57's activity interest continued to be the same. It indicated R57 was unable to communicate her</p>	F 248			

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F 248	<p>Continued From page 2</p> <p>needs, family visited weekly and staff encourage sensory stimulation daily. An activity progress note dated 3/7/14 further confirmed that R57 was unable to communicate her needs. Staff assist her to and from destinations and husband visits weekly. Her husband stated R57 likes music. Staff offer prayer and music 5- times a week and resident is offered soft stimuli to hold. R57 does not open her eyes but does have facial expression at times.</p> <p>Review of the care plan dated 9/9/11 included approaches of religion: Catholic, to encourage appropriate activities and assist her to them as needed (PRN) and encourage involvement in activities. 6/3/11 resident needs calm unhurried environment that is similar to past recreational interests and surroundings. The goal was for resident to complete assessed recreational interests and surroundings including listening to short stories, listening to prayers, listening music during group and 1:1 daily.</p> <p>Review of the activity logs from 1/1/14 to 5/11/11 indicated that R57 attended music on 1/13, stations of the cross on 3/5, 3/12, 3/28, 4/2, 4/16 and KIDS visits 3/4, 4/23 and 4/25.</p> <p>During observation throughout the survey 5/5/14 - 5/9/14 R57 was not involved in any activities. R57 was brought out to meals and was then laid down in bed after the meal. Music was not heard playing except during the evening meal on 5/12/14. A morning devotion was said at breakfast while staff held resident's hand. R57 did not respond verbally to any attempts at interaction by the surveyor although she did make eye contact.</p>	F 248			

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F 248	<p>Continued From page 3</p> <p>During interview with the activity director (AD) on 5/8/14, at 11:08 a.m. she stated, "we shake hands and do devotions every morning, that is our sensory;" "She did go to stations of the cross and goes to KIDS program if they come." She stated that R57's husband "tries" to come once a week and wheel her around the facility. AD stated that R57 is the one who makes the decision whether resident will attend activities on a daily basis, "like if she is leaning too much she goes to bed." She verified that R57 had not been to any activities all week and the activity logs were accurate. She then stated "well you know we really don't do that much with the people that don't understand what's going on and don't participate..... you know how it is." "We are always at the other end of the building so we don't do much down here (memory care). They go to special music events and we turn the music on down here for them."</p> <p>R22's diagnoses included Alzheimer's disease, depression, glaucoma and macular degeneration. The quarterly Minimum Data Set (MDS) dated 3/13/14, identified R22 as having moderate to severe cognitive impairment and the activities assessment indicated it is very important to R22 to be with groups of people and perform activities of enjoyment which included attending mass, polka music and square dancing.</p> <p>The plan of care dated 2/17/2012, indicated R22 needed environmental stimuli to prevent sensory deprivation and staff were to assist to church events. The activity care plan indicated the following approach: staff will observe for participation in activities-encourage daily activities, was a social woman in the past, use to square dance, church was very important to her. The activity goal stated: religion is important;</p>	F 248			

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F 248	<p>Continued From page 4</p> <p>resident will show overall comfort & pleasure with small group & during daily events in north lobby area.</p> <p>Review of the activity log in 2014 revealed that activity staff provided R22 the following:</p> <p>(1) January-staff visited 3 times for 5-8 minutes/each;</p> <p>(2) February- 30 minutes of church and 5 minute of staff visit;</p> <p>(3) March- attended "Stations of the Cross-prayers twice and watched children play bean bag toss for 45 minutes, 10 minutes staff visit;</p> <p>(4) April- 10 minutes of staff visits twice & Stations of the Cross; and</p> <p>(5) May- 10 minutes of music.</p> <p>The following observations were noted:</p> <p>On 5/7/14, at 10:10 a.m. R22 was observed in a common area with several other residents and music was playing. On 5/7/14, at 10:45 a.m. R22 was observed sitting in hallway by nurses station within listening distance of music playing in the common area of the memory unit. R22's eyes were open and appeared calm. On 5/7/14, at 2:45 p.m. R22 was observed sleeping in bed. No activity involvement was noted which included small group activities and/or individualized music preference as identified in the plan of care.</p> <p>On 5/8/14, at 9:35 a.m. R22 was observed sleeping in bed with continued observations of R22 sleeping in bed throughout the morning hours. On 5/8/14, at 11:00 a.m. R22 was assisted to get out of bed and dressed for the day. On 5/8/14, at 11:15 a.m. R22 was observed sitting in the common area of the memory unit and music was playing. R22 fell asleep</p>	F 248			

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F 248	<p>Continued From page 5</p> <p>frequently. On 5/8/14 at 1:45 p.m., R22 was observed seated in the common area of the memory care unit with music playing until 3:15 p.m. It was also noted that a church service was taking place in another area of the facility beginning at 2:30 p.m. and R22 was not given the opportunity to attend.</p> <p>An interview was conducted with the AD on 5/8/14, at 1:15 p.m. The AD stated R22 did not like to be overstimulated. R22 liked to listen to music and attend religious activities. She also indicated there was a music player in R22's room. AD denied any other planned activities for R22 and indicated her time was limited and was unable to provide enough activities for all the residents who reside in the facility.</p> <p>R22's written records included a physicians note dated 9/18/13 which indicated R22 had significant difficulty with vision and some difficulty with hearing. R22's cognitive deficits include moderate to severe difficulty with attention, concentration and verbal memory but R22 enjoys being with people, attending mass, past involvement with square dancing and polkas. Another progress note was written by the doctor on 2/20/14 with similar information.</p> <p>The facility's policy titled "Daily Programming" dated 12/01/06, indicated the activity staff will provide activities which stimulate the cardiovascular system and assist in range of motion; offer activities that are intellectually challenging; provide activities designated specifically for the confused or disoriented on a daily basis.</p>	F 248	<ol style="list-style-type: none"> Residents R57 & R22 had a new activity assessment completed 6/5/14. Residents R57 & R22 careplans were updated to include the activities of interest and ability per assessment results. The care plans will be individualized to follow the results of the assessment. <i>6/5/14</i> All other residents with dementia or with severe cognitive loss will be reassessed quarterly, annually, and with significant change. <i>with 6/5/14 & ongoing</i> The activity director or designated staff will do random audits of these residents charts to see that all these residents have a new activity assessment completed initially, quarterly, annually and with significant changes. Activity Director will monitor ongoing activity programs for Northwood Trails unit (unit the residents are located on and incorrectly referred to as a memory care unit per 2567) weekly x 4, monthly x 3, and quarterly x 4. The results of the audits will be discussed at the monthly Quality Assurance Meetings. <i>ongoing</i> 		
F 329	483.25(l) DRUG REGIMEN IS FREE FROM	F 329			

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F 329 SS=D	<p>Continued From page 6 UNNECESSARY DRUGS</p> <p>Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.</p> <p>Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to follow up with the primary physician regarding recommended medication changes by psychiatry for 1 of 5 residents (R13) reviewed for unnecessary medications.</p> <p>Findings include:</p> <p>R13 was admitted to the facility on 3/25/09 with</p>	F 329			

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F 329	<p>Continued From page 7</p> <p>diagnoses including depression, anxiety, dementia and non organic psychosis.</p> <p>Review of R13's medical record revealed physician orders that included:</p> <ol style="list-style-type: none"> (1) Zyprexa (anti-psychotic medication) 1.25 mg (milligrams) orally (po) at bedtime; (2) Lexapro (anti-depressant medication) 10 mg po daily; (3) Ativan 0.5 mg (anti-anxiety medication) po every 6 hours PRN (as needed) with special instructions: take when resident has attempts to self > (greater than) 1 or > 1 repeated toilet requests with no voiding noted; and (4) Ativan 0.5 mg po twice a day (Initiated on 4/29/14 by R13's primary physician). <p>Review of the physician progress notes revealed R13 had been seen by psychiatry via telehealth (the delivery of health-related services and information via telecommunications technologies) on 12/23/13, 9/13/13, and 4/21/14. The suggestions given by the psychiatrist at the 4/21/14 appointment were as follows:</p> <ol style="list-style-type: none"> (1) d/c Zyprexa and pm Ativan; (2) Add Trazodone 50 mg po every 2 p.m., Trazodone 25 mg po every 6 hours pm severe agitation; (3) keep pt. (patient) busy, involved in activities, use distraction, redirection and calm, gentle approach; and (4) f/u (follow up) in 4 weeks. <p>Further review of the record revealed a fax to the resident's primary medical doctor (MD) from nursing dated 4/29/14 included the following: (1) an increase in anxiety noted in past few weeks; (2) PRN Ativan 0.5 mg given daily and sometimes two times daily for the past 2 weeks; and (3) suggestion was made that she might</p>	F 329			

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F 329	<p>Continued From page 8</p> <p>benefit from a scheduled dose of Ativan 0.5 mg po bid (twice daily) at this time and monitor for decreased anxiety. An order for Ativan 0.5 mg po bid was approved by the physician after this communication had been relayed.</p> <p>During interview on 5/8/14, at 1:00 p.m. registered nurse (RN)- C confirmed that R13 continued to take Zyprexa and Ativan as the resident's primary MD had not yet reviewed the recommendations by psychiatry from 4/21/14. RN-C further stated the primary MD would have to approve and order the changes recommended by the psychiatrist before any changes could be made. RN-C stated the primary MD would be doing rounds on 5/15/14 and would review the recommendations from the psychiatrist at that time. RN-C further verified the primary MD had not been informed yet of the recommendations by psychiatrist. RN-C further confirmed the order requested by nursing to the primary MD for Ativan 0.5 mg po bid (on 4/29/14) was after the appointment with the psychiatrist (4/21/14). RN-C stated R13's husband had requested the Ativan be given at scheduled times rather than just PRN and they are obligated to comply with the family's wishes. RN-C further stated she was unaware of the psychiatrist's recommendations as she had not attended the last appointment and the communication to the primary MD had been missed.</p> <p>During interview on 5/8/14, at 2:58 p.m., R13's spouse (FM)-A stated that he had been informed of the psychiatry appointment last month but was not advised any recommendations.</p> <p>During interview on 5/9/14, at 9:54 a.m., the director of nursing (DON) confirmed the</p>	F 329	<p>F329</p> <ol style="list-style-type: none"> 1. Psychiatry consult note was faxed to primary MD for review with recommendations and current medication list on 5/9/2014. MD did make some changes in medication regimen as recommended by psychiatrist. 5/9/14 2. The tele-med process was discussed at Quality Assurance Meeting on 5/22/14. A new procedure was developed for follow up on the tele-med and Psychiatry recommendations. Final process will be presented at the Quality Assurance Meeting 6/5/2014. Social service and Case managers were educated on the process by 6/2/14. 6/5/14 3. Audits will be completed by DON or delegated nurse monthly for 6 months. Then quarterly for 12 months. ongoing 	

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F 329	Continued From page 9 appointment with the psychiatrist on 4/21/14 with recommendations for medication changes should have been faxed to the primary MD. The DON stated their process included notification of the primary MD and then the decision whether to wait until rounds at the nursing home to implement changes would be determined by the physician. The DON confirmed the lapse in communication was a problem. The DON further confirmed the primary MD had presented for rounds on 5/1/14 and the psychiatric recommendations should have been addressed at during that visit.	F 329			
F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. This REQUIREMENT is not met as evidenced by: Based on interview and document review the consulting pharmacist failed to identify recommended medication changes by psychiatry for 1 of 5 residents (R13) reviewed for unnecessary medications. Findings include: R13 was admitted to the facility on 3/25/09 with	F 428			

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F 428	<p>Continued From page 10</p> <p>diagnoses including depression, anxiety, dementia and nonorganic psychosis.</p> <p>Review of R13's medical record revealed physician orders that included:</p> <ul style="list-style-type: none"> (1) Zyprexa (anti-psychotic medication) 1.25 mg (milligrams) orally (po) at bedtime; (2) Lexapro (anti-depressant medication) 10 mg po daily; (3) Ativan 0.5 mg (anti-anxiety medication) po every 6 hours PRN (as needed) with special instructions: take when resident has attempts to self > (greater than) 1 or > 1 repeated toilet requests with no voiding noted; and (4) Ativan 0.5 mg po twice a day (Initiated on 4/29/14 by R13's primary physician). <p>Review of the physician progress notes revealed R13 had been seen by psychiatry via telehealth (the delivery of health-related services and information via telecommunications technologies) on 12/23/13, 9/13/13, and 4/21/14. The suggestions given by the psychiatrist at the 4/21/14 appointment were as follows:</p> <ul style="list-style-type: none"> (1) d/c Zyprexa and prn Ativan; (2) Add Trazodone 50 mg po every 2 p.m., Trazodone 25 mg po every 6 hours prn severe agitation; (3) keep pt. (patient) busy, involved in activities, use distraction, redirection and calm, gentle approach; and (4) F/u (follow up) in 4 weeks. <p>Further review of the record revealed a fax to the resident's primary medical doctor (MD) from nursing dated 4/29/14 included the following: (1) an increase in anxiety noted in past few weeks; (2) PRN Ativan 0.5 mg given daily and sometimes two times daily for the past 2 weeks; and (3) suggestion was made that she might</p>	F 428			

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F 428	<p>Continued From page 11</p> <p>benefit from a scheduled dose of Ativan 0.5 mg po bid (twice daily) at this time and monitor for decreased anxiety. An order for Ativan 0.5 mg po bid was approved by the physician after this communication had been relayed.</p> <p>During interview on 5/8/14, at 1:00 p.m. registered nurse (RN)- C confirmed that R13 continued to take Zyprexa and Ativan as the resident's primary MD had not yet reviewed the recommendations by psychiatry from 4/21/14. RN-C further stated the primary MD would have to approve and order the changes recommended by the psychiatrist before any changes could be made. RN-C stated the primary MD would be doing rounds on 5/15/14 and would review the recommendations from the psychiatrist at that time. RN-C further verified the primary MD had not been informed yet of the recommendations by psychiatrist. RN-C further confirmed the order requested by nursing to the primary MD for Ativan 0.5 mg po bid (on 4/29/14) was after the appointment with the psychiatrist (4/21/14). RN-C stated R13's husband had requested the Ativan be given at scheduled times rather than just PRN and they are obligated to comply with the family's wishes. RN-C further stated she was unaware of the psychiatrist's recommendations as she had not attended the last appointment and the communication to the primary MD had been missed.</p> <p>During interview on 5/8/14, at 2:58 p.m., R13's spouse (FM)-A stated that he had been informed of the psychiatry appointment last month but was not advised any recommendations.</p> <p>During interview on 5/9/14 at 9:34 a.m., the pharmacist confirmed the last review of R13's</p>	F 428			

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NAME OF PROVIDER OR SUPPLIER MINNEOTA MANOR HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 700 NORTH MONROE STREET MINNEOTA, MN 56264		
(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 428	<p>Continued From page 12</p> <p>medication regimine had been on 5/1/14. The pharmacist stated he was unaware R13 had been seen on 4/21/14 and that recommendations had been made regarding discontinuation of the prn Ativan and scheduled Zyprexa and the addition of Trazodone. The pharmacist further stated the recommendations should have been addressed with the primary MD.</p> <p>During interview on 5/9/14 at 9:54 a.m., the director of nursing (DON) confirmed the appointment with the psychiatrist on 4/21/14 with recommendations for medication changes should have been faxed to the primary MD. The DON stated their process included notification of the primary MD and then the decision whether to wait until rounds at the nursing home to implement changes would be determined by the physician. The DON confirmed the lapse in communication was a problem. The DON further confirmed the primary MD had presented for rounds on 5/1/14 and the psychiatric recommendations should have been addressed at during that visit.</p>	F 428	<p>F428</p> <ol style="list-style-type: none"> 1. Psychiatry consult note was faxed to primary MD for review with recommendations and current medication list on 5/9/2014. MD did make some changes in medication regimen as recommended by psychiatrist. <i>5/9/14</i> 2. The tele-med process was discussed at Quality Assurance Meeting on 5/22/14. A new procedure was developed for follow up on the tele-med and Psychiatry recommendations. Final process will be presented at the Quality Assurance Meeting 6/5/2014. Social service and Case managers were educated on the process on 6/2/14. As part of the new process the recommendations will be filed in the consult section of the paper chart to be available for the pharmacist to review. <i>6/5/14</i> 3. Pharmacy Consultant was informed of the issue on 5/9/2014. He will be educated on the new process on 6/5/2014. <i>6/5/14</i> 4. Audits will be completed by DON or delegated nurse monthly for 6 months. Then quarterly for 12 months. <i>ongoing</i> 		

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

F5496022

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K 000	<p>INITIAL COMMENTS</p> <p>FIRE SAFETY</p> <p>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.</p> <p>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.</p> <p>A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division, on May 8, 2014. At the time of this survey, Minneota Manor Health Care Center was found not to be in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) 101 Life Safety Code (LSC), Chapter 19 Existing Health Care Occupancies.</p> <p>PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO:</p> <p>Health Care Fire Inspections State Fire Marshal Division 445 Minnesota Street, Suite 145 St. Paul, MN 55101-5145, or</p>	K 000	<p>Handwritten notes:</p> <p>FS OK w/ AW for K67 FS 6-9-14</p> <p>RECEIVED JUN - 9 2014 MN DEPT. OF PUBLIC SAFETY STATE FIRE MARSHAL DIVISION</p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Kathy Johnson

Administrator

6/6/14

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

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K 000	<p>Continued From page 1</p> <p>By eMail to: Marian.Whitney@state.mn.us</p> <p>THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION:</p> <ol style="list-style-type: none"> 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. <p>Minneota Manor Health Care Center was constructed as follows: The original building was constructed in 1972, is one-story in height, has no basement, is fully fire sprinkler protected and was determined to be of Type II(111) construction; The 1995 building addition is one-story in height, has no basement, is fully fire sprinkler protected and was determined to be of Type II(111) construction.</p> <p>The nursing home is separated from an assisted living facility by 2-hour fire walls, with opening protectives consisting of labeled, self-closing, positive latching, 90-minute fire-rated door assemblies.</p> <p>The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors, which is monitored for automatic fire department notification. The facility has a capacity of 67 beds and had a census of 62 at time of the survey.</p>	K 000			

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K 067 SS=F	<p>The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Heating, ventilating, and air conditioning comply with the provisions of section 9.2 and are installed in accordance with the manufacturer's specifications. 19.5.2.1, 9.2, NFPA 90A, 19.5.2.2</p> <p>This STANDARD is not met as evidenced by: Based on observation and a staff interview, it was determined the facility's general ventilating and air conditioning system (HVAC) was not installed in accordance with NFPA 101 (2000), Chapter 19, Section 19.5.2.1 and Chapter 9 Section 9.2 and NFPA 90A (1999). In a fire emergency, a noncompliant HVAC system could adversely affect 67 of 67 residents.</p> <p>FINDINGS INCLUDE:</p> <p>On 05/08/2014 at 1:10 PM, observation revealed the ventilation system in the 1972 building utilized the egress corridors as a return air plenum for the building HVAC system. Specifically, resident rooms were equipped with supply air diffusers only, and the bathroom exhaust fans were switched, i.e., did not run continuously. Further, the concealed spaces above the drop-ceiling assembly in the egress corridors were used to provide the return air for the building HVAC system. This arrangement was not in conformance with the requirements at NFPA 90A</p>	K 067	An annual/continuing waiver has been requested from CMS .	6/6/14	

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K 067	Continued From page 3 (1999) Chapter 2, Section 2-3.11.1 and CMS Ref: S&C-06-18. This finding was verified with the chief building engineer.	K 067			

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL
PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: ENZN
Facility ID: 00887

1. MEDICARE/MEDICAID PROVIDER NO. (L1) 245496	3. NAME AND ADDRESS OF FACILITY (L3) MINNEOTA MANOR HEALTH CARE CENTER (L4) 700 NORTH MONROE STREET (L5) MINNEOTA, MN (L6) 56264	4. TYPE OF ACTION: <u>2</u> (L8) 1. Initial 2. Recertification 3. Termination 4. CHOW 5. Validation 6. Complaint 7. On-Site Visit 9. Other 8. Full Survey After Complaint
2.STATE VENDOR OR MEDICAID NO. (L2) 611042800	5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9)	FISCAL YEAR ENDING DATE: (L35) 09/30
6. DATE OF SURVEY 05/09/2014 (L34)	7. PROVIDER/SUPPLIER CATEGORY <u>02</u> (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	
8. ACCREDITATION STATUS: <u> </u> (L10) 0 Unaccredited 1 TJC 2 AOA 3 Other	10.THE FACILITY IS CERTIFIED AS: X A. In Compliance With Program Requirements Compliance Based On: <u>X</u> 1. Acceptable POC B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: B,5 (L12) And/Or Approved Waivers Of The Following Requirements: <u> </u> 2. Technical Personnel <u> </u> 6. Scope of Services Limit <u> </u> 3. 24 Hour RN <u> </u> 7. Medical Director <u> </u> 4. 7-Day RN (Rural SNF) <u> </u> 8. Patient Room Size <u>X</u> 5. Life Safety Code <u> </u> 9. Beds/Room	

11. LTC PERIOD OF CERTIFICATION From (a) : To (b) :	12.Total Facility Beds 67 (L18)	13.Total Certified Beds 67 (L17)
14. LTC CERTIFIED BED BREAKDOWN 18 SNF 18/19 SNF 19 SNF ICF IID 67 (L37) (L38) (L39) (L42) (L43)	15. FACILITY MEETS 1861 (e) (1) or 1861 (j) (1): (L15)	

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

See Attached Remarks

17. SURVEYOR SIGNATURE <u>Pamela Manzke, HFE NE II</u> (L19)	Date : 06/05/2014	18. STATE SURVEY AGENCY APPROVAL <u>Kamala Fiske-Downing, Enforcement Specialist</u> (L20)	Date: 06/24/2014
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PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY <u> </u> 1. Facility is Eligible to Participate <u> </u> 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 : <u> </u>
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22. ORIGINAL DATE OF PARTICIPATION 09/01/1987 (L24)	23. LTC AGREEMENT BEGINNING DATE (L41)	24. LTC AGREEMENT ENDING DATE (L25)	26. TERMINATION ACTION: (L30) VOLUNTARY <u>00</u> INVOLUNTARY 01-Merger, Closure 05-Fail to Meet Health/Safety 02-Dissatisfaction W/ Reimbursement 06-Fail to Meet Agreement 03-Risk of Involuntary Termination OTHER 04-Other Reason for Withdrawal 07-Provider Status Change 00-Active
25. LTC EXTENSION DATE: (L27)	27. ALTERNATIVE SANCTIONS A. Suspension of Admissions: (L44) B. Rescind Suspension Date: (L45)		

28. TERMINATION DATE: (L28)	29. INTERMEDIARY/CARRIER NO. 03001 (L31)	30. REMARKS AW K67 PDF_ACO 06/26/2014 Emailed CMS 06/26/2014 Posted 06/26/2014 Co.
31. RO RECEIPT OF CMS-1539 (L32)	32. DETERMINATION OF APPROVAL DATE (L33)	
		DETERMINATION APPROVAL

C&T REMARKS - CMS 1539 FORM

STATE AGENCY REMARKS

CCN-24-5496

At the time of the Standard survey, the facility was not in substantial compliance with Federal Certification Regulations. This survey found the most serious deficiencies in the facility to widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), Post Certification Revisit to follow. Please refer to the CMS 2567 along with the facility's plan of correction.

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Kathy Johnson

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6/6/14

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K 067	Continued From page 3 (1999) Chapter 2, Section 2-3.11.1 and CMS Ref: S&C-06-18. This finding was verified with the chief building engineer.	K 067			

Sheehan, Pat (DPS)

From: Sheehan, Pat (DPS)
Sent: Monday, June 09, 2014 3:38 PM
To: 'rochi_jsc@cms.hhs.gov'
Cc: Shellum, George (DPS); 'kathy@minmanor.com'; Dietrich, Shellae (MDH); 'Fiske-Downing, Kamala'; Henderson, Mary (MDH); 'Johnston, Kate'; Kleppe, Anne (MDH); Leach, Colleen (MDH); Meath, Mark (MDH); Zwart, Benjamin (MDH)
Subject: Minneota Manor Health Care Center (245496) 2014 K67 Annual Waiver Request - Previously approved - No Changes

This is to inform you that Minneota Manor HCC is again requesting an annual waiver for K67, corridors as a plenum. The exit date was 5-9-14.

I am recommending that CMS approved this waiver request.

Patrick Sheehan, Fire Safety Supervisor
Office: 651-201-7205 Cell: 651-470-4416
Health Care & Corrections Fire Inspections
Minnesota State Fire Marshal Division Est. 1905
445 Minnesota St., Suite 145, St Paul, MN 55101-5145
FAX: 651-215-0525
Web: fire.state.mn.us



Name of Facility
 Minnesota Manor Health Care Center

2000 CODE

PART IV 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
K84 K067 The building heating, ventilation & air conditioning equipment (HVAC) does not comply with LSC (00) Section 9.2, and NFPA 90A, 1999 Ed., because the corridors are being used as a plenum.	An annual/continuing waiver is being requested for K067. A. Compliance with this provision will cause an unreasonable/financial hardship because: 1. The most recent cost estimate dated 10/29/2013 for complying ducted HVAC system is \$90000-\$100000. 2. A ducted system would decrease the corridor headroom to less than that required by the LSC. 3. The building electrical system would need to be upgraded to support a new ducted system. 4. The ducted system would need to penetrate load bearing walls, decreasing building structural integrity. 5. Installation of a ducted system would require asbestos abatement which would increase the cost. 6. Existing non-complying HVAC systems can be allowed to continue in use. B. There will be no adverse effect on the building occupant's safety because: 1. The building is protected by a complete fire sprinkler system that complies with NFPA 13, 1999 Edition. 2. The existing HVAC system ventilation fans do automatically shut down upon activation of the fire alarm system, or detection of smoke in the HVAC system. 3. The corridors are equipped with a complying smoke detection system. 4. The facility is in compliance with all other fire safety requirements. 5. This annual/continuing waiver has been approved in the past. (Document attached)

Surveyor (Signature)	Title	Office	Date
 Fire Authority Official (Signature)	Title	Office	Date
 Fire Safety Supervisor	Fire Safety Supervisor	State Fire Marshal	6-9-14

Bisbee Plumbing & Heating

Complete Commercial Mechanical Contracting and Metal Fabricating

604 North Hwy. 59, P.O. Box 3
Marshall, Minnesota 56258

PHONE: 507-537-0596
FAX: 507-537-1431

October 29, 2013

Mrs. Johnson
Minneota Manor
700 North Monroe St.
Minneota, Minnesota 56264

RE: Return Air Ducting

Mrs. Johnson,

Bisbee Plumbing & Heating did research into the Minneota Manor return air system for the South Wing, North Wing and a couple of rooms in West Wing. Looking at these systems, in order to install return air duct out of every room walls will need to be busted through into hallways and ceilings will have to be taken down in rooms (partially) and all of the hallways ceilings in order for us to install return air duct back to the rooftop air handling units. Also required would be sprinkler contractor to remove some of the sprinkler lines that are above the ceilings and in the way. Because of going from room to hallway there may be fire dampers or fire/smoke damper required for fire protection.

With this being said Bisbee's is estimating that the cost to do this work could be in the range of \$ 90,000 to \$ 100,000.00 depending on what will be required.

Sincerely,
Bisbee Plumbing & Heating

Jack Mead

FIRE SAFETY SURVEY REPORT 2000 CODE - HEALTH CARE
Medicare – Medicaid

1. (A) PROVIDER NUMBER
K1 245496

1. (B) MEDICAID I.D. NO.
K2

PART I — Life Safety Code, New and Existing
PART IV — Waiver Recommendation Form

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

2. NAME OF FACILITY Minneota Manor Health Care Center	2. (A) MULTIPLE CONSTRUCTION (BLDGS) A. BUILDING <u>01</u> B. WING _____ C. FLOOR _____ K3	2. (B) ADDRESS OF FACILITY (STREET, CITY, STATE, ZIP CODE) 700 North Monroe Street Minneota, MN 56264	A. <input checked="" type="radio"/> Fully Sprinklered (All required areas are sprinklered) B. <input type="radio"/> Partially Sprinklered (Not all required areas are sprinklered) C. <input type="radio"/> None (No sprinkler system) K0180
---	--	---	---

3. SURVEY FOR <input checked="" type="checkbox"/> MEDICARE <input checked="" type="checkbox"/> MEDICAID	4. DATE OF SURVEY K4 05/08/2014	DATE OF PLAN APPROVAL K6	SURVEY UNDER 5. <input checked="" type="checkbox"/> 2000 EXISTING 6. <input type="checkbox"/> 2000 NEW K7
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5. SURVEY FOR CERTIFICATION OF

1. HOSPITAL 2. SKILLED/NURSING FACILITY 4. ICF/MR 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 <u>67</u>	b. NUMBER OF HOSPITAL BEDS CERTIFIED FOR MEDICARE _____	c. NUMBER OF SKILLED BEDS CERTIFIED FOR MEDICARE <u>67</u>	d. NUMBER OF SKILLED BEDS CERTIFIED FOR MEDICAID <u>67</u>	e. NUMBER OF NF or ICF/MR BEDS CERTIFIED FOR MEDICAID _____
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7. A. THE FACILITY MEETS, 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) <i>George Shellum</i>	TITLE Deputy State Fire Marshal	OFFICE State Fire Marshal	DATE 05/08/2014
SURVEYOR ID K10 <u>22373</u>			
FIRE AUTHORITY OFFICIAL (Signature) <i>[Signature]</i>	TITLE Fire Safety Supervisor	OFFICE State Fire Marshal	DATE 5-16-14

ID PREFIX		MET	NOT MET	N/A	REMARKS
PART I - LSC REQUIREMENTS - Items in italics relate to the FSES					
BUILDING CONSTRUCTION					
K11	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 shall be protected by approved self-closing fire doors with at least 1½ hour fire resistance rating 18.1.1.4.1, 18.1.1.4.2, 18.2.3.2, 19.1.1.4.1, 19.1.1.4.2				
K12	2000 EXISTING Building construction type and height meets one of the following: 19.1.6.2, 19.1.6.3, 19.1.6.4, 19.3.5.1				
1	I (443), I (332), II (222)				Any Height
2	II (111)				One story only (non-sprinklered).
3	II (111)				Not over three stories with complete automatic sprinkler system.
4	III (211)				Not over two stories with complete automatic sprinkler system.
5	V (111)				
6	IV (2HH)				
7	II (000)				Not over one story with complete automatic sprinkler system.
8	III (200)				
9	V (000)				
<input type="checkbox"/> Building contains fire treated wood. 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.					

ID PREFIX				MET	NOT MET	N/A	REMARKS
K12	2000 NEW Building construction type and height meets one of the following: 18.1.6.2, 18.1.6.3, 18.3.5.1.						
1		I (443), I (332), II (222)	Any height with complete automatic sprinkler system				
2		II (111)	Not over three stories with complete automatic sprinkler system				
3		III (211)	Not over one story with complete automatic sprinkler system.				
4		V (111)					
5		IV (2HH)					
6		II (000)					
7		III (200)	Not Permitted				
8		V (000)					
<input type="checkbox"/> Building contains fire treated wood. 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.							
K103	Interior walls and partitions in buildings of Type I or Type II construction shall be noncombustible or limited-combustible materials. 18.1.6.3, 19.1.6.3 (Indicate N/A for existing buildings using listed fire retardant treated wood studs within non-load bearing one-hour rated partitions.)						

ID PREFIX		MET	NOT MET	N/A	REMARKS
INTERIOR FINISH					
K14	<p>2000 EXISTING</p> <p>Interior finish for means of egress, including exposed interior surfaces of buildings such as fixed or movable walls, partitions, columns, and ceilings has a flame spread rating of Class A or Class B. Interior finishes existing before December 17, 2010 that are applied directly to wall and ceilings with a thickness of less than 1/28 inch shall be permitted to remain in use without flame spread rating documentation. 10.2, 19.3.3.1, 19.3.3.2, NFPA TIA 00-2</p> <p><i>Indicate flame spread rating/s _____</i></p>				
	<p>2000 NEW</p> <p>Interior finish for means of egress, including exposed interior surfaces of buildings such as fixed or movable walls, partitions, columns, and ceilings has a flame spread rating of Class A or Class B. Lower half of corridor walls, not exceeding 4ft in height, may have a Class C flame spread rating. 10.2, 18.3.3.1, 18.3.3.2, NFPA TIA 00-2</p> <p><i>Indicate flame spread rating/s _____</i></p>				
K15	<p>2000 EXISTING</p> <p>Interior finish for rooms and spaces not used for corridors or exitways, including exposed interior surfaces of buildings such as fixed or movable walls, partitions, columns, and ceilings has a flame spread rating of Class A or Class B. (In fully-sprinklered buildings, flame spread rating of Class C may be continued in use within rooms separated in accordance with 19.3.6 from the exit access corridors.) 19.3.3.1, 19.3.3.2</p> <p><i>Indicate flame spread rating/s _____</i></p>				
	<p>2000 NEW</p> <p>Interior finish for rooms and spaces not used for corridors or exitways, including exposed interior surfaces of buildings such as fixed or movable walls, partitions, columns, and ceilings has a flame spread rating of Class A or Class B. (Rooms not over 4 persons in capacity may have a flame spread rating of Class A, Class B, or Class C). 18.3.3.1, 18.3.3.2.</p> <p><i>Indicate flame spread rating/s _____</i></p>				

ID PREFIX		MET	NOT MET	N/A	REMARKS
K16	<p>2000 EXISTING</p> <p>Newly installed interior floor finish complying with 10.2.7 shall be permitted in corridors and exits if Class I. 19.3.3.3</p> <p>In smoke compartments protected throughout by an approved, supervised automatic sprinkler system in accordance with 19.3.5.2, no interior floor finish requirements shall apply.</p>				
CORRIDOR WALLS AND DOORS					
K17	<p>2000 EXISTING</p> <p>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 passage of smoke. In non-sprinklered 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. Charting and clerical stations, waiting areas, dining rooms, and activity spaces may be open to corridor under certain conditions specified in the Code. Gift shops may be separated from corridors by non-fire rated walls if the gift shop is fully sprinklered.) 19.3.6.1, 19.3.6.2, 19.3.6.4, 19.3.6.5</p> <p><i>If the walls have a fire resistance rating, give rating _____ if the walls terminate at the underside of a ceiling, give a brief description in REMARKS, of the ceiling, describing the ceiling throughout the floor area.</i></p> <hr style="border-top: 1px dashed black;"/> <p>2000 NEW</p> <p>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. 18.3.6.1, 18.3.6.2, 18.3.6.4, 18.3.6.5</p>				

ID PREFIX		MET	NOT MET	N/A	REMARKS
K18	<p>2000 EXISTING</p> <p>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. Clearance between bottom of door and floor covering is not exceeding 1 inch. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. 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 a means suitable for keeping the door closed. 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 8.2.3.2.1. Roller latches are prohibited by CMS regulations in all health care facilities. 19.3.6.3</p> <p><i>Show in REMARKS, details of doors, such as fire protection ratings, automatic closing devices, etc.</i></p> <p>2000 NEW</p> <p>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 positive latching hardware. Dutch doors meeting 18.3.6.3.6 are permitted. Roller latches shall be prohibited. 18.3.6.3</p> <p><i>Show in REMARKS, details of doors, such as fire protection ratings, automatic closing devices, etc.</i></p>				
K19	<p>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.) In other than smoke compartments containing patient bedrooms, miscellaneous opening are permitted in vision panels or doors provided the aggregate area of the opening per room does not exceed 20 in.² and the opening is installed in bottom half of the wall (80 in.² in fully sprinklered buildings). 18.3.6.5, 19.3.6.2.3, 19.3.6.3.8, 19.3.6.5</p>				

ID PREFIX	MET	NOT MET	N/A	REMARKS
VERTICAL OPENINGS				
K20				
				<p>2000 EXISTING</p> <p>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 one hour. An atrium may be used in accordance with 8.2.5, 8.2.5.6, 19.3.1.1 <i>If all vertical openings are properly enclosed with construction providing at least a two hour fire resistance rating, also check this box.</i> <input type="checkbox"/></p> <p><i>If enclosures are less than required, give a brief description and specific location in REMARKS.</i></p>
				<p>2000 NEW</p> <p>Stairways, elevator shafts, light and ventilation shafts, chutes, and other vertical openings between floors are enclosed with construction having a fire resistance rating of at least two hours connecting four stories or more. (One hour for single story building and buildings up to three stories in height.) An atrium may be used in accordance with 8.2.5.6, 8.2.5, 18.3.1.1. <i>If enclosures are less than required, give a brief description and specific location in REMARKS.</i></p>
K21				<p>Doors in an exit passageway, stairway enclosure, horizontal exit, smoke barrier or hazardous area enclosure are self-closing and kept in the closed position, unless held open by as 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:</p> <ul style="list-style-type: none"> <input type="checkbox"/> (a) The required manual fire alarm system and <input type="checkbox"/> (b) Local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system and <input type="checkbox"/> (c) The automatic sprinkler system, if installed 18.2.2.2.6, 18.3.1.2, 19.2.2.2.6, 19.3.1.2, 7.2.1.8.2 <p>Door assemblies in vertical openings are of an approved type with appropriate fire protection rating. 8.2.3.2.3.1</p> <p>Boiler rooms, heater rooms, and mechanical equipment rooms doors are kept closed.</p>

ID PREFIX		MET	NOT MET	N/A	REMARKS
	Describe method used in REMARKS				
SMOKE COMPARTMENTATION AND CONTROL					
K23	<p>2000 EXISTING</p> <p>Smoke barriers shall be provided to form at least two smoke compartments on every sleeping room floor for more than 30 patients. 19.3.7.1, 19.3.7.2</p>				
	<p>2000 NEW</p> <p>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. Smoke barriers shall also be provided on floors that are usable, but unoccupied. 18.3.7.1, 18.3.7.2</p>				
K24	<p>The smoke compartments shall not exceed 22,500 square feet and the travel distance to and from any point to reach a door in the required smoke barrier shall not exceed 200 feet. 18.3.7.1, 19.3.7.1</p>				
	<p><i>Detail in REMARKS zone dimensions including length of zones and dead end corridors.</i></p>				
K25	<p>2000 EXISTING</p> <p>Smoke barriers shall be constructed to provide at least a one half hour fire resistance rating and constructed in accordance with 8.3. Smoke barriers shall be permitted to terminate at an atrium wall. Windows shall be protected by fire-rated glazing or by wired glass panels and steel frames. 8.3, 19.3.7.3, 19.3.7.5</p>				
	<p>2000 NEW</p> <p>Smoke barriers shall be constructed to provide at least a one hour fire resistance rating and constructed in accordance with 8.3. Smoke barriers shall be permitted to terminate at an atrium wall. Windows shall be protected by fire-rated glazing or by wired glass panels in approved frames. 8.3, 18.3.7.3, 18.3.7.5</p>				
K26	<p>Space shall be provided on each side of smoke barriers to adequately accommodate the total number of occupants in adjoining compartments. 18.3.7.4, 19.3.7.4</p>				

ID PREFIX		MET	NOT MET	N/A	REMARKS									
K27	<p>2000 EXISTING</p> <p>Doors in smoke barriers have at least a 20 minute fire protection rating or are at least 1¾ inch thick solid bonded core wood. Non-rated protective plates that do not exceed 48 inches from the bottom of the door are permitted. Horizontal sliding doors comply with 7.2.1.14. Doors shall be self-closing or automatic-closing in accordance with 19.2.2.2.6. Swinging doors are not required to swing with egress and positive latching is not required. 19.3.7.5, 19.3.7.6, 19.3.7.7</p> <hr/> <p>2000 NEW</p> <p>Doors in smoke barriers have at least a 20 minute fire protection rating or are at least 1¾ inch thick solid bonded core wood. Non-rated protective plates that do not exceed 48 inches from the bottom of the door 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. 18.3.7.5, 18.3.7.6, 18.3.7.8</p>													
K28	<p>2000 EXISTING</p> <p>Door openings in smoke barriers shall provide a minimum clear width of 32 inches (81 cm) for swinging or horizontal doors. 19.3.7.7</p> <hr/> <p>2000 NEW</p> <p>Door openings in smoke barriers are installed as swinging or horizontal doors shall provide a minimum clear width as follows:</p> <table border="1" data-bbox="191 1154 957 1349"> <thead> <tr> <th data-bbox="191 1154 485 1203">Provider Type</th> <th data-bbox="485 1154 674 1203">Swinging Doors</th> <th data-bbox="674 1154 957 1203">Horizontal Sliding Doors</th> </tr> </thead> <tbody> <tr> <td data-bbox="191 1203 485 1276">Hospitals and Nursing Facilities</td> <td data-bbox="485 1203 674 1276">41.5 inches (105 cm)</td> <td data-bbox="674 1203 957 1276">83 inches (211 cm)</td> </tr> <tr> <td data-bbox="191 1276 485 1349">Psychiatric Hospitals and Limited Care Facilities</td> <td data-bbox="485 1276 674 1349">32 inches (81 cm)</td> <td data-bbox="674 1276 957 1349">64 inches (163 cm)</td> </tr> </tbody> </table> <p>18.3.7.7</p>	Provider Type	Swinging Doors	Horizontal Sliding Doors	Hospitals and Nursing Facilities	41.5 inches (105 cm)	83 inches (211 cm)	Psychiatric Hospitals and Limited Care Facilities	32 inches (81 cm)	64 inches (163 cm)				
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ID PREFIX		MET	NOT MET	N/A	REMARKS																																
K104	Penetrations of smoke barriers by ducts are protected in accordance with 8.3.5. Dampers are not required in duct penetrations of smoke barriers in fully ducted HVAC systems where a sprinkler system in accordance with 18/19.3.5 is provided for adjacent smoke compartments. 18.3.7.3, 19.3.7.3. Hospitals may apply a 6-year damper testing interval conforming to NFPA 80 & NFPA 105. All other health care facilities must maintain a 4-year damper maintenance interval. 8.3.5																																				
	Describe any mechanical smoke control system in REMARKS.																																				
	HAZARDOUS AREAS																																				
K29	2000 EXISTING One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors. Doors shall be self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 <table border="1" data-bbox="197 938 951 1135"> <thead> <tr> <th>Area</th> <th>Automatic Sprinkler</th> <th>Separation</th> <th>N/A</th> </tr> </thead> <tbody> <tr> <td>a. Boiler and Fuel-Fired Heater Rooms</td> <td></td> <td></td> <td></td> </tr> <tr> <td>c. Laundries (greater than 100 sq feet)</td> <td></td> <td></td> <td></td> </tr> <tr> <td>d. Repair Shops and Paint Shops</td> <td></td> <td></td> <td></td> </tr> <tr> <td>e. Laboratories (if classified a Severe Hazard - see K31)</td> <td></td> <td></td> <td></td> </tr> <tr> <td>f. Combustible Storage Rooms/Spaces (over 50 sq feet)</td> <td></td> <td></td> <td></td> </tr> <tr> <td>g. Trash Collection Rooms</td> <td></td> <td></td> <td></td> </tr> <tr> <td>i. Soiled Linen Rooms</td> <td></td> <td></td> <td></td> </tr> </tbody> </table> <p>Describe the floor and zone locations of hazardous areas that are deficient in REMARKS.</p>	Area	Automatic Sprinkler	Separation	N/A	a. Boiler and Fuel-Fired Heater Rooms				c. Laundries (greater than 100 sq feet)				d. Repair Shops and Paint Shops				e. Laboratories (if classified a Severe Hazard - see K31)				f. Combustible Storage Rooms/Spaces (over 50 sq feet)				g. Trash Collection Rooms				i. Soiled Linen Rooms							
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	<p>2000 NEW</p> <p>Hazardous areas are protected in accordance with 8.4. The areas shall be enclosed with a one hour fire-rated barrier, with a ¾ hour fire-rated door, without windows (in accordance with 8.4). 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, 18.3.5.1.</p> <table border="1" data-bbox="197 496 949 743"> <thead> <tr> <th>Area</th> <th>Automatic Sprinkler</th> <th>Separation</th> <th>N/A</th> </tr> </thead> <tbody> <tr> <td>a. Boiler and Fuel-Fired Heater Rooms</td> <td></td> <td></td> <td></td> </tr> <tr> <td>c. Laundries (greater than 100 sq feet)</td> <td></td> <td></td> <td></td> </tr> <tr> <td>d. Repair, Maintenance and Paint Shops</td> <td></td> <td></td> <td></td> </tr> <tr> <td>e. Laboratories (if classified a Severe Hazard - see K31)</td> <td></td> <td></td> <td></td> </tr> <tr> <td>f. Combustible Storage Rooms/Spaces (over 50 and less than 100 sq feet)</td> <td></td> <td></td> <td></td> </tr> <tr> <td>g. Trash Collection Rooms</td> <td></td> <td></td> <td></td> </tr> <tr> <td>i. Soiled Linen Rooms</td> <td></td> <td></td> <td></td> </tr> <tr> <td>m. Combustible Storage Rooms/Spaces (over 100 sq feet)</td> <td></td> <td></td> <td></td> </tr> </tbody> </table> <p><i>Describe the floor and zone locations of hazardous areas that are deficient in REMARKS.</i></p>	Area	Automatic Sprinkler	Separation	N/A	a. Boiler and Fuel-Fired Heater Rooms				c. Laundries (greater than 100 sq feet)				d. Repair, Maintenance and Paint Shops				e. Laboratories (if classified a Severe Hazard - see K31)				f. Combustible Storage Rooms/Spaces (over 50 and less than 100 sq feet)				g. Trash Collection Rooms				i. Soiled Linen Rooms				m. Combustible Storage Rooms/Spaces (over 100 sq feet)							
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K30	<p>Gift shops shall be protected as hazardous areas when used for storage or display of combustibles in quantities considered hazardous. Non-rated walls may separate gift shops that are not considered hazardous, have separate protected storage and that are completely sprinkled. Gift shops may be open to the corridor if they are not considered hazardous, have separate protected storage, are completely sprinklered and do not exceed 500 square feet. 18.3.2.5, 19.3.2.5</p> <table border="1" data-bbox="197 1127 949 1205"> <thead> <tr> <th>Area</th> <th>Automatic Sprinkler</th> <th>Separation</th> <th>N/A</th> </tr> </thead> <tbody> <tr> <td>L. Gift Shop storing hazardous quantities of combustibles</td> <td></td> <td></td> <td></td> </tr> </tbody> </table>	Area	Automatic Sprinkler	Separation	N/A	L. Gift Shop storing hazardous quantities of combustibles																																			
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ID PREFIX		MET	NOT MET	N/A	REMARKS
K211	Where Alcohol Based Hand Rub (ABHR) dispensers are installed: <input type="checkbox"/> The corridor is at least 6 feet wide <input type="checkbox"/> The maximum individual fluid dispenser capacity shall be 1.2 liters (2 liters in suites of rooms) <input type="checkbox"/> The dispensers shall have a minimum spacing of 4 ft from each other <input type="checkbox"/> Not more than 10 gallons are used in a single smoke compartment outside a storage cabinet. <input type="checkbox"/> Dispensers are not installed over or adjacent to an ignition source. <input type="checkbox"/> If the floor is carpeted, the building is fully sprinklered. 18.3.2.7, CFR 403.744, 418.110, 460.72, 482.41, 483.70, 485.623				
EXITS AND EGRESS					
K22	Access to exits shall be marked by approved, readily visible signs in all cases where the exit or way to reach exit is not readily apparent to the occupants. Doors, passages or stairways that are not a way of exit that are likely to be mistaken for an exit have a sign designating "No Exit". 7.10, 18.2.10.1, 19.2.10.1				
K32	Not less than two exits, remote from each other, are provided for each floor or fire section of the building. Not less than one exit from each floor or fire section shall be a door leading outside, stair, smoke-proof enclosure, ramp, or exit passageway. Only one of these two exits may be a horizontal exit. Egress shall not return through the zone of fire origin. 18.2.4.1, 18.2.4.2, 19.2.4.1, 19.2.4.2				
K33	2000 EXISTING Exit enclosures (such as stairways) are enclosed with construction having a fire resistance rating of at least one hour, are arranged to provide a continuous path of escape, and provide protection against fire or smoke from other parts of the building. 7.1.3.2, 8.2.5.2, 8.2.5.4, 19.3.1.1 <i>If all vertical openings are properly enclosed with construction providing at least a two hour fire resistance rating, also check this box.</i> <input type="checkbox"/> <hr style="border-top: 1px dashed black;"/> <i>If enclosures are less than required, give a brief description and specific location in REMARKS.</i>				

ID PREFIX		MET	NOT MET	N/A	REMARKS
	<p>2000 NEW</p> <p>Exit enclosures (such as stairways) in buildings four stories or more are enclosed with construction having a fire resistance rating of at least two hours, are arranged to provide a continuous path of escape, and provide a protection against fire and smoke from other parts of the building. In all buildings less than four stories, the enclosure is at least one hour. 7.1.3.2, 8.2.5.2, 8.2.5.4, 18.3.1.1, 18.2.2.3</p> <p><i>If enclosures are less than required, give a brief description and specific location in REMARKS.</i></p>				
K34	<p>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</p>				
K35	<p>The capacity of required mean of egress is based on its width, in accordance with 7.3.</p>				
K36	<p>Travel distance (exit access) to exits are measured in accordance with 7.6.</p> <ul style="list-style-type: none"> • Room door to exit ≤ 100 ft (≤ 150 ft sprinklered) • Point in room or suite to exit ≤ 150 ft (≤ 200 ft sprinklered) • Point in room to room door ≤ 50 ft • Point in suite to suite door ≤ 100 ft <p>18.2.6, 19.2.6</p>				
K37	<p>2000 EXISTING</p> <p>Existing dead-end corridors shall be permitted to be continued to be used if it is impractical and unfeasible to alter them so that exists are accessible in not less than two different directions from all points in aisles, passageways, and corridors. 19.2.5.10</p> <p>2000 NEW</p> <p>Every exit and exit access shall be arranged so that no corridor, aisle or passageway has a pocket or dead-end exceeding 30 feet. 18.2.5.10</p>				
K38	<p>Exit access is so arranged that exits are readily accessible at all times in accordance with 7.1. 18.2.1, 19.2.1</p>				
K39	<p>2000 EXISTING</p> <p>Width of aisles or corridors (clear and unobstructed) serving as exit access shall be at least 4 feet. 19.2.3.3</p>				

ID PREFIX		MET	NOT MET	N/A	REMARKS
	<p>2000 NEW</p> <p>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. 18.2.3.3, 18.2.3.4</p>				
K40	<p>2000 EXISTING</p> <p>Exit access doors and exit doors used by health care occupants are of the swinging type and are at least 32 inches in clear width. An exception is provided for existing 34-inch doors in existing occupancies. 19.2.3.5</p>				
	<p>2000 NEW</p> <p>Exit access doors and exit doors used by health care occupants are of the swinging type and are at least 41.5 inches in clear width. Doors in exit stairway enclosures shall be no less than 32 inches in clear width. In psychiatric hospitals or limited care facilities (e.g., ICF/MD providing medical treatment) doors are at least 32 inches wide. 18.2.3.5</p>				
K41	<p>All sleeping rooms have a door leading to a corridor providing access to an exit or have a door leading directly to grade. One room may intervene in accordance with 18.2.5.1, 19.2.5.1 <i>If doors lead directly to grade from each room, check this box.</i> <input type="checkbox"/></p>				
K42	<p>Any patient sleeping room or suite of rooms of more than 1,000 sq. ft. has at least 2 exit access doors remote from each other. 18.2.5.2, 19.2.5.2</p>				
K43	<p>Patient room doors are arranged such that the patients can open the door from inside without using a key.</p> <p>Special door locking arrangements are permitted in facilities. 18.2.2.2.4, 18.2.2.2.5, 19.2.2.2.4, 19.2.2.2.5</p> <p><i>If door locking arrangement without delay egress is used indicate in REMARKS</i> 18.2.2.2.2, 19.2.2.2.2</p>				
K44	<p>Horizontal exits, if used, are in accordance with 7.2.4. 18.2.2.5, 19.2.2.5</p>				
K47	<p>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, 19.2.10.1</p> <p>(Indicate N/A in one story existing occupancies with less than 30 occupants where the line of exit travel is obvious.)</p>				

ID PREFIX		MET	NOT MET	N/A	REMARKS
K72	Means of egress shall be continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. No furnishings, decorations, or other objects shall obstruct exits, access thereto, egress there from, or visibility thereof shall be in accordance with 7.1.10. 18.2.1, 19.2.1				
ILLUMINATION					
K45	Illumination of means of egress, including exit discharge, is arranged so that failure of any single lighting fixture will not leave the area in darkness. Lighting system shall be either continuously in operation or capable of automatic operation without manual intervention. 18.2.8, 19.2.8, 7.8				
K46	Emergency lighting of at least 1½ hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1.				
K105	2000 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. 18.2.9.2., 18.2.10.2 (Indicate N/A if life support equipment is for emergency purposes only).				
EMERGENCY PLAN AND FIRE DRILLS					
K48	There is a written plan for the protection of all patients and for their evacuation in the event of an emergency. 18.7.1.1, 19.7.1.1				
K50	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. 18.7.1.2, 19.7.1.2				

ID PREFIX		MET	NOT MET	N/A	REMARKS
FIRE ALARM SYSTEMS					
K51	<p>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. Fire alarm system wiring or other transmission paths are monitored for integrity. 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. Occupant notification is provided 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 fire. The fire alarm automatically activates required control functions. System records are maintained and readily available. 18.3.4, 19.3.4, 9.6</p>				
K52	<p>A fire alarm system required for life safety shall be, tested, and maintained in accordance with NFPA 70 National Electric Code and NFPA 72 National Fire Alarm Code and records kept readily available. The system shall have an approved maintenance and testing program complying with applicable requirement of NFPA 70 and 72. 9.6.1.4, 9.6.1.7,</p>				
K155	<p>Where a required fire alarm system is out of service 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. 9.6.1.8</p>				
K53	<p>2000 EXISTING (INDICATE N/A FOR HOSPITAL AND FULLY SPRINKLERED NURSING HOMES)</p> <p>In an existing nursing home, not fully sprinklered, the resident sleeping rooms and public areas (dining rooms, activity rooms, resident meeting rooms, etc) are to be equipped with single station battery-operated smoke detectors. There will be a testing, maintenance and battery replacement program to ensure proper operation. CFR 483.70</p>				

ID PREFIX		MET	NOT MET	N/A	REMARKS
	<p>2000 NEW (NURSING HOME AND EXISTING LIMITED CARE FACILITIES)</p> <p>An automatic smoke detection system is installed in all corridors. (As an alternative to the corridor smoke detection system on patient sleeping room floors, smoke detectors may be installed in each patient sleeping room and at smoke barrier or horizontal exit doors in the corridor.) Such detectors are electrically interconnected to the fire alarm system. 18.3.4.5.3</p>				
K109	<p>2000 EXISTING LIMITED CARE FACILITIES (INDICATE N/A FOR HOSPITALS OR NURSING HOMES)</p> <p>An automatic smoke detection system is installed in all corridors with detector spacing no further apart than 30 ft on center in accordance with NFPA 72. (As an alternative to the corridor smoke detection system on patient sleeping room floors, smoke detectors may be installed in each patient sleeping room and at smoke barrier or horizontal exit doors in the corridors.) Such detectors are electrically interconnected to the fire alarm system. 19.3.4.5.1</p> <p>Smoke Detection System</p> <ul style="list-style-type: none"> <input type="checkbox"/> Corridors <input type="checkbox"/> Rooms <input type="checkbox"/> Bath 				
K54	<p>All required smoke detectors, including those activating door hold-open devices, are approved, maintained, inspected and tested in accordance with the manufacturer's specifications. 9.6.1.3</p> <p><i>Give a brief description, in REMARKS of any smoke detection system which may be installed.</i></p>				
K55	<p>2000 EXISTING</p> <p>Every patient sleeping room shall have an outside window or outside door. Except for newborn nurseries and rooms intended for occupancy for less than 24 hours. 19.3.8</p> <p>2000 NEW</p> <p>Every patient sleeping room shall have an outside window or outside door. The allowable sill height shall not exceed 36 inches (91 cm) above the floor. Windows are not required for recovery rooms, newborn nurseries, emergency rooms, and similar rooms</p>				

ID PREFIX		MET	NOT MET	N/A	REMARKS
	intended for occupancy for less than 24 hours. Window sill height for limited care facilities shall not exceed 44 inches (112 cm) above the floor. 18.3.8				
K60	Initiation of the required fire alarm systems shall be by manual fire alarm initiation, automatic detection, or extinguishing system operation. 18.3.4.2, 19.3.4.2, 9.6.2.1				
	AUTOMATIC SPRINKLER SYSTEMS				
K56	<p>2000 EXISTING</p> <p>Where required by section 19.1.6, Health care facilities shall be protected throughout by an approved, supervised automatic sprinkler system in accordance with section 9.7. Required sprinkler systems are equipped with water flow and tamper switches which are electrically interconnected to the building fire alarm. In Type I and II construction, alternative protection measures shall be permitted to be substituted for sprinkler protection in specific areas where State or local regulations prohibit sprinklers. 19.3.5, 19.3.5.1, NPFA 13</p> <hr style="border-top: 1px dashed black;"/> <p>2000 NEW</p> <p>There is an automatic sprinkler system installed in accordance with NFPA13, Standard for the Installation of Sprinkler Systems, with approved components, device and equipment, to provide complete coverage of all portions of the facility. Systems are equipped with waterflow and tamper switches, which are connected to the fire alarm system. In Type I and II construction, alternative protection measures shall be permitted to be substituted for sprinkler protection in specific areas where State or local regulations prohibit sprinklers. 18.3.5, 18.3.5.1.</p>				
K154	<p>Where a required automatic sprinkler system is out of service 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 system be provided for all parties left unprotected by the shutdown until the sprinkler system has been returned to service. 9.7.6.1.</p> <hr style="border-top: 1px dashed black;"/> <p>A. Date sprinkler system last checked and necessary maintenance provided. _____</p>				

ID PREFIX		MET	NOT MET	N/A	REMARKS
	B. Show who provided the service. _____				
	C. Note the source of water supply for the automatic sprinkler system. _____				
	<i>(Provide, in REMARKS, information on coverage for any non-required or partial automatic sprinkler system.)</i>				
K61	Automatic sprinkler system supervisory attachments are installed and monitored for integrity in accordance with NFPA 72, 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				
K62	Automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 18.7.6, 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5				
K63	Required automatic sprinkler systems have an adequate and reliable water supply which provides continuous and automatic pressure. 9.7.1.1, NFPA 13				
K64	Portable fire extinguishers shall be installed, inspected, and maintained in all health care occupancies in accordance with 9.7.4.1, NFPA 10. 18.3.5.6, 19.3.5.6				
	SMOKING REGULATIONS				
K66	Smoking regulations shall be adopted and shall include not less than the following provisions: 18.7.4, 19.7.4, 8-6.4.2 (NFPA 99) (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. Exception: In facilities where smoking is prohibited and signs are prominently placed at all major entrances, secondary signs that prohibit smoking in use areas are not required. (Note: This exception is not applicable to medical gas storage areas.) 8-3.1.11.3 (NFPA 99)				

ID PREFIX		MET	NOT MET	N/A	REMARKS
	(2) Smoking by patients classified as not responsible shall be prohibited, except when under direct supervision. (3) Ashtrays of noncombustible material and safe design shall be provided in all areas where smoking is permitted. (4) Metal containers with self-closing cover devices into which ashtrays can be emptied shall be readily available to all areas where smoking is permitted.				
	BUILDING SERVICE EQUIPMENT				
K67	Heating, ventilating, 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, NFPA 90A, 18.5.2.2, 19.5.2.2				
K68	Combustion and ventilation air for boiler, incinerator and heater rooms is taken from and discharged to the outside air. 18.5.2.2, 19.5.2.2.				
K69	Cooking facilities shall be protected in accordance with 9.2.3. 18.3.2.6, 19.3.2.6, NFPA 96				
K70	Portable space heating devices shall be prohibited in all health care occupancies. Except it shall be permitted to be used in non-sleeping staff and employee areas where the heating elements of such devices do not exceed 212°F (100°C). 18.7.8, 19.7.8				
K71	Rubbish Chutes, Incinerators and Laundry Chutes. 18.5.4, 19.5.4, 9.5, 8.4, NFPA 82 (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.				

ID PREFIX		MET	NOT MET	N/A	REMARKS
	(4) Existing flue-fed incinerators shall be sealed by fire resistive construction to prevent further use.				
K160	<p>2000 EXISTING</p> <p>Elevators comply with the provision of 9.4. Elevators are inspected and tested as specified in A17.1, Safety Code for Elevators and Escalators. Fire Fighter’s Service is operated monthly with a written record.</p> <p>Existing elevators conform to ASME/ANSI A17.3, <i>Safety Code for Existing Elevators & Escalators</i>. All existing elevators, having a travel distance of 25 ft or more above or below the level that best serves the needs of emergency personnel for fire fighting purposes, conform with Firefighter’s Service Requirements of ASME/ANSI A17.3. 9.4.2, 9.4.3, 19.5.3</p> <p>(Includes firefighters service phase I key recall and smoke detector automatic recall, firefighters service phase II emergency in-car key operation, machine room smoke detectors, and elevator lobby smoke detectors.)</p> <hr/> <p>2000 NEW</p> <p>Elevators comply with the provision of 9.4. Elevators are inspected and tested as specified in A17.1, Safety Code for Elevators and Escalators. Fire Fighter’s Service is operated monthly with a written record.</p> <p>New elevators conform to ASME/ANSI A17.1, Safety Code for Elevators and Escalators, including Fire Fighter’s Service Requirements. 9.4.2, 9.4.3, 18.5.3</p> <p>(Includes firefighters service phase I key recall and smoke detector automatic recall, firefighters service phase II emergency in-car key operation, machine room smoke detectors, and elevator lobby smoke detectors.)</p>				
K161	<p>2000 EXISTING</p> <p>Escalators, dumbwaiters, and moving walks comply with the provisions of 9.4.</p> <p>All existing escalators, dumbwaiters, and moving walks conform to the requirements of ASME/ANSI A17.3, <i>Safety Code for Existing Elevators and Escalators</i>. 19.5.3, 9.4.2.2</p>				

ID PREFIX		MET	NOT MET	N/A	REMARKS
	<p>(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.)</p> <p>-----</p> <p>2000 NEW</p> <p>Escalators, dumbwaiters, and moving walks comply with the provisions of 9.4.</p> <p>All escalators and conveyors comply with ASME/ANSI A17.1, <i>Safety Code for Elevators and Escalators</i>. 18.5.3, 9.4.2.1</p>				
	FURNISHINGS AND DECORATIONS				
K73	Combustible decorations shall be prohibited unless they are flame-retardant or in such limited quantity that hazard of fire development or spread is not present. 18.7.5.4, 19.7.5.4				
K74	<p>Draperies, curtains, including cubicle curtains, and other loosely hanging fabrics and films serving as furnishings or decorations are flame resistant in accordance with NFPA 701 except for shower curtains. Sprinklers in areas where cubical curtains are installed shall be in accordance with NFPA 13 to avoid obstruction of the sprinkler. 10.3.1, 18.3.5.5, 19.3.5.5, 18.7.5.1, 19.7.5.1, NFPA 13</p> <p><input type="checkbox"/> Newly introduced upholstered furniture shall meet the char length and heat release criteria specified when tested in accordance with the methods cited in 10.3.2 (2) and 10.3.3, 18.7.5.2, 19.7.5.2.</p> <p><input type="checkbox"/> Newly introduced mattresses shall meet the char length and heat release criteria specified when tested in accordance with the method cited in 10.3.2 (3) and 10.3.4. 18.7.5.3, 19.7.5.3</p> <p><input type="checkbox"/> Newly introduced upholstered furniture and mattresses means purchased since March, 2003.</p>				
K75	Soiled linen or trash collection receptacles shall not exceed 32 gal (121 L) in capacity. The average density of container capacity in a room or space shall not exceed .5 gal/ft ² (20.4 L/m ²). A				

ID PREFIX		MET	NOT MET	N/A	REMARKS
	capacity of 32 gal (121 L) shall not be exceeded within any 64-ft ² (5.9-m ²) area. Mobile soiled linen or trash collection receptacles with capacities greater than 32 gal (121 L) shall be located in a room protected as a hazardous area when not attended. 18.7.5.5, 19.7.5.5				
	LABORATORIES				
K31	Laboratories employing quantities of flammable, combustible, or hazardous materials that are considered a severe hazard shall be protected in accordance with NFPA 99. (Laboratories that are not considered to be severe hazard shall meet the provision of K29.) 18.3.2.2, 19.3.2.2, Chapter 10 (NFPA 99)				
K136	Procedures for laboratory emergencies shall be developed. Such procedures shall include alarm actuation, evacuation, and equipment shutdown procedures, and provisions for control of emergencies that could occur in the laboratory, including specific detailed plans for control operations by an emergency control group within the organization or a public fire department in accordance with 10-2.1.3.1 (NFPA 99), 18.3.2.2., 19.3.2.1				
K131	Emergency procedures shall be established for controlling chemical spills in accordance with 10-2.1.3.2 (NFPA 99)				
K132	Continuing safety education and supervision shall be provided, incidents shall be reviewed monthly, and procedures reviewed annually shall be in accordance with 10-2.1.4.2 (NFPA 99).				
K133	Fume hoods shall be in accordance with 5-4.3, 5-6.2 (NFPA 99).				
K134	Where the eyes or body of any person can be exposed to injurious corrosive materials, suitable fixed facilities for quick drenching or flushing of the eyes and body shall be provided within the work area for immediate emergency use. Fixed eye baths designed and installed to avoid injurious water pressure shall be in accordance with 10-6 (NFPA 99).				
K135	Flammable and combustible liquids shall be used from and stored in approved containers in accordance with NFPA 30, Flammable and Combustible Liquids Code, and NFPA 45, Standard on Fire Protection for Laboratories Using Chemicals.				

ID PREFIX		MET	NOT MET	N/A	REMARKS
	Storage cabinets for flammable and combustible liquids shall be constructed in accordance with NFPA 30, Flammable and Combustible liquids Code, 4-3 (NFPA 99), 10-7.2.1 (NFPA 99)				
	MEDICAL GASES AND ANESTHETIZING AREAS				
K76	Medical gas storage and administration areas shall be protected in accordance with NFPA 99, Standard for Health Care Facilities. (a) Oxygen storage locations of greater than 3,000 cu.ft. are enclosed by a one-hour separation. (b) Locations for supply systems of greater than 3,000 cu.ft. are vented to the outside. 4-3.1.1.2 (NFPA 99), 8-3.1.11.1 (NFPA 99), 18.3.2.4, 19.3.2.4				
K77	Piped in medical gas, vacuum and waste anesthetic gas disposal systems comply with NFPA 99, Chapter 4.				
K78	Anesthetizing locations shall be protected in accordance with NFPA 99, Standard for Health Care Facilities. (a) Shutoff valves are located outside each anesthetizing location and arranged so that shutting off one room or location will not affect others. (b) Relative humidity is maintained equal to or great than 35% 4-3.1.2.3(n) and 5-4.1.1 (NFPA 99), 18.3.2.3, 19.3.2.3				
K140	Medical gas warning systems shall be in accordance with NFPA 99, Standard for Health Care Facilities. (a) Master alarm panels are in two separate locations and have audible and visible signals. (b) There are high/low alarms for +/- 20% operating pressure. This section shall be in accordance with NFPA 99, 4-3.1.2.2 (c) Where a level 2 gas system is used, one alarm panel that complies with 4-3.1.2.2(b)3a,b,c,d and with 4-3.1.2.2(c)2,5 shall be permitted. 4-4.1 (NFPA 99) exception No. 4. 4-3.1.2.2 (NFPA 99)				
K141	Medical gas storage areas shall have a precautionary sign, readable from a distance of 5 ft, that is conspicuously displayed on each door or gate of the storage room or enclosure. The sign shall include the following wording as a minimum: CAUTION, OXIDIZING GAS(ES) STORED WITHIN, NO SMOKING. 18.3.2.4, 19.3.2.4, 8-3.1.11.3 (NFPA 99)				

ID PREFIX		MET	NOT MET	N/A	REMARKS
K142	All occupancies containing hyperbaric facilities shall comply with NFPA 99, Standard for Health Care Facilities, Chapter 19.				
K143	Transferring of liquid oxygen from one container to another shall be accomplished at a location specifically designated for the transferring that is as follows:: (a) separated from any portion of a facility wherein patients are housed, examined, or treated by a separation of a fire barrier of 1-hour fire-resistive construction; and (b) the area that is mechanically ventilated, sprinklered, and has ceramic or concrete flooring; and (c) in an area that is posted with signs indicating that transferring is occurring, and that smoking in the immediate area is not permitted in accordance with NFPA 99 and Compressed Gas Association. 8-6.2.5.2 (NFPA 99)				
ELECTRICAL AND EMERGENCY POWER					
K106	Hospitals and inpatient hospices with life support equipment have an Type I Essential Electric System, and nursing homes have a Type II ESS that are powered by a generator with a transfer switch and separate power supply in accordance with NFPA 99. 12-3.3.2, 13-3.3.2.1, 16-3.3.2 (NFPA 99)				
K107	Required alarm and detection systems are provided with an alternative power supply in accordance with NFPA 72. 9.6.1.4, 18.3.4.1, 19.3.4.1				
K108	2000 NEW (INDICATE N/A FOR EXISTING) Power for Alarms, emergency communication systems, and illumination of generator set locations are in accordance with essential electrical system of NFPA 99. 18.5.1.2				
K144	Generators inspected weekly and exercised under load for 30 minutes per month and shall be in accordance with NFPA 99 and NFPA 110. 3-4.4.1 and 8-4.2 (NFPA 99), Chapter 6 (NFPA 110)				
K145	The Type I EES is divided into the critical branch, life safety branch and the emergency system and Type II EES is divided into the emergency and critical systems in accordance with 3-4.2.2.2, 3-5.2.2 (NFPA 99)				

ID PREFIX		MET	NOT MET	N/A	REMARKS
K146	The nursing home/hospice with no life support equipment shall have an alternate source of power separate and independent from the normal source that will be effective for minimum of 1½ hour after loss of the normal source 3-6. (NFPA 99)				
K147	Electrical wiring and equipment shall be in accordance with National Electrical Code. 9-1.2 (NFPA 99) 18.9.1, 19.9.1				
K130	Miscellaneous List in the REMARKS sections, any items that are not listed previously, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567.				

PART IV 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
K84	

Surveyor (<i>Signature</i>)	Title	Office	Date
Fire Authority Official (<i>Signature</i>)	Title	Office	Date

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

PROVIDER NUMBER K1 245496	FACILITY NAME MINNEOTA MANOR HEALTH CARE CENTER	SURVEY DATE *K4 05/08/2014
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K6 DATE OF PLAN APPROVAL	K3 : MULTIPLE CONSTRUCTION TOTAL NUMBER OF BUILDINGS <u>1</u> NUMBER OF THIS BUILDING <u>01</u>	<input checked="" type="checkbox"/> A A BUILDING <input type="checkbox"/> B WING <input type="checkbox"/> C FLOOR <input type="checkbox"/> D APARTMENT UNIT
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<p>LSC FORM INDICATOR</p> <table border="1" style="width:100%; border-collapse: collapse; margin-bottom: 5px;"> <tr><th align="center" colspan="3">Health Care Form</th></tr> <tr><td style="width:5%;">12</td><td style="width:20%;">2786 R</td><td style="width:75%;">2000 EXISTING</td></tr> <tr><td>13</td><td>2786 R</td><td>2000 NEW</td></tr> </table> <table border="1" style="width:100%; border-collapse: collapse; margin-bottom: 5px;"> <tr><th align="center" colspan="3">ASC Form</th></tr> <tr><td style="width:5%;">14</td><td style="width:20%;">2786 U</td><td style="width:75%;">2000 EXISTING</td></tr> <tr><td>15</td><td>2786 U</td><td>2000 NEW</td></tr> </table> <table border="1" style="width:100%; border-collapse: collapse;"> <tr><th align="center" colspan="3">ICF/MR Form</th></tr> <tr><td style="width:5%;">16</td><td style="width:20%;">2786 V, W, X</td><td style="width:75%;">2000 EXISTING</td></tr> <tr><td>17</td><td>2786 V, W, X</td><td>2000 NEW</td></tr> </table> <p>*K7 <input type="checkbox"/> 12 SELECT NUMBER OF FORM USED FROM ABOVE</p> <p><i>(Check if K29 or K56 are marked as not applicable in the 2786 M, R, T, U, V, W, X, Y and Z.)</i></p> <p>K29: <input type="checkbox"/> 3 K56: <input type="checkbox"/> 3</p>	Health Care Form			12	2786 R	2000 EXISTING	13	2786 R	2000 NEW	ASC Form			14	2786 U	2000 EXISTING	15	2786 U	2000 NEW	ICF/MR Form			16	2786 V, W, X	2000 EXISTING	17	2786 V, W, X	2000 NEW	<p>COMPLETE IF ICF/MR IS SURVEYED UNDER CHAPTER 21</p> <p>SMALL (16 BEDS OR LESS)</p> <p>K8: <input type="checkbox"/> 1 PROMPT 2 SLOW 3 IMPRACTICAL</p> <hr/> <p>LARGE</p> <p>K8: <input type="checkbox"/> 4 PROMPT 5 SLOW 6 IMPRACTICAL</p> <hr/> <p>APARTMENT HOUSE</p> <p>K8: <input type="checkbox"/> 7 PROMPT 8 SLOW 9 IMPRACTICAL</p> <hr/> <p>ENTER E-SCORE HERE</p> <p>K5: <input type="checkbox"/> e.g 2.5</p>
Health Care Form																												
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***K9 : FACILITY MEETS LSC BASED ON:** *(Check all that apply)*

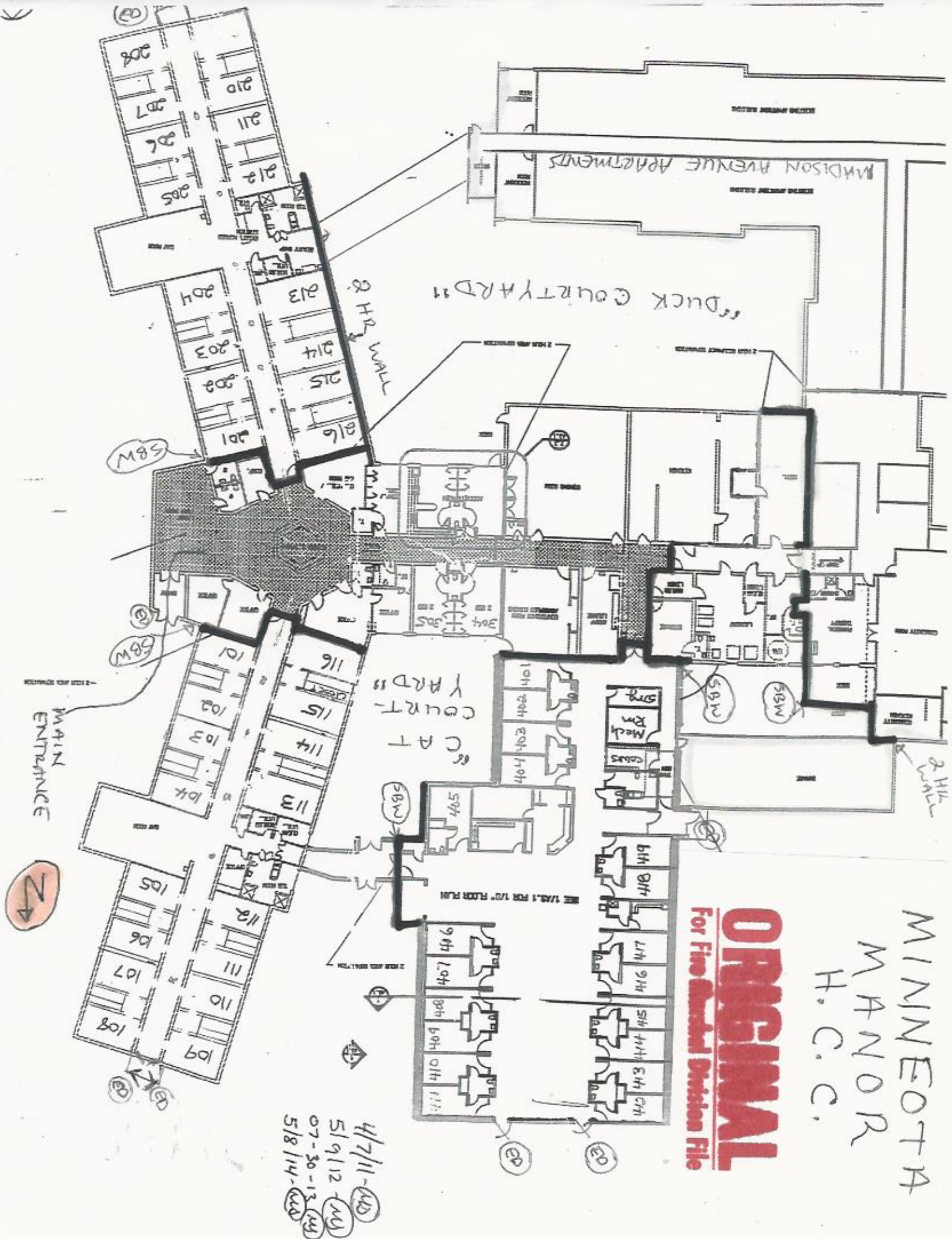
A1 <input type="checkbox"/>	A2 <input checked="" type="checkbox"/>	A3 <input checked="" type="checkbox"/>	A4 <input type="checkbox"/>	A5 <input type="checkbox"/>
(COMP. WITH ALL PROVISIONS)	(ACCEPTABLE POC)	(WAIVERS)	(FSSES)	(PERFORMANCE BASED DESIGN)

FACILITY DOES NOT MEET LSC: B. <input type="checkbox"/>	K180: <table style="width:100%;"> <tr> <td style="text-align: center; width: 33%;">A. <input checked="" type="checkbox"/></td> <td style="text-align: center; width: 33%;">B. <input type="checkbox"/></td> <td style="text-align: center; width: 33%;">C. <input type="checkbox"/></td> </tr> <tr> <td style="text-align: center;">FULLY SPRINKLERED <small>(All required areas are sprinklered)</small></td> <td style="text-align: center;">PARTIALLY SPRINKLERED <small>(Not all required areas are sprinklered)</small></td> <td style="text-align: center;">NONE <small>(No sprinkler system)</small></td> </tr> </table>	A. <input checked="" type="checkbox"/>	B. <input type="checkbox"/>	C. <input type="checkbox"/>	FULLY SPRINKLERED <small>(All required areas are sprinklered)</small>	PARTIALLY SPRINKLERED <small>(Not all required areas are sprinklered)</small>	NONE <small>(No sprinkler system)</small>
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FULLY SPRINKLERED <small>(All required areas are sprinklered)</small>	PARTIALLY SPRINKLERED <small>(Not all required areas are sprinklered)</small>	NONE <small>(No sprinkler system)</small>					

***MANDATORY**

MINNEOTA
MANOR
H. C. C.

ORIGINAL
For Fire Marshal Division File



4/7/11 - (MS)
5/9/12 - (MS)
07-30-13 (MS)
5/8/14 - (MS)

PROJECT NUMBER:	PROVIDER NAME	SURVEY DATE
Administrator:		Phone Number:
Email address:		
State Fire Inspector:		
These are preliminary findings only. A complete and final Statement of Deficiencies 2567 report will be provided by US Mail.		
<input type="checkbox"/> At the time of this inspection, this facility was found to comply with the requirements of the 2000 Life Safety Code applicable to: <input type="checkbox"/> SNF/NF <input type="checkbox"/> Hospital <input type="checkbox"/> ICFMR <input type="checkbox"/> ASC Facilities participating in the Medicare/Medicaid programs.		
<input type="checkbox"/> The following fire/life safety deficiencies were found during this inspection:		
K TAG S & S	<input type="checkbox"/> Draft Summary of Deficiency(ies) <input type="checkbox"/> Revisit <input type="checkbox"/> Clearance	
	DRAFT	

Sheehan, Pat (DPS)

From: Sheehan, Pat (DPS)
Sent: Monday, June 09, 2014 3:38 PM
To: 'rochi_jsc@cms.hhs.gov'
Cc: Shellum, George (DPS); 'kathy@minmanor.com'; Dietrich, Shellae (MDH); 'Fiske-Downing, Kamala'; Henderson, Mary (MDH); 'Johnston, Kate'; Kleppe, Anne (MDH); Leach, Colleen (MDH); Meath, Mark (MDH); Zwart, Benjamin (MDH)
Subject: Minneota Manor Health Care Center (245496) 2014 K67 Annual Waiver Request - Previously approved - No Changes

This is to inform you that Minneota Manor HCC is again requesting an annual waiver for K67, corridors as a plenum. The exit date was 5-9-14.

I am recommending that CMS approved this waiver request.

Patrick Sheehan, Fire Safety Supervisor
Office: 651-201-7205 Cell: 651-470-4416
Health Care & Corrections Fire Inspections
Minnesota State Fire Marshal Division Est. 1905
445 Minnesota St., Suite 145, St Paul, MN 55101-5145
FAX: 651-215-0525
Web: fire.state.mn.us



Name of Facility
 Minnesota Manor Health Care Center

2000 CODE

PART IV 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
K84 K067 The building heating, ventilation & air conditioning equipment (HVAC) does not comply with LSC (00) Section 9.2, and NFPA 90A, 1999 Ed., because the corridors are being used as a plenum.	An annual/continuing waiver is being requested for K067. A. Compliance with this provision will cause an unreasonable/financial hardship because: 1. The most recent cost estimate dated 10/29/2013 for complying ducted HVAC system is \$90000-\$100000. 2. A ducted system would decrease the corridor headroom to less than that required by the LSC. 3. The building electrical system would need to be upgraded to support a new ducted system. 4. The ducted system would need to penetrate load bearing walls, decreasing building structural integrity. 5. Installation of a ducted system would require asbestos abatement which would increase the cost. 6. Existing non-complying HVAC systems can be allowed to continue in use. B. There will be no adverse effect on the building occupant's safety because: 1. The building is protected by a complete fire sprinkler system that complies with NFPA 13, 1999 Edition. 2. The existing HVAC system ventilation fans do automatically shut down upon activation of the fire alarm system, or detection of smoke in the HVAC system. 3. The corridors are equipped with a complying smoke detection system. 4. The facility is in compliance with all other fire safety requirements. 5. This annual/continuing waiver has been approved in the past. (Document attached)

Surveyor (Signature)	Title	Office	Date
 Fire Authority Official (Signature)	Title	Office	Date
 Fire Safety Supervisor	Fire Safety Supervisor	State Fire Marshal	6-9-14

Bisbee Plumbing & Heating

Complete Commercial Mechanical Contracting and Metal Fabricating

604 North Hwy. 59, P.O. Box 3
Marshall, Minnesota 56258

PHONE: 507-537-0596
FAX: 507-537-1431

October 29, 2013

Mrs. Johnson
Minneota Manor
700 North Monroe St.
Minneota, Minnesota 56264

RE: Return Air Ducting

Mrs. Johnson,

Bisbee Plumbing & Heating did research into the Minneota Manor return air system for the South Wing, North Wing and a couple of rooms in West Wing. Looking at these systems, in order to install return air duct out of every room walls will need to be busted through into hallways and ceilings will have to be taken down in rooms (partially) and all of the hallways ceilings in order for us to install return air duct back to the rooftop air handling units. Also required would be sprinkler contractor to remove some of the sprinkler lines that are above the ceilings and in the way. Because of going from room to hallway there may be fire dampers or fire/smoke damper required for fire protection.

With this being said Bisbee's is estimating that the cost to do this work could be in the range of \$ 90,000 to \$ 100,000.00 depending on what will be required.

Sincerely,
Bisbee Plumbing & Heating

Jack Mead