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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: KKF4

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00191

1. MEDICARE/MEDICAID PROVIDER NO.(L1) **245587**

2. STATE VENDOR OR MEDICAID NO. (L2) **810542100**

3. NAME AND ADDRESS OF FACILITY
(L3) **EBENEZER CARE CENTER**
(L4) **2545 PORTLAND AVENUE SOUTH**
(L5) **MINNEAPOLIS, MN** (L6) **55404**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9) **05/01/2012**

6. DATE OF SURVEY **02/19/2016** (L34)

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

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

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

FISCAL YEAR ENDING DATE: (L35) **06/30**

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

12.Total Facility Beds **127** (L18)

13.Total Certified Beds **127** (L17)

10.THE FACILITY IS CERTIFIED AS:

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

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

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

* Code: **A** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	34	93		
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Gloria Derfus, Unit Supervisor 02/29/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 02/29/2016 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION **06/01/1991** (L24)

23. LTC AGREEMENT BEGINNING DATE (L41)

24. LTC AGREEMENT ENDING DATE (L25)

25. LTC EXTENSION DATE: (L27)

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

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

28. TERMINATION DATE: (L28)

29. INTERMEDIARY/CARRIER NO. **00320** (L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE (L33)

DETERMINATION APPROVAL

MDH
Minnesota
Department
of Health

Protecting, maintaining and improving the health of all Minnesotans

CMS Certification Number (CCN): 245587

February 29, 2016

Mr. Joel Prevost, Administrator
Ebenezer Care Center
2545 Portland Avenue South
Minneapolis, MN 55404

Dear Mr. Prevost:

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 February 8, 2016 the above facility is certified for:

127 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 127 skilled nursing facility beds.

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

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

Please contact me if you have any questions.

Sincerely,

Kamala Fiske-Downing

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

MDH
Minnesota
Department
of Health

Protecting, maintaining and improving the health of all Minnesotans

Electronically delivered
February 29, 2016

Mr. Joel Prevost, Administrator
Ebenezer Care Center
2545 Portland Avenue South
Minneapolis, MN 55404

RE: Project Number S5587025

Dear Mr. Prevost:

On January 15, 2016, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on December 30, 2015. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required.

On February 19, 2016, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on February 26, 2016 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on December 30, 2015. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of February 8, 2016. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on December 30, 2015, effective February 8, 2016 and therefore remedies outlined in our letter to you dated January 15, 2016, will not be imposed.

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

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

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

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
245587 Y1	A. Building B. Wing Y2	2/19/2016 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
EBENEZER CARE CENTER	2545 PORTLAND AVENUE SOUTH MINNEAPOLIS, MN 55404

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).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0157	Correction	ID Prefix F0176	Correction	ID Prefix F0226	Correction
Reg. # 483.10(b)(11)	Completed	Reg. # 483.10(n)	Completed	Reg. # 483.13(c)	Completed
LSC	02/08/2016	LSC	02/08/2016	LSC	02/08/2016
ID Prefix F0279	Correction	ID Prefix F0356	Correction	ID Prefix F0371	Correction
Reg. # 483.20(d), 483.20(k)(1)	Completed	Reg. # 483.30(e)	Completed	Reg. # 483.35(i)	Completed
LSC	02/08/2016	LSC	02/08/2016	LSC	02/08/2016
ID Prefix F0431	Correction	ID Prefix F0441	Correction	ID Prefix F0465	Correction
Reg. # 483.60(b), (d), (e)	Completed	Reg. # 483.65	Completed	Reg. # 483.70(h)	Completed
LSC	02/08/2016	LSC	02/08/2016	LSC	02/08/2016
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
	GD/kfd	2/29/2016	18623	02/19/2016
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON
12/30/2015

☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
245587	A. Building 01 - MAIN BUILDING 01 B. Wing	2/26/2016

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
EBENEZER CARE CENTER	2545 PORTLAND AVENUE SOUTH MINNEAPOLIS, MN 55404

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).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix Reg. # NFPA 101 LSC K0012	Correction Completed 02/08/2016	ID Prefix Reg. # NFPA 101 LSC K0038	Correction Completed 01/13/2016	ID Prefix Reg. # NFPA 101 LSC K0040	Correction Completed 01/13/2016
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 STATE AGENCY ☐	REVIEWED BY (INITIALS) TL/kfd	DATE 2/29/2016	SIGNATURE OF SURVEYOR 19251	DATE 2/26/2016
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	
12/29/2015	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: KKF4

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00191

1. MEDICARE/MEDICAID PROVIDER NO.(L1) **245587**

2. STATE VENDOR OR MEDICAID NO. (L2) **810542100**

3. NAME AND ADDRESS OF FACILITY
(L3) **EBENEZER CARE CENTER**
(L4) **2545 PORTLAND AVENUE SOUTH**
(L5) **MINNEAPOLIS, MN** (L6) **55404**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9) **05/01/2012**

6. DATE OF SURVEY **12/30/2015** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 03 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
06/30

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

12.Total Facility Beds **127** (L18)

13.Total Certified Beds **127** (L17)

10.THE FACILITY IS CERTIFIED AS:

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

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

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

* Code: **B** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	34	93		
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Magdalene Jares, HFE NE II 01/26/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 02/26/2016 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
06/01/1991
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
00320
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

MDH
Minnesota
Department
of Health

Protecting, maintaining and improving the health of all Minnesotans

Electronically delivered
January 15, 2016

Mr. Joel Prevost, Administrator
Ebenezer Care Center
2545 Portland Avenue South
Minneapolis, MN 55404

RE: Project Number S5587025

Dear Mr. Prevost:

On December 30, 2015, 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 the facility to 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. In addition, at the time of the December 30, 2015 standard survey the Minnesota Department of Health completed an investigation of complaint number H5587040 that was found to be unsubstantiated.

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

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

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

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

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

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

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

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

DEPARTMENT CONTACT

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

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

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by February 8, 2016, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

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

- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is

acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,

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

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

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

Original deficiencies not corrected

If your facility has not achieved substantial compliance, we will impose the remedies described above. If the

level of noncompliance worsened to a point where a higher category of remedy may be imposed, we will recommend to the CMS Region V Office that those other remedies be imposed.

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by March 30, 2016 (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 June 30, 2016 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable 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:

Tom Linhoff, Fire Safety Supervisor
Health Care Fire Inspections
State Fire Marshal Division
Email: tom.linhoff@state.mn.us
Phone: (651) 430-3012 Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245587	A. BUILDING _____ B. WING _____	12/30/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EBENEZER CARE CENTER	**2545 PORTLAND AVENUE SOUTH MINNEAPOLIS, MN 55404**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic 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. In addition during the recertification survey complaint investigation were also completed at the time of the standard survey. An investigation of complaint H5587040 was completed. The complaint was unsubstantiated.	F 000		
F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of	F 157		2/8/16

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

Electronically Signed | 01/25/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245587	A. BUILDING _____ B. WING _____	12/30/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EBENEZER CARE CENTER	**2545 PORTLAND AVENUE SOUTH MINNEAPOLIS, MN 55404**

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F 157	Continued From page 1 treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure 1 of 1 resident (R30) court appointed guardian had been notified timely after falls and medications changes reviewed for notification of change. Findings include: On 12/28/15, at 3:11 p.m. during a telephone interview when R30's court appointed guardian was asked if R30 a change in condition within the past several months, guardian stated R30 had a decline in her mobility and was dependent on staff with a transfer lift. The guardian indicated she had been appointed as guardian last summer and prior to her involvement R30 had been admitted to the facility for rehabilitation. Guardian indicated R30 had a language barrier and disability thus she was the person who was	F 157	The facility will immediately inform the resident; consult with resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility. The facility will also promptly notify	

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F 157	Continued From page 2 notified of all medications, treatments, accidents and any change in condition. Guardian clarified the change in condition was not acute. R30's care plan dated 7/30/14, indicated resident was at risk for psychosocial difficulty related to developmental disabilities, had limited ability to verbally communicate in her primary language and need for someone to make decisions for her. The care plan indicated R30's guardian handled R30's affairs and decisions her behalf and staff was to consult with guardian and provide information and options for decisions as needed. During review of R30 falls/incident reports dated 12/1/14, through 12/30/15, it was revealed R30 had several falls without injury but on 12/3/14, it had been indicated as "deferred to next shift" for primary contact to be updated. In addition on 8/2/15, R30 had been found crying and crawling out of the door of her room and on the incident report had been indicated for contacting primary contact "No. too late to call family, left note for the day nurse to call." Review of all progress notes following the falls lacked documentation either the family or guardian had been updated on the falls. R30's cognitive loss/dementia Care Area Assessment (CAA) dated 5/14/15, indicated R30 had triggered secondary to severe cognitive impairment and presence of behaviors. The CAA indicated R30 had impaired decision making skills, did not verbalize needs to staff but will on occasion use gestures to communicate needs. In addition the CAA identified R30 had cerebral palsy and had mild intellectual disabilities. Review District Court Fourth Judicial District Probate-Mental Health Division letter for	F 157	the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in ¿483.15(e)(2); or a change in resident rights under Federal or State law or regulations The guardian of R30 has been updated of all changes in medications and/or conditions. By 1/22/16 all licensed and registered nurses have been educated of the requirement to immediately notify primary contacts/guardian of such changes. Additional review of condition changes, health updates and review of responsible party contact information are conducted during resident care conferences with resident and/or responsible party. Audits are being conducted to ensure compliance and will continue for 3 months or until ongoing compliance is achieved. The director of nursing has oversight of this audit process and audit results will be reported and reviewed at the facility QAPI meeting.	

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F 157	Continued From page 3	F 157		

guardianship dated 7/23/15, revealed R30 had been assigned a guardian.

R30's diagnoses included moderate mental retardation, cerebral palsy with spastic/ataxia diplegia, non-morbid obesity, epilepsy and presence of cerebrospinal fluid drainage obtained from Admission Record dated 8/5/15.

On 9/30/15, R30 had a dentist appointment had been found to have gum infection and was prescribed an oral rinse twice daily for 14 days but no documentation the guardian had been notified of the infection.

On 11/13/15, R30's dietary supplement medications had been discontinued and had and changed but there was no documentation of the guardian being notified of the changes in treatments/medications.

Physician Order dated 12/11/15, R30's omeprazole (medication for acid reflux) had been decreased to 10 milligrams (mg) but no documentation of the guardian being notified of the change.

On 12/30/15, at 3:10 p.m. registered nurse manager (RN)-F verified the primary contact(s) had been notified of the falls. RN-F stated she thought the staff had contacted R30's family at the time of the fall 12/3/14, but acknowledged there was no documentation. RN-F also verified R30 also some medications orders that either had been discontinued, changed or decreased and the fall on 8/2/15, no documentation of the guardian being notified. RN-F stated "definitely we should notify the family or guardian on any changes with resident treatment and condition."

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F 157	Continued From page 4 On 12/30/15, at 4:24 p.m. the nurse practitioner was called and did not receive a call back. On 12/30/15, at 4:34 p.m. when asked if she expected the guardian, power of attorney or family to be notified of medication reductions or changes the director of nursing (DON) stated "not for the reduction. I don't think so for medications being discontinued or started. It depends what it's for." When asked if the staff were supposed to notify the guardian of all the falls DON stated "yes." DON further stated the MDS coordinator was working on a plan of correction. Change Of Condition/Notification policy dated 12/2014, indicated the family and/or responsible party was to be notified anytime there was a change in a resident's condition or plan of care. The policy indicated family/responsible party would be notified on a timely manner, and if family had not been called during the night time hours, would be notified the next morning.	F 157		
F 176 SS=D	483.10(n) RESIDENT SELF-ADMINISTER DRUGS IF DEEMED SAFE An individual resident may self-administer drugs if the interdisciplinary team, as defined by §483.20(d)(2)(ii), has determined that this practice is safe. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to determine whether the practice of self-administration of nebulizer medication was safe for 1 of 1 residents (R52)	F 176	The facility will ensure self-administration of drugs is done so safely according to interdisciplinary team review and recommendation. Unless deemed safe by	2/8/16

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F 176	Continued From page 5 who observed self-administering medications. Findings include: On 12/30/15, at 7:03 a.m. R52 was up in chair dressed, opened eyes slightly and responded to verbal stimulus. A nebulized (neb) medication was running, no nurse was in the room to supervise the administration. R52 had captured the nebulizer tubing with his right index finger and had pulled the face mask slightly. Registered nurse (RN)-A who had been working at the medication cart near the nursing station, walked into the room with a cup of thin clear liquid in his hands and a medication cup. RN-A stated he was unsure if R52 had a SAM assessment or a SAM order. When asked if he was also going to give the medications in his hand, RN-A stated "his medication was the neb." RN-A then removed the neb tubing, placed it on the bedside table and left the room with the water and medication cup, continuing down to the end of the hall. R52 was admitted to the facility on 8/30/05, and had admission diagnoses of dementia, functional quadriplegia (loss of body control for all four limbs and several body functions) and dysphagia (inability to swallow thin liquids) per the Admission Record. The significant change Minimum Data Set dated 10/27/15, indicated R52 was never or rarely understood. According to staff assessment R52 experienced short term and long term memory problems, had severely impaired cognition function and mild depression, evidenced by poor appetite and trouble concentrating. R52 was required total dependence for transfers, extensive assistance of two staff for toilet use, bed mobility,	F 176	the interdisciplinary team, residents will not be allowed to self-administer medication. RN-A were educated at the time of survey about proper self administration of medicine including R52's plan of care. All nurses were educated about proper self administration of medicine by 1/22/16. Audits are being conducted with oversight by the director of nursing and will continue for 3 months or until ongoing compliance is achieved. Audits will be reported and reviewed at the monthly QAPI meetings.	

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F 176	Continued From page 6	F 176		

and dressing.

The significant change Care Area Assessment dated 10/27/15, indicated R52 had a diagnosis of dementia with behavior disturbances, was unable to recognize staff, room, season or that he was in a nursing home. R52 did not communicate verbally. R52 rarely makes self-understood and rarely understands, staff anticipate all needs. He had an increase with difficulty swallowing and had had times when he lets food and fluids run out of his mouth.

R52 had a Physician's Order dated 10/28/15, for Duoneb Solution (breathing medication), nebulized four times a day for chronic obstructive pulmonary disease.

The care plan dated 11/10/15, indicated R52 had a self-care deficit and required staff to meet all his needs due to left sided hemiplegia, from stroke and dementia. R52 was fed by staff and had a decline in swallowing ability. R52's care plan did not indicate R52 could SAM their medications(s).

On 12/29/15, at 3:20 p.m. nursing assistant-C stated R52 has been like this in the one and 1/2 years she had worked here, "but pretty unresponsive, with his eyes looking left."

On 12/30/15, at 8:30 a.m. RN-B stated, R52 does not have a SAM, because he was not capable of self-administering, so he had not been assessed. A SAM policy was not found by RN-B.

On 12/30/15, at 9:00 a.m. the director of nursing stated she would expect the staff nurse to stay with a patient receiving a nebulized medication, if

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F 176	Continued From page 7 the patient were unable to self-administer medications.	F 176		
F 226 SS=E	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to complete references checks for 3 of 5 employees (E-2, E-3, E-4) prior to employment. This had the potential to affect 74 of 122 residents residing at the facility as the staff worked in multiple areas of the facility. Finding include: New employee personnel files were reviewed: E-2, a therapeutic recreation staff (TR), had a hire date of 10/16/15. No reference checks were conducted or documented as done. E-3, a nursing assistant (NA), had a hire date of 8/10/15. No reference checks were conducted. E-4, a receptionist, had a hire date of 9/10/15. No reference checks were conducted or documented. The administrator handed the employee files back without the references check on 12/30/15,	F 226	The facility has developed and implemented written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. The facility conducts background checks on all staff prior to employment. The facility also does an additional background check which is not required by DHS in order to be extra thorough. The facility does a comprehensive interview of each candidate as well as proper licensure checks prior to employment. The superivors for E-2, E-3 and E-4 were all educated of the expectation to conduct reference checks prior to offering employment to any candidate. All hiring managers and human resources personnel were educated of the expectation to conduct reference checks prior to offering a job to any candidate.	2/8/16

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F 226	Continued From page 8 at 11:04 a.m. stated "It is best practice to do them, I'd like them to be done more, but we can't produce things we have not done" when asked if the facility completed reference checks for all the staff prior to employment. The facility's Abuse Prevention Plan dated 2015, indicated: "Screening 1. All potential employees will receive a background check. 2. In addition to this, all licensed potential employees will receive license status verification via the State Board of Licensure/Registry for that particular practice. 3. Ebenezer Care Center does not employ or continue to employ anyone who has a history of documented patient abuse, neglect or misappropriation of property." The policy lacked direction to include attempting to obtain information from previous and/or current employers.	F 226	The reference check requirement has been added to the Human resources checklist. Human resource personnel file audits will be conducted by the director of human resources for 3 months or until ongoing compliance is achieved. Audits will be reported and reviewed at the facility QAPI meeting.	
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's	F 279		2/8/16

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F 279	Continued From page 9 highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on interview and document review, facility failed to develop a comprehensive care plan for 1 of 1 resident (R95) reviewed for behaviors. Findings include: R95's quarterly Minimum Data Set (MDS) dated 12/10/15, indicated R95 was cognitively intact and had diagnoses of lung and colon cancer, stroke and diabetes. The quarterly MDS also indicated R95 displayed physical behavioral symptoms directed toward others (hitting, kicking, pushing, scratching, grabbing, and abusing others sexually) one to three times in the last seven days. During interview on 12/29/15, at 3:09 p.m. registered nurse (RN)-C, MDS coordinator verified the MDS indicated R95 had behaviors directed towards others. RN-C stated, it was a known behavior for R95 that R95 joked around and pushed people. RN-C verified R95 did not have a behavior section in R95's care plan. RN-C stated, "These behaviors should have been care planned." During interview on 12/30/15, at 12:12 p.m. licensed social worker (LSW) said if that was a	F 279	A facility uses the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility has developed a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. R95 care plan was updated 12/29/15 to reflect behavioral focus and interventions & is current. Interdisciplinary team including (RN)-C and (LSW) was educated on 12/30/15 on development and changes to comprehensive care plans in order to maintain current documentation and plans of care. Audits are being conducted with oversight by the director of nursing and will continue for 3 months or until ongoing compliance is achieved.	

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F 279	Continued From page 10 base line behavior for R95 the facility ' s practice would be to have interventions in place on the care plan and ensure the staff have the tools in place to carry out the interventions. The facility ' s policy for Admission Care Plan revised 12/13, instructed staff: "Each resident admitted to facility will have a Care Plan begun on admission to ensure each resident's needs are assessed and all care needs are met."	F 279	Audits will be reported and reviewed at the monthly QAPI meetings.	
F 356 SS=C	483.30(e) POSTED NURSE STAFFING INFORMATION The facility must post the following information on a daily basis: o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows: o Clear and readable format. o In a prominent place readily accessible to residents and visitors. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community	F 356		2/8/16

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F 356	Continued From page 11 standard. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure the report of nursing staff directly responsible for resident care was updated daily to reflect actual hours worked. This practice had the potential to affect all 122 residents who resided in the facility, family and visitors who wished to view the information. Findings include: During the initial tour on 12/28/15, at 11:30 a.m. the Daily Nursing Hours was observed posted on the wall in the facility's main lobby. The posting included the facility name, current resident census, hours of labor for registered nurses (RNs), licensed practical nurses (LPNs) and nursing assistants (NAs). The posting was dated 12/23/15, which was five days prior. -At 12:33 p.m. The Daily Nursing Hours had been changed for that day 12/28/15, on a follow up tour. -At 12:44 p.m. infection control registered nurse stated "I did the staff posting today because the staffing coordinator is out sick today. The staffing coordinator posts it in the morning, anywhere from 7:00 to 10:30 a.m. because her hours vary. I am not sure who takes care of it on the weekends." Staff verified the posting hanging at time of entrance was dated 12/23/15. -At 1:01 p.m. the infection control registered	F 356	The facility posts the following information on a daily basis: o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. The facility posts the nurse staffing data specified above on a daily basis at the beginning of each shift. Data is posted as follows: o Clear and readable format. o In a prominent place readily accessible to residents and visitors. The facility, upon oral or written request, makes nurse staffing data available to the public for review at a cost not to exceed the community standard. The facility maintains the posted daily	

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F 356	Continued From page 12 nurse approached and stated the nursing supervisor was responsible for posting on the weekend. During interview on 12/30/15, at 12:04 p.m. the director of nursing (DON) stated, "the nursing department is responsible the staffing posting. My staffer normally does it but she has been out sick. Nursing did not pick it up. I am aware it was posted wrong from 12/23 through 12/28. I am working on a system and education to ensure this problem does not repeat itself." Posting "Daily Nursing Hours" dated 1/06, instructed staff 1. The facility staffer, or designee will post the projected "Daily Nursing Hours" report for that day at the resident care Office by 8am M-F and 9a S-S."	F 356	nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. The posting of staffing information is the responsibility of the staffing coordinator or selected designee. Staffing, nurse leadership, nurse monitors and receptionist were all educated on the necessity of daily posting of staff information 12/30/15. The receptionist's checklist now includes checking for current day staffing information on the posting in order to maintain compliance. Audits are being conducted with oversight by the director of nursing and will continue for 3 months or until ongoing compliance is achieved. Audits will be reported and reviewed at the monthly QAPI meetings.	
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced	F 371		2/8/16

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F 371	Continued From page 13 by: Based on observation, interview, and document review, the facility failed to ensure safe and sanitary conditions for kitchen equipment that had direct contact with food preparation and storage. In addition, the facility failed to ensure hair restraints were worn to effectively keep hair from contacting exposed food. This had the potential to affect 122 of 122 residents in the facility who ate out of the kitchen. Findings include: During initial kitchen tour on 12/28/15, at 11:54 a.m. the dietary director (DD) the following was observed: - Hobart Stand up mixer was covered with plastic bag. When the bag was taken off, there was white hardened food splatter and heavy buildup of white/brown food debris around the bottom arm, backside and on and around the underside of the mixer. Food would come in contact with the debris. The DD verified the mixer needed to be cleaned, stating "it was probably used this weekend." On 12/28/15, at 5:30 p.m. during dinner meal service the following was observed: - The Two South six foot closed room tray cart had a heavy buildup of brown, white food splatter and debris on and around the inside tray holders and around the entire outside bottom of the unit and sides of the cart. The assistant dietary director (ADD) verified the cart was dirty and had staff wipe it down before filling it with the room service evening meal. DD verified the cart needed cleaning,"it is supposed to be wiped down	F 371	The facility (1) Procures food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Stores, prepares, distributes and serves food under sanitary conditions. All kitchen staff were educated by 12/29/15 regarding the requirements to wear hair restraints and proper use of the hand sink. The dietary team has redeveloped and implemented daily staff cleaning check lists which includes cleaning of the Hobart mixer, cleaning of room tray carts (including the 2 South 6-foot closed room tray cart), cleaning of the red dish racks, cleaning of the Robocoupe mixer, cleaning of soup kettle and covering of soup kettles. The dietary supervisor has developed implemented a supervisory checklist which includes: hair restraint use, inspection of cleanliness for the Hobart mixer, cleanliness of room tray carts, proper use of the hand sink, cleanliness of red dish racks, cleanliness of Robocoupe mixer, cleanliness of soup kettles and proper covering of kettles. Audits are being conducted by the Dietary manager and will continue for 3 months or until ongoing compliance is achieved. Audit results will be reviewed at the facility QAPI meeting.	

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F 371	Continued From page 14 after each meal." Food would come in contact with the debris. During followup kitchen tour on 12/29/15, at 2:05 p.m. with the registered dietitian (RD) the following was observed: - On entering the dishwashing area, a dish rack was observed to be sitting on the top of the employee hand sink. Red dish racks with cutout/indentation areas on the sides of racks had a build up of food debris in the cutout areas. After three continuous cycles of wash/rinse cycles this food debris was softened and easily removed with a paper towel. RD verified the racks were not clean and instructed the aides to remove all red racks. Clean dishes would have come in contact the leftover food debris that was present prior to the three cycles of washing. During an interview on 12/28/15, at 4:40 p.m. DD stated staff have specific duties for each position and there was a supervisor checklist but cleaning "was not being done, probably not for the past six months, the supervisor checkoff list is empty." Review of Ebenezer Care Center daily cooks cleaning and task schedule with revision date 1/14/13 indicated to "clean and sanitize Robo Coupe, mixer, soup kettle and cover if used" and to initial the assigned cleaning duties after they have been completed. There was no indication that cleaning had been completed. Review of undated Ebenezer Care Center dietary aide daily cleaning/task schedule, position four included "clean and sanitize all carts, including tall bus cart." There was no indication that cleaning had been completed.	F 371		

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F 431	Continued From page 15	F 431		
F 431 SS=E	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by:	F 431		2/8/16

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F 431	Continued From page 16 Based on observation, interview, and document review, facility failed to ensure medications were stored at the proper temperature for 13 residents (R40, R95, R101, R123, R60, R69, R7, R132, R23, R74, R38, R104, R59, R54) who received refrigerated insulins and eye drops. In addition, the facility failed to ensure that fentanyl patches were properly destroyed for 3 of 3 residents (R27, R24, R48) to prevent diversion. Findings include: Second North: During tour looking at medication storage on the second north unit on 12/28/15, at 2:00 p.m. licensed practical nurse (LPN)-A verified the temperature of the refrigerator was 52 degrees. LPN-A stated the listed medications were stored in the refrigerator and the medications were to be stored between 30 to 40 degrees. -12 Lantus Solostar Pens (used to control blood sugar) total for R40, R95, R123, -Six Novolog FlexPens (used to control blood sugar) total for R40, and R95, -Three Humalog KwikPen (used to control blood sugar) for R101 and, -Two bottles latanoprost (reducing intraocular pressure in patients with open-angle glaucoma) solution 0.005% for R60. For the facility, the medications were: -20 prefilled influenza vaccine syringes -Fluzone High dose and, -One vial influenza dated open 11/25/15, verified by registered nurse (RN)-D. During interview on 12/28/15, at 2:15 p.m. dietary manager stated "the fridge is not working." Temperature of 66 degrees verified by dietary manager using digital probe.	F 431	The facility obtains the services of a licensed pharmacist who has a system of records of receipt and disposition of all controlled drugs in sufficient detail which enables an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility stores all drugs and biologicals in locked compartments under proper temperature controls, and permits only authorized personnel to have access to the keys. The facility provides separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. New thermometers were ordered and placed in refrigerators 2-north and 3-north. Maintenance director verified all refrigerators to be properly functioning/operating order and	

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F 431	Continued From page 17 On 12/28/15, at 4:30 p.m. RN-D verified there was no record of daily temps. RN-D stated dietary was supposed to check the temperature and it was not done. Third North: During tour looking at medication storage on the third north unit on 12/28/15, at 3:10 p.m. RN-G verified the temperature of the refrigerator was 56 degrees. RN-G stated the listed medications were stored in the refrigerator and that the medications were to be stored between 30 to 40 degrees: -14 Lantus Solostar Pens total for R69, R7, R23, R74, -Three vials of Lantus for R38, -One Novolog FlexPens total for R69, -One vial of Novolog for R38, -11 Humalog KwikPen total for R7, and R23, -One prefilled Prevenar (a pneumococcal vaccine) 13 for R132 and, -Four-30 ml bottles of lorazepam (used for anxiety-Ativan) 2mg/ml total for R54, R59, and R104. On 12/28/15, at 3:15 p.m. it was observed four bottles of lorazepam were locked in a red box attached to the shelf in the refrigerator. The shelf was not attached to the refrigerator and slid out when pulled on. RN-E verified "anyone could walk away with it." RN-E verified the last time the temperature was checked was 12/26/15, and the temperature at that time was 46 degrees. Fentanyl Patches Second Floor North: On 12/29/15, at 9:15 a.m. a tour of the medication cart was completed with RN-H. During the tour inside the narcotic box was observed an	F 431	maintaining proper temperatures. 12/28/15. Nursing staff is required to check refrigerator temps daily. All nursing was educated as to this requirement by 1/22/16. All medications from the refrigerators on 2-north and 3-north were removed, destroyed and ordered for replacement on 12/28/15. This protected all residents on the floors including (R40, R95, R101, R123, R60, R69, R7, R132, R23, R74, R38, R104, R59, R54) New refrigerators were ordered specifically for refrigerated medication and refrigerated narcotic storage and will be placed on units. Until these refrigerators are placed and put to use, all refrigerated narcotic medications are properly locked and stored in an existing double-locked refrigerator. Fentanyl Patches: RN-H and LPN-B have been educated as to the requirements of proper destruction of Fentanyl patches and the requirement for double signatures for administration of narcotics. All nursing staff were educated on proper destruction of Fentanyl patches and for double signature requirements for wasting of Fentanyl patches by 1/22/16. Audits are being conducted with oversight	

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F 431	Continued From page 18 opened box of Fentanyl patches for R27. When asked what the facility policy was for disposing used patches RN-H stated, they change the Fentanyl patches at night and one nurse signs them out in the computer. RN-H verified the narcotic book only had signatures for application and none for destruction. Review of Medication Administration Records (MAR) from September to December 2015 indicated only one staff member signed for removal of Fentanyl patch. During review of R27's narcotic book record, from 12/21/15 to 12/27/15, it was revealed R27 had received the Fentanyl patch three times, each of which only one nurse had documented the destruction. First Floor South: On 12/29/15, at 8:00 a.m. a tour of the medication cart was completed. LPN-B verified R48's Fentanyl patch had not been double signed by two nurses when removed. LPN-B stated when a Fentanyl patch was removed two people are to sign it out in the narcotic book and fold it in half and put it in the sharps container. Review of MAR from September to December 2015 indicated only one staff member signed for removal of Fentanyl patch. During review of R48's narcotic book record, from 12/13/15 to 12/28/15, it was revealed R48 had received the Fentanyl patch six times, each of which only one nurse had documented the destruction. R24's Order Summary Report printed 12/30/15, indicated R24 had an order for Fentanyl patch 50mcg/hour (hr apply every 72 hours. Review of MAR from September to December 2015 indicated only one staff member signed for removal of Fentanyl patch. During review of R24's narcotic book record, from 12/13/15 to 12/28/15,	F 431	by the director of nursing and will continue for 3 months or until ongoing compliance is achieved. Audit results will be reviewed at the facility QAPI meeting.	

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F 431	Continued From page 19 it was revealed R48 had received the Fentanyl patch seven times, each of which only one nurse had documented the destruction During interview on 12/29/15, at 10:16 a.m. RN-D said, "Only one person signs for removal of the fentanyl patch and they do it on the MAR." During interview on 12/29/15 at 3:28 p.m. the director of nurses (DON) said, the nurses are to fold and cut the Fentanyl patch and put it in the sharps container. They sign it in the MAR for removal and replacement. According to our policy we ask for two signatures, because it is a narcotic that is highly abused. The said the temperature in the refrigerator should be no warmer than 40 degrees. The housekeepers do a log daily and notify the nurses if the temperature was out of the ranges. "Nursing should be checking the logs to ensure the temperatures are in range. Narcotics are expected to be under double lock. That would include Ativan in the third floor fridge. They [nurses] are to date multiuse vials when they open." The DON indicated 17 nurses, 25 nursing assistants, three housekeepers and six dietary staff have access to the refrigerators where medications are stored. During interview on 12/29/15, at 4:00 p.m. environmental service director stated the housekeepers only check the temperatures of the refrigerators on Tuesdays. Storage of Medications-Long Term Care reviewed 12/2014 instructed staff: "XI. Medications requiring "refrigeration or "temperature between 2 [degree] C [Celsius -36 degrees Fahrenheit (F)] and 8 C [46 degrees F]" are kept in a refrigerator with a thermometer to	F 431		

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F 431	Continued From page 20 allow temperature monitoring. Medications requiring storage in a cool place are refrigerated unless otherwise directed on the label. Controlled substances that require refrigeration are stored within a locked box within the refrigerator. This box must be attached to the inside of the refrigerator." Controlled Substance Disposal-Long Term Care reviewed October 2014, instructed staff: "III. When a Fentanyl patch needs to be removed/replaced the following procedures should be followed for proper destruction of the used patch...F. Documentation of disposal must be signed by person disposing of used patch, along with witness (licensed staff) on drug destruction log sheet or narcotic book."	F 431		
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program	F 441		2/8/16

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F 441	Continued From page 21 determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure the standard the shared razor(s) was disinfected, this had the potential to affect 12 residents (R14, R28, R32, R43, R47, R52, R54, R58, R59, R85, R96, R131). In addition, the facility failed to ensure glucometers were cleaned properly for 2 of 2 residents (R138, R45) who had blood sugar checks to prevent the spread of blood borne infection. This had the potential to affect 23 residents who have a glucometer check. Findings include: On 12/30/15, at 8:30 a.m. electric razors were noted in the 3 south nursing station window seal. # 1. Remington electric razor that was in pieces. # 2. Phillips Norelco (blue handle) that had a	F 441	The facility has established and maintained an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. All razors are currently disinfected between different resident uses. New razors have been ordered for each resident requiring shaving which will allow for no-longer needing residents to share electric razors. Razors will still be properly maintained for infection control purposes. This includes razors for (R14, R28, R32, R43, R47, R52, R54, R58, R59, R85, R96, R131).	

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F 441	Continued From page 22 razor head with debris inside. Registered nurse (RN)-B stated that they were shared razors for the entire floor, except for the people who can use it themselves and have their own razor. The residents that we shave use that one, but staff are supposed to clean it in between and we wash it down and have multiple heads [to change out]. RN-B was aware of disease that could be spread by microscopic blood particles and stated that was why we use alcohol to wash it down. -At 9:30 the director of nursing (DON) stated expect the razors to be cleaned between residents, according to policy -at 9:40 nursing assistant (NA)-D on 3 south, demonstrated cleaning of razor, disassembled, cleaned with water and brush, soap and water, stated "dries it" (and demonstrated rubbing it dry with paper towels), then cleans with alcohol swab. NA-D stated he had not shaved anyone today, but had shaved R28 with the razor yesterday morning, and had left it to dry on the window sill (in pieces). He had not used the blue Norelco razor and could not say who had used it last. -At 10:00 the infection control nurse stated the shared razors were cleaned, and then cleaned with alcohol, then further stated we do have stronger wipes that could be used, like on the glucometers [PDA sanitizing wipes]. -At 11:30 NA-A stated that he had not shaved anyone that day, and did not know when he had last used the Blue Norelco razor. -At 1:00 R25 stated he had his own electric razor and had considered purchasing another, because he "would never share a razor." -At 1:05 R98 stated he used the shared razor on 1st floor. -At 1:10 R32 verified the use of a shared razor -At 109, R47 verified the use of a shared razor. -At 1:30 p.m. R54's sister verified use of the	F 441	All nurses including RN-I and RN-J were educated on proper infection control practices regarding glucometers by 1/22/16. All nurses and nursing assistants including RN-B, NA-D and NA-A were trained on proper disinfection of razors by 1/29/16. This training included demonstrations by the participants to ensure a thorough understanding. Audits are being conducted with oversight by the director of nursing and will continue for 3 months or until ongoing compliance is achieved. Audit results will be reviewed and reported at the facility QAPI meeting.	

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F 441	Continued From page 23 shared electric razor Of the 24 residents on the unit, 14 residents were shaved 2 own razors, and 12 used the shared razors. R14 was admitted to the facility on 9/17/12, with admission diagnoses of vascular dementia with behavioral disorder, stroke and hemiplegia (loss of use of 1 side of body) per the Admission Record. The nursing assistant care sheet printed on 12/30/15, directed assist of one with all personal hygiene including shaving. R28 was admitted to the facility on 3/3/14, with admission diagnoses of dementia, allergic rhinitis and major depression per the Admission Record. The nursing assistant care sheet printed on 12/30/15, directed staff to physically assist with shaving as needed. R32 was admitted to the facility on 7/10/14, with admission diagnoses of dementia, rheumatoid arthritis, and type II diabetes per the Admission Record. The nursing assistant care sheet printed on 12/30/15, directed assist of one with all personal hygiene including shaving as needed. R32 verified that she was shaved with the shared electric razor. R43 was admitted to the facility on 11/4/14, with admission diagnoses of dementia with behavioral disorder, anxiety disorder, and hypertension (high blood pressure) per the Admission Record. The nursing assistant care sheet printed on 12/30/15, directed assist of one with all personal hygiene including shaving. R47 was admitted to the facility on 9/23/15, with	F 441		

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	245587	A. BUILDING _____ B. WING _____	12/30/2015

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admission diagnoses of COPD (lung disease), kidney disease and high blood pressure per the Admission Record. The nursing assistant care sheet printed on 12/30/15, directed: assist of one with all personal hygiene including shaving. R47 verified use of the shared electric razor.

R54 was admitted to the facility on 8/5/12, with admission diagnoses of dementia with behavioral disorder and major depression per the Admission Record. The nursing assistant care sheet printed on 12/30/15, directed staff to physically assist with grooming and shave resident as needed. R54's sister verified the use of the shared razor.

R58 was admitted to the facility on 5/11/06, with admission diagnoses of schizophrenia, major depression, and vitamin D deficiency per the Admission Record. The nursing assistant care sheet printed on 12/30/15, directed: staff assist of one with all grooming tasks including shaving as needed.

R59 was admitted to the facility on 11/2/09, with admission diagnoses of dementia, Alzheimer's disease and dysphagia (difficulty swallowing) per the Admission Record. The nursing assistant care sheet printed on 12/30/15, directed staff to assist of one with grooming. On 12/30/15, at 9:00 a.m. RN-B stated sometimes assist of one with grooming indicated shaving as well.

R85 was admitted to the facility on 1/6/09, with admission diagnoses of vascular dementia with behavioral disturbances, lung disease, rash and other skin disorders per the Admission Record. The nursing assistant care sheet printed on 12/30/15, directed: assist of one with all personal hygiene including shaving.

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R96 was admitted to the facility on 10/17/12, with admission diagnoses of Parkinson's disease, dementia, and seborrhea dermatitis per the Admission Record. The nursing assistant care sheet printed on 12/30/15, indicated R96 received physical assist with grooming.

R98 was admitted to the facility on 3/19/10, with admission diagnoses of dementia, cardiomyopathy and tachycardia per the Admission Record. The nursing assistant care sheet printed on 12/30/15, indicated independent with grooming, assist of one as needed, and special care with grooming due to risk of infection related to cardiomyopathy. R98 verified he used a shared razor on the 1st floor.

R131 was admitted to the facility on 4/8/15, with admission diagnoses of dementia with behavioral disturbance, insomnia and vitamin D deficiency per the Admission Record. The nursing assistant care sheet directed: assist of one with all personal hygiene including shaving.

A razor disinfecting policy was requested but not provided.

R138's quarterly MDS dated 10/22/15, indicated R139 had a diagnosis of diabetes and received insulin daily.

During observation of glucometer (a machine used to check blood sugars) check on 12/28/15, at 5:23 p.m. RN-I brought R138 to room and placed glucometer on the bedside table. RN-I put on gloves and cleaned R138's finger. RN-I obtained a drop of blood, put it on the strip, removed gloves, removed strip and threw strip

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and lancet in a cup and disposed of the contents of the cup in the sharps container. RN-I placed barrier on medication cart and wiped glucometer off with a PDI Sani-Cloth AF for 40 seconds, then placed the glucometer in plastic carrier case.

During an interview on 12/28/15, at 5:30 p.m. RN-I said, "What is the difference if I put it on the cart to dry or back in the container? I won't use it for at least three minutes, until it is dry. I scrubbed it and then placed it in the container." This was how the facility taught us to clean the glucometer.

R45's quarterly MDS dated 11/25/15, indicated R45 had a diagnosis of diabetes and received insulin daily.

During medication administration observation on 12/30/15, at 7:27 a.m. RN-J entered R45's room and set plastic carrying case on bedside table without a barrier. RN-J performed blood sugar check-wiped finger, obtained drop of blood, tested blood. RN-J showed results to R45, removed test strip and placed glucometer in carry case on top of five insulin FlexPens and put carrying case in medication cart. When RN-J was asked when planned on disinfecting the glucometer, RN-J responded that the night shift cleans them. RN-J stated, "I will wipe it off with an alcohol wipe before I use it. Asked RN-J if the glucometer needed to disinfect it now. RN-J said no it was fine to wait until need to use it again and that it was ok to have it touching the pens because they have covers on. RN-J went to give a resident a medication. The medication cart was kept under observation until 7:43 a.m. when RN-J returned and surveyor had to intervene and request glucometer be disinfected. RN-J agreed

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to do so. RN-J removed glucometer from carrying case where it was sitting on five insulin pens and wiped the glucometer off with a PDI Sani-Cloth AF wipe. RN-J immediately placed the glucometer on the top of the medication cart. Glucometer was dry in less than one minute. RN-J stated, "I have to wait three minutes before I can put it in the case." Asked RN-J how long the glucometer was to remain wet with disinfectant. RN-J said, " I just need to wipe and air dry. It does not have to be visible wet. " RN-J was asked to view the instructions on the PDI Sani-Cloth AF wipe. The package instruction stated that it must remain visible wet for three minutes.

During interview on 12/30/15, at 8:00 a.m. the infection control nurse stated glucometers are to be immediately wiped down by the nurse using it with a sani wipe using a three minute wet time. The glucometer is then placed in the carrier case. The infection control nurse verified it was not ok to wipe with alcohol pad as it did not disinfect against blood borne pathogens. The infection control nurse verified it was not ok to have the night shift nurse do the disinfecting.

During interview on 12/29/15, at 3:28 p.m. the director of nurses (DON) stated the nurses were to disinfect the glucometers using the PDI wipes according to the direction on the wipe.

Cleaning/Disinfecting Blood Glucose Monitor and INR Machine revised 7/12, instructed staff:
"The Blood Glucose Monitor/INR machine will be cleaned/disinfected after each use with appropriate cleaner to prevent the spread of blood borne pathogens.
1. Gather your equipment.

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F 441	Continued From page 28 2. Place the 2 paper towels (one on top of the other) on the bedside table to create a barrier between the table and the equipment. 3. After using the diagnostic equipment, wearing disposable gloves, machine will be disinfected using the appropriate cleaner wipes at point of service. 4. If the machine is visibly soiled with blood or body fluids clean the machine twice; use one cloth to cleanse the soiled area and one cloth to disinfect the machine. NOTE: This is to be done before taking the machine out to the nurse's cart. 5. Using the top paper towel, carry diagnostic equipment out to the nurse's cart to continue drying. Remove gloves and wash hands. The nurse will monitor the machine for continuous wet contact time and put on gloves and re-wipe if necessary. NOTE: The treated surface must remain visible wet for a full two minutes or as directed by manufacturer. Use additional wipes as needed to assure wet contact time. Let air dry." PDI Sani-Cloth AF Germicidal Disposable wipe undated, instructed users: TO DISINFECT: " Use a wipe to remove heavy soil. Unfold a clean wipe and thoroughly wet surface. Treated surface must remain visibly wet for a full three (3) minutes. Use additional wipe(s) if needed to ensure continuous 3 minute wet contact time. "	F 441		
F 465 SS=D	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for	F 465		2/8/16

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F 465	Continued From page 29 residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observations, interview, and document review, the facility failed to ensure a safe , functional and sanitary environment for 2 of 2 residents (R11, R53) reviewed for environmental concerns. In addition, the facility failed to ensure safe and sanitary conditions for kitchen equipment that had direct contact with food preparation and storage. This had the potential to affect 122 of 122 residents in the facility who ate out of the kitchen. Findings include: On 12/30/15, at 11:47 a.m. to 12:34 p.m. an environment tour was conducted with the environmental service director (ESD) and the supervisor for housekeeping and laundry (SHK) and during the following were reviewed. R11's bathroom on 12/28/15, at 3:21 p.m. during room observations the wall to the left of a grab bar on the left side of the sink was observed with holes into the wall sheetrock which appeared was due to installing new grab bar but was never sanded down or filled. In addition the right grab bar next to the toilet was observed with a blue dysom secured with blue peeling tape which exposed the adhesive part hanging off it, was soiled and was not a cleanable surface On 12/30/15, at 11:51 a.m. ESD verified stated the holes were from replacing a grab bar and had not been finished off. ESD acknowledged the wall had holes/groves in the sheetrock did create a	F 465	The facility provides a safe, functional, sanitary, and comfortable environment for residents, staff and the public. The holes in the sheetrock in R11's room were patched and painted on 12/28/15. The Blue Dysom and Blue Tape was removed on 12/28/15. The foot grips identified were removed on 12/30/15. Environmental services staff were educated on identifying and reporting non-cleanable surfaces on 12/31/15. A housewide audit was conducted on 1/23/16 for identifying non-cleanable surfaces. All findings are entered in to the CMMS (work-order) system to be completed no later than 2/8/16. An inspection for non-cleanable services has been added to the supervising housekeeper deep-cleaning inspection schedule. Any findings will be entered into the CMMS system for repair. A housewide audit of foot grips was completed on 1/23/16.Findings are entered into the CMMS program for completion by 2/8/16. Environemental services staff were educated on foot grips/cleanable surfaces on 12/31/15.	

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F 465	Continued From page 30 rough surface. ESD verified the peeling tape and acknowledged was not a cleanable surface. ESD stated he would replace it with a textured grab bar. At 12:37 p.m. when asked how often the staff cleaned the rooms the supervisor for housekeeping and laundry stated rooms were cleaned daily. Both her and ESD stated even though the staff cleaned the rooms daily it would have been difficult to see the peeling tape on the grab bar as it was the same color as the plastic cloth it was securing. The supervisor for housekeeping and laundry stated the facility did not have a policy on cleaning such surfaces. Foot Grip R53's floor by the bed was observed with peeling off black foot grips. When asked about the foot grips R53 stated she had assumed they had put there for a purpose but thought did not look good. On 12/30/15, at 12:09 p.m. ESD and the supervisor for housekeeping verified the foot grip was peeling off the floor and was not a cleanable surface. ESD stated to R53 he would remove it and replaced. The supervisor for housekeeping and laundry stated staff were supposed to alert the maintenance staff of any concerns and would be followed up. On 12/30/15, at 3:35 p.m. ESD stated the facility did not have a specific policy to the concerns identified and indicated the staff were supposed to report and a work order would be initiated for his department to address. Kitchen	F 465	An inspection of foot grips has been added to the supervising housekeeper deep cleaning inspection schedule. Audits are in place with oversight by the Maintenance Director. Audits will continue for 3 months or until ongoing compliance is achieved. Audit results will be reviewed at the facility QAPI meeting. The clean dish area including the window sills was thoroughly cleaned on 12/29/15. The dirty dish area table was thoroughly cleaned including the table, table legs, wall and floor. The table caulking was removed and the floor drain was replaced on 12/29/15. The soup kettle, piping, wall, flooring, perimeter baseboards and walk in cooler door handle were all thoroughly cleaned 12/30/15. The dietary team has redeveloped and implemented a daily staff cleaning check list. This includes cleaning of the dish areas, the soup kettle area, cooler door handle and the perimeter baseboards around the legs of equipment. The dietary supervisor check list has been developed and implemented to monitor for compliance this includes the dish areas, the soup kettle area, cooler door handle and the perimeter baseboards around the legs of equipment. Audits are being conducted with oversight	

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F 465	Continued From page 31 On 12/28/15, at 11:54 a.m. during the initial kitchen tour with the dietary director (DD) the following was observed: - the clean dish area contained an eight foot stainless steel table situated to the left of the high temperature one compartment dishwasher situated in a corner of the kitchen. Directly above this clean dish area, there were two, three foot by four foot windows with an eight inch wide window sill below them. Both the windows and sill were dirty and splattered with food particles. There was a build up of food debris along the back of and in the corners of the window sill. To the right of the dishwasher in the dirty dish area was another eight foot stainless steel table with white caulking where the table meets the wall. Approximately four feet of this caulking was black with a mold type substance. The wall behind the entire length of the table was heavily splattered with a brown substance and food particles. On and around all table legs and where the wall meets the floor there was a grimy, brown/black buildup of food debris. The top of the floor drain was missing below the dishwasher where water drained into the floor. DD verified the area was dirty, needed to be cleaned and the black caulking most likely was mold and needed to be removed and replaced by maintenance. On 12/29/15, at 2:05 p.m. during a second tour of the kitchen the following was observed and verified by the DD: - Behind the soup kettle, the piping, wall and flooring had a heavy black/brown greasy substance. Behind the same soup kettle and to the right of the walk in cooler door an approximate two inch wide by three feet in long	F 465	by the dietary manager with respect to kitchen sanitation. Audits conducted in resident spaces are overseen by the maintenance director. Audits will continue for 3 months or until ongoing compliance is achieved. Audits will be reviewed at the QAPI meeting.	

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white molding strip was heavily soiled with a brown, sticky substance. The walk in cooler door stainless steel handle was heavily soiled with brown/black substance.

- Around the entire perimeter of the kitchen along the baseboards and on and around all legs of equipment there was a heavy buildup of black/brown grime and food debris.

During an interview on 12/28/2015, at 4:40 p.m. DD stated kitchen staff have specific duties for each position and there is a supervisor checklist but cleaning "was not being done, probably not for the past six months, the supervisor check off list is empty."

During an interview on 12/29/15, at 2:20 p.m. the cook and DD stated the floor are cleaned every night and that maintenance was in charge of deep cleaning the floors and behind all equipment.

During an interview on 12/29/15, at 3:30 p.m. registered dietitian stated there was no deep cleaning policy for the kitchen.

During an interview on 12/29/15, at 3:45 p.m. the administrator stated the floors were last deep cleaned in September and due to be cleaned in December. Administrator further stated, "I would have liked it cleaned before this."

During an interview on 12/29/15, at 4:00 p.m. the environmental service director stated housekeeping was responsible for cleaning the ceilings, walls and floors in the kitchen and verified the perimeter of the kitchen was dirty and needed cleaning.

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F 465	Continued From page 33 Review of the "Ebenezer Care Center dietary aide daily cleaning & task schedule, positions 9-5" revised 2/14/15 included that all shelves and tables on clean side be cleaned and sanitized, floors swept and moped in dish room, walls cleaned on dirty side, both by tables and opposite wall, all racks off floor at all times and floor carts be cleaned and set up for evening. There was no indication that these cleaning tasks had been completed. Review of the undated facility cleaning schedule indicated "tile and ceramic floor needs to be thoroughly scrubbed. Kitchen duties should be clean every two/three months. After task is completed date and sign off." The schedule indicated the kitchen ceiling and walls had been cleaned 11/6/15, and the "kitchen/front of coffee maker/ceramic floor scrub" had been cleaned 9/15.	F 465		

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	245587	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**12/29/2015**

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K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, Fire marshal Division on December 29, 2015. At the time of this survey, Ebenezer Care Center (Builidng 1) was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES TO: Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		01/25/2016

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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EBENEZER CARE CENTER	**2545 PORTLAND AVENUE SOUTH** **MINNEAPOLIS, MN 55404**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	Continued From page 1 By email to: Marian.Whitney@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. Ebenezer Care Center is a 3-story building with a full basement. The building was constructed at 3 different times. The original building was constructed in 1919 and was determined to be of Type III(200) construction. In 1924, an addition was constructed to the North side of the building that was determined to be of Type III(200) construction. In 1928, another addition was constructed to the South side of the building that was determined to be of Type III(200) construction. Because the original building and the 2 additions to this builidng are all of the same construction type, even though the Type III(200) construction type does not meet the code for existing buildings, this building was surveyed as one building, but the entire facility was surveyed as two buildings under two booklets. The building has a complete fire sprinkler system throughout. The facility has a complete fire alarm system with smoke detection in the corridors and	K 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245587	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**12/29/2015**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EBENEZER CARE CENTER	**2545 PORTLAND AVENUE SOUTH** **MINNEAPOLIS, MN 55404**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	Continued From page 2 spaces open to the corridor, that is monitored for automatic fire department notification. The facility has a licensed capacity of 127 beds and had a census of 121 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 012 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD 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 This STANDARD is not met as evidenced by: Based on observation and interview, this building does not meet the requirement for construction type and height. This deficient practice could affect all residents. Findings include: On facility tour between 9:30 AM and 1:30 PM on 12/29/2015, observation revealed that this 3-story, wood frame facility of Type III(200) construction does not meet the minimum construction requirements for a building of this height. This deficient practice was verified by the Maintenance Supervisor at the time of the inspection. Note: This deficiency need not be corrected if an FSES can establish that the facility has an overall level of fire safety equivalent to that required by	K 012	The facility has achieved a passing FSES score to remedy this deficiency.	2/8/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245587	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**12/29/2015**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EBENEZER CARE CENTER	**2545 PORTLAND AVENUE SOUTH MINNEAPOLIS, MN 55404**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 012	Continued From page 3 the Life Safety Code.	K 012		
K 038 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to provide means of egress in accordance with the following requirements of 2000 NFPA 101, Section 7.2.1.5.4. The deficient practice could affect all residents. Findings include: On facility tour between 9:30 AM and 1:30 PM on 12/29/2015, observation revealed that the south stairway doors on the second and third floors swing against the path of egress travel. These deficient practices were verified by the Maintenace Supervisor at the time of the inspection. Note: This deficiency need not be corrected if an FSES can establish that the facility has an overall level of fire safety equivalent to that required by the Life Safety Code.	K 038	The facilitiy has achieved a passing FSES score to remedy this deficiency.	1/13/16
K 040 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD 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. 19.2.3.5	K 040		1/13/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245587	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**12/29/2015**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EBENEZER CARE CENTER	**2545 PORTLAND AVENUE SOUTH** **MINNEAPOLIS, MN 55404**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 040	Continued From page 4 This STANDARD is not met as evidenced by: Based on observation and interview, the resident room doors do not meet the 32-inch clear width requirement. This deficient practice could affect all residents. Findings include: On facility tour between 9:30 AM and 1:30 PM on 12/29/2015, observation revealed that the doors in the 1919 construction year building were found to be only 29-30 inches in clear width. This does not meet the 32-inch requirement for existing exit access doors. This deficient practice was verified by the Maintenance Supervisor at the time of the inspection. Note: This deficiency need not be corrected if an FSES can establish that the fire has an overall level of fire safety equivalent to that required by the Life Safety Code.	K 040	The facility has achieved a passing FSES score to remedy this deficiency.	

Report of Consultant FSES Findings

Ebenezer Care Center

2545 Portland Avenue South

Minneapolis, MN 55404

Provider No. 245587

Date of Survey: January 13, 2016

Prepared by:
Robert L. Imholte, President
Fire Safety Resources, LLC
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January 14, 2016

Joel G. Prevost
Administrator
Ebenezer Care Center
2545 Portland Avenue South
Minneapolis, Minnesota 55404

RE: FSES at Ebenezer Care Center

Dear Mr. Prevost:

Enclosed please find the survey information relating to the fire safety evaluation of Ebenezer Care Center, 2545 Portland Avenue South in Minneapolis conducted on 01/13/2016. This evaluation was conducted in accordance with the Fire Safety Evaluation System (FSES) specified in Chapter 4 of NFPA 101A(01), *Guide to Alternative Approaches to Life Safety*. As you're aware, the FSES is a rating system designed to evaluate the level of fire/life safety in health care facilities and serves as a method to demonstrate alternative compliance with the 2000 edition of the *Life Safety Code*® (NFPA 101). An FSES was made necessary in this case because of deficiencies cited against the facility relating to:

- K012 – Construction type and height,
- K038 – Stairway door swing, and
- K040 – Resident room door width.

Ebenezer Care Center consists of two buildings: Building 01 – Main Building (consisting of the 1919 original building and 1924 and 1928 additions) and Building 02 – 1952 addition. Buildings 01 and 02 are separated by construction having a fire resistance rating of at least 2 hours. Because the deficiencies that triggered the FSES were cited in Building 01 (Main Building), this FSES covers that building only. The following factors served as the basis for this evaluation:

- Because the original building and additions were constructed prior to 03/11/2003, Ebenezer Care Center Building 01 (Main Building) was considered an existing building.
- Ebenezer Care Center Building 01 (Main Building) is three stories in height and has three separate unoccupied attics and a full basement. For purposes of this FSES, the four occupied building levels were divided into eleven (11) separate smoke zones.
- For purposes of this FSES, it was assumed that the basement level of the 1928 addition does not involve resident housing, treatment or customary access.

Based on conditions found during the 01/13/2016 on-site visit, all four parameters in Table 7 of the FSES worksheets, ZONE FIRE SAFETY EQUIVALENCY EVALUATION, in all eleven (11) zones evaluated were found to have a score of zero or greater. *Fire Safety Resources* finds, therefore, that Ebenezer Care Center has achieved a passing FSES score.

Wishing you a safe day!

Robert L. Imholte

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

Enclosures
RLI/rli

FIRE SAFETY EVALUATION

Name of Facility: Ebenezer Care Center
Address: 2545 Portland Avenue South, Minneapolis, MN 55404
Phone: 612-879-2262
Licensed capacity: 127
Census at time of survey: 120

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

What follows is a report on the findings of a fire safety evaluation of the above-named facility that was conducted during an on-site visit to the facility between 0850 hours and 1530 hours on 01/13/2016. This evaluation was conducted in accordance with the Fire Safety Evaluation System (FSES) specified in Chapter 4 of NFPA 101A(01), *Guide to Alternative Approaches to Life Safety*. Based on this evaluation, Ebenezer Care Center has achieved a passing score on the FSES.

In addition to the 01/13/2016 tour of the facility, the findings outlined herein are based on:

- Information provided by Mr. Joel Prevost, Administrator, and Mr. Jason (Jay) Hill, Environmental Services Director, and
- A review of the Draft Statement of Deficiencies from a fire/life safety recertification survey conducted on 12/29/2015.

Initial Comments:
Ebenezer Care Center consists of two buildings: Building 01 – Main Building (consisting of the 1919 original building and 1924 and 1928 additions) and Building 02 – 1952 addition. Buildings 01 and 02 are separated by construction having a fire resistance rating of at least 2 hours. Because the deficiencies that triggered the FSES were cited in Building 01 (Main Building), this FSES covers that building only.

At the east end of the building's South Wing the nursing home is connected to a business occupancy called the Annex. At the west end of the basement level of the North Wing there is a connection to an adjacent apartment building. Because neither the Annex nor the apartment building is used for purposes of housing, treatment or customary access by the facility's residents and because both are separated from the nursing home by 2-hour-rated fire barriers, those buildings were not included in this evaluation.

Building 01 (Main Building) was determined to be of Type III(200) construction based on the following:

a. The original (Center) building was constructed in 1919 as a 3-story building with an attic and basement. This portion of the facility, constructed of masonry exterior bearing walls and wood floor/ceiling and roof assemblies was assigned a Type III(200) construction type in accordance with NFPA 220(99), Sec. 3-3 and Table 3-1 (while the floor/ceiling assemblies on the upper levels are protected by gypsum wallboard/plaster on wire mesh, the basement ceiling is of exposed wood joist construction).
b. In 1924 a 3-story addition with an attic and basement was constructed to the north. Building construction was determined to be identical to that of the original (Center) building and was, therefore, assigned a construction type of Type III(200). In 1992 a new elevator, housed in a noncombustible shaft, was added to the north side of this wing.
c. In 1928 a 3-story addition with an attic and basement was constructed to the south. Again, building construction was determined to be identical to that of the original (Center) building and assigned a construction type of Type III(200).

Because the original building and additions were constructed prior to 03/11/2003, Ebenezer Care Center Building 01 (Main Building) is considered an existing building for federal certification purposes. The building was, therefore, treated as such for assigning values on the FSES worksheets.

Building 01 (Main Building) is three stories in height and has three separate attic spaces and a full basement. The attic spaces were found to be vacant and unoccupied and are protected by automatic sprinklers. The facility's residents are not allowed on this level. As allowed by NFPA 101A(01), Sec. 4.3.2(4)c, therefore, the attic level was not included in this evaluation. The facility has implemented the following measures to ensure that the attic spaces remain vacant and unoccupied:

- Facility staff has been notified that no storage is allowed in the attic areas
- The attic access doors are kept locked to restrict access to authorized personnel only
- Signage has been placed on all attic doors stating : "Authorized Personnel Only"
- Maintenance personnel tour the attics quarterly to ensure they remain empty and unused

The building is protected throughout by a supervised, wet-pipe automatic sprinkler system consisting of quick-response sprinklers. Based on documentation review, the system is being inspected, tested and maintained in accordance with NFPA 25.

The facility has an addressable manual fire alarm system, which is monitored for automatic fire department notification. There is automatic smoke detection in the corridors and spaces open to the corridors and automatic heat detection in selected areas. Based on documentation review, the fire alarm system and automatic detectors are being inspected, tested and maintained in accordance with NFPA 72.

Building 01 (Main Building) is subdivided by fire barrier walls as follows:

- The original (Center) building is separated from the South Wing by a 2-hour-rated fire barrier.
- There are also 2-hour-rated fire barriers between the original (Center) building and the North Wing on the 2nd and 3rd floors.

For purposes of this FSES, the various building levels in Building 01 (Main Building) were divided into eleven (11) separate smoke zones as follows:

Zone 1 – Basement Center/North
Zone 2 – Basement South
Zone 3 – First Floor Center
Zone 4 – First Floor North
Zone 5 – First Floor South
Zone 6 – Second Floor Center
Zone 7 – Second Floor North
Zone 8 – Second Floor South
Zone 9 – Third Floor Center
Zone 10 – Third Floor North
Zone 11 – Third Floor South

This report is intended to serve as an explanation of the scores entered on Tables 1, 4 and 8 of the FSES worksheets (i.e. Forms CMS-2786T) for the facility as it was found on 01/13/2016. The score assigned to each item is noted in brackets ([ ]). It must be noted that numbers were rounded to the nearest tenth of a point and that measurements of over one-half inch were rounded to the nearest inch. To ensure that the FSES addresses the "worst-case scenario", the product of the multiplication in Table 3B (i.e. value of "R") was rounded up to the nearest whole number. Code references are provided where appropriate. Codes referenced include the 2001 edition of NFPA 101A and the 2000 edition of the *Life Safety Code*® (NFPA 101).

With the exception of Table 8, which applies to all zones, this narrative will address each of the eleven (11) zones separately.

All Levels – TABLE 8. FACILITY FIRE SAFETY REQUIREMENTS WORKSHEET

In accordance with NFPA 101A(01), Sec. 4.7, Step 8, only one copy of this table is required to be filled out for each building. For convenience, however, this table was filled out on the worksheets for all zones evaluated. All items in Table 8 could be checked 'Met' with the exception of Items B and L, which were checked 'Not Applicable'. Because Ebenezer Care Center is an existing facility (Item B) and does not meet the definition of a high rise (Item L), these two items do not apply in this case. The remaining items were identified as 'Met' based on the following:

- Building utilities and heating and air conditioning systems appeared to be in conformance with NFPA 101(00), Sections 9.1 and 9.2.
- No incinerator or space heaters were found.
- The facility's evacuation plan and fire drill records were reviewed and appeared to be in order.
- The facility's smoking regulations were reviewed and appeared to be in order. Ebenezer Care Center is a smoke-free building.
- Based on review of documentation, draperies, cubicle curtains, upholstered furniture, mattresses and decorations were found to be in accordance with NFPA 101(00), Sec. 19.7.5.
- Portable fire extinguishers, EXIT signage and emergency lighting appeared to be provided in accordance with applicable requirements.

Zone 1 – Basement Level Center/North:

TABLE 1. OCCUPANY RISK PARAMETER FACTORS

1. Resident Mobility (*M*) [Value assigned = 3.2]: While there are no sleeping rooms in this zone, some residents in the zone may need assistance with evacuation.
2. Patient Density (*D*) [Value assigned = 1.0]: This level is used primarily for staff services, utilities and facility storage, but the corridor space from the north elevator to the 1952 addition (Building 02) located to the east is used on a regular basis during the day by facility residents to access the Beauty Shop and Adult Day Program located in the 1952 addition. It was reported that there are a maximum of four (4) residents in this zone at any one time.
3. Zone Location (*L*) [Value assigned = 1.6]: This zone is located below grade level.
4. Ratio of Patients to Attendants (*T*) [Value assigned = 1.0]: It was reported that there is one (1) staff person for each two (2) residents present in this zone.
5. Patient Average Age (*A*) [Value assigned = 1.2]: Residents using this zone average over 65 years of age.

TABLE 4. SAFETY PARAMETERS and SAFETY PARAMETER VALUES

1. Construction [Score: -4]:
   The building was assigned a Type III(200) construction type.
2. Interior Finish (Corridors and Exits) [Score: +3]:
   Documentation was provided certifying that the exposed wood in the ceiling in the corridors and spaces open to the corridor was treated with Flame Control No. 40-40A Fire Retardant Intumescent Paint to achieve a Class A (25 or less) flame spread rating.
3. Interior Finish (Rooms) [Score: -3]:
   No documentation was provided proving that the exposed wood in the ceiling in some of the rooms separated from the corridor had a flame spread rating of better than Class C.

4. Corridor Partitions/Walls [Score: +2]:
   The corridor walls are of constructed of brick and extend to the floor deck above.
5. Doors to Corridor [Score: +1]:
   Corridor doors were found to be a mixture of 1¾-inch-thick steel and 20-minute-rated construction.
6. Zone Dimensions [Score: 0]:
   According to past review of architectural drawings, this zone measures approximately 145 feet in length.
7. Vertical Openings [Score: 0]:
   - Openings into most of the stair enclosures were found to be protected with 90-minute fire-rated self-closing door assemblies. The self-closing door at the top of the stairway connecting the basement level to the 1st Floor kitchen, however, was found to be of 1¾-inch solid wood core construction, which provides a fire resistance of less than 1 hour.
   - The loading doors into the soiled linen chute on the upper floors were also found to be protected with 90-minute fire-rated self-closing door assemblies. The door assembly into the chute termination room was found to carry a 60-minute fire protection rating.
8. Hazardous Areas [Score: 0]:
   Hazardous areas were found to be sprinkler protected as required by NFPA 101A(01), Sec. 4.6.8.2 and smoke-separated as required by NFPA 101(00), Sec. 19.3.2.1.
9. Smoke Control [Score: 0]:
   A fire/smoke barrier serves this zone.
10. Emergency Movement Routes [Score: -2]:
    There are multiple distinctly separated movement routes from this zone, three of which are horizontal exits. However, because of utility piping (e.g. steam and water pipes) running across the corridor and across doorways, headroom at multiple locations was found to be only 69 - 75 inches instead of the 80 inches required by NFPA 101(00), Sec. 7.1.5.
11. Manual Fire Alarm [Score: +2]:
    There are manual fire alarm pull stations at each exit stair enclosure and at the bottom of the stair leading to the exterior near Kitchen Storeroom B-21. The fire alarm system is monitored by Armour Security.
12. Smoke Detection and Alarm [Score: +3]:
    This score was assigned per instruction in Footnote *g* to this Table. System-connected smoke detectors were found in the egress corridors and the zone is protected with quick-response sprinklers.
13. Automatic Sprinklers [Score: +10]:
    The entire facility is protected by a supervised, wet-pipe automatic sprinkler system consisting of quick-response sprinklers.

<u>Zone 2 – Basement Level South</u>:

TABLE 1. OCCUPANY RISK PARAMETER FACTORS

The facility's residents are not allowed in this area of the basement. For purposes of this FSES, therefore, it was assumed that this level did not involve resident housing, treatment or customary access. This area of the basement was found to house maintenance, the facility laundry and storage. As a result, in accordance with instruction given in NFPA 101A(01), Sec. 4.3.2(4)a, only Item 3, Zone Location (*L*), of Table 1 was addressed and the value of factor *F* in Table 2, OCCUPANCY RISK FACTOR CALCULATION, was assigned a factor of 1.6 (i.e. the value assigned to basements in factor *L* of Table 1).

TABLE 4. SAFETY PARAMETERS and SAFETY PARAMETER VALUES

1. Construction [Score: -4]:
   The building was assigned a Type III(200) construction type.
2. Interior Finish (Corridors and Exits) [Score: +3]:
   Ceiling finish was found to be plaster. Wall finish was found to be brick.
3. Interior Finish (Rooms) [Score: +3]:
   Wall and ceiling finish was found to be combination of gypsum and plaster.
4. Corridor Partitions/Walls [Score: +2]:
   For purposes of this FSES, this zone was treated as a suite in accordance with NFPA 101(00), Sec. 19.2.5. Based on building information provided at the time of the survey, this suite is approximately 4,256 ft^2 in size and is separated from the corridor in the adjacent 1919 original building by a 2-hour-rated fire barrier.
5. Doors to Corridor [Score: +2]:
   Again, for purposes of this FSES, this zone was treated as a suite in accordance with NFPA 101(00), Sec. 19.2.5. The door opening into the corridor in the adjacent 1919 original building was found to be a 90-minute fire-rated assembly.
6. Zone Dimensions [Score: 0]:
   This score was assigned per instruction in Footnote *b* to this Table. According to building information provided, this zone measures approximately 112 feet in length and, based on actual measurements, has dead-ends in the hallway measuring approximately 30 feet in length at the east end and approximately 60 feet in length at the west end. Parameter 10, Emergency Movement Routes, is assigned a score of -8.
7. Vertical Openings [Score: 0]:
   This score was assigned per instruction in Footnote *e* to this Table. Openings into the stair enclosure in this zone were found to be protected with 90-minute fire-rated self-closing door assemblies. The loading doors into the soiled linen chute on the upper floors as well as the door into the chute termination room in this zone were also found to be 90-minute fire-rated self-closing door assemblies. However, Parameter 1, Construction, is based on an unprotected type of construction ("200").
8. Hazardous Areas [Score: 0]:
   No hazardous area deficiencies were found in this zone.
9. Smoke Control [Score: 0]:
   A fire/smoke barrier serves this zone.
10. Emergency Movement Routes [Score: -8]:
    This score was assigned for the following reasons:
    - The two exits from this zone are not remotely located from each other as required by NFPA 101(00), Sections 7.5.1.3 and 7.5.1.4.
    - Because of utility piping (e.g. steam and water pipes) running across the corridor, headroom at multiple locations was found to be only 73 - 75 inches instead of the 80 inches required by NFPA 101(00), Sec. 7.1.5.
11. Manual Fire Alarm [Score: +2]:
    There is a manual fire alarm pull station near the exit stair enclosure serving this zone. The fire alarm system is monitored by Armour Security.
12. Smoke Detection and Alarm [Score: +3]:
    This score was assigned per instruction in Footnote *g* to this Table. System-connected smoke detectors were found in the hallway and the zone is protected with quick-response sprinklers.
13. Automatic Sprinklers [Score: +10]:
    The entire facility is protected by a supervised, wet-pipe automatic sprinkler system consisting of quick-response sprinklers.

Zone 3 – First Floor Center

TABLE 1. OCCUPANY RISK PARAMETER FACTORS

1. Resident Mobility (*M*) [Value assigned = 1.6]: It was reported that all residents housed in this zone are capable of removing themselves from danger exclusively by their own efforts, but the rate of travel for some of the residents is slowed due to mobility impairments. For this reason it was felt that these residents do not meet the definition of "Mobile".
2. Patient Density (*D*) [Value assigned = 2.0]: Five (5) residents are housed in this zone. The zone also contains the facility dining room, gift shop and a lounge, however, which are available for use by all residents.
3. Zone Location (*L*) [Value assigned = 1.1]: This zone is less than one-half floor height above grade.
4. Ratio of Patients to Attendants (*T*) [Value assigned = 4.0]: There are no staff immediately available to this zone on the night shift. It was reported that one of the two staff persons attending the North Wing makes rounds in this zone every 2 hours.
5. Patient Average Age (*A*) [Value assigned = 1.2]: Residents using this zone average over 65 years of age.

TABLE 4. SAFETY PARAMETERS and SAFETY PARAMETER VALUES

1. Construction [Score: -2]:
   The building was assigned a Type III(200) construction type.
2. Interior Finish (Corridors and Exits) [Score: +3]:
   Documentation was provided certifying that interior wall and ceiling finishes (i.e. vinyl wall coverings and acoustical ceiling tile) in corridors and exits carry a Class A (25 or less) flame spread rating.
3. Interior Finish (Rooms) [Score: +3]:
   Documentation was provided certifying that interior wall and ceiling finishes (i.e. vinyl wall coverings and acoustical ceiling tile) in rooms carry a Class A (25 or less) flame spread rating.
4. Corridor Partitions/Walls [Score: +2]:
   Corridor walls are a mixture of gypsum wallboard and plaster on both sides of wood studs. A 32" x 44" wired glass vision panel mounted in a steel frame was observed in the corridor wall at Therapy Room 127. The Gift Shop was treated as a space open to the corridor as allowed by NFPA 101(00), Sec. 19.3.2.5 and Sec. 19.3.6.1, Exception No. 4 – it is protected by automatic fire sprinklers and automatic smoke detection. The IT closet, which has a transfer grille on one side, was also treated as a space open to the corridor as allowed by Exception No. 1 to NFPA 101(00), Sec. 19.3.6.1 – it is protected by automatic fire sprinklers and automatic smoke detection.
5. Doors to Corridor [Score: +1]:
   Corridor doors in this zone were found to be of 1-5/8-inch-thick solid wood construction.
6. Zone Dimensions [Score: 0]:
   This score was assigned per instruction in Footnote *b* to this Table. According to building information provided, this zone measures approximately 104 feet in length. Due to the lack of complying means of egress out of this level, a dead-end condition is created. Parameter 10, Emergency Movement Routes, was assigned a score of -8.
7. Vertical Openings [Score: 0]:
   The main stair enclosure in this zone is enclosed with construction providing a minimum 2-hour fire resistance. The self-closing door at the top of the stairway connecting the 1st Floor kitchen to the basement level, however, was found to be of 1¾-inch solid wood core construction, which provides a fire resistance of less than 1 hour.
8. Hazardous Areas [Score: 0]:
   Hazardous areas were found to be sprinkler protected as required by NFPA 101A(01), Sec. 4.6.8.2 and smoke-separated as required by NFPA 101(00), Sec. 19.3.2.1.

9. Smoke Control [Score: 0]:
   There is a 1-hour-rated separation between this zone and the 1924 building and a 2-hour-rated fire separation between this zone and the 1928 building.
10. Emergency Movement Routes [Score: -8]:
    This score was assigned for the following reasons:
    - The corridor doors on this level were found to measure only 29-30 inches in clear width. As a result, they could not be credited as an egress route [see NFPA 101A(01), Sec. 4.6.10.3.2].
    - The second means of egress from the Dining Room was found to be through the adjoining Conservatory, as allowed by NFPA 101(00), Sec. 7.5.1.7, but the door from the Conservatory to the egress corridor swings against egress travel. Since the Dining room serves an occupant load of more than 50, this does not meet the requirements of NFPA 101(00), Sec. 7.2.1.4.2.
11. Manual Fire Alarm [Score: +2]:
    A manual fire alarm pull station was found along the path of travel to the main exit from this level. The fire alarm system is monitored by Armour Security.
12. Smoke Detection and Alarm [Score: +3]:
    This score was assigned per instruction in Footnote *g* to this Table. System-connected smoke detectors were found in the egress corridors and the zone is protected with quick-response sprinklers.
13. Automatic Sprinklers [Score: +10]:
    The entire facility is protected by a supervised, wet-pipe automatic sprinkler system consisting of quick-response sprinklers.

Zone 4 – First Floor North

TABLE 1. OCCUPANY RISK PARAMETER FACTORS

1. Resident Mobility (*M*) [Value assigned = 3.2]: It was reported that some residents in the zone may need assistance with evacuation.
2. Patient Density (*D*) [Value assigned = 2.0]: There is bed capacity for up to 17 residents in this zone. The zone also contains the facility chapel, which is available for use by all residents.
3. Zone Location (*L*) [Value assigned = 1.1]: This zone is less than one-half floor height above grade.
4. Ratio of Patients to Attendants (*T*) [Value assigned = 1.5]: It was reported that there are two staff persons attending this zone on the night shift. One staff person is assigned to make rounds of the remainder of the First Floor every 2 hours.
5. Patient Average Age (*A*) [Value assigned = 1.2]: Residents using this zone average over 65 years of age.

TABLE 4. SAFETY PARAMETERS and SAFETY PARAMETER VALUES

1. Construction [Score: -2]:
   The building was assigned a Type III(200) construction type.
2. Interior Finish (Corridors and Exits) [Score: +3]:
   Documentation was provided certifying that interior wall and ceiling finishes (i.e. vinyl wall coverings and acoustical ceiling tile) in corridors and exits carry a Class A (25 or less) flame spread rating.
3. Interior Finish (Rooms) [Score: +3]:
   Documentation was provided certifying that interior wall and ceiling finishes (i.e. vinyl wall coverings and acoustical ceiling tile) in rooms carry a Class A (25 or less) flame spread rating.

4. Corridor Partitions/Walls [Score: +2]:
   Corridor walls are constructed of a mixture of gypsum and plaster on both sides of wood studs. The Chapel was treated as a space open to the corridor as allowed by NFPA 101(00), Sec. 19.3.6.1, Exception No. 1 – it is protected by automatic fire sprinklers and automatic smoke detection.
5. Doors to Corridor [Score: +1]:
   Corridor doors were found to be of 1-5/8-inch-thick solid wood construction.
6. Zone Dimensions [Score: 0]:
   This score was assigned per instruction in Footnote *b* to this Table. According to building information provided, this zone measures approximately 112 feet in length. Due to the lack of complying means of egress out of this level, a dead-end condition is created. Parameter 10, Emergency Movement Routes, was assigned a score of -8.
7. Vertical Openings [Score: 0]:
   This score was assigned per Footnote *e* to this Table. Openings into the stair enclosures were found to be protected with 90-minute fire-rated self-closing door assemblies. The doors into the soiled linen chute in this zone were also found to be protected with 90-minute fire-rated self-closing door assemblies. The door assembly into the chute termination room was found to carry a 60-minute fire protection rating. However, Parameter 1, Construction, is based on an unprotected type of construction ("200").
8. Hazardous Areas [Score: 0]:
   Hazardous areas were found to be sprinkler protected as required by NFPA 101A(01), Sec. 4.6.8.2 and smoke-separated as required by NFPA 101(00), Sec. 19.3.2.1.
9. Smoke Control [Score: 0]:
   There is a 1-hour-rated fire separation between this zone and the adjacent 1919 building and a 2-hour-rated fire separation between this zone and the adjacent 1950 building.
10. Emergency Movement Routes [Score: -8]:
    This score was assigned for the following reasons:
    - The corridor doors on this level were found to measure only 29-30 inches in clear width. As a result, these components could not be credited as an egress route [see NFPA 101A(01), Sec. 4.6.10.3.2].
    - Access to the second exit from the Chapel is through a space used for storage, which does not meet the requirements of NFPA 101(00), Sec. 7.5.1.7.
    - An approximately 5-inch grade change was found outside the second exit from the Chapel, which does not meet the requirements of NFPA 101(00), Sec. 7.2.1.3.
11. Manual Fire Alarm [Score: +2]:
    Manual fire alarm pull stations were found near the elevator lobby, at the second exit from the Chapel and at the nurses' station serving the zone, which meets the intent of Exception No. 1 to NFPA 101(00), Sec. 19.3.4.2. The fire alarm system is monitored by Armour Security.
12. Smoke Detection and Alarm [Score: +3]:
    This score was assigned per instruction in Footnote *g* to this Table. System-connected smoke detectors were found in the egress corridors and the zone is protected with quick-response sprinklers.
13. Automatic Sprinklers [Score: +10]:
    The entire facility is protected by a supervised, wet-pipe automatic sprinkler system consisting of quick-response sprinklers.

Zone 5 – First Floor South

TABLE 1. OCCUPANY RISK PARAMETER FACTORS

1. Resident Mobility (*M*) [Value assigned = 1.6]: It was reported that all residents housed in this zone are capable of removing themselves from danger exclusively by their own efforts, but the rate of travel for some of the residents is slowed due to mobility impairments. For this reason it was felt that these residents do not meet the definition of "Mobile".
2. Patient Density (*D*) [Value assigned = 1.5]: There is bed capacity for up to eight (8) residents in this zone. The zone also contains an exercise/physical therapy space. It was reported that there are a maximum of three (3) residents in the therapy space at any one time.
3. Zone Location (*L*) [Value assigned = 1.1]: This zone is less than one-half floor height above grade
4. Ratio of Patients to Attendants (*T*) [Value assigned = 4.0]: There are no staff immediately available to this zone on the night shift. It was reported that one of the two staff persons attending the North Wing makes rounds in this zone every 2 hours.
5. Patient Average Age (*A*) [Value assigned = 1.2]: Residents using this zone average over 65 years of age.

TABLE 4. SAFETY PARAMETERS and SAFETY PARAMETER VALUES

1. Construction [Score: -2]:
   The building was assigned a Type III(200) construction type.
2. Interior Finish (Corridors and Exits) [Score: +3]:
   Documentation was provided certifying that interior wall and ceiling finishes (i.e. vinyl wall coverings and acoustical ceiling tile) in corridors and exits carry a Class A (25 or less) flame spread rating.
3. Interior Finish (Rooms) [Score: +3]:
   Documentation was provided certifying that interior wall and ceiling finishes (i.e. vinyl wall coverings and acoustical ceiling tile) in rooms carry a Class A (25 or less) flame spread rating.
4. Corridor Partitions/Walls [Score: 0]:
   Corridor walls are constructed of a mixture of gypsum and plaster on both sides of wood studs. A 32" x 46" wired glass vision panel in a wood frame was found in the corridor wall at the physical therapy space. As a result, the corridor walls were graded as "<½ hour".
5. Doors to Corridor [Score: +1]:
   Corridor doors were found to be of 1-5/8-inch-thick solid wood construction.
6. Zone Dimensions [Score: 0]:
   This score was assigned per instruction in Footnote *b* to this Table. According to building information provided, this zone measures approximately 126 feet in length. Due to the lack of complying means of egress out of this level, a dead-end condition is created. Parameter 10, Emergency Movement Routes, was assigned a score of -8.
7. Vertical Openings [Score: 0]:
   This score was assigned per instruction in Footnote *e* to this Table. Openings into the stair enclosures, soiled linen chute and chute termination room in this zone were found to be protected with 90-minute fire-rated self-closing door assemblies; however, Parameter 1, Construction, is based on an unprotected type of construction ("200").
8. Hazardous Areas [Score: 0]:
   Hazardous areas were found to be sprinkler protected as required by NFPA 101A(01), Sec. 4.6.8.2 and smoke-separated as required by NFPA 101(00), Sec. 19.3.2.1.
9. Smoke Control [Score: 0]:
   There is a 2-hour-rated fire separation between this zone and the adjacent 1924 building.

10. Emergency Movement Routes [Score: -8]:
    The corridor doors in this zone were found to measure only 29-30 inches in clear width. As a result, they could not be credited as an egress route [see NFPA 101A(01), Sec. 4.6.10.3.2].
11. Manual Fire Alarm [Score: +2]:
    Manual fire alarm pull stations were found along the path of egress travel to both exterior exit doors from this zone. The fire alarm system is monitored by Armour Security.
12. Smoke Detection and Alarm [Score: +3]:
    This score was assigned per instruction in Footnote *g* to this Table. System-connected smoke detectors were found in the egress corridors and the zone is protected with quick-response sprinklers.
13. Automatic Sprinklers [Score: +10]:
    The entire facility is protected by a supervised, wet-pipe automatic sprinkler system consisting of quick-response sprinklers.

Zone 6 – Second Floor Center

TABLE 1. OCCUPANY RISK PARAMETER FACTORS

1. Resident Mobility (*M*) [Value assigned = 3.2]: It was reported that some residents in the zone may need assistance with evacuation.
2. Patient Density (*D*) [Value assigned = 1.5]: There is bed capacity for up to 11 residents in this zone.
3. Zone Location (*L*) [Value assigned = 1.2]: This zone is one floor height above First Floor.
4. Ratio of Patients to Attendants (*T*) [Value assigned = 1.5]: It was reported that there is at least one (1) staff person assigned to this zone on the night shift resulting in a ratio of one (1) staff for over ten (10) residents.
5. Patient Average Age (*A*) [Value assigned = 1.2]: Residents using this zone average over 65 years of age.

TABLE 4. SAFETY PARAMETERS and SAFETY PARAMETER VALUES

1. Construction [Score: -4]:
    The building was assigned a Type III(200) construction type.
2. Interior Finish (Corridors and Exits) [Score: +3]:
    Documentation was provided certifying that interior wall and ceiling finishes (i.e. vinyl wall coverings and acoustical ceiling tile) in corridors and exits carry a Class A (25 or less) flame spread rating.
3. Interior Finish (Rooms) [Score: +3]:
    Documentation was provided certifying that interior wall and ceiling finishes (i.e. vinyl wall coverings and acoustical ceiling tile) in rooms carry a Class A (25 or less) flame spread rating.
4. Corridor Partitions/Walls [Score: +2]:
    Corridor walls are constructed of a mixture of gypsum and plaster on both sides of wood studs.
5. Doors to Corridor [Score: +1]:
    Corridor doors were found to be of 1-5/8-inch-thick solid wood construction.
6. Zone Dimensions [Score: 0]:
    This score was assigned per instruction in Footnote *b* to this Table. According to building information provided, this zone measures approximately 104 feet in length. Due to the lack of complying means of egress out of this level, a dead-end condition is created. Parameter 10, Emergency Movement Routes, was assigned a score of -8.
7. Vertical Openings [Score: 0]:
    This score was assigned per instruction in Footnote *e* to this Table. The stair enclosure in this zone is enclosed with construction providing a minimum 2-hour fire resistance, but Parameter 1, Construction, is based on an unprotected type of construction (“200”).

8. Hazardous Areas [Score: 0]:
   Hazardous areas were found to be sprinkler protected as required by NFPA 101A(01), Sec. 4.6.8.2 and smoke-separated as required by NFPA 101(00), Sec. 19.3.2.1.
9. Smoke Control [Score: 0]:
   There are 2-hour-rated fire separations at both ends of this zone, which separate this zone from the adjacent 1924 and 1928 buildings.
10. Emergency Movement Routes [Score: -8]:
    The corridor doors on this level were found to measure only 29-30 inches in clear width. As a result, they could not be credited as an egress route [see NFPA 101A(01), Sec. 4.6.10.3.2].
11. Manual Fire Alarm [Score: +2]:
    Manual fire alarm pull stations were found along the path of travel from this zone and at the nurses' station serving the zone, which meets the intent of Exception No. 1 to NFPA 101(00), Sec. 19.3.4.2. The fire alarm system is monitored by Armour Security.
12. Smoke Detection and Alarm [Score: +3]:
    This score was assigned per instruction in Footnote *g* to this Table. System-connected smoke detectors were found in the egress corridors and the zone is protected with quick-response sprinklers.
13. Automatic Sprinklers [Score: +10]:
    The entire facility is protected by a supervised, wet-pipe automatic sprinkler system consisting of quick-response sprinklers.

Zone 7 – Second Floor North

TABLE 1. OCCUPANY RISK PARAMETER FACTORS

1. Resident Mobility (*M*) [Value assigned = 3.2]: It was reported that some residents in the zone may need assistance with evacuation.
2. Patient Density (*D*) [Value assigned = 1.5]: There is bed capacity for up to 15 residents in this zone.
3. Zone Location (*L*) [Value assigned = 1.2]: This zone is one floor height above First Floor.
4. Ratio of Patients to Attendants (*T*) [Value assigned = 1.5]: It was reported that there is at least one (1) staff person assigned to this zone on the night shift resulting in a ratio of one (1) staff for over ten (10) residents.
5. Patient Average Age (*A*) [Value assigned = 1.2]: Residents using this zone average over 65 years of age.

TABLE 4. SAFETY PARAMETERS and SAFETY PARAMETER VALUES

1. Construction [Score: -4]:
   The building was assigned a Type III(200) construction type.
2. Interior Finish (Corridors and Exits) [Score: +3]:
   Documentation was provided certifying that interior wall and ceiling finishes (i.e. vinyl wall coverings and acoustical ceiling tile) in corridors and exits carry a Class A (25 or less) flame spread rating.
3. Interior Finish (Rooms) [Score: +3]:
   Documentation was provided certifying that interior wall and ceiling finishes (i.e. vinyl wall coverings and acoustical ceiling tile) in rooms carry a Class A (25 or less) flame spread rating.
4. Corridor Partitions/Walls [Score: +2]:
   Corridor walls are constructed of a mixture of gypsum and plaster on both sides of wood studs.

5. Doors to Corridor [Score: +1]:
   Corridor doors were found to be of 1-5/8-inch-thick solid wood construction. Transfer grilles were found in the door to the IT closet located in this zone. As allowed by Exception No. 1 to NFPA 101(00), Sec. 19.3.6.1, this closet was treated as a space open to the corridor – it is protected by automatic fire sprinklers and automatic smoke detection. For purposes of this FSES, therefore, this door was not considered in classifying "Doors to Corridor".
6. Zone Dimensions [Score: 0]:
   This score was assigned per instruction in Footnote *b* to this Table. According to building information provided, this zone measures approximately 112 feet in length and was found to have a dead-end of approximately 50 feet in length. Parameter 10, Emergency Movement Routes, was assigned a score of -8.
7. Vertical Openings [Score: 0]:
   This score was assigned per Footnote *e* to this Table. Openings into the stair enclosures were found to be protected with 90-minute fire-rated self-closing door assemblies. The doors into the soiled linen chute were also found to be protected with 90-minute fire-rated self-closing door assemblies. The door assembly into the chute termination room was found to carry a 60-minute fire protection rating. Parameter 1, Construction, is based on an unprotected type of construction ("200").
8. Hazardous Areas [Score: 0]:
   Hazardous areas were found to be sprinkler protected as required by NFPA 101A(01), Sec. 4.6.8.2 and smoke-separated as required by NFPA 101(00), Sec. 19.3.2.1.
9. Smoke Control [Score: 0]:
   There are 2-hour-rated fire separations between this zone and the adjacent 1924 and 1950 buildings.
10. Emergency Movement Routes [Score: -8]:
    The door to the exterior from the east exit enclosure in this zone measures only 30 inches in clear width, which does not meet the requirements of NFPA 101(00), Sec. 19.2.3.5. The corridor doors on this level were found to measure only 29-30 inches in clear width. As a result, these components could not be credited as an egress route [see NFPA 101A(01), Sec. 4.6.10.3.2]
11. Manual Fire Alarm [Score: +2]:
    Manual fire alarm pull stations were found near the elevator lobby and at the nurses' station serving the zone, which meets the intent of Exception No. 1 to NFPA 101(00), Sec. 19.3.4.2. The fire alarm system is monitored by Armour Security.
12. Smoke Detection and Alarm [Score: +3]:
    This score was assigned per instruction in Footnote *g* to this Table. System-connected smoke detectors were found in the egress corridors and the zone is protected with quick-response sprinklers.
13. Automatic Sprinklers [Score: +10]:
    The entire facility is protected by a supervised, wet-pipe automatic sprinkler system consisting of quick-response sprinklers.

Zone 8 – Second Floor South

TABLE 1. OCCUPANY RISK PARAMETER FACTORS

1. Resident Mobility (*M*) [Value assigned = 3.2]: It was reported that some residents in the zone may need assistance with evacuation.
2. Patient Density (*D*) [Value assigned = 1.5]: There is bed capacity for up to 15 residents in this zone.
3. Zone Location (*L*) [Value assigned = 1.2]: This zone is one floor height above First Floor.

4. Ratio of Patients to Attendants (*T*) [Value assigned = 1.5]: It was reported that there is at least one (1) staff person assigned to this zone on the night shift resulting in a ratio of one (1) staff for over ten (10) residents.
5. Patient Average Age (*A*) [Value assigned = 1.2]: Residents using this zone average over 65 years of age.

TABLE 4. SAFETY PARAMETERS and SAFETY PARAMETER VALUES

1. Construction [Score: -4]:
   The building was assigned a Type III(200) construction type.
2. Interior Finish (Corridors and Exits) [Score: +3]:
   Documentation was provided certifying that interior wall and ceiling finishes (i.e. vinyl wall coverings and acoustical ceiling tile) in corridors and exits carry a Class A (25 or less) flame spread rating.
3. Interior Finish (Rooms) [Score: +3]:
   Documentation was provided certifying that interior wall and ceiling finishes (i.e. vinyl wall coverings and acoustical ceiling tile) in rooms carry a Class A (25 or less) flame spread rating.
4. Corridor Partitions/Walls [Score: +2]:
   Corridor walls are constructed of a mixture of gypsum and plaster on both sides of wood studs. The dining/lounge area is open to the corridor as allowed by the exceptions to NFPA 101(00), Sec. 19.3.6.1.
5. Doors to Corridor [Score: +1]:
   Corridor doors were found to be of 1-5/8-inch-thick solid wood construction.
6. Zone Dimensions [Score: 0]:
   This score was assigned per instruction in Footnote *b* to this Table. According to building information provided, this zone measures approximately 126 feet in length and was found to have a dead-end of approximately 45 feet in length at the east end of the corridor. Parameter 10, Emergency Movement Routes, was assigned a score of -8.
7. Vertical Openings [Score: 0]:
   This score was assigned per instruction in Footnote *e* to this Table. Openings into the stair enclosures, soiled linen chute and chute termination room in this zone were found to be protected with 90-minute fire-rated self-closing door assemblies; however, Parameter 1, Construction, is based on an unprotected type of construction (“200”).
8. Hazardous Areas [Score: 0]:
   Hazardous areas were found to be sprinkler protected as required by NFPA 101A(01), Sec. 4.6.8.2 and smoke-separated as required by NFPA 101(00), Sec. 19.3.2.1.
9. Smoke Control [Score: 0]:
   There is a 2-hour-rated fire separation between this zone and the adjacent 1919 building.
10. Emergency Movement Routes [Score: -8]:
    This score was assigned for the following reasons:
    - The corridor doors in this zone were found to measure only 29-30 inches in clear width. As a result, they could not be credited as an egress route [see NFPA 101A(01), Sec. 4.6.10.3.2].
    - The doors into the exit stair enclosures serving this zone swing against egress travel, which does not meet the requirements of NFPA 101(00), Sec. 7.2.1.4.3.
11. Manual Fire Alarm [Score: +2]:
    A manual fire alarm pull station was found at the nurses’ station serving the zone, which meets the intent of Exception No. 1 to NFPA 101(00), Sec. 19.3.4.2. The fire alarm system is monitored by Armour Security.
12. Smoke Detection and Alarm [Score: +3]:
    This score was assigned per instruction in Footnote *g* to this Table. System-connected smoke detectors were found in the egress corridors and the zone is protected with quick-response sprinklers.

13. Automatic Sprinklers [Score: +10]:
    The entire facility is protected by a supervised, wet-pipe automatic sprinkler system consisting of quick-response sprinklers.

Zone 9 – Third Floor Center

TABLE 1. OCCUPANY RISK PARAMETER FACTORS

1. Resident Mobility (*M*) [Value assigned = 3.2]: It was reported that some residents in the zone may need assistance with evacuation.
2. Patient Density (*D*) [Value assigned = 1.5]: There is bed capacity for up to 11 residents in this zone.
3. Zone Location (*L*) [Value assigned = 1.2]: This zone is two floor heights above First Floor.
4. Ratio of Patients to Attendants (*T*) [Value assigned = 1.5]: It was reported that there is at least one (1) staff person assigned to this zone on the night shift resulting in a ratio of one (1) staff for over ten (10) residents.
5. Patient Average Age (*A*) [Value assigned = 1.2]: Residents using this zone average over 65 years of age.

TABLE 4. SAFETY PARAMETERS and SAFETY PARAMETER VALUES

1. Construction [Score: -9]:
   The building was assigned a Type III(200) construction type.
2. Interior Finish (Corridors and Exits) [Score: +3]:
   Documentation was provided certifying that interior wall and ceiling finishes (i.e. vinyl wall coverings and acoustical ceiling tile) in corridors and exits carry a Class A (25 or less) flame spread rating.
3. Interior Finish (Rooms) [Score: +3]:
   Documentation was provided certifying that interior wall and ceiling finishes (i.e. vinyl wall coverings and acoustical ceiling tile) in rooms carry a Class A (25 or less) flame spread rating.
4. Corridor Partitions/Walls [Score: +2]:
   Corridor walls are constructed of a mixture of gypsum and plaster on both sides of wood studs.
5. Doors to Corridor [Score: +1]:
   Corridor doors were found to be of 1-5/8-inch-thick solid wood construction.
6. Zone Dimensions [Score: 0]:
   This score was assigned per instruction in Footnote *b* to this Table. According to building information provided, this zone measures approximately 104 feet in length. Due to the lack of complying means of egress out of this level, a dead-end condition is created. Parameter 10, Emergency Movement Routes, was assigned a score of -8.
7. Vertical Openings [Score: 0]:
   This score was assigned per instruction in Footnote *e* to this Table. The stair enclosure in this zone is enclosed with construction providing a minimum 2-hour fire resistance, but Parameter 1, Construction, is based on an unprotected type of construction (“200”).
8. Hazardous Areas [Score: 0]:
   Hazardous areas were found to be sprinkler protected as required by NFPA 101A(01), Sec. 4.6.8.2 and smoke-separated as required by NFPA 101(00), Sec. 19.3.2.1.
9. Smoke Control [Score: 0]:
   There are 2-hour-rated fire separations at both ends of this zone, which separate this zone from the adjacent 1924 and 1928 buildings.
10. Emergency Movement Routes [Score: -8]:
    The corridor doors on this level were found to measure only 29-30 inches in clear width. As a result, they could not be credited as an egress route [see NFPA 101A(01), Sec. 4.6.10.3.2].

11. Manual Fire Alarm [Score: +2]:
    Manual fire alarm pull stations were found along the path of travel and at the nurses' station serving the zone, which meets the intent of Exception No. 1 to NFPA 101(00), Sec. 19.3.4.2. The fire alarm system is monitored by Armour Security.
12. Smoke Detection and Alarm [Score: +3]:
    This score was assigned per instruction in Footnote *g* to this Table. System-connected smoke detectors were found in the egress corridors and the zone is protected with quick-response sprinklers.
13. Automatic Sprinklers [Score: +10]:
    The entire facility is protected by a supervised, wet-pipe automatic sprinkler system consisting of quick-response sprinklers.

Zone 10 – Third Floor North

TABLE 1. OCCUPANY RISK PARAMETER FACTORS

1. Resident Mobility (*M*) [Value assigned = 3.2]: It was reported that some residents in the zone may need assistance with evacuation.
2. Patient Density (*D*) [Value assigned = 1.5]: There is bed capacity for up to 14 residents in this zone.
3. Zone Location (*L*) [Value assigned = 1.2]: This zone is two floor heights above First Floor.
4. Ratio of Patients to Attendants (*T*) [Value assigned = 1.5]: It was reported that there is at least one (1) staff person assigned to this zone on the night shift resulting in a ratio of one (1) staff for over ten (10) residents.
5. Patient Average Age (*A*) [Value assigned = 1.2]: Residents using this zone average over 65 years of age.

TABLE 4. SAFETY PARAMETERS and SAFETY PARAMETER VALUES

1. Construction [Score: -9]:
    The building was assigned a Type III(200) construction type.
2. Interior Finish (Corridors and Exits) [Score: +3]:
    Documentation was provided certifying that interior wall and ceiling finishes (i.e. vinyl wall coverings and acoustical ceiling tile) in corridors and exits carry a Class A (25 or less) flame spread rating.
3. Interior Finish (Rooms) [Score: +3]:
    Documentation was provided certifying that interior wall and ceiling finishes (i.e. vinyl wall coverings and acoustical ceiling tile) in rooms carry a Class A (25 or less) flame spread rating.
4. Corridor Partitions/Walls [Score: +2]:
    Corridor walls are constructed of a mixture of gypsum and plaster on both sides of wood studs.
5. Doors to Corridor [Score: +1]:
    Corridor doors were found to be of 1-5/8-inch-thick solid wood construction. Transfer grilles were found in the door to the IT closet located in this zone. As allowed by Exception No. 1 to NFPA 101(00), Sec. 19.3.6.1, this closet was treated as a space open to the corridor – it is protected by automatic fire sprinklers and automatic smoke detection. For purposes of this FSES, therefore, this door was not considered in classifying "Doors to Corridor".
6. Zone Dimensions [Score: 0]:
    This score was assigned per instruction in Footnote *b* to this Table. According to building information provided, the zone measures approximately 112 feet in length and was found to have a dead-end of approximately 50 feet in length. Parameter 10, Emergency Movement Routes, was assigned a score of -8.

7. Vertical Openings [Score: 0]:
   This score was assigned per Footnote *e* to this Table. Openings into the stair enclosures were found to be protected with 90-minute fire-rated self-closing door assemblies. The doors into the soiled linen chute were also found to be protected with 90-minute fire-rated self-closing door assemblies. The door assembly into the chute termination room was found to carry a 60-minute fire protection rating. Parameter 1, Construction, is based on an unprotected type of construction ("200").
8. Hazardous Areas [Score: 0]:
   Hazardous areas were found to be sprinkler protected as required by NFPA 101A(01), Sec. 4.6.8.2 and smoke-separated as required by NFPA 101(00), Sec. 19.3.2.1.
9. Smoke Control [Score: 0]:
   There are 2-hour-rated fire separations between this zone and the adjacent 1919 and 1950 buildings.
10. Emergency Movement Routes [Score: -8]:
    The door to the exterior from the east exit enclosure in this zone measures only 30 inches in clear width, which does not meet the requirements of NFPA 101(00), Sec. 19.2.3.5. The corridor doors on this level were found to measure only 29-30 inches in clear width. As a result, these components could not be credited as an egress route [see NFPA 101A(01), Sec. 4.6.10.3.2].
11. Manual Fire Alarm [Score: +2]:
    A manual fire alarm pull station was found adjacent to the door into the east exit enclosure and at the nurses' station serving the zone, which meets the intent of Exception No. 1 to NFPA 101(00), Sec. 19.3.4.2. The fire alarm system is monitored by Armour Security.
12. Smoke Detection and Alarm [Score: +3]:
    This score was assigned per instruction in Footnote *g* to this Table. System-connected smoke detectors were found in the egress corridors and the zone is protected with quick-response sprinklers.
13. Automatic Sprinklers [Score: +10]:
    The entire facility is protected by a supervised, wet-pipe automatic sprinkler system consisting of quick-response sprinklers.

Zone 11 – Third Floor South

TABLE 1. OCCUPANY RISK PARAMETER FACTORS

1. Resident Mobility (*M*) [Value assigned = 3.2]: It was reported that some residents in the zone may need assistance with evacuation.
2. Patient Density (*D*) [Value assigned = 1.5]: There is bed capacity for up to 14 residents in this zone.
3. Zone Location (*L*) [Value assigned = 1.2]: This zone is two floor heights above First Floor.
4. Ratio of Patients to Attendants (*T*) [Value assigned = 1.5]: It was reported that there is at least one (1) staff person assigned to this zone on the night shift resulting in a ratio of one (1) staff for over ten (10) residents in each zone.
5. Patient Average Age (*A*) [Value assigned = 1.2]: Residents using this zone average over 65 years of age.

TABLE 4. SAFETY PARAMETERS and SAFETY PARAMETER VALUES

1. Construction [Score: -9]:
   The building was assigned a Type III(200) construction type.
2. Interior Finish (Corridors and Exits) [Score: +3]:
   Documentation was provided certifying that interior wall and ceiling finishes (i.e. vinyl wall coverings and acoustical ceiling tile) in corridors and exits carry a Class A (25 or less) flame spread rating.

3. Interior Finish (Rooms) [Score: +3]:
   Documentation was provided certifying that interior wall and ceiling finishes (i.e. vinyl wall coverings and acoustical ceiling tile) in rooms carry a Class A (25 or less) flame spread rating.
4. Corridor Partitions/Walls [Score: +2]:
   Corridor walls are constructed of a mixture of gypsum and plaster on both sides of wood studs. The dining/lounge area is open to the corridor as allowed by the exceptions to NFPA 101(00), Sec. 19.3.6.1.
5. Doors to Corridor [Score: +1]:
   Corridor doors were found to be of 1-5/8-inch-thick solid wood construction.
6. Zone Dimensions [Score: 0]:
   This score was assigned per instruction in Footnote *b* to this Table. According to building information provided, this zone measures approximately 126 feet in length and was found to have a dead-end of approximately 40 feet in length at the east end of the corridor. Parameter 10, Emergency Movement Routes, was assigned a score of -8.
7. Vertical Openings [Score: 0]:
   This score was assigned per instruction in Footnote *e* to this Table. Openings into the stair enclosures, soiled linen chute and chute termination room in this zone were found to be protected with 90-minute fire-rated self-closing door assemblies; however, Parameter 1, Construction, is based on an unprotected type of construction ("200").
8. Hazardous Areas [Score: 0]:
   Hazardous areas were found to be sprinkler protected as required by NFPA 101A(01), Sec. 4.6.8.2 and smoke-separated as required by NFPA 101(00), Sec. 19.3.2.1.
9. Smoke Control [Score: 0]:
   There is a 2-hour-rated fire separation between this zone and the adjacent 1919 building.
10. Emergency Movement Routes [Score: -8]:
    This score was assigned for the following reasons:
    - The corridor doors in this zone were found to measure only 29-30 inches in clear width. As a result, they could not be credited as an egress route [see NFPA 101A(01), Sec. 4.6.10.3.2].
    - The doors into the exit stair enclosures serving this zone swing against egress travel, which does not meet the requirements of NFPA 101(00), Sec. 7.2.1.4.3.
11. Manual Fire Alarm [Score: +2]:
    There is a manual fire alarm pull station at the nurses' station, which meets the intent of Exception No. 1 to NFPA 101(00), Sec. 19.3.4.2. The fire alarm system is monitored by Armour Security.
12. Smoke Detection and Alarm [Score: +3]:
    This score was assigned per instruction in Footnote *g* to this Table. System-connected smoke detectors were found in the egress corridors and the zone is protected with quick-response sprinklers.
13. Automatic Sprinklers [Score: +10]:
    The entire facility is protected by a supervised, wet-pipe automatic sprinkler system consisting of quick-response sprinklers.

It must be noted that the scores and values assigned to the parameters in the tables on the FSES worksheets were based on conditions found during an on-site visit to the facility between 0850 hours and 1530 hours on 01/13/2016. Any changes in those conditions after that date could affect the scores and values, either positively or negatively. Again, based on this evaluation, Ebenezer Care Center **has** achieved a passing score on the FSES. No other assessment of the level of safety in this facility is either intended or implied by *Fire Safety Resources, LLC*.

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

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ZONE 1 OF 11 ZONES

FIRE/SMOKE ZONE* EVALUATION WORKSHEET FOR HEALTH CARE FACILITIES

2000 LIFE SAFETY CODE

FACILITY	BUILDING
EBENEZER CARE CENTER	01-MAIN BUILDING
ZONE(S) EVALUATED: BASEMENT – CENTER/NORTH	
PROVIDER/VENDOR NO.: 245587	DATE OF SURVEY: 01/13/2016

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

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

TABLE 1. OCCUPANCY RISK PARAMETER FACTORS

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

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

TABLE 2. OCCUPANCY RISK FACTOR CALCULATION

	M		D		L		T		A		F
OCCUPANCY RISK	3.2	X	1.0	X	1.6	X	1.0	X	1.2	=	6.1

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

TABLE 3A. (NEW BUILDINGS)

	F		R
1.0 X		=	

TABLE 3B. (EXISTING BUILDINGS)

	F		R	
0.6 X	6.1	=	3.7	= 4

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

SURVEYOR SIGNATURE: Robert J. Vinhole, FIRE SAFETY RESOURCES, LLC	TITLE: PRESIDENT	DATE: 01/14/2016
FIRE AUTHORITY SIGNATURE: Thomas Linhoff 12424	TITLE: Supervisor	DATE: 02-18-2016

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

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

TABLE 4.

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

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

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

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

NOTE:

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

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

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

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

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

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

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

For SI units: 1 ft = 0.3048 m

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

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

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

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

TABLE 5. INDIVIDUAL SAFETY EVALUATIONS

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

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

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

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

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

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

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

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

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

TABLE 7. ZONE FIRE SAFETY EQUIVALENCY EVALUATION								Yes	No
Containment Safety (S_1)	minus	Mandatory Containment (S_a)	≥ 0	S_1 9	−	S_a 9	= C 0	√	
Extinguishment Safety (S_2)	minus	Mandatory Extinguishment (S_b)	≥ 0	S_2 11	−	S_b 6	= E 5	√	
People Movement Safety (S_3)	minus	Mandatory People Movement (S_c)	≥ 0	S_3 10	−	S_c 3	= P 7	√	
General Safety (S_4)	minus	Occupancy Risk (R)	≥ 0	S_4 12	−	R 4	= G 8	√	

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

CONCLUSIONS

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

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

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

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

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ZONE 2 OF 11 ZONES

FIRE/SMOKE ZONE* EVALUATION WORKSHEET FOR HEALTH CARE FACILITIES

2000 LIFE SAFETY CODE

FACILITY	BUILDING
EBENEZER CARE CENTER	01-MAIN BUILDING
ZONE(S) EVALUATED: BASEMENT-SOUTH	
PROVIDER/VENDOR NO.: 245587	DATE OF SURVEY: 01/13/2016

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

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

TABLE 1. OCCUPANCY RISK PARAMETER FACTORS

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

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

TABLE 2. OCCUPANCY RISK FACTOR CALCULATION

	M		D		L		T		A		F
OCCUPANCY RISK	[ ]	X	[ ]	X	[ ]	X	[ ]	X	[ ]	=	[1.6]

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

TABLE 3A. (NEW BUILDINGS)

	F		R
1.0 X	[ ]	=	[ ]

TABLE 3B. (EXISTING BUILDINGS)

	F		R
0.6 X	[1.6]	=	[1]

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

SURVEYOR SIGNATURE: Robert V. Tinkelle, FIRE SAFETY RESOURCES, LLC	TITLE: PRESIDENT	DATE: 01/14/2016
FIRE AUTHORITY SIGNATURE: Thomas Linhoff 12424	TITLE: Supervisor	DATE: 02-18-2016

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

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

TABLE 4.

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

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

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

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

NOTE:

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

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

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

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

For SI units: 1 ft = 0.3048 m

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

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

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

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

A. Transfer each of the 13 circled Safety Parameter Values from Table 4 to every unshaded block in the line with the corresponding Safety Parameter in Table 5. For Safety Parameter 13 (Sprinklers) the value entered in the People Movement Safety column is recorded in Table 5 as 1/2 the corresponding value circled in Table 4.

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

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

TABLE 5. INDIVIDUAL SAFETY EVALUATIONS

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

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

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

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

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

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

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

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

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

TABLE 7. ZONE FIRE SAFETY EQUIVALENCY EVALUATION								Yes	No
Containment Safety (S_1)	minus	Mandatory Containment (S_a)	≥ 0	S_1 16	−	S_a 9	= C 7	√	
Extinguishment Safety (S_2)	minus	Mandatory Extinguishment (S_b)	≥ 0	S_2 11	−	S_b 6	= E 5	√	
People Movement Safety (S_3)	minus	Mandatory People Movement (S_c)	≥ 0	S_3 5	−	S_c 3	= P 2	√	
General Safety (S_4)	minus	Occupancy Risk (R)	≥ 0	S_4 13	−	R 1	= G 12	√	

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

CONCLUSIONS

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

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

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

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

Form Approved
OMB Exempt

ZONE 3 OF 11 ZONES

FIRE/SMOKE ZONE* EVALUATION WORKSHEET FOR HEALTH CARE FACILITIES

2000 LIFE SAFETY CODE

FACILITY	BUILDING
EBENEZER CARE CENTER	01-MAIN BUILDING
ZONE(S) EVALUATED: FIRST FLOOR CENTER	
PROVIDER/VENDOR NO.: 245587	DATE OF SURVEY: 01/13/2016

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

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

TABLE 1. OCCUPANCY RISK PARAMETER FACTORS

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

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

TABLE 2. OCCUPANCY RISK FACTOR CALCULATION

	M		D		L		T		A		F
OCCUPANCY RISK	1.6	X	2.0	X	1.1	X	4.0	X	1.2	=	16.9

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

TABLE 3A. (NEW BUILDINGS)

	F		R
1.0 X		=	

TABLE 3B. (EXISTING BUILDINGS)

	F		R		
0.6 X	16.9	=	10.1	=	11

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

SURVEYOR SIGNATURE	TITLE	DATE
Robert J. Vinitsky FIRE SAFETY RESOURCES, LLC	PRESIDENT	01/14/2016
FIRE AUTHORITY SIGNATURE	TITLE	DATE
Thomas Linhoff 12424	Supervisor	02-18-2016

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

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

TABLE 4.

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

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

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

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

NOTE:

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

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

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

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

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

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

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

For SI units: 1 ft = 0.3048 m

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

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

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

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

TABLE 5. INDIVIDUAL SAFETY EVALUATIONS

Safety Parameters	Containment Safety (S_1)	Extinguishment Safety (S_2)	People Movement Safety (S_3)	General Safety (S_4)
1. Construction	-2	-2		-2
2. Interior Finish (Corr. and Exit)	3		3	3
3. Interior Finish (Rooms)	3			3
4. Corridor Partitions/Walls	2			2
5. Doors to Corridor	1		1	1
6. Zone Dimensions			0	0
7. Vertical Openings	0		0	0
8. Hazardous Areas	0	0		0
9. Smoke Control			0	0
10. Emergency Movement Routes			-8	-8
11. Manual Fire Alarm		2		2
12. Smoke Detection and Alarm		3	3	3
13. Automatic Sprinklers	10	10	10 ÷ 2 = 5	10
Total Value	S_1= 17	S_2= 13	S_3= 4	S_4= 14

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

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

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

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

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

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

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

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

TABLE 7. ZONE FIRE SAFETY EQUIVALENCY EVALUATION									Yes	No
Containment Safety (S_1)	minus	Mandatory Containment (S_a)	≥ 0	S_1 17	−	S_a 5	=	C 12	√	
Extinguishment Safety (S_2)	minus	Mandatory Extinguishment (S_b)	≥ 0	S_2 13	−	S_b 4	=	E 9	√	
People Movement Safety (S_3)	minus	Mandatory People Movement (S_c)	≥ 0	S_3 4	−	S_c 1	=	P 3	√	
General Safety (S_4)	minus	Occupancy Risk (R)	≥ 0	S_4 14	−	R 11	=	G 3	√	

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

CONCLUSIONS

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

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

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

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

Form Approved
OMB Exempt

ZONE 4 OF 11 ZONES

FIRE/SMOKE ZONE* EVALUATION WORKSHEET FOR HEALTH CARE FACILITIES

2000 LIFE SAFETY CODE

FACILITY	BUILDING
EBENEZER CARE CENTER	01 - MAIN BUILDING
ZONE(S) EVALUATED: FIRST FLOOR NORTH	
PROVIDER/VENDOR NO. 245587	DATE OF SURVEY 01/13/2016

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

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

TABLE 1. OCCUPANCY RISK PARAMETER FACTORS

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

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

TABLE 2. OCCUPANCY RISK FACTOR CALCULATION

	M		D		L		T		A		F
OCCUPANCY RISK	3.2	X	2.0	X	1.1	X	1.5	X	1.2	=	12.7

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

TABLE 3A. (NEW BUILDINGS)

	F		R
1.0 X		=	

TABLE 3B. (EXISTING BUILDINGS)

	F		R	
0.6 X	12.7	=	7.6	= 8

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

SURVEYOR SIGNATURE Robert J. Vinciotte, FIRE SAFETY RESOURCES, LLC	TITLE PRESIDENT	DATE 01/14/2016
FIRE AUTHORITY SIGNATURE Thomas Linhoff 12424	TITLE Supervisor	DATE 02-18-2016

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

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

TABLE 4.

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

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

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

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

NOTE:

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

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

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

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

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

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

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

For SI units: 1 ft = 0.3048 m

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

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

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

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

TABLE 5. INDIVIDUAL SAFETY EVALUATIONS

Safety Parameters	Containment Safety (S_1)	Extinguishment Safety (S_2)	People Movement Safety (S_3)	General Safety (S_4)
1. Construction	-2	-2		-2
2. Interior Finish (Corr. and Exit)	3		3	3
3. Interior Finish (Rooms)	3			3
4. Corridor Partitions/Walls	2			2
5. Doors to Corridor	1		1	1
6. Zone Dimensions			0	0
7. Vertical Openings	0		0	0
8. Hazardous Areas	0	0		0
9. Smoke Control			0	0
10. Emergency Movement Routes			-8	-8
11. Manual Fire Alarm		2		2
12. Smoke Detection and Alarm		3	3	3
13. Automatic Sprinklers	10	10	10 ÷ 2 = 5	10
Total Value	S_1= 17	S_2= 13	S_3= 4	S_4= 14

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

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

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

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

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

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

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

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

TABLE 7. ZONE FIRE SAFETY EQUIVALENCY EVALUATION								Yes	No
Containment Safety (S_1)	minus	Mandatory Containment (S_a)	≥ 0	S_1 17	−	S_a 5	= C 12	√	
Extinguishment Safety (S_2)	minus	Mandatory Extinguishment (S_b)	≥ 0	S_2 13	−	S_b 4	= E 9	√	
People Movement Safety (S_3)	minus	Mandatory People Movement (S_c)	≥ 0	S_3 4	−	S_c 1	= P 3	√	
General Safety (S_4)	minus	Occupancy Risk (R)	≥ 0	S_4 14	−	R 8	= G 6	√	

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

CONCLUSIONS

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

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

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

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

Form Approved
OMB Exempt

ZONE 5 OF 11 ZONES

FIRE/SMOKE ZONE* EVALUATION WORKSHEET FOR HEALTH CARE FACILITIES

2000 LIFE SAFETY CODE

FACILITY	BUILDING
EBENEZER CARE CENTER	01-MAIN BUILDING
ZONE(S) EVALUATED: FIRST FLOOR SOUTH	
PROVIDER/VENDOR NO.: 245587	DATE OF SURVEY: 01/13/2016

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

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

TABLE 1. OCCUPANCY RISK PARAMETER FACTORS

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

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

TABLE 2. OCCUPANCY RISK FACTOR CALCULATION

	M		D		L		T		A		F
OCCUPANCY RISK	1.6	X	1.5	X	1.1	X	4.0	X	1.2	=	12.7

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

TABLE 3A. (NEW BUILDINGS)

	F		R
1.0 X		=	

TABLE 3B. (EXISTING BUILDINGS)

	F		R	
0.6 X	12.7	=	7.6	=8

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

SURVEYOR SIGNATURE	TITLE	DATE
Robert V. Umfville, FIRE SAFETY RESOURCES, LLC	PRESIDENT	01/14/2016
FIRE AUTHORITY SIGNATURE	TITLE	DATE
Thomas Linhoff 12424	Supervisor	02-18-2016

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

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

TABLE 4.

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

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

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

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

NOTE:

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

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

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

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

For SI units: 1 ft = 0.3048 m

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

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

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

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

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

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

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

TABLE 5. INDIVIDUAL SAFETY EVALUATIONS

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

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

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

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

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

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

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

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

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

TABLE 7. ZONE FIRE SAFETY EQUIVALENCY EVALUATION									Yes	No
Containment Safety (S_1)	minus	Mandatory Containment (S_a)	≥ 0	S_1 15	−	S_a 5	=	C 10	√	
Extinguishment Safety (S_2)	minus	Mandatory Extinguishment (S_b)	≥ 0	S_2 13	−	S_b 4	=	E 9	√	
People Movement Safety (S_3)	minus	Mandatory People Movement (S_c)	≥ 0	S_3 4	−	S_c 1	=	P 3	√	
General Safety (S_4)	minus	Occupancy Risk (R)	≥ 0	S_4 12	−	R 8	=	G 4	√	

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

CONCLUSIONS

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

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

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

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

Form Approved
OMB Exempt

ZONE 6 OF 11 ZONES

FIRE/SMOKE ZONE* EVALUATION WORKSHEET FOR HEALTH CARE FACILITIES

2000 LIFE SAFETY CODE

FACILITY	BUILDING
EBENEZER CARE CENTER	01-MAIN BUILDING
ZONE(S) EVALUATED: SECOND FLOOR CENTER	
PROVIDER/VENDOR NO.: 245587	DATE OF SURVEY: 01/13/2016

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

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

TABLE 1. OCCUPANCY RISK PARAMETER FACTORS

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

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

TABLE 2. OCCUPANCY RISK FACTOR CALCULATION

	M		D		L		T		A		F
OCCUPANCY RISK	3.2	X	1.5	X	1.2	X	1.5	X	1.2	=	10.4

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

TABLE 3A. (NEW BUILDINGS)

	F		R
1.0 X		=	

TABLE 3B. (EXISTING BUILDINGS)

	F		R	
0.6 X	10.4	=	6.2	=7

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

SURVEYOR SIGNATURE: Robert W. Imhoff, FIRE SAFETY RESOURCES, LLC	TITLE: PRESIDENT	DATE: 01/14/2016
FIRE AUTHORITY SIGNATURE: Thomas Linhoff 12424	TITLE: Supervisor	DATE: 02-18-2016

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

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

TABLE 4.

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

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

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

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

NOTE:

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

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

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

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

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

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

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

For SI units: 1 ft = 0.3048 m

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

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

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

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

TABLE 5. INDIVIDUAL SAFETY EVALUATIONS

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

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

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

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

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

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

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

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

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

TABLE 7. ZONE FIRE SAFETY EQUIVALENCY EVALUATION									Yes	No
Containment Safety (S_1)	minus	Mandatory Containment (S_a)	≥ 0	S_1 15	−	S_a 9	=	C 6	√	
Extinguishment Safety (S_2)	minus	Mandatory Extinguishment (S_b)	≥ 0	S_2 11	−	S_b 6	=	E 5	√	
People Movement Safety (S_3)	minus	Mandatory People Movement (S_c)	≥ 0	S_3 4	−	S_c 3	=	P 1	√	
General Safety (S_4)	minus	Occupancy Risk (R)	≥ 0	S_4 12	−	R 7	=	G 5	√	

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

CONCLUSIONS

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

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

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

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

Form Approved
OMB Exempt

ZONE 7 OF 11 ZONES

FIRE/SMOKE ZONE* EVALUATION WORKSHEET FOR HEALTH CARE FACILITIES

2000 LIFE SAFETY CODE

FACILITY	BUILDING
EBENEZER CARE CENTER	01-MAIN BUILDING
ZONE(S) EVALUATED: SECOND FLOOR NORTH	
PROVIDER/VENDOR NO.: 245587	DATE OF SURVEY: 01/13/2016

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

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

TABLE 1. OCCUPANCY RISK PARAMETER FACTORS

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

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

TABLE 2. OCCUPANCY RISK FACTOR CALCULATION

	M		D		L		T		A		F
OCCUPANCY RISK	3.2	X	1.5	X	1.2	X	1.5	X	1.2	=	10.4

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

TABLE 3A. (NEW BUILDINGS)

	F		R
1.0 X		=	

TABLE 3B. (EXISTING BUILDINGS)

	F		R	
0.6 X	10.4	=	6.2	= 7

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

SURVEYOR SIGNATURE: Robert W. Umhoffer — FIRE SAFETY RESOURCES, LLC	TITLE: PRESIDENT	DATE: 01/14/2016
FIRE AUTHORITY SIGNATURE: Thomas Linhoff 12424	TITLE: Supervisor	DATE: 02-18-2016

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

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

TABLE 4.

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

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

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

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

NOTE:

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

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

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

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

For SI units: 1 ft = 0.3048 m

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

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

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

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

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

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

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

TABLE 5. INDIVIDUAL SAFETY EVALUATIONS

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

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

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

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

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

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

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

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

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

TABLE 7. ZONE FIRE SAFETY EQUIVALENCY EVALUATION								Yes	No
Containment Safety (S_1)	minus	Mandatory Containment (S_a)	≥ 0	S_1 15	−	S_a 9	= C 6	√	
Extinguishment Safety (S_2)	minus	Mandatory Extinguishment (S_b)	≥ 0	S_2 11	−	S_b 6	= E 5	√	
People Movement Safety (S_3)	minus	Mandatory People Movement (S_c)	≥ 0	S_3 4	−	S_c 3	= P 1	√	
General Safety (S_4)	minus	Occupancy Risk (R)	≥ 0	S_4 12	−	R 7	= G 5	√	

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

CONCLUSIONS

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

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

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

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

Form Approved
OMB Exempt

ZONE 8 OF 11 ZONES

FIRE/SMOKE ZONE* EVALUATION WORKSHEET FOR HEALTH CARE FACILITIES

2000 LIFE SAFETY CODE

FACILITY	BUILDING
EBENEZER CARE CENTER	01-MAIN BUILDING
ZONE(S) EVALUATED: SECOND FLOOR SOUTH	
PROVIDER/VENDOR NO.: 245587	DATE OF SURVEY: 01/13/2016

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

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

TABLE 1. OCCUPANCY RISK PARAMETER FACTORS

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

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

TABLE 2. OCCUPANCY RISK FACTOR CALCULATION

	M		D		L		T		A		F
OCCUPANCY RISK	3.2	X	1.5	X	1.2	X	1.5	X	1.2	=	10.4

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

TABLE 3A. (NEW BUILDINGS)

	F		R
1.0 X		=	

TABLE 3B. (EXISTING BUILDINGS)

	F		R
0.6 X	10.4	=	6.2 = 7

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

SURVEYOR SIGNATURE: Robert V. Vintille, FIRE SAFETY RESOURCES, LLC	TITLE: PRESIDENT	DATE: 01/14/2016
FIRE AUTHORITY SIGNATURE: Thomas Linhoff 12424	TITLE: Supervisor	DATE: 02-18-2016

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

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

TABLE 4.

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

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

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

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

NOTE:

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

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

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

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

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

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

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

For SI units: 1 ft = 0.3048 m

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

A. Transfer each of the 13 circled Safety Parameter Values from Table 4 to every unshaded block in the line with the corresponding Safety Parameter in Table 5. For Safety Parameter 13 (Sprinklers) the value entered in the People Movement Safety column is recorded in Table 5 as 1/2 the corresponding value circled in Table 4.

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

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

TABLE 5. INDIVIDUAL SAFETY EVALUATIONS

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

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

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

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

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

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

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

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

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

TABLE 7. ZONE FIRE SAFETY EQUIVALENCY EVALUATION									Yes	No
Containment Safety (S_1)	minus	Mandatory Containment (S_a)	≥ 0	S_1 15	−	S_a 9	=	C 6	√	
Extinguishment Safety (S_2)	minus	Mandatory Extinguishment (S_b)	≥ 0	S_2 11	−	S_b 6	=	E 5	√	
People Movement Safety (S_3)	minus	Mandatory People Movement (S_c)	≥ 0	S_3 4	−	S_c 3	=	P 1	√	
General Safety (S_4)	minus	Occupancy Risk (R)	≥ 0	S_4 12	−	R 7	=	G 5	√	

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

CONCLUSIONS

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

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

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

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

Form Approved
OMB Exempt

ZONE 9 OF 11 ZONES

FIRE/SMOKE ZONE* EVALUATION WORKSHEET FOR HEALTH CARE FACILITIES

2000 LIFE SAFETY CODE

FACILITY	BUILDING
EBENEZER CARE CENTER	01-MAIN BUILDING
ZONE(S) EVALUATED: THIRD FLOOR CENTER	
PROVIDER/VENDOR NO.: 245587	DATE OF SURVEY: 01/13/2016

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

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

TABLE 1. OCCUPANCY RISK PARAMETER FACTORS

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

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

TABLE 2. OCCUPANCY RISK FACTOR CALCULATION

	M		D		L		T		A		F
OCCUPANCY RISK	3.2	X	1.5	X	1.2	X	1.5	X	1.2	=	10.4

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

TABLE 3A. (NEW BUILDINGS)

	F		R
1.0 X		=	

TABLE 3B. (EXISTING BUILDINGS)

	F		R
0.6 X	10.4	=	6.2 = 7

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

SURVEYOR SIGNATURE	TITLE	DATE
Robert V. Imbrotta, FIRE SAFETY RESOURCES, LLC	PRESIDENT	01/14/2016
FIRE AUTHORITY SIGNATURE	**TITLE**	**DATE**
Thomas Linhoff 12424	Supervisor	02-18-2016

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

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

TABLE 4.

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

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

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

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

NOTE:

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

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

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

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

For SI units: 1 ft = 0.3048 m

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

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

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

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

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

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

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

TABLE 5. INDIVIDUAL SAFETY EVALUATIONS

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

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

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

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

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

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

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

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

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

TABLE 7. ZONE FIRE SAFETY EQUIVALENCY EVALUATION									Yes	No
Containment Safety (S_1)	minus	Mandatory Containment (S_a)	≥ 0	S_1 10	−	S_a 9	=	C 1	√	
Extinguishment Safety (S_2)	minus	Mandatory Extinguishment (S_b)	≥ 0	S_2 6	−	S_b 6	=	E 0	√	
People Movement Safety (S_3)	minus	Mandatory People Movement (S_c)	≥ 0	S_3 4	−	S_c 3	=	P 1	√	
General Safety (S_4)	minus	Occupancy Risk (R)	≥ 0	S_4 7	−	R 7	=	G 0	√	

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

CONCLUSIONS

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

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

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

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

Form Approved
OMB Exempt

ZONE 10 OF 11 ZONES

FIRE/SMOKE ZONE* EVALUATION WORKSHEET FOR HEALTH CARE FACILITIES

2000 LIFE SAFETY CODE

FACILITY	BUILDING
EBENEZER CARE CENTER	01-MAIN BUILDING
ZONE(S) EVALUATED: THIRD FLOOR NORTH	
PROVIDER/VENDOR NO.: 245587	DATE OF SURVEY: 01/13/2016

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

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

TABLE 1. OCCUPANCY RISK PARAMETER FACTORS

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

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

TABLE 2. OCCUPANCY RISK FACTOR CALCULATION

	M		D		L		T		A		F
OCCUPANCY RISK	3.2	X	1.5	X	1.2	X	1.5	X	1.2	=	10.4

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

TABLE 3A. (NEW BUILDINGS)

F		R
1.0 X		=

TABLE 3B. (EXISTING BUILDINGS)

F		R
0.6 X	10.4	= 6.2 = 7

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

SURVEYOR SIGNATURE	TITLE	DATE
Robert L. Vinhale, FIRE SAFETY RESOURCES, LLC	PRESIDENT	01/14/2016
FIRE AUTHORITY SIGNATURE	TITLE	DATE
Thomas Linhoff 12424	Supervisor	02-18-2016

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

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

TABLE 4.

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

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

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

7. Vertical Openings	Open 4 or More Floors	Open 2 or 3 Floors	Enclosed with Indicated Fire Resist.		
			<1 hr	≥1 hr to <2 hr	≥2 hr
	-14	-10	0	2(0)[e]	3(0)[e]
8. Hazardous Areas	Double Deficiency		Single Deficiency		No Deficiencies
	In Zone	Outside Zone	In Zone	In Adjacent Zone	
	-11	-5	-6	-2	(0)
9. Smoke Control	No Control	Smoke Barrier Serves Zone	Mech. Assisted Systems by Zone		
	-5(0)[c]	(0)	3		

10. Emergency Movement Routes	<2 Routes	Multiple Routes			
		Deficient	W/O Horizontal Exit(s)	Horizontal Exit(s)	Direct Exit(s)
	(-8)	-2	0	1	5
11. Manual Fire Alarm	No Manual Fire Alarm		Manual Fire Alarm		
			W/O F.D. Conn.	W/F.D. Conn	
	-4		1	(2)	
12. Smoke Detection and Alarm	None	Corridor Only	Rooms Only	Corridor and Habit. Spaces	Total Spaces In Zone
	0(3)[g]	2(3)[g]	3(3)[g]	4	5
13. Automatic Sprinklers	None	Corridor and Habit. Space	Entire Building		
	0	8	(10)		

NOTE:

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

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

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

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

For SI units: 1 ft = 0.3048 m

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

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

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

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

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

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

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

TABLE 5. INDIVIDUAL SAFETY EVALUATIONS

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

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

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

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

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

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

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

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

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

TABLE 7. ZONE FIRE SAFETY EQUIVALENCY EVALUATION								Yes	No
Containment Safety (S_1)	minus	Mandatory Containment (S_a)	≥ 0	S_1 10	−	S_a 9	= C 1	√	
Extinguishment Safety (S_2)	minus	Mandatory Extinguishment (S_b)	≥ 0	S_2 6	−	S_b 6	= E 0	√	
People Movement Safety (S_3)	minus	Mandatory People Movement (S_c)	≥ 0	S_3 4	−	S_c 3	= P 1	√	
General Safety (S_4)	minus	Occupancy Risk (R)	≥ 0	S_4 7	−	R 7	= G 0	√	

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

CONCLUSIONS

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

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

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

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

Form Approved
OMB Exempt

ZONE 11 OF 11 ZONES

FIRE/SMOKE ZONE* EVALUATION WORKSHEET FOR HEALTH CARE FACILITIES

2000 LIFE SAFETY CODE

FACILITY	BUILDING
EBENEZER CARE CENTER	01-MAIN BUILDING
ZONE(S) EVALUATED: THIRD FLOOR SOUTH	
PROVIDER/VENDOR NO.: 245587	DATE OF SURVEY: 01/13/2016

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

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

TABLE 1. OCCUPANCY RISK PARAMETER FACTORS

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

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

TABLE 2. OCCUPANCY RISK FACTOR CALCULATION

	M		D		L		T		A		F
OCCUPANCY RISK	3.2	X	1.5	X	1.2	X	1.5	X	1.2	=	10.4

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

TABLE 3A. (NEW BUILDINGS)

	F		R
1.0 X		=	

TABLE 3B. (EXISTING BUILDINGS)

	F		R
0.6 X	10.4	=	6.2

= 7

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

SURVEYOR SIGNATURE	TITLE	DATE
Robert V. Intrabartolo, FIRE SAFETY RESOURCES, LLC	PRESIDENT	01/14/2016
FIRE AUTHORITY SIGNATURE	TITLE	DATE
Thomas Linhoff 12424	Supervisor	02-18-2016

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

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

TABLE 4.

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

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

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

7. Vertical Openings	Open 4 or More Floors	Open 2 or 3 Floors	Enclosed with Indicated Fire Resist.		
			<1 hr	≥1 hr to <2 hr	≥2 hr
	-14	-10	0	2(0)[e]	3(0)[e]
8. Hazardous Areas	Double Deficiency		Single Deficiency		No Deficiencies
	In Zone	Outside Zone	In Zone	In Adjacent Zone	
	-11	-5	-6	-2	(0)
9. Smoke Control	No Control	Smoke Barrier Serves Zone	Mech. Assisted Systems by Zone		
	-5(0)[c]	(0)	3		

10. Emergency Movement Routes	<2 Routes	Multiple Routes			
		Deficient	W/O Horizontal Exit(s)	Horizontal Exit(s)	Direct Exit(s)
	(-8)	-2	0	1	5
11. Manual Fire Alarm	No Manual Fire Alarm		Manual Fire Alarm		
			W/O F.D. Conn.	W/F.D. Conn	
	-4		1	(2)	
12. Smoke Detection and Alarm	None	Corridor Only	Rooms Only	Corridor and Habit. Spaces	Total Spaces In Zone
	0(3)[g]	2(3)[g]	3(3)[g]	4	5
13. Automatic Sprinklers	None	Corridor and Habit. Space	Entire Building		
	0	8	(10)		

NOTE:

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

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

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

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

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

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

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

For SI units: 1 ft = 0.3048 m

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

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

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

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

TABLE 5. INDIVIDUAL SAFETY EVALUATIONS

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

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

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

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

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

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

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

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

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

TABLE 7. ZONE FIRE SAFETY EQUIVALENCY EVALUATION									Yes	No
Containment Safety (S_1)	minus	Mandatory Containment (S_a)	≥ 0	S_1 10	−	S_a 9	=	C 1	√	
Extinguishment Safety (S_2)	minus	Mandatory Extinguishment (S_b)	≥ 0	S_2 6	−	S_b 6	=	E 0	√	
People Movement Safety (S_3)	minus	Mandatory People Movement (S_c)	≥ 0	S_3 4	−	S_c 3	=	P 1	√	
General Safety (S_4)	minus	Occupancy Risk (R)	≥ 0	S_4 7	−	R 7	=	G 0	√	

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

CONCLUSIONS

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

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245587	A. BUILDING **02 - BLDG TWO** B. WING _____	**12/29/2015**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EBENEZER CARE CENTER	**2545 PORTLAND AVENUE SOUTH MINNEAPOLIS, MN 55404**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS FIRE SAFETY A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, Fire marshal Division on December 29, 2015. At the time of this survey, Ebenezer Care Center (Builidng 2) was found in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. Ebenezer Care Center Building 2 is a 3-story building with a full basement. The building was constructed in 1952 and was determined to be of Type I (332) construction. The building is fully fire sprinklered throughout. The facility has a complete fire alarm system with smoke detection in the corridors and spaces open to the corridor, that is monitored for automatic fire department notification. The facility has a licensed capacity of 127 beds and had a census of 121 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is MET as evidenced by:	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		01/25/2016

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.

MDH
Minnesota
Department
of Health

Protecting, maintaining and improving the health of all Minnesotans

Electronically submitted
January 15, 2016

Mr. Joel Prevost, Administrator
Ebenezer Care Center
2545 Portland Avenue South
Minneapolis, MN 55404

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5587025

Dear Mr. Prevost:

The above facility was surveyed on December 28, 2015 through December 30, 2015 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and to investigate complaint number H5587040 that was found to be unsubstantiated. At the time of the survey, the survey team from the Minnesota Department of Health, Health Regulation Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

To assist in complying with the correction order(s), a "suggested method of correction" has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the deficiency within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

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

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

PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,
"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES

ONLY. THIS WILL APPEAR ON EACH PAGE.

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

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should contact Gloria Derfus at 651-201-3792.

You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.

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

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00191	A. BUILDING: _____ B. WING _____	12/30/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EBENEZER CARE CENTER	2545 PORTLAND AVENUE SOUTH MINNEAPOLIS, MN 55404

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm The State licensing orders are delineated on the attached Minnesota	2 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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2 000	Continued From page 1 Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. On December 28, 2015 through 12/30/15, surveyors of this Department's staff, visited the above provider and the following correction orders are issued. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed. Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY.	2 000		

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2 000	Continued From page 2 THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000		
2 265	MN Rule 4658.0085 Notification of Chg in Resident Health Status A nursing home must develop and implement policies to guide staff decisions to consult physicians, physician assistants, and nurse practitioners, and if known, notify the resident's legal representative or an interested family member of a resident's acute illness, serious accident, or death. At a minimum, the director of nursing services, and the medical director or an attending physician must be involved in the development of these policies. The policies must have criteria which address at least the appropriate notification times for: A. an accident involving the resident which results in injury and has the potential for requiring physician intervention; B. a significant change in the resident's physical, mental, or psychosocial status, for example, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications; C. a need to alter treatment significantly, for example, a need to discontinue an existing form of treatment due to adverse consequences, or to begin a new form of treatment; D. a decision to transfer or discharge the resident from the nursing home; or	2 265		2/8/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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2 265	Continued From page 3 E. expected and unexpected resident deaths. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure 1 of 1 resident (R30) court appointed guardian had been notified timely after falls and medications changes reviewed for notification of change. Findings include: On 12/28/15, at 3:11 p.m. during a telephone interview when R30's court appointed guardian was asked if R30 a change in condition within the past several months, guardian stated R30 had a decline in her mobility and was dependent on staff with a transfer lift. Guardian indicated she had been appointed as the guardian this last summer and prior to her involvement R30 had been admitted to the facility for rehabilitation. Guardian indicated R30 had a language barrier and disability thus she was the person who was notified of all medications, treatments, accidents and any change in condition. Guardian clarified the change in condition was not acute. R30's diagnoses included moderate mental retardation, cerebral palsy with spastic/ataxia diplegia, non-morbid obesity, epilepsy and presence of cerebrospinal fluid drainage obtained from Admission Record dated 8/5/15. Review District Court Fourth Judicial District Probate-Mental Health Division letter for guardianship dated 7/23/15, revealed R30 had been assigned a guardian.	2 265	The facility has developed and implemented policies to guide staff decisions to consult physicians, physician assistants, and nurse practitioners, and if known, notify the resident's legal representative or an interested family member of a resident's acute illness, serious accident, or death. At a minimum, the director of nursing services, and the medical director or an attending physician is involved in the development of these policies. The policies have criteria which address at least the appropriate notification times for: A. an accident involving the resident which results in injury and has the potential for requiring physician intervention; B. a significant change in the resident's physical, mental, or psychosocial status, for example, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications; C. a need to alter treatment significantly, for example, a need to discontinue an existing form of treatment due to adverse consequences, or to begin a new form of treatment; D. a decision to transfer or discharge the resident from the nursing home; or	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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2 265	Continued From page 4 During review of R30 falls/incident reports dated 12/1/14, through 12/30/15, it was revealed R30 had several falls without injury but on 12/3/14, it had been indicated as "deferred to next shift" for primary contact to be updated. In addition on 8/2/15, R30 had been found crying and crawling out of the door of her room and on the incident report had been indicated for contacting primary contact "No. too late to call family, left note for the day nurse to call." Review of all progress notes following the falls lacked documentation either the family or guardian had been updated on the falls. During further document review the following were revealed: -Physician Order dated 12/11/15, R30's Omeprazole (medication for acid reflux) had been decreased to 10 milligrams (mg) but no documentation of the guardian being notified of the change. -On 11/13/15, R30's dietary supplement medications had been discontinued and had and changed but there was no documentation of the guardian being notified of the changes in treatments/medications. -On 9/30/15, R30 had a dentist appointment had been found to have gum infection and was prescribed an oral rinse twice daily for 14 days but no documentation the guardian had been notified of the infection. R30's cognitive loss/dementia Care Area Assessment (CAA) dated 5/14/15, indicated R30 had triggered secondary to severe cognitive impairment and presence of behaviors. The CAA indicated R30 had impaired decision making skills, did not verbalize needs to staff but will on occasion use gestures to communicate needs. In addition the CAA identified R30 had cerebral palsy and had mild intellectual disabilities. R30's	2 265	E. expected and unexpected resident deaths.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00191	A. BUILDING: _____ B. WING _____	12/30/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EBENEZER CARE CENTER	2545 PORTLAND AVENUE SOUTH MINNEAPOLIS, MN 55404

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2 265	Continued From page 5	2 265		

care plan dated 7/30/14, indicated resident was at risk for psychosocial difficulty related to developmental disabilities, had limited ability to verbally communicate in her primary language and need for someone to make decisions for her. The care plan indicated R30's guardian handled R30's affairs and decisions her behalf and staff was to consult with guardian and provide information and options for decisions as needed.

On 12/30/15, at 3:10 p.m. registered nurse manager (RN)-F verified the primary contact(s) had been notified for the falls. RN-F stated she thought the staff had contacted R30's family but acknowledged there was no documentation. RN-F also verified R30 also some medications orders either medications had been discontinued, changed or decreased and no documentation of the guardian being notified. RN-F stated "definitely we should notify the family or guardian on any changes with resident treatment and condition."

On 12/30/15, at 4:24 p.m. the nurse practitioner was called and did not receive a call back.

On 12/30/15, at 4:34 p.m. when asked if she expected the guardian, POA or family to be notified of medication reductions or changes the director of nursing stated "not for the reduction. I don't think so for medications being discontinued or started. It depends what it's for." When asked if the staff were supposed to notify the guardian of all the falls DON stated "yes." DON further stated the MDS coordinator was working on a plan of correction.

Change Of Condition/Notification policy dated 12/2014, indicated the family and/or responsible party was to be notified anytime there was a

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2 265	Continued From page 6 change in a resident's condition or plan of care. The policy indicated family/responsible party would be notified on a timely manner, and if family had not been called during the night time hours, would be notified the next morning. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could develop policies and procedures to ensure each resident's representative is promptly notified of all changes in condition and/or changes in treatments. The DON or designee could educate all appropriate staff on the policies/procedures, and monitor to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty One (21) Days.	2 265		
2 560	MN Rule 4658.0405 Subp. 2 Comprehensive Plan of Care; Contents Subp. 2. Contents of plan of care. The comprehensive plan of care must list measurable objectives and timetables to meet the resident's long- and short-term goals for medical, nursing, and mental and psychosocial needs that are identified in the comprehensive resident assessment. The comprehensive plan of care must include the individual abuse prevention plan required by Minnesota Statutes, section 626.557, subdivision 14, paragraph (b). This MN Requirement is not met as evidenced by: Based on interview and document review, facility failed to develop a comprehensive care plan for 1 of 1 resident (R95) reviewed for behaviors. Findings include:	2 560	The facility will ensure that comprehensive plans of care list measurable objectives and timetables to meet the resident's long and short term goals for medical, nursing, and mental and psychosocial needs that	2/8/16

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2 560	Continued From page 7 R95's quarterly Minimum Data Set (MDS) dated 12/10/15, indicated R95 was cognitively intact and had diagnoses of lung and colon cancer, stroke and diabetes. The quarterly MDS also indicated R95 displayed physical behavioral symptoms directed toward others (hitting, kicking, pushing, scratching, grabbing, and abusing others sexually) one to three times in the last seven days. During interview on 12/29/15, at 3:09 p.m. registered nurse (RN)-C, MDS coordinator verified the MDS indicated R95 had behaviors directed towards others. RN-C stated, it was a known behavior for R95 that R95 joked around and pushed people. RN-C verified R95 did not have a behavior section in R95's care plan. RN-C stated, "These behaviors should have been care planned." During interview on 12/30/15, at 12:12 p.m. licensed social worker (LSW) said if that was a base line behavior for R95 the facility's practice would be to have interventions in place on the care plan and ensure the staff have the tools in place to carry out the interventions. The facility's policy for Admission Care Plan revised 12/13, instructed staff: "Each resident admitted to facility will have a Care Plan begun on admission to ensure each resident's needs are assessed and all care needs are met." SUGGESTED METHOD OF CORRECTION: The director of nursing or designee could direct staff to develop a care plan to include appropriate interventions for all identified care needs. A monitoring program could be established in order	2 560	are identified in the comprehensive resident assessment. The comprehensive plan of care includes the individual abuse prevention plan. R95 care plan was updated 12/29/15 to reflect behavioral focus and interventions & is current. Interdisciplinary team including (RN)-C and (LSW) was educated on 12/30/15 on development and changes to comprehensive care plans in order to maintain current documentation and plans of care. Audits are being conducted with oversight by the director of nursing and will continue for 3 months or until ongoing compliance is achieved. Audits will be reported and reviewed at the monthly QAPI meetings.	

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2 560	Continued From page 8 to assure ongoing and effective care plan interventions in response to resident care needs. TIME PERIOD FOR CORRECTION: Twenty One (21) days.	2 560		
21134	MN RULE 4658.0670 Supb. 2. Dishwashing; Sanitation, storage Sanitization; storage. All utensils and equipment must be thoroughly cleaned, and food-contact surfaces of utensils and equipment must be given sanitization treatment and must be stored in such a manner as to be protected from contamination. Cleaned and sanitized equipment and utensils must be handled in a way that protects them from contamination. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure safe and sanitary conditions for kitchen equipment that had direct contact with food preparation and storage. In addition, the facility failed to ensure hair restraints were worn to effectively keep hair from contacting exposed food. This had the potential to affect 122 of 122 residents in the facility who ate out of the kitchen. Findings include: During initial kitchen tour on 12/28/15, at 11:54 a.m. the dietary director (DD) the following was observed: - Hobart Stand up mixer was covered with plastic	21134	The facility will ensure all utensils and equipment are thoroughly cleaned and food contact surfaces of utensils and equipment are given sanitization treatment and are stored in such a manner as to be protected from contamination. Cleaned and sanitized equipment and utensils are handled in a way that protects them from contamination. All kitchen staff were educated by 12/29/15 regarding the requirements to wear hair restraints and proper use of the hand sink. The dietary team has redeveloped and implemented daily staff cleaning check	1/29/16

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21134	Continued From page 9 bag. When the bag was taken off, there was white hardened food splatter and heavy buildup of white/brown food debris around the bottom arm, backside and on and around the underside of the mixer. Food would come in contact with the debris. The DD verified the mixer needed to be cleaned, stating "it was probably used this weekend." On 12/28/15, at 5:30 p.m. during dinner meal service the following was observed: - The Two South six foot closed room tray cart had a heavy buildup of brown, white food splatter and debris on and around the inside tray holders and around the entire outside bottom of the unit and sides of the cart. The assistant dietary director (ADD) verified the cart was dirty and had staff wipe it down before filling it with the room service evening meal. DD verified the cart needed cleaning,"it is supposed to be wiped down after each meal." Food would come in contact with the debris. During followup kitchen tour on 12/29/15, at 2:05 p.m. with the registered dietitian (RD) the following was observed: - On entering the dishwashing area, a dish rack was observed to be sitting on the top of the employee hand sink. Red dish racks with cutout/indentation areas on the sides of racks had a build up of food debris in the cutout areas. After three continuous cycles of wash/rinse cycles this food debris was softened and easily removed with a paper towel. RD verified the racks were not clean and instructed the aides to remove all red racks. Clean dishes would have come in contact the leftover food debris that was present prior to the three cycles of washing.	21134	lists which includes cleaning of the Hobart mixer, cleaning of room tray carts (including the 2 South 6-foot closed room tray cart), cleaning of the red dish racks, cleaning of the Robocoupe mixer, cleaning of soup kettle and covering of soup kettles. The dietary supervisor has developed implemented a supervisory checklist which includes: hair restraint use, inspection of cleanliness for the Hobart mixer, cleanliness of room tray carts, proper use of the hand sink, cleanliness of red dish racks, cleanliness of Robocoupe mixer, cleanliness of soup kettles and proper covering of kettles. Audits are being conducted by the Dietary manager and will continue for 3 months or until ongoing compliance is achieved. Audit results will be reviewed at the facility QAPI meeting.	

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21134	Continued From page 10 During an interview on 12/28/15, at 4:40 p.m. DD stated staff have specific duties for each position and there was a supervisor checklist but cleaning "was not being done, probably not for the past six months, the supervisor checkoff list is empty." Review of Ebenezer Care Center daily cooks cleaning and task schedule with revision date 1/14/13 indicated to "clean and sanitize Robo Coupe, mixer, soup kettle and cover if used" and to initial the assigned cleaning duties after they have been completed. There was no indication that cleaning had been completed. Review of undated Ebenezer Care Center dietary aide daily cleaning/task schedule, position four included "clean and sanitize all carts, including tall bus cart." There was no indication that cleaning had been completed. SUGGESTED METHOD OF CORRECTION: The dietary director could ensure all staff have been educated and are following cleaning and reporting maintenance issues policies. Audits could be conducted and the results brought to the quality committee for review. TIME PERIOD FOR CORRECTION: Fourteen (14) days.	21134		
21385	MN Rule 4658.0800 Subp. 3 Infection Control; Staff assistance Subp. 3. Staff assistance with infection control. Personnel must be assigned to assist with the infection control program, based on the needs of the residents and nursing home, to implement the policies and procedures of the infection control program.	21385		2/8/16

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21385	Continued From page 11 This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure the standard the shared razor(s) was disinfected, this had the potential to affect 12 residents (R14, R28, R32, R43, R47, R52, R54, R58, R59, R85, R96, R131). In addition, the facility failed to ensure glucometers were cleaned properly for 2 of 2 residents (R138, R45) who had blood sugar checks to prevent the spread of blood borne infection. This had the potential to affect 23 residents who have a glucometer check. Findings include: On 12/30/15, at 8:30 a.m. electric razors were noted in the 3 south nursing station window seal. # 1. Remington electric razor that was in pieces. # 2. Phillips Norelco (blue handle) that had a razor head with debris inside. Registered nurse (RN)-B stated that they were shared razors for the entire floor, except for the people who can use it themselves and have their own razor. The residents that we shave use that one, but staff are supposed to clean it in between and we wash it down and have multiple heads [to change out]. RN-B was aware of disease that could be spread by microscopic blood particles and stated that was why we use alcohol to wash it down. -At 9:30 the director of nursing (DON) stated expect the razors to be cleaned between residents, according to policy -at 9:40 nursing assistant (NA)-D on 3 south, demonstrated cleaning of razor, disassembled, cleaned with water and brush, soap and water, stated "dries it" (and demonstrated rubbing it dry with paper towels), then cleans with alcohol swab.	21385	All razors are currently disinfected between different resident uses. New razors have been ordered for each resident requiring shaving which will allow for no longer needing residents to share electric razors. Razors will still be properly maintained for infection control purposes. This includes razors for (R14, R28, R32, R43, R47, R52, R54, R58, R59, R85, R96, R131). All nurses including RN-I and RN-J were educated on proper infection control practices for glucometers by 1/22/16. All nursing assistants and nurses including RN-B, NA-A and NA-D were trained on proper disinfection of razors 1/29/16. This training included demonstrations by the participants to ensure a thorough understanding. Audits are being conducted with oversight by the director of nursing and will continue for 3 months or until ongoing compliance is achieved. Audit results will be reviewed and reported at the facility QAPI meeting.	

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21385	Continued From page 12 NA-D stated he had not shaved anyone today, but had shaved R28 with the razor yesterday morning, and had left it to dry on the window sill (in pieces). He had not used the blue Norelco razor and could not say who had used it last. -At 10:00 the infection control nurse stated the shared razors were cleaned, and then cleaned with alcohol, then further stated we do have stronger wipes that could be used, like on the glucometers [PDA sanitizing wipes]. -At 11:30 NA-A stated that he had not shaved anyone that day, and did not know when he had last used the Blue Norelco razor. -At 1:00 R25 stated he had his own electric razor and had considered purchasing another, because he "would never share a razor." -At 1:05 R98 stated he used the shared razor on 1st floor. -At 1:10 R32 verified the use of a shared razor -At 109, R47 verified the use of a shared razor. -At 1:30 p.m. R54's sister verified use of the shared electric razor Of the 24 residents on the unit, 14 residents were shaved 2 own razors, and 12 used the shared razors. R14 was admitted to the facility on 9/17/12, with admission diagnoses of vascular dementia with behavioral disorder, stroke and hemiplegia (loss of use of 1 side of body) per the Admission Record. The nursing assistant care sheet printed on 12/30/15, directed assist of one with all personal hygiene including shaving. R28 was admitted to the facility on 3/3/14, with admission diagnoses of dementia, allergic rhinitis and major depression per the Admission Record. The nursing assistant care sheet printed on 12/30/15, directed staff to physically assist with	21385		

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21385	Continued From page 13 shaving as needed. R32 was admitted to the facility on 7/10/14, with admission diagnoses of dementia, rheumatoid arthritis, and type II diabetes per the Admission Record. The nursing assistant care sheet printed on 12/30/15, directed assist of one with all personal hygiene including shaving as needed. R32 verified that she was shaved with the shared electric razor. R43 was admitted to the facility on 11/4/14, with admission diagnoses of dementia with behavioral disorder, anxiety disorder, and hypertension (high blood pressure) per the Admission Record. The nursing assistant care sheet printed on 12/30/15, directed assist of one with all personal hygiene including shaving. R47 was admitted to the facility on 9/23/15, with admission diagnoses of COPD (lung disease), kidney disease and high blood pressure per the Admission Record. The nursing assistant care sheet printed on 12/30/15, directed: assist of one with all personal hygiene including shaving. R47 verified use of the shared electric razor. R54 was admitted to the facility on 8/5/12, with admission diagnoses of dementia with behavioral disorder and major depression per the Admission Record. The nursing assistant care sheet printed on 12/30/15, directed staff to physically assist with grooming and shave resident as needed. R54's sister verified the use of the shared razor. R58 was admitted to the facility on 5/11/06, with admission diagnoses of schizophrenia, major depression, and vitamin D deficiency per the Admission Record. The nursing assistant care sheet printed on 12/30/15, directed: staff assist of	21385		

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21385	Continued From page 14 one with all grooming tasks including shaving as needed. R59 was admitted to the facility on 11/2/09, with admission diagnoses of dementia, Alzheimer's disease and dysphagia (difficulty swallowing) per the Admission Record. The nursing assistant care sheet printed on 12/30/15, directed staff to assist of one with grooming. On 12/30/15, at 9:00 a.m. RN-B stated sometimes assist of one with grooming indicated shaving as well. R85 was admitted to the facility on 1/6/09, with admission diagnoses of vascular dementia with behavioral disturbances, lung disease, rash and other skin disorders per the Admission Record. The nursing assistant care sheet printed on 12/30/15, directed: assist of one with all personal hygiene including shaving. R96 was admitted to the facility on 10/17/12, with admission diagnoses of Parkinson's disease, dementia, and seborrhea dermatitis per the Admission Record. The nursing assistant care sheet printed on 12/30/15, indicated R96 received physical assist with grooming. R98 was admitted to the facility on 3/19/10, with admission diagnoses of dementia, cardiomyopathy and tachycardia per the Admission Record. The nursing assistant care sheet printed on 12/30/15, indicated independent with grooming, assist of one as needed, and special care with grooming due to risk of infection related to cardiomyopathy. R98 verified he used a shared razor on the 1st floor. R131 was admitted to the facility on 4/8/15, with admission diagnoses of dementia with behavioral disturbance, insomnia and vitamin D deficiency	21385		

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21385	Continued From page 15 per the Admission Record. The nursing assistant care sheet directed: assist of one with all personal hygiene including shaving. A razor disinfecting policy was requested but not provided. R138's quarterly MDS dated 10/22/15, indicated R139 had a diagnosis of diabetes and received insulin daily. During observation of glucometer (a machine used to check blood sugars) check on 12/28/15, at 5:23 p.m. RN-I brought R138 to room and placed glucometer on the bedside table. RN-I put on gloves and cleaned R138's finger. RN-I obtained a drop of blood, put it on the strip, removed gloves, removed strip and threw strip and lancet in a cup and disposed of the contents of the cup in the sharps container. RN-I placed barrier on medication cart and wiped glucometer off with a PDI Sani-Cloth AF for 40 seconds, then placed the glucometer in plastic carrier case. During an interview on 12/28/15, at 5:30 p.m. RN-I said, "What is the difference if I put it on the cart to dry or back in the container? I won't use it for at least three minutes, until it is dry. I scrubbed it and then placed it in the container." This was how the facility taught us to clean the glucometer. R45's quarterly MDS dated 11/25/15, indicated R45 had a diagnosis of diabetes and received insulin daily. During medication administration observation on 12/30/15, at 7:27 a.m. RN-J entered R45's room and set plastic carrying case on bedside table	21385		

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21385	Continued From page 16	21385		

without a barrier. RN-J performed blood sugar check-wiped finger, obtained drop of blood, tested blood. RN-J showed results to R45, removed test strip and placed glucometer in carry case on top of five insulin FlexPens and put carrying case in medication cart. When RN-J was asked when planned on disinfecting the glucometer, RN-J responded that the night shift cleans them. RN-J stated, "I will wipe it off with an alcohol wipe before I use it. Asked RN-J if the glucometer needed to disinfect it now. RN-J said no it was fine to wait until need to use it again and that it was ok to have it touching the pens because they have covers on. RN-J went to give a resident a medication. The medication cart was kept under observation until 7:43 a.m. when RN-J returned and surveyor had to intervene and request glucometer be disinfected. RN-J agreed to do so. RN-J removed glucometer from carrying case where it was sitting on five insulin pens and wiped the glucometer off with a PDI Sani-Cloth AF wipe. RN-J immediately placed the glucometer on the top of the medication cart. Glucometer was dry in less than one minute. RN-J stated, "I have to wait three minutes before I can put it in the case." Asked RN-J how long the glucometer was to remain wet with disinfectant. RN-J said, " I just need to wipe and air dry. It does not have to be visible wet. " RN-J was asked to view the instructions on the PDI Sani-Cloth AF wipe. The package instruction stated that it must remain visible wet for three minutes.

During interview on 12/30/15, at 8:00 a.m. the infection control nurse stated glucometers are to be immediately wiped down by the nurse using it with a sani wipe using a three minute wet time. The glucometer is then placed in the carrier case. The infection control nurse verified it was not ok

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21385	Continued From page 17 to wipe with alcohol pad as it did not disinfect against blood borne pathogens. The infection control nurse verified it was not ok to have the night shift nurse do the disinfecting. During interview on 12/29/15, at 3:28 p.m. the director of nurses (DON) stated the nurses were to disinfect the glucometers using the PDI wipes according to the direction on the wipe. Cleaning/Disinfecting Blood Glucose Monitor and INR Machine revised 7/12, instructed staff: "The Blood Glucose Monitor/INR machine will be cleaned/disinfected after each use with appropriate cleaner to prevent the spread of blood borne pathogens. 1. Gather your equipment. 2. Place the 2 paper towels (one on top of the other) on the bedside table to create a barrier between the table and the equipment. 3. After using the diagnostic equipment, wearing disposable gloves, machine will be disinfected using the appropriate cleaner wipes at point of service. 4. If the machine is visibly soiled with blood or body fluids clean the machine twice; use one cloth to cleanse the soiled area and one cloth to disinfect the machine. NOTE: This is to be done before taking the machine out to the nurse's cart. 5. Using the top paper towel, carry diagnostic equipment out to the nurse's cart to continue drying. Remove gloves and wash hands. The nurse will monitor the machine for continuous wet contact time and put on gloves and re-wipe if necessary. NOTE: The treated surface must remain visible wet for a full two minutes or as directed by manufacturer. Use additional wipes as needed to assure wet contact time. Let air dry."	21385		

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21385	Continued From page 18 PDI Sani-Cloth AF Germicidal Disposable wipe undated, instructed users: TO DISINFECT: "Use a wipe to remove heavy soil. Unfold a clean wipe and thoroughly wet surface. Treated surface must remain visibly wet for a full three (3) minutes. Use additional wipe(s) if needed to ensure continuous 3 minute wet contact time." SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could develop, review and/or revise policies and procedures to ensure infection control procedures and standards are maintained by all staff as appropriate. The DON or designee could educate all appropriate staff on the policies/procedures, and could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-One (21) Days.	21385		
21426	MN St. Statute 144A.04 Subd. 3 Tuberculosis Prevention And Control (a) A nursing home provider must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in CDC's Morbidity and Mortality Weekly Report (MMWR). This program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, residents, and volunteers. The Department of Health shall provide technical assistance	21426		2/8/16

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21426	Continued From page 19 regarding implementation of the guidelines. (b) Written compliance with this subdivision must be maintained by the nursing home. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to document complete results of the tuberculosis (TB) skin test (TST) that was given for 5 of 5 residents (R21, R47, R107, R53, R100) reviewed for TB screening. Findings include: R21 was admitted to the facility on 11/29/15, per R21's admission Minimum Data Set (MDS). R21's immunization record revealed R21 was given the first step TST on 11/30/15. The date read results was not documented. The second TST was given on 12/30/15 with results pending. R53 was admitted to the facility on 10/10/15, per R53's admission MDS. R53's immunization record revealed R53 was given the first step TST on 10/10/15, and the second step TST on 10/20/15. Both tests did not have the date read results documented. R100 was admitted to the facility on 10/14/15, per T100's admission MDS immunization record revealed R100 was given the first step TST on 10/14/15, and the second step TST on 10/20/15. Both tests did not have the date read results documented.	21426	The facility has established and maintained a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines. Verified R53, R100, R107, R47 TB test results were 0 millimeters induration through communication with test read nurses. Proper documentation placed in resident's immunization record charts by 12/30/15 All nurses were educated on the facility protocol for TB reading by 1/22/16. Audits are in place with oversight by the director of nursing and will continue for 3 months or until ongoing compliance is achieved. Audits results will be reviewed at the facility QAPI meeting.	

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21426	Continued From page 20 R107 was admitted to the facility on 11/5/15, per R107's admission MDS. R107's immunization record revealed R107 was given the first step TST on 11/5/15, and the second step TST on 11/15/15. Both tests did not have the date read results documented. R47 was admitted to the facility on 9/23/15, per R47's admission MDS. R47's immunization record revealed R47 was given the first step TST on 7/23/15, and the second step TST on 8/9/15. The first step TST did not have the date read results documented. In addition, both first and second step TST's did not have millimeters (mm) of duration documented. On 12/30/15, at 12:48 p.m. infection control nurse (ICN) confirmed the TST results for residents lacked complete information. ICN stated she expected when nurses read TB results they should be entering both negative results and mm of induration. The facility tuberculosis screening - resident policy dated 8/15, directed "upon admission: all residents will be assessed for symptoms of and risk factors for tuberculosis and have a 2-step TST unless otherwise indicated. Factors that may preclude the 2-step TST are: admitted from another qualified hospital or nursing facility with documentation of TST administered at that facility within the last 3 months." SUGGESTED METHOD OF CORRECTION: The director of nursing or designee, could review/revise policies on resident and employee Tuberculosis screening and perform audits to ensure the policy was being followed.	21426		

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21426	Continued From page 21 TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21426		
21565	MN Rule 4658.1325 Subp. 4 Administration of Medications Self Admin Subp. 4. Self-administration. A resident may self-administer medications if the comprehensive resident assessment and comprehensive plan of care as required in parts 4658.0400 and 4658.0405 indicate this practice is safe and there is a written order from the attending physician. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to determine whether the practice of self-administration of nebulizer medication was safe for 1 of 1 residents (R52) who observed self-administering medications. Findings include: On 12/30/15, at 7:03 a.m. R52 was up in chair dressed, opened eyes slightly and responded to verbal stimulus. A nebulized (neb) medication was running, no nurse was in the room to supervise the administration. R52 had captured the nebulizer tubing with his right index finger and had pulled the face mask slightly. Registered nurse (RN)-A who had been working at the medication cart near the nursing station, walked into the room with a cup of thin clear liquid in his hands and a medication cup. RN-A stated he was unsure if R52 had a SAM assessment or a SAM order. When asked if he was also going to give the medications in his hand, RN-A stated "his medication was the neb." RN-A then removed the neb tubing, placed it on the bedside table and left	21565	The facilitiy will ensure residents are allowed to self-administer medications if their assessment and comprehensive plan of care reflect that they are safe to do so. RN-A and RN-B were educated at the time of survey about proper self administration of medicine including R52's plan of care. All nurses were educated about proper self administration of medicine by 1/22/16. Audits are being conducted with oversight by the director of nursing and will continue for 3 months or until ongoing compliance is achieved. Audits will be reported and reviewed at the monthly QAPI meetings.	1/29/16

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21565	Continued From page 22 the room with the water and medication cup, continuing down to the end of the hall. R52 was admitted to the facility on 8/30/05, and had admission diagnoses of dementia, functional quadriplegia (loss of body control for all four limbs and several body functions) and dysphagia (inability to swallow thin liquids) per the Admission Record. The significant change Minimum Data Set dated 10/27/15, indicated R52 was never or rarely understood. According to staff assessment R52 experienced short term and long term memory problems, had severely impaired cognition function and mild depression, evidenced by poor appetite and trouble concentrating. R52 was required total dependence for transfers, extensive assistance of two staff for toilet use, bed mobility, and dressing. The significant change Care Area Assessment dated 10/27/15, indicated R52 had a diagnosis of dementia with behavior disturbances, was unable to recognize staff, room, season or that he was in a nursing home. R52 did not communicate verbally. R52 rarely makes self-understood and rarely understands, staff anticipate all needs. He had an increase with difficulty swallowing and had had times when he lets food and fluids run out of his mouth. R52 had a Physician's Order dated 10/28/15, for Duoneb Solution (breathing medication), nebulized four times a day for chronic obstructive pulmonary disease. The care plan dated 11/10/15, indicated R52 had a self-care deficit and required staff to meet all his needs due to left sided hemiplegia, from	21565		

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21565	Continued From page 23 stroke and dementia. R52 was fed by staff and had a decline in swallowing ability. R52's care plan did not indicate R52 could SAM their medications(s). On 12/29/15, at 3:20 p.m. nursing assistant-C stated R52 has been like this in the one and 1/2 years she had worked here, "but pretty unresponsive, with his eyes looking left." On 12/30/15, at 8:30 a.m. RN-B stated, R52 does not have a SAM, because he was not capable of self-administering, so he had not been assessed. A SAM policy was not found by RN-B. On 12/30/15, at 9:00 a.m. the director of nursing stated she would expect the staff nurse to stay with a patient receiving a nebulized medication, if the patient were unable to self-administer medications. SUGGESTED METHOD OF CORRECTION: The director of nursing could ensure policies are current for SAM, and licensed staff have been trained. Residents who wish to SAM could be assessed, and a system for indicating this to staff could be devised. Audits could be conducted at medication pass times, and the results brought to the quality committee for review. TIME PERIOD FOR CORRECTION: Fourteen (14) days.	21565		
21615	MN Rule 4658.1340 Subp. 2 MedicineCabinet & Preparation Area;ScheduleII Subp. 2. Storage of Schedule II drugs. A nursing home must provide separately locked compartments, permanently affixed to the	21615		1/22/16

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21615	Continued From page 24 physical plant or medication cart for storage of controlled drugs listed in Minnesota Statutes, section 152.02, subdivision 3. This MN Requirement is not met as evidenced by: Based on observation interview and document review facility failed to ensure medications were stored at the proper temperature for 13 residents (R40, R95, R101, R123, R60, R69, R7, R132, R23, R74, R38, R104, R59, R54) who received refrigerated insulin's and eye drops. Findings include: Second North: During tour looking at medication storage on the second north unit on 12/28/15, at 2:00 p.m. licensed practical nurse (LPN)-A verified the temperature of the refrigerator was 52 degrees. LPN-A stated the listed medications were stored in the refrigerator and the medications were to be stored between 30 to 40 degrees. -12 Lantus Solostar Pens (used to control blood sugar) total for R40, R95, R123, -Six Novolog FlexPens (used to control blood sugar) total for R40, and R95, -Three Humalog KwikPen (used to control blood sugar) for R101 and, -Two bottles latanoprost (reducing intraocular pressure in patients with open-angle glaucoma) solution 0.005% for R60. For the facility, the medications were: -20 prefilled influenza vaccine syringes -Fluzone High dose and, -One vial influenza dated open 11/25/15, verified by registered nurse (RN)-D. During interview on 12/28/15, at 2:15 p.m. dietary	21615	The facility provides separately locked compartments, permanently affixed to the physical plant or medication cart for storage of controlled drugs. New thermometers were ordered and placed in refrigerators 2-north and 3-north. Maintenance director verified all refrigerators to be properly functioning/operating order and maintaining proper temperatures 12/28/15. Nursing staff is required to check refrigerator temps daily. All nursing was educated as to this requirement by 1/22/16. All medications from the refrigerators on 2-north and 3-north were removed, destroyed and ordered for replacement on 12/28/15. This protected all residents on the floors including (R40, R95, R101, R123, R60, R69, R7, R132, R23, R74, R38, R104, R59, R54). New refrigerators were ordered specifically for medication and refrigerated narcotic storage and will be placed on units. Until these refrigerators are placed and put to use, all refrigerated narcotic medications are properly locked and stored in an existing double-locked	

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21615	Continued From page 25 manager stated "the fridge is not working." Temperature of 66 degrees verified by dietary manager using digital probe. On 12/28/15, at 4:30 p.m. RN-D verified there was no record of daily temps. RN-D stated dietary was supposed to check the temperature and it was not done. Third North: During tour looking at medication storage on the third north unit on 12/28/15, at 3:10 p.m. RN-G verified the temperature of the refrigerator was 56 degrees. RN-G stated the listed medications were stored in the refrigerator and that the medications were to be stored between 30 to 40 degrees: -14 Lantus Solostar Pens total for R69, R7, R23, R74, -Three vials of Lantus for R38, -One Novolog FlexPens total for R69, -One vial of Novolog for R38, -11 Humalog KwikPen total for R7, and R23, -One prefilled Prevenar (a pneumococcal vaccine) 13 for R132 and, -Four-30 ml bottles of lorazepam (used for anxiety-Ativan) 2mg/ml total for R54, R59, and R104. On 12/28/15, at 3:15 p.m. it was observed four bottles of lorazepam were locked in a red box attached to the shelf in the refrigerator. The shelf was not attached to the refrigerator and slid out when pulled on. RN-E verified "anyone could walk away with it." RN-E verified the last time the temperature was checked was 12/26/15, and the temperature at that time was 46 degrees. During interview on 12/29/15, at 10:16 a.m. RN-D said, "Only one person signs for removal of the fentanyl patch and they do it on the MAR."	21615	refrigerator. All nursing staff were educated on proper destruction of Fentanyl patches and for double signature requirements for wasting of Fentanyl patches by 1/22/16. Audits are being conducted with oversight by the director of nursing and will continue for 3 months or until ongoing compliance is achieved. Audit results will be reviewed at the facility QAPI meeting.	

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21615	Continued From page 26 During interview on 12/29/15 at 3:28 p.m. the director of nurses (DON) said, the nurses are to fold and cut the Fentanyl patch and put it in the sharps container. They sign it in the MAR for removal and replacement. According to our policy we ask for two signatures, because it is a narcotic that is highly abused. The said the temperature in the refrigerator should be no warmer than 40 degrees. The housekeepers do a log daily and notify the nurses if the temperature was out of the ranges. " Nursing should be checking the logs to ensure the temperatures are in range. Narcotics are expected to be under double lock. That would include Ativan in the third floor fridge. They [nurses] are to date multiuse vials when they open. " The DON indicated 17 nurses, 25 nursing assistants, three housekeepers and six dietary staff have access to the refrigerators where medications are stored. During interview on 12/29/15, at 4:00 p.m. environmental service director stated the housekeepers only check the temperatures of the refrigerators on Tuesdays. Storage of Medications-Long Term Care reviewed 12/2014 instructed staff: "XI. Medications requiring "refrigeration or "temperature between 2 [degree] C [Celsius -36 degrees Fahrenheit (F)] and 8 C [46 degrees F]" are kept in a refrigerator with a thermometer to allow temperature monitoring. Medications requiring storage in a cool place are refrigerated unless otherwise directed on the label. Controlled substances that require refrigeration are stored within a locked box within the refrigerator. This box must be attached to the inside of the refrigerator."	21615		

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21615	Continued From page 27 Controlled Substance Disposal-Long Term Care reviewed October 2014, instructed staff: "III. When a Fentanyl patch needs to be removed/replaced the following procedures should be followed for proper destruction of the used patch...F. Documentation of disposal must be signed by person disposing of used patch, along with witness (licensed staff) on drug destruction log sheet or narcotic book." SUGGESTED METHOD OF CORRECTION: The director of nursing or designee could educate all appropriate staff members on the processes. The director of nursing or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Seven (7) days.	21615		
21630	MN Rule 4658.1350 Subp. 2 A.B. Disposition of Medications; Destruction Subp. 2. Destruction of medications. A. Unused portions of controlled substances remaining in the nursing home after death or discharge of a resident for whom they were prescribed, or any controlled substance discontinued permanently must be destroyed in a manner recommended by the Board of Pharmacy or the consultant pharmacist. The board or the pharmacist must furnish the necessary instructions and forms, a copy of which must be kept on file in the nursing home for two years. B. Unused portions of other prescription drugs remaining in the nursing home after the death or discharge of the resident for whom they were prescribed or any prescriptions discontinued permanently, must be destroyed according to part 6800.6500, subpart 3, or must	21630		2/8/16

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21630	Continued From page 28 be returned to the pharmacy according to part 6800.2700, subpart 2. A notation of the destruction listing the date, quantity, name of medication, prescription number, signature of the person destroying the drugs, and signature of the witness to the destruction must be recorded on the clinical record. This MN Requirement is not met as evidenced by: Based on observation interview and document review facility failed to ensure fentanyl patches were properly destroyed for 3 of 3 residents (R27, R24, R48) to prevent diversion Findings include: Second Floor North: On 12/29/15, at 9:15 a.m. a tour of the medication cart was completed with RN-H. During the tour inside the narcotic box was observed an opened box of Fentanyl patches for R27. When asked what the facility policy was for disposing used patches RN-H stated, they change the Fentanyl patches at night and one nurse signs them out in the computer. RN-H verified the narcotic book only had signatures for application and none for destruction. Review of Medication Administration Records (MAR) from September to December 2015 indicated only one staff member signed for removal of Fentanyl patch. During review of R27's narcotic book record, from 12/21/15 to 12/27/15, it was revealed R27 had received the Fentanyl patch three times, each of which only one nurse had documented the destruction. First Floor South: On 12/29/15, at 8:00 a.m. a tour of the	21630	The facility will ensure that controlled substances are properly disposed including Fentanyl patches. RN-H and LPN-B have been educated as to the requirements of proper destruction of Fentanyl patches and the requirement for double signatures for administration of narcotics. All nursing staff were educated on proper destruction of Fentanyl patches and for double signature requirements for wasting of Fentanyl patches by 1/22/16. Audits are being conducted with oversight by the director of nursing and will continue for 3 months or until ongoing compliance is achieved. Audit results will be reviewed at the facility QAPI meeting.	

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21630	Continued From page 29 medication cart was completed. LPN-B verified R48's Fentanyl patch had not been double signed by two nurses when removed. LPN-B stated when a Fentanyl patch was removed two people are to sign it out in the narcotic book and fold it in half and put it in the sharps container. Review of MAR from September to December 2015 indicated only one staff member signed for removal of Fentanyl patch. During review of R48's narcotic book record, from 12/13/15 to 12/28/15, it was revealed R48 had received the Fentanyl patch six times, each of which only one nurse had documented the destruction. R24's Order Summary Report printed 12/30/15, indicated R24 had an order for Fentanyl patch 50mcg/hour (hr apply every 72 hours. Review of MAR from September to December 2015 indicated only one staff member signed for removal of Fentanyl patch. During review of R24's narcotic book record, from 12/13/15 to 12/28/15, it was revealed R48 had received the Fentanyl patch seven times, each of which only one nurse had documented the destruction During interview on 12/29/15, at 10:16 a.m. RN-D said, "Only one person signs for removal of the fentanyl patch and they do it on the MAR." During interview on 12/29/15 at 3:28 p.m. the director of nurses (DON) said, the nurses are to fold and cut the Fentanyl patch and put it in the sharps container. They sign it in the MAR for removal and replacement. According to our policy we ask for two signatures, because it is a narcotic that is highly abused." Controlled Substance Disposal-Long Term Care reviewed October 2014, instructed staff: "III. When a Fentanyl patch needs to be	21630		

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21630	Continued From page 30 removed/replaced the following procedures should be followed for proper destruction of the used patch...F. Documentation of disposal must be signed by person disposing of used patch, along with witness (licensed staff) on drug destruction log sheet or narcotic book." SUGGESTED METHOD OF CORRECTION: The pharmacist and/or director of nursing could in-service all staff responsible for medications the need to secure medications and follow disposal of medications according to the facility policy/procedure. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21630		
21695	MN Rule 4658.1415 Subp. 4 Plant Housekeeping, Operation, & Maintenance Subp. 4. Housekeeping. A nursing home must provide housekeeping and maintenance services necessary to maintain a clean, orderly, and comfortable interior, including walls, floors, ceilings, registers, fixtures, equipment, lighting, and furnishings. This MN Requirement is not met as evidenced by: Based on observations, interview and document review, the facility failed to ensure a safe , functional and sanitary environment for 2 of 2 residents (R11, R53) reviewed for environmental concerns. In addition, the facility failed to ensure safe and sanitary conditions for kitchen equipment that had direct contact with food preparation and storage. This had the potential to affect 122 of 122 residents in the facility who ate out of the kitchen.	21695	The facility provides housekeeping and maintenance services as necessary to maintain a clean, orderly and comfortable interior. The holes in the sheetrock in R11's room were patched and painted on 12/28/15. The Blue Dysom and Blue Tape was removed on 12/28/15.	2/8/16

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21695	Continued From page 31 Findings include: On 12/30/15, at 11:47 a.m. to 12:34 p.m. an environment tour was conducted with the environmental service director (ESD) and the supervisor for housekeeping and laundry (SHK) and during the following were reviewed. R11's bathroom on 12/28/15, at 3:21 p.m. during room observations the wall to the left of a grab bar on the left side of the sink was observed with holes into the wall sheetrock which appeared was due to installing new grab bar but was never sanded down or filled. In addition the right grab bar next to the toilet was observed with a blue dysom secured with blue peeling tape which exposed the adhesive part hanging off it, was soiled and was not a cleanable surface On 12/30/15, at 11:51 a.m. ESD verified stated the holes were from replacing a grab bar and had not been finished off. ESD acknowledged the wall had holes/groves in the sheetrock did create a rough surface. ESD verified the peeling tape and acknowledged was not a cleanable surface. ESD stated he would replace it with a textured grab bar. At 12:37 p.m. when asked how often the staff cleaned the rooms the supervisor for housekeeping and laundry stated rooms were cleaned daily. Both her and ESD stated even though the staff cleaned the rooms daily it would have been difficult to see the peeling tape on the grab bar as it was the same color as the plastic cloth it was securing. The supervisor for housekeeping and laundry stated the facility did not have a policy on cleaning such surfaces. Foot Grip R53's floor by the bed was observed with peeling	21695	The foot grips identified were removed on 12/30/15. Environmental services staff were educated on identifying and reporting non-cleanable surfaces on 12/31/15. A housewide audit was conducted on 1/23/16 for identifying non-cleanable surfaces. All findings are entered in to the CMMS (work-order) system to be completed no later than 2/8/16. An inspection for non-cleanable services has been added to the supervising housekeeper deep-cleaning inspection schedule. Any findings will be entered into the CMMS system for repair. A housewide audit of foot grips was completed on 1/23/16.Findings are entered into the CMMS program for completion by 2/8/16. Environemental services staff were educated on foot grips/cleanable surfaces on 12/31/15. An inspection of foot grips has been added to the supervising housekeeper deep cleaning inspection schedule. Audits are in place with oversight by the Maintenance Director. Audits will continue for 3 months or until ongoing compliance is achieved. Audit results will be reviewed at the facility QAPI meeting. The clean dish area including the window sills was thoroughly cleaned on 12/29/15. The dirty dish area table was thoroughly cleaned including the table, table legs, wall	

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21695	Continued From page 32 off black foot grips. When asked about the foot grips R53 stated she had assumed they had put there for a purpose but thought did not look good. On 12/30/15, at 12:09 p.m. ESD and the supervisor for housekeeping verified the foot grip was peeling off the floor and was not a cleanable surface. ESD stated to R53 he would remove it and replaced. The supervisor for housekeeping and laundry stated staff were supposed to alert the maintenance staff of any concerns and would be followed up. On 12/30/15, at 3:35 p.m. ESD stated the facility did not have a specific policy to the concerns identified and indicated the staff were supposed to report and a work order would be initiated for his department to address. Kitchen On 12/28/15, at 11:54 a.m. during the initial kitchen tour with the dietary director (DD) the following was observed: - the clean dish area contained an eight foot stainless steel table situated to the left of the high temperature one compartment dishwasher situated in a corner of the kitchen. Directly above this clean dish area, there were two, three foot by four foot windows with an eight inch wide window sill below them. Both the windows and sill were dirty and splattered with food particles. There was a build up of food debris along the back of and in the corners of the window sill. To the right of the dishwasher in the dirty dish area was another eight foot stainless steel table with white caulking where the table meets the wall. Approximately four feet of this caulking was black with a mold	21695	and floor. The table caulking was removed and the floor drain was replaced on 12/29/15. The soup kettle, piping, wall, flooring, perimeter baseboards and walk in cooler door handle were all thoroughly cleaned 12/30/15. The dietery team has redeveloped and implemented a daily staff cleaning check list. This includes cleaning of the dish areas, the soup kettle area, cooler door handle and the perimeter baseboards around the legs of equipment. The dietary supervisor check list has been developed and implemented to monitor for compliance this includes the dish areas, the soup kettle area, cooler door handle and the perimeter baseboards around the legs of equipment. Audits are being conducted with oversight by the dietary manager with respect to kitchen sanitation. Audits conducted in resident spaces are overseen by the maintenance director. Audits will continue for 3 months or until ongoing compliance is achieved. Audits will be reviewed at the QAPI meeting.	

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21695	Continued From page 33	21695		

type substance. The wall behind the entire length of the table was heavily splattered with a brown substance and food particles. On and around all table legs and where the wall meets the floor there was a grimy, brown/black buildup of food debris. The top of the floor drain was missing below the dishwasher where water drained into the floor. DD verified the area was dirty, needed to be cleaned and the black caulking most likely was mold and needed to be removed and replaced by maintenance.

On 12/29/15, at 2:05 p.m. during a second tour of the kitchen the following was observed and verified by the DD:

- Behind the soup kettle, the piping, wall and flooring had a heavy black/brown greasy substance. Behind the same soup kettle and to the right of the walk in cooler door an approximate two inch wide by three feet in long white molding strip was heavily soiled with a brown, sticky substance. The walk in cooler door stainless steel handle was heavily soiled with brown/black substance.

- Around the entire perimeter of the kitchen along the baseboards and on and around all legs of equipment there was a heavy buildup of black/brown grime and food debris.

During an interview on 12/28/2015, at 4:40 p.m. DD stated kitchen staff have specific duties for each position and there is a supervisor checklist but cleaning "was not being done, probably not for the past six months, the supervisor check off list is empty."

During an interview on 12/29/15, at 2:20 p.m. the cook and DD stated the floor are cleaned every

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21695	Continued From page 34 night and that maintenance was in charge of deep cleaning the floors and behind all equipment. During an interview on 12/29/15, at 3:30 p.m. registered dietitian stated there was no deep cleaning policy for the kitchen. During an interview on 12/29/15, at 3:45 p.m. the administrator stated the floors were last deep cleaned in September and due to be cleaned in December. Administrator further stated, "I would have liked it cleaned before this." During an interview on 12/29/15, at 4:00 p.m. the environmental service director stated housekeeping was responsible for cleaning the ceilings, walls and floors in the kitchen and verified the perimeter of the kitchen was dirty and needed cleaning. Review of the "Ebenezer Care Center dietary aide daily cleaning & task schedule, positions 9-5" revised 2/14/15 included that all shelves and tables on clean side be cleaned and sanitized, floors swept and moped in dish room, walls cleaned on dirty side, both by tables and opposite wall, all racks off floor at all times and floor carts be cleaned and set up for evening. There was no indication that these cleaning tasks had been completed. Review of the undated facility cleaning schedule indicated "tile and ceramic floor needs to be thoroughly scrubbed. Kitchen duties should be clean every two/three months. After task is completed date and sign off." The schedule indicated the kitchen ceiling and walls had been cleaned 11/6/15, and the "kitchen/front of coffee maker/ceramic floor scrub" had been cleaned	21695		

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21695	Continued From page 35 9/15. SUGGESTED METHOD OF CORRECTION: The administrator could develop a cleaning schedule which included all areas of the building, including the walk-in freezers and the areas around the stove/hood. An audit could be conducted periodically and report to the quality assurance committee at the quarterly meetings. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21695		
22000	MN St. Statute 626.557 Subd. 14 (a)-(c) Reporting - Maltreatment of Vulnerable Adults Subd. 14. Abuse prevention plans. (a) Each facility, except home health agencies and personal care attendant services providers, shall establish and enforce an ongoing written abuse prevention plan. The plan shall contain an assessment of the physical plant, its environment, and its population identifying factors which may encourage or permit abuse, and a statement of specific measures to be taken to minimize the risk of abuse. The plan shall comply with any rules governing the plan promulgated by the licensing agency. (b) Each facility, including a home health care agency and personal care attendant services providers, shall develop an individual abuse prevention plan for each vulnerable adult residing there or receiving services from them. The plan shall contain an individualized assessment of: (1) the person's susceptibility to abuse by other individuals, including other vulnerable adults; (2) the person's risk of abusing other vulnerable adults; and (3) statements of the specific measures to be taken to minimize the	22000		2/8/16

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22000	Continued From page 36 risk of abuse to that person and other vulnerable adults. For the purposes of this paragraph, the term "abuse" includes self-abuse. (c) If the facility, except home health agencies and personal care attendant services providers, knows that the vulnerable adult has committed a violent crime or an act of physical aggression toward others, the individual abuse prevention plan must detail the measures to be taken to minimize the risk that the vulnerable adult might reasonably be expected to pose to visitors to the facility and persons outside the facility, if unsupervised. Under this section, a facility knows of a vulnerable adult's history of criminal misconduct or physical aggression if it receives such information from a law enforcement authority or through a medical record prepared by another facility, another health care provider, or the facility's ongoing assessments of the vulnerable adult. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to complete references checks for 3 of 5 employees (E-2, E-3, E-4) prior to employment. This had the potential to affect 74 of 122 residents residing at the facility as the staff worked in multiple areas of the facility. Finding include: New employee personnel files were reviewed: E-2, a therapeutic recreation staff (TR), had a	22000	The facility has an abuse prevention plan. The facility has hiring practices that include efforts to review backgrounds and references of candidates in an effort in aid in abuse prevention. The facility conducts background checks on all staff prior to employment. The facility also does an additional background check which is not required by DHS in order to be extra thorough. The facility does a comprehensive interview of each	

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22000	Continued From page 37 hire date of 10/16/15. No reference checks were conducted or documented as done. E-3, a nursing assistant (NA), had a hire date of 8/10/15. No reference checks were conducted. E-4, a receptionist, had a hire date of 9/10/15. No reference checks were conducted or documented. The administrator handed the employee files back without the references check on 12/30/15, at 11:04 a.m. stated "It is best practice to do them, I'd like them to be done more, but we can't produce things we have not done" when asked if the facility completed reference checks for all the staff prior to employment. The facility's Abuse Prevention Plan dated 2015, indicated: "Screening 1. All potential employees will receive a background check. 2. In addition to this, all licensed potential employees will receive license status verification via the State Board of Licensure/Registry for that particular practice. 3. Ebenezer Care Center does not employ or continue to employ anyone who has a history of documented patient abuse, neglect or misappropriation of property." The policy lacked direction to include attempting to obtain information from previous and/or current employers." Suggested Method of Correction: The director of nursing (DON) could work with the administrator to ensure the abuse prohibiton policy was implemented as written to meet Federal requriements, and then could educate staff. The	22000	candidate as well as proper licensure checks prior to employment. The superivors for E-2, E-3 and E-4 were all educated of the expectation to conduct reference checks prior to offering employment to any candidate. All hiring managers and human resources personnel were educated of the expectation to conduct reference checks prior to offering a job to any candidate. The reference check requirement has been added to the Human resources checklist. Human resource personnel file audits will be conducted by the director of human resources for 3 months or until ongoing compliance is achieved. Audits will be reported and reviewed at the facility QAPI meeting.	

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22000	Continued From page 38 DON or designee could also perform audits to ensure reports to the SA occurred in the requried timeframes. Time Period for Correction: Twenty-one (21) days.	22000		

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3 000	INITIAL COMMENTS *****ATTENTION****** BOARDING CARE HOME LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm The State licensing orders are	3 000		

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3 000	Continued From page 1 delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. On December 28, 2015 through 12/30/15, surveyors of this Department's staff, visited the above provider and the following correction orders are issued. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed. Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS	3 000		

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3 000	Continued From page 2 APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	3 000		
3 601	MN St. Statute 144.56 Subp. 2c Tuberculosis Prevention And Control (a) A boarding care home must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in CDC's Morbidity and Mortality Weekly Report (MMWR). This program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, residents, and volunteers. The Department of Health shall provide technical assistance regarding implementation of The guidelines. (b) Written compliance with this subdivision must be maintained by the boarding care home. This MN Requirement is not met as evidenced	3 601		2/8/16

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3 601	Continued From page 3 by: Based on interview and document review, the facility failed to document complete results of the tuberculosis (TB) skin test (TST) that was given for 5 of 5 residents (R21, R47, R107, R53, R100) reviewed for TB screening. Findings include: R21 was admitted to the facility on 11/29/15, per R21's admission Minimum Data Set (MDS). R21's immunization record revealed R21 was given the first step TST on 11/30/15. The date read results was not documented. The second TST was given on 12/30/15 with results pending. R53 was admitted to the facility on 10/10/15, per R53's admission MDS. R53's immunization record revealed R53 was given the first step TST on 10/10/15, and the second step TST on 10/20/15. Both tests did not have the date read results documented. R100 was admitted to the facility on 10/14/15, per T100's admission MDS immunization record revealed R100 was given the first step TST on 10/14/15, and the second step TST on 10/20/15. Both tests did not have the date read results documented. R107 was admitted to the facility on 11/5/15, per R107's admission MDS. R107's immunization record revealed R107 was given the first step TST on 11/5/15, and the second step TST on 11/15/15. Both tests did not have the date read results documented. R47 was admitted to the facility on 9/23/15, per R47's admission MDS. R47's immunization record revealed R47 was given the first step TST	3 601	The facility has established and maintained a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines. Verified R53, R100, R107, R47 TB test results were 0 millimeters induration through communication with test read nurses. Proper documentation placed in resident's immunization record charts. 12/30/15 All nurses were educated on the facility protocol for TB reading by 1/22/16. Audits are in place with oversight by the director of nursing and will continue for 3 months or until ongoing compliance is achieved. Audits results will be reviewed at the facility QAPI meeting.	

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3 601	Continued From page 4 on 7/23/15, and the second step TST on 8/9/15. The first step TST did not have the date read results documented. In addition, both first and second step TST's did not have millimeters (mm) of duration documented. On 12/30/15, at 12:48 p.m. infection control nurse (ICN) confirmed the TST results for residents lacked complete information. ICN stated she expected when nurses read TB results they should be entering both negative results and mm of induration. The facility tuberculosis screening - resident policy dated 8/15, directed "upon admission: all residents will be assessed for symptoms of and risk factors for tuberculosis and have a 2-step TST unless otherwise indicated. Factors that may preclude the 2-step TST are: admitted from another qualified hospital or nursing facility with documentation of TST administered at that facility within the last 3 months." TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	3 601		
31120	MN Rule 4655.7820 Subp. 3 Medicine Cabinet; Refrigerated medications Subp. 3. Refrigerated drugs. Biologicals and other medications requiring refrigeration shall be kept in a specially locked, securely attached, and labeled, impervious container in a general use refrigerator. This MN Requirement is not met as evidenced by: Based on observation interview and document	31120	Biologicals and other medications	1/29/16

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31120	Continued From page 5 review facility failed to ensure medications were stored at the proper temperature for 13 residents (R40, R95, R101, R123, R60, R69, R7, R132, R23, R74, R38, R104, R59, R54) who received refrigerated insulin's and eye drops. Findings include: Second North: During tour looking at medication storage on the second north unit on 12/28/15, at 2:00 p.m. licensed practical nurse (LPN)-A verified the temperature of the refrigerator was 52 degrees. LPN-A stated the listed medications were stored in the refrigerator and the medications were to be stored between 30 to 40 degrees. -12 Lantus Solostar Pens (used to control blood sugar) total for R40, R95, R123, -Six Novolog FlexPens (used to control blood sugar) total for R40, and R95, -Three Humalog KwikPen (used to control blood sugar) for R101 and, -Two bottles latanoprost (reducing intraocular pressure in patients with open-angle glaucoma) solution 0.005% for R60. For the facility, the medications were: -20 prefilled influenza vaccine syringes -Fluzone High dose and, -One vial influenza dated open 11/25/15, verified by registered nurse (RN)-D. During interview on 12/28/15, at 2:15 p.m. dietary manager stated "the fridge is not working." Temperature of 66 degrees verified by dietary manager using digital probe. On 12/28/15, at 4:30 p.m. RN-D verified there was no record of daily temps. RN-D stated dietary was supposed to check the temperature and it was not done.	31120	requiring refrigeration are to be kept in a specially locked, securely attached, and labeled, impervious container in a general use refrigerator. New thermometers were ordered and placed in refrigerators 2-north and 3-north. Maintenance director verified all refrigerators to be properly functioning/operating order and maintaining proper temperatures. 12/28/15. Nursing staff is required to check refrigerator temps daily. All nursing was educated as to this requirement by 1/22/16. All medications from the refrigerators on 2-north and 3-north were removed, destroyed and ordered for replacement on 12/28/15. This protected all residents on the floors including (R40, R95, R101, R123, R60, R69, R7, R132, R23, R74, R38, R104, R59, R54) New refrigerators were ordered specifically for medication and narcotic storage and will be placed on units. Until these refrigerators are placed and put to use, all narcotic medications are properly locked and stored in an existing double-locked refrigerator. Audits are being conducted with oversight by the director of nursing and will continue for 3 months or until ongoing compliance is achieved. Audit results will be reviewed at the facility QAPI meeting.	

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31120	Continued From page 6 Third North: During tour looking at medication storage on the third north unit on 12/28/15, at 3:10 p.m. RN-G verified the temperature of the refrigerator was 56 degrees. RN-G stated the listed medications were stored in the refrigerator and that the medications were to be stored between 30 to 40 degrees: -14 Lantus Solostar Pens total for R69, R7, R23, R74, -Three vials of Lantus for R38, -One Novolog FlexPens total for R69, -One vial of Novolog for R38, -11 Humalog KwikPen total for R7, and R23, -One prefilled Prevenar (a pneumococcal vaccine) 13 for R132 and, -Four-30 ml bottles of lorazepam (used for anxiety-Ativan) 2mg/ml total for R54, R59, and R104. On 12/28/15, at 3:15 p.m. RN-E verified the last time the temperature was checked was 12/26/15, and the temperature at that time was 46 degrees. During interview on 12/29/15 at 3:28 p.m. the director of nurses (DON) said, the said the temperature in the refrigerator should be no warmer than 40 degrees. The housekeepers do a log daily and notify the nurses if the temperature was out of the ranges. "Nursing should be checking the logs to ensure the temperatures are in range. They [nurses] are to date multiuse vials when they open." During interview on 12/29/15, at 4:00 p.m. environmental service director stated the housekeepers only check the temperatures of the refrigerators on Tuesdays. Storage of Medications-Long Term Care reviewed	31120		

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31120	Continued From page 7 12/2014 instructed staff: "XI. Medications requiring "refrigeration or "temperature between 2 [degree] C [Celsius -36 degrees Fahrenheit (F)] and 8 C [46 degrees F]" are kept in a refrigerator with a thermometer to allow temperature monitoring. Medications requiring storage in a cool place are refrigerated unless otherwise directed on the label. Controlled substances that require refrigeration are stored within a locked box within the refrigerator. This box must be attached to the inside of the refrigerator." TIME PERIOD FOR CORRECTION: Fourteen (14) days.	31120		
31165	MN Rule 4655.7850 Subp. 3 Disposition of Medications; Record Subp. 3. Recording of disposition. A notation of such destruction giving date, quantity, name of medication, and prescription number shall by recorded on the resident's personal care record. Such destruction shall be witnessed and the notation signed by both persons. This MN Requirement is not met as evidenced by: Based on observation interview and document review facility failed to ensure fentanyl patches were properly destroyed for 3 of 3 residents (R27, R24, R48) to prevent diversion Findings include: Second Floor North: On 12/29/15, at 9:15 a.m. a tour of the medication cart was completed with RN-H. During	31165	The facility will ensure that medications are properly disposed including proper witnesses and documentation. Fentanyl Patches: RN-H and LPN-B have been educated as to the requirements of proper destruction of Fentanyl patches and the requirement for double signatures for administration of	2/8/16

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31165	Continued From page 8 the tour inside the narcotic box was observed an opened box of Fentanyl patches for R27. When asked what the facility policy was for disposing used patches RN-H stated, they change the Fentanyl patches at night and one nurse signs them out in the computer. RN-H verified the narcotic book only had signatures for application and none for destruction. Review of Medication Administration Records (MAR) from September to December 2015 indicated only one staff member signed for removal of Fentanyl patch. During review of R27's narcotic book record, from 12/21/15 to 12/27/15, it was revealed R27 had received the Fentanyl patch three times, each of which only one nurse had documented the destruction. First Floor South: On 12/29/15, at 8:00 a.m. a tour of the medication cart was completed. LPN-B verified R48's Fentanyl patch had not been double signed by two nurses when removed. LPN-B stated when a Fentanyl patch was removed two people are to sign it out in the narcotic book and fold it in half and put it in the sharps container. Review of MAR from September to December 2015 indicated only one staff member signed for removal of Fentanyl patch. During review of R48's narcotic book record, from 12/13/15 to 12/28/15, it was revealed R48 had received the Fentanyl patch six times, each of which only one nurse had documented the destruction. R24's Order Summary Report printed 12/30/15, indicated R24 had an order for Fentanyl patch 50mcg/hour (hr apply every 72 hours. Review of MAR from September to December 2015 indicated only one staff member signed for removal of Fentanyl patch. During review of R24's narcotic book record, from 12/13/15 to 12/28/15,	31165	narcotics. All nursing staff were educated on proper destruction of Fentanyl patches and for double signature requirements for wasting of Fentanyl patches by 1/22/16. Audits are being conducted with oversight by the director of nursing for 3 months or until ongoing compliance is achieved. Audits will be reported to the facility QAPI meeting.	

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31165	Continued From page 9 it was revealed R48 had received the Fentanyl patch seven times, each of which only one nurse had documented the destruction During interview on 12/29/15, at 10:16 a.m. RN-D said, "Only one person signs for removal of the fentanyl patch and they do it on the MAR." During interview on 12/29/15, at 3:28 p.m. the director of nurses (DON) said, the nurses are to fold and cut the Fentanyl patch and put it in the sharps container. They sign it in the MAR for removal and replacement. According to our policy we ask for two signatures, because it is a narcotic that is highly abused." Controlled Substance Disposal-Long Term Care reviewed October 2014, instructed staff: "III. When a Fentanyl patch needs to be removed/replaced the following procedures should be followed for proper destruction of the used patch...F. Documentation of disposal must be signed by person disposing of used patch, along with witness (licensed staff) on drug destruction log sheet or narcotic book." TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	31165		
31240	MN Rule 4655.8520 E Dietary Staff Requirements;Sanitary condition Dietary staff: E. Sanitary procedures and conditions shall be maintained in the operation of the dietary department at all times.	31240		2/8/16

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31240	Continued From page 10 This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure safe and sanitary conditions for kitchen equipment that had direct contact with food preparation and storage. In addition, the facility failed to ensure hair restraints were worn to effectively keep hair from contacting exposed food. This had the potential to affect 122 of 122 residents in the facility who ate out of the kitchen. Findings include: During initial kitchen tour on 12/28/15, at 11:54 a.m. the dietary director (DD) the following was observed: - Hobart Stand up mixer was covered with plastic bag. When the bag was taken off, there was white hardened food splatter and heavy buildup of white/brown food debris around the bottom arm, backside and on and around the underside of the mixer. Food would come in contact with the debris. The DD verified the mixer needed to be cleaned, stating "it was probably used this weekend." On 12/28/15, at 5:30 p.m. during dinner meal service the following was observed: - The Two South six foot closed room tray cart had a heavy buildup of brown, white food splatter and debris on and around the inside tray holders and around the entire outside bottom of the unit and sides of the cart. The assistant dietary director (ADD) verified the cart was dirty and had staff wipe it down before filling it with the room service evening meal. DD verified the cart needed cleaning,"it is supposed to be wiped down	31240	Sanitary procedures and conditions are maintained in the operation of the dietary department at all times. All kitchen staff were educated by 12/29/15 regarding the requirements to wear hair restraints and proper use of the hand sink. The dietary team has redeveloped and implemented daily staff cleaning check lists which includes cleaning of the Hobart mixer, cleaning of room tray carts (including the 2 South 6-foot closed room tray cart), cleaning of the red dish racks, cleaning of the Robocoupe mixer, cleaning of soup kettle and covering of soup kettles. The dietary supervisor has developed and implemented a supervisory checklist which includes: hair restraint use, inspection of cleanliness for the Hobart mixer, cleanliness of room tray carts, proper use of the hand sink, cleanliness of red dish racks, cleanliness of Robocoupe mixer, cleanliness of soup kettles and proper covering of kettles. Audits are being conducted with oversight by the dietary manager with respect to kitchen sanitation. Audits conducted in resident spaces are overseen by the maintenance director. Audits will continue for 3 months or until ongoing compliance is achieved. Audits will be reviewed at the QAPI meeting.	

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31240	Continued From page 11 after each meal." Food would come in contact with the debris. During followup kitchen tour on 12/29/15, at 2:05 p.m. with the registered dietitian (RD) the following was observed: - On entering the dishwashing area, a dish rack was observed to be sitting on the top of the employee hand sink. Red dish racks with cutout/indentation areas on the sides of racks had a build up of food debris in the cutout areas. After three continuous cycles of wash/rinse cycles this food debris was softened and easily removed with a paper towel. RD verified the racks were not clean and instructed the aides to remove all red racks. Clean dishes would have come in contact the leftover food debris that was present prior to the three cycles of washing. During an interview on 12/28/15, at 4:40 p.m. DD stated staff have specific duties for each position and there was a supervisor checklist but cleaning "was not being done, probably not for the past six months, the supervisor checkoff list is empty." Review of Ebenezer Care Center daily cooks cleaning and task schedule with revision date 1/14/13 indicated to "clean and sanitize Robo Coupe, mixer, soup kettle and cover if used" and to initial the assigned cleaning duties after they have been completed. There was no indication that cleaning had been completed. Review of undated Ebenezer Care Center dietary aide daily cleaning/task schedule, position four included "clean and sanitize all carts, including tall bus cart." There was no indication that cleaning had been completed. TIME PERIOD FOR CORRECTION: Twenty-one	31240		

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31240	Continued From page 12 (21) days.	31240		
31455	MN Rule 4655.9000 Subp. 1 Housekeeping; General Requirements Subpart 1. General requirements. The entire facility, including walls, floors, ceilings, registers, fixtures, equipment, and furnishings shall be maintained in a clean, sanitary, and orderly condition throughout and shall be kept free from offensive odors, dust, rubbish, and safety hazards. Accumulation of combustible material or waste in unassigned areas is prohibited. This MN Requirement is not met as evidenced by: Based on observations, interview and document review, the facility failed to ensure a safe , functional and sanitary environment for 2 of 2 residents (R11, R53) reviewed for environmental concerns. In addition, the facility failed to ensure safe and sanitary conditions for kitchen equipment that had direct contact with food preparation and storage. This had the potential to affect 122 of 122 residents in the facility who ate out of the kitchen. Findings include: On 12/30/15, at 11:47 a.m. to 12:34 p.m. an environment tour was conducted with the environmental service director (ESD) and the supervisor for housekeeping and laundry (SHK) and during the following were reviewed. R11's bathroom on 12/28/15, at 3:21 p.m. during room observations the wall to the left of a grab bar on the left side of the sink was observed with	31455	The entire facility, including walls, floors, ceilings, registers, fixtures, equipment, and furnishings are maintained in a clean, sanitary, and orderly condition throughout and are kept free from offensive odors, dust, rubbish, and safety hazards. The holes in the sheetrock in R11's room were patched and painted on 12/28/15. The Blue Dysom and Blue Tape was removed on 12/28/15. The foot grips identified were removed on 12/30/15. Environmental services staff were educated on identifying and reporting non-cleanable surfaces on 12/31/15. A housewide audit was conducted on 1/23/16 for identifying non-cleanable surfaces. All findings are entered in to the CMMS (work-order) system to be	2/8/16

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31455	Continued From page 13 holes into the wall sheetrock which appeared was due to installing new grab bar but was never sanded down or filled. In addition the right grab bar next to the toilet was observed with a blue dysom secured with blue peeling tape which exposed the adhesive part hanging off it, was soiled and was not a cleanable surface On 12/30/15, at 11:51 a.m. ESD verified stated the holes were from replacing a grab bar and had not been finished off. ESD acknowledged the wall had holes/groves in the sheetrock did create a rough surface. ESD verified the peeling tape and acknowledged was not a cleanable surface. ESD stated he would replace it with a textured grab bar. At 12:37 p.m. when asked how often the staff cleaned the rooms the supervisor for housekeeping and laundry stated rooms were cleaned daily. Both her and ESD stated even though the staff cleaned the rooms daily it would have been difficult to see the peeling tape on the grab bar as it was the same color as the plastic cloth it was securing. The supervisor for housekeeping and laundry stated the facility did not have a policy on cleaning such surfaces. Foot Grip R53's floor by the bed was observed with peeling off black foot grips. When asked about the foot grips R53 stated she had assumed they had put there for a purpose but thought did not look good. On 12/30/15, at 12:09 p.m. ESD and the supervisor for housekeeping verified the foot grip was peeling off the floor and was not a cleanable surface. ESD stated to R53 he would remove it and replaced. The supervisor for housekeeping and laundry stated staff were supposed to alert the maintenance staff of any concerns and would be followed up.	31455	completed no later than 2/8/16. An inspection for non-cleanable services has been added to the supervising housekeeper deep-cleaning inspection schedule. Any findings will be entered into the CMMS system for repair. A housewide audit of foot grips was completed on 1/23/16.Findings are entered into the CMMS program for completion by 2/8/16. Environemental services staff were educated on foot grips/cleanable surfaces on 12/31/15. An inspection of foot grips has been added to the supervising housekeeper deep cleaning inspection schedule. Audits are in place with oversight by the Maintenance Director. Audits will continue for 3 months or until ongoing compliance is achieved. Audit results will be reviewed at the facility QAPI meeting. The clean dish area including the window sills was thoroughly cleaned on 12/29/15. The dirty dish area table was thoroughly cleaned including the table, table legs, wall and floor. The table caulking was removed and the floor drain was replaced on 12/29/15. The soup kettle, piping, wall, flooring, perimeter baseboards and walk in cooler door handle were all thoroughly cleaned 12/30/15. The dietary team has redeveloped and	

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31455	Continued From page 14 On 12/30/15, at 3:35 p.m. ESD stated the facility did not have a specific policy to the concerns identified and indicated the staff were supposed to report and a work order would be initiated for his department to address. On 12/28/15, at 11:54 a.m. during the initial kitchen tour with the dietary director (DD) the following was observed: - the clean dish area contained an eight foot stainless steel table situated to the left of the high temperature one compartment dishwasher situated in a corner of the kitchen. Directly above this clean dish area, there were two, three foot by four foot windows with an eight inch wide window sill below them. Both the windows and sill were dirty and splattered with food particles. There was a build up of food debris along the back of and in the corners of the window sill. To the right of the dishwasher in the dirty dish area was another eight foot stainless steel table with white caulking where the table meets the wall. Approximately four feet of this caulking was black with a mold type substance. The wall behind the entire length of the table was heavily splattered with a brown substance and food particles. On and around all table legs and where the wall meets the floor there was a grimy, brown/black buildup of food debris. The top of the floor drain was missing below the dishwasher where water drained into the floor. DD verified the area was dirty, needed to be cleaned and the black caulking most likely was mold and needed to be removed and replaced by maintenance. On 12/29/15, at 2:05 p.m. during a second tour of the kitchen the following was observed and verified by the DD:	31455	implemented a daily staff cleaning check list. This includes cleaning of the dish areas, the soup kettle area, cooler door handle and the perimeter baseboards around the legs of equipment. The dietary supervisor check list has been developed and implemented to monitor for compliance this includes the dish areas, the soup kettle area, cooler door handle and the perimeter baseboards around the legs of equipment. Audits are being conducted with oversight by the dietary manager with respect to kitchen sanitation. Audits conducted in resident spaces are overseen by the maintenance director. Audits will continue for 3 months or until ongoing compliance is achieved. Audits will be reviewed at the QAPI meeting.	

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31455	Continued From page 15 - Behind the soup kettle, the piping, wall and flooring had a heavy black/brown greasy substance. Behind the same soup kettle and to the right of the walk in cooler door an approximate two inch wide by three feet in long white molding strip was heavily soiled with a brown, sticky substance. The walk in cooler door stainless steel handle was heavily soiled with brown/black substance. - Around the entire perimeter of the kitchen along the baseboards and on and around all legs of equipment there was a heavy buildup of black/brown grime and food debris. During an interview on 12/28/2015, at 4:40 p.m. DD stated kitchen staff have specific duties for each position and there is a supervisor checklist but cleaning "was not being done, probably not for the past six months, the supervisor check off list is empty." During an interview on 12/29/15, at 2:20 p.m. the cook and DD stated the floor are cleaned every night and that maintenance was in charge of deep cleaning the floors and behind all equipment. During an interview on 12/29/15, at 3:30 p.m. registered dietitian stated there was no deep cleaning policy for the kitchen. During an interview on 12/29/15, at 3:45 p.m. the administrator stated the floors were last deep cleaned in September and due to be cleaned in December. Administrator further stated, "I would have liked it cleaned before this." During an interview on 12/29/15, at 4:00 p.m. the environmental service director stated	31455		

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31455	Continued From page 16 housekeeping was responsible for cleaning the ceilings, walls and floors in the kitchen and verified the perimeter of the kitchen was dirty and needed cleaning. Review of the "Ebenezer Care Center dietary aide daily cleaning & task schedule, positions 9-5" revised 2/14/15 included that all shelves and tables on clean side be cleaned and sanitized, floors swept and moped in dish room, walls cleaned on dirty side, both by tables and opposite wall, all racks off floor at all times and floor carts be cleaned and set up for evening. There was no indication that these cleaning tasks had been completed. Review of the undated facility cleaning schedule indicated "tile and ceramic floor needs to be thoroughly scrubbed. Kitchen duties should be clean every two/three months. After task is completed date and sign off." The schedule indicated the kitchen ceiling and walls had been cleaned 11/6/15, and the "kitchen/front of coffee maker/ceramic floor scrub" had been cleaned 9/15. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	31455		
31830	MN Rule 144.651 Subd. 10 Patients & Residents of HCF Bill of Rights Subd. 10. Participation in planning treatment; notification of family members. (a) Residents shall have the right to participate in the planning of their health care. This right includes the opportunity to discuss treatment and alternatives with individual caregivers, the	31830		2/8/16

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opportunity to request and participate in formal care conferences, and the right to include a family member or other chosen representative, or both. In the event that the resident cannot be present, a family member or other representative chosen by the resident may be included in such conferences.

(b) If a resident who enters a facility is unconscious or comatose or is unable to communicate, the facility shall make reasonable efforts as required under paragraph (c) to notify either a family member or a person designated in writing by the resident as the person to contact in an emergency that the resident has been admitted to the facility. The facility shall allow the family member to participate in treatment planning, unless the facility knows or has reason to believe the resident has an effective advance directive to the contrary or knows the resident has specified in writing that they do not want a family member included in treatment planning. After notifying a family member but prior to allowing a family member to participate in treatment planning, the facility must make reasonable efforts, consistent with reasonable medical practice, to determine if the resident has executed an advance directive relative to the Resident's health care decisions. For purposes of this paragraph, "reasonable efforts" include:

(1) examining the personal effects of the resident;

(2) examining the medical records of the resident in the possession of the facility;

(3) inquiring of any emergency contact or family member contacted under this section whether the resident has executed an advance directive and whether the resident has a physician to whom the resident normally goes for care; and

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31830	Continued From page 18 (4) inquiring of the physician to whom the resident normally goes for care, if known, whether the resident has executed an advance directive. If a facility notifies a family member or designated emergency contact or allows a family member to participate in treatment planning in accordance with this paragraph, the facility is not liable to resident for damages on the grounds that the notification of the family member or emergency contact or the participation of the family member was improper or violated the patient ' s privacy rights. (c) In making reasonable efforts to notify a family member or designated emergency contact, the facility shall attempt to identify family members or a designated emergency contact by examining the personal effects of the resident and the medical records of the resident in the possession of the facility. If the facility is unable to notify a family member or designated emergency contact within 24 hours after the admission, the facility shall notify the county social service agency or local law enforcement agency that the resident has been admitted and the facility has been unable to notify a family member or designated emergency contact. The county social service agency and local law enforcement agency shall assist the facility in identifying and notifying a family member or designated emergency contact. A county social service agency or local law enforcement agency that assists a facility in implementing this subdivision is not liable to the resident for damages on the grounds that the notification of the family member or emergency contact or the participation of the family member was improper or violated the patient's privacy rights.	31830		

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31830	Continued From page 19 This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure 1 of 1 resident (R30) court appointed guardian had been notified timely after falls and medications changes reviewed for notification of change. Findings include: On 12/28/15, at 3:11 p.m. during a telephone interview when R30's court appointed guardian was asked if R30 a change in condition within the past several months, guardian stated R30 had a decline in her mobility and was dependent on staff with a transfer lift. Guardian indicated she had been appointed as the guardian this last summer and prior to her involvement R30 had been admitted to the facility for rehabilitation. Guardian indicated R30 had a language barrier and disability thus she was the person who was notified of all medications, treatments, accidents and any change in condition. Guardian clarified the change in condition was not acute. R30's diagnoses included moderate mental retardation, cerebral palsy with spastic/ataxia diplegia, non-morbid obesity, epilepsy and presence of cerebrospinal fluid drainage obtained from Admission Record dated 8/5/15. Review District Court Fourth Judicial District Probate-Mental Health Division letter for guardianship dated 7/23/15, revealed R30 had been assigned a guardian. During review of R30 falls/incident reports dated 12/1/14, through 12/30/15, it was revealed R30 had several falls without injury but on 12/3/14, it had been indicated as "deferred to next shift" for	31830	The facility will properly notify family members after falls, medication changes or changes of condition. The guardian of R30 has been updated of all changes in medications and/or conditions. By 1/22/16 all licensed and registered nurses have been educated of the requirement to immediately notify primary contacts/guardian of such changes. Additional review of condition changes, health updates and review of responsible party contact information are conducted during resident care conferences with resident and/or responsible party. Audits are being conducted to ensure compliance and will continue for 3 months or until ongoing compliance is achieved. The director of nursing has oversight of this audit process and audit results will be reported and reviewed at the facility QAPI meeting.	

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31830	Continued From page 20 primary contact to be updated. In addition on 8/2/15, R30 had been found crying and crawling out of the door of her room and on the incident report had been indicated for contacting primary contact "No. too late to call family, left note for the day nurse to call." Review of all progress notes following the falls lacked documentation either the family or guardian had been updated on the falls. During further document review the following were revealed: -Physician Order dated 12/11/15, R30's Omeprazole (medication for acid reflux) had been decreased to 10 milligrams (mg) but no documentation of the guardian being notified of the change. -On 11/13/15, R30's dietary supplement medications had been discontinued and had and changed but there was no documentation of the guardian being notified of the changes in treatments/medications. -On 9/30/15, R30 had a dentist appointment had been found to have gum infection and was prescribed an oral rinse twice daily for 14 days but no documentation the guardian had been notified of the infection. R30's cognitive loss/dementia Care Area Assessment (CAA) dated 5/14/15, indicated R30 had triggered secondary to severe cognitive impairment and presence of behaviors. The CAA indicated R30 had impaired decision making skills, did not verbalize needs to staff but will on occasion use gestures to communicate needs. In addition the CAA identified R30 had cerebral palsy and had mild intellectual disabilities. R30's care plan dated 7/30/14, indicated resident was at risk for psychosocial difficulty related to developmental disabilities, had limited ability to verbally communicate in her primary language	31830		

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and need for someone to make decisions for her. The care plan indicated R30's guardian handled R30's affairs and decisions her behalf and staff was to consult with guardian and provide information and options for decisions as needed.

On 12/30/15, at 3:10 p.m. registered nurse manager (RN)-F verified the primary contact(s) had been notified for the falls. RN-F stated she thought the staff had contacted R30's family but acknowledged there was no documentation. RN-F also verified R30 also some medications orders either medications had been discontinued, changed or decreased and no documentation of the guardian being notified. RN-F stated "definitely we should notify the family or guardian on any changes with resident treatment and condition."

On 12/30/15, at 4:24 p.m. the nurse practitioner was called and did not receive a call back.

On 12/30/15, at 4:34 p.m. when asked if she expected the guardian, POA or family to be notified of medication reductions or changes the director of nursing stated "not for the reduction. I don't think so for medications being discontinued or started. It depends what it's for." When asked if the staff were supposed to notify the guardian of all the falls DON stated "yes." DON further stated the MDS coordinator was working on a plan of correction.

Change Of Condition/Notification policy dated 12/2014, indicated the family and/or responsible party was to be notified anytime there was a change in a resident's condition or plan of care. The policy indicated family/responsible party would be notified on a timely manner, and if family had not been called during the night time

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31830	Continued From page 22 hours, would be notified the next morning. TIME PERIOD FOR CORRECTION: Twenty One (21) Days.	31830		
32000	MN Rule 626.557 Subd. 14 Reporting Maltreatment of Vulnerable Adults Subd. 14. Abuse prevention plans. (a) Each facility, except home health agencies and personal care attendant services providers, shall establish and enforce an ongoing written abuse prevention plan. The plan shall contain an assessment of the physical plant, its environment, and its population identifying factors which may encourage or permit abuse, and a statement of specific measures to be taken to minimize the risk of abuse. The plan shall comply with any rules governing the plan promulgated by the licensing agency. (b) Each facility, including a home health care agency and personal care attendant services providers, shall develop an individual abuse prevention plan for each vulnerable adult residing there or receiving services from them. The plan shall contain an individualized assessment of: (1) the person ' s susceptibility to abuse by other individuals, including other vulnerable adults; (2) the person's risk of abusing other vulnerable adults; and (3) statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For the purposes of this paragraph, the term "abuse" includes self-abuse. (c) If the facility, except home health agencies and personal care attendant services providers,	32000		2/8/16

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32000	Continued From page 23 knows that the vulnerable adult has committed a violent crime or an act of physical aggression toward others, the individual abuse prevention plan must detail the measures to be taken to minimize the risk that the vulnerable adult might reasonably be expected to pose to visitors to the facility and persons outside the facility, if unsupervised. Under this section, a facility knows of a vulnerable adult's history of criminal misconduct or physical aggression if it receives such information from a law enforcement authority or through a medical record prepared by another facility, another health care provider, or the facility ' s ongoing assessments of the vulnerable adult. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to complete references checks for 3 of 5 employees (E-2, E-3, E-4) prior to employment. This had the potential to affect 74 of 122 residents residing at the facility as the staff worked in multiple areas of the facility. Finding include: New employee personnel files were reviewed: E-2, a therapeutic recreation staff (TR), had a hire date of 10/16/15. No reference checks were conducted or documented as done. E-3, a nursing assistant (NA), had a hire date of 8/10/15. No reference checks were conducted. E-4, a receptionist, had a hire date of 9/10/15. No reference checks were conducted or documented.	32000	The facility will ensure reference checks are included as part of the hiring process to contribute to abuse prevention. The facility conducts background checks on all staff prior to employment. The facility also does an additional background check which is not required by DHS in order to be extra thorough. The facility does a comprehensive interview of each candidate as well as proper licensure checks prior to employment. The supervisors for E-2, E-3 and E-4 were all educated of the expectation to conduct reference checks prior to offering employment to any candidate. All hiring managers and human resources personnel were educated of the expectation to conduct reference checks	

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32000	Continued From page 24 The administrator handed the employee files back without the references check on 12/30/15, at 11:04 a.m. stated "It is best practice to do them, I'd like them to be done more, but we can't produce things we have not done" when asked if the facility completed reference checks for all the staff prior to employment. The facility's Abuse Prevention Plan dated 2015, indicated: "Screening 1. All potential employees will receive a background check. 2. In addition to this, all licensed potential employees will receive license status verification via the State Board of Licensure/Registry for that particular practice. 3. Ebenezer Care Center does not employ or continue to employ anyone who has a history of documented patient abuse, neglect or misappropriation of property." The policy lacked direction to include attempting to obtain information from previous and/or current employers. TIME PERIOD FOR CORRECTION: Twenty One (21) days.	32000	prior to offering a job to any candidate. The reference check requirement has been added to the Human resources checklist. Human resource personnel file audits will be conducted by the director of human resources for 3 months or until ongoing compliance is achieved. Audits will be reported and reviewed at the facility QAPI meeting.	