DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

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

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MEDICARE/MEDICAID PROVID NO.(L1) 245587	ER	3. NAME AND AD (L3) EBENEZER				4. TYPE OF ACTI	ON: 7 (L8) 2. Recertification	
2. STATE VENDOR OR MEDICAID (L2) 810542100	NO.	(L4) 2545 PORTI (L5) MINNEAPO		JE SOUTH	(L6) 55404	3. Termination 5. Validation	4. CHOW6. Complaint	
5. EFFECTIVE DATE CHANGE OF (L9) 05/01/2012	OWNERSHIP	7. PROVIDER/SU 01 Hospital	OF HHA	GORY 09 ESRD	03 (L7) 13 PTIP 22 CLIA	7. On-Site Visit 8. Full Survey Aft	9. Other er Complaint	
6. DATE OF SURVEY 02/1 8. ACCREDITATION STATUS: 0 Unaccredited 1 TJC 2 AOA 3 Other	9/2016 (L34) (L10)	02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	06 PRTF 07 X-Ray 08 OPT/SP	10 NF 11 ICF/IID 12 RHC	14 CORF 15 ASC 16 HOSPICE	FISCAL YEAR END	ING DATE: (L35)	
11LTC PERIOD OF CERTIFICATION From (a): To (b): 12. Total Facility Beds 13. Total Certified Beds	127 (L18) 127 (L17)	Compliance1. Ac B. Not in Comp	equirements e Based On: cceptable POC	am	And/Or Approved Waivers Of 2. Technical Personnel 3. 24 Hour RN 4. 7-Day RN (Rural St 5. Life Safety Code	1	Services Limit Director om Size	
14. LTC CERTIFIED BED BREAKDO	WN	Requirements	and/or Applied V	Waivers:	* Code: A 15. FACILITY MEETS	(L12)		
18 SNF 18/19 SNF 34	19 SNF 93	ICF	IID		1861 (e) (1) or 1861 (j) (1):	(L15)		
(L37) (L38)	(L39)	(L42)	(L43)					
16. STATE SURVEY AGENCY REM	ARKS (IF APPLICA	ABLE SHOW LTC CA	ANCELLATION :	DATE):				
17. SURVEYOR SIGNATURE		Date :			18. STATE SURVEY AGENCY	Y APPROVAL	Date:	
Gloria Derfus, Unit Superv	isor	0	2/29/2016	(L19)	K <u>amala Fiske-Downing, I</u>	Enforcement Spec	ialist 02/29/2016	
PA	RT II - TO BE	COMPLETED I	BY HCFA RI	EGIONAI	L OFFICE OR SINGLE S	STATE AGENCY		
DETERMINATION OF ELIGIBII	Participate		IPLIANCE WITI ITS ACT:	H CIVIL	 Statement of Financial Solvency (HCFA-2572) Ownership/Control Interest Disclosure Stmt (HCFA-1513) Both of the Above : 			
22. ORIGINAL DATE	23. LTC AGREE	MENT 24	4. LTC AGREEN	MENT	26. TERMINATION ACTION	ſ:	(L30)	
OF PARTICIPATION 06/01/1991	BEGINNING	G DATE	ENDING DA	TE	VOLUNTARY 00 01-Merger, Closure	05-Fail to	NTARY Meet Health/Safety	
(L24)	(L41)		(L25)		02-Dissatisfaction W/ Reimburs		Meet Agreement	
25. LTC EXTENSION DATE: (L27)	A. Suspension	VE SANCTIONS n of Admissions:	(L44)		03-Risk of Involuntary Termination 04-Other Reason for Withdrawal	OTHER	der Status Change e	
	D. Resema Si	aspension Date.	(L45)					
28. TERMINATION DATE:	29	. INTERMEDIARY/			30. REMARKS			
		00320						
	(L28)			(L31)				
31. RO RECEIPT OF CMS-1539	32	. DETERMINATION	OF APPROVAL	DATE				
	(L32)			(L33)	DETERMINATION APP	ROVAL		
·		•	-		·		·	



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, Program Specialist

Licensing and Certification Program

Kumala Fiske Downing

Health Regulation Division

Minnesota Department of Health

Kamala.Fiske-Downing@state.mn.us

Telephone: (651) 201-4112 Fax: (651) 215-9697



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 \$5587025

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, Program Specialist

Licensing and Certification Program

Kumala Fiske Downing

Health Regulation Division

Minnesota Department of Health

Kamala.Fiske-Downing@state.mn.us

Telephone: (651) 201-4112 Fax: (651) 215-9697

POST-CERTIFICATION REVISIT REPORT

	MULTIPLE CONSTRUCTION			DATE OF REV	/ISIT
	A. Building B. Wing		Y2	2/19/2016	Y3
NAME OF FACILITY		STREET ADDRESS, CITY, STATE, ZIP CODE		l.	
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).

ITE Y4			DATE Y5	ITEM Y4			DATE Y5	ITEM Y4			DATE Y5
ID Prefix	F0157	(Correction	ID Prefix	F0176)	Correction	ID Prefix			Correction
Reg. #	483.10(b)(11)	(Completed	Reg. #	483.10	0(n)	Completed	Reg. #	483.13(c)		Completed
LSC		C	02/08/2016	LSC			02/08/2016	LSC			02/08/2016
ID Prefix	F0279	(Correction	ID Prefix	F0356	3	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		C	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	i	Completed	Reg. #	483.70(h)		Completed
LSC		C	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			
REVIEWE STATE AC		REVIEWE (INITIALS)		DATE 2/29/20	016	SIGNATURE OF	SURVEYOR 8623			DATE	19/2016
REVIEWS CMS RO	ED BY	REVIEWE (INITIALS)	D BY	DATE		TITLE				DATE	
FOLLOWUP TO SURVEY COMPLETED ON 12/30/2015					R ANY UNCORREC				☐ YE	s 🗆 no	

POST-CERTIFICATION REVISIT REPORT

	MULTIPLE CONSTRUCTION A. Building 01 - MAIN BUILDING 01			DATE OF REV	/ISIT
				0/00/0040	
245587 _{Y1}	B. Wing		Y2	2/26/2016	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).

ITE Y4		DATE Y5	ITEM Y4		DATE Y5	ITEM Y4			DATE Y5
ID Prefix Reg. # LSC	NFPA 101 K0012	Correction Completed 02/08/2016	Reg. #	PA 101	Correction Completed 01/13/2016	ID Prefix Reg. # LSC	NFPA 101 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 PrefixReg. #		Correction Completed	ID Prefix Reg. # LSC			Correction Completed
ID Prefix Reg. # LSC		Correction	ID PrefixReg. #		Correction Completed	ID Prefix Reg. # LSC			Correction Completed
REVIEWE STATE AC REVIEWE CMS RO	ED BY	REVIEWED BY (INITIALS) TL/kfd REVIEWED BY (INITIALS) Y COMPLETED ON		TITLE FOR ANY UNCORRECT	9251		A SUMMARY OF	2/26/ DATE	2016
FOLLOWUP TO SURVEY COMPLETED ON 12/29/2015				RECTED DEFICIENCIE			IE E4 OII IT) (0	YE	s 🗆 no

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

ID: KKF4

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY Facility ID: 00191 1. MEDICARE/MEDICAID PROVIDER 3. NAME AND ADDRESS OF FACILITY 4. TYPE OF ACTION: 2 (L8) (L3) EBENEZER CARE CENTER 245587 NO.(L1) 1. Initial 2. Recertification (L4) 2545 PORTLAND AVENUE SOUTH 4. CHOW 3. Termination 2. STATE VENDOR OR MEDICAID NO. (L6) 55404 810542100 (L5) MINNEAPOLIS, MN 5. Validation 6. Complaint (L2) 7. On-Site Visit 9. Other 5. EFFECTIVE DATE CHANGE OF OWNERSHIP 7. PROVIDER/SUPPLIER CATEGORY 03 8. Full Survey After Complaint (L9) **05/01/2012** 05 HHA 13 PTIP 01 Hospital 09 ESRD 22 CLIA 6. DATE OF SURVEY 12/30/2015 (L34) 02 SNF/NF/Dual 06 PRTF 10 NF 14 CORF FISCAL YEAR ENDING DATE: (L35)8. ACCREDITATION STATUS: __ (L10) 03 SNF/NF/Distinct 07 X-Ray 11 ICF/IID 15 ASC 12 RHC 16 HOSPICE 06/30 0 Unaccredited 1 TJC 04 SNF 08 OPT/SP 2 AOA 3 Other 11. .LTC PERIOD OF CERTIFICATION 10.THE FACILITY IS CERTIFIED AS: A. In Compliance With And/Or Approved Waivers Of The Following Requirements: From (a): ____ 2. Technical Personnel To (b): Program Requirements 6. Scope of Services Limit Compliance Based On: ___ 3. 24 Hour RN 7. Medical Director 4. 7-Day RN (Rural SNF) 1. Acceptable POC 12. Total Facility Beds 127 (L18) 8. Patient Room Size ___ 5. Life Safety Code 127 (L17) 13. Total Certified Beds **X** B. Not in Compliance with Program 9. Beds/Room Requirements and/or Applied Waivers: (L12)* Code: 14. LTC CERTIFIED BED BREAKDOWN 15. FACILITY MEETS 19 SNF IID (L15)18 SNF 18/19 SNF ICE 1861 (e) (1) or 1861 (j) (1): 34 93 (L37) (L38) (L39) (L42)(L43) 16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE): 17. SURVEYOR SIGNATURE Date: 18. STATE SURVEY AGENCY APPROVAL 02/26/2016 (L20) 01/26/2016 Magdalene Jares, HFF NF II Kamala Fiske-Downing, Enforcement Specialist PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY 19. DETERMINATION OF ELIGIBILITY 20. COMPLIANCE WITH CIVIL 1. Statement of Financial Solvency (HCFA-2572) Ownership/Control Interest Disclosure Stmt (HCFA-1513) RIGHTS ACT: Facility is Eligible to Participate Both of the Above : Facility is not Eligible (L21) 22. ORIGINAL DATE 23. LTC AGREEMENT 24. LTC AGREEMENT 26. TERMINATION ACTION: (L30) 00 OF PARTICIPATION BEGINNING DATE ENDING DATE **VOLUNTARY** INVOLUNTARY 06/01/1991 01-Merger, Closure 05-Fail to Meet Health/Safety 02-Dissatisfaction W/ Reimbursement 06-Fail to Meet Agreement (L24)(L41)(L25)03-Risk of Involuntary Termination 25. LTC EXTENSION DATE: 27. ALTERNATIVE SANCTIONS 04-Other Reason for Withdrawal A. Suspension of Admissions: 07-Provider Status Change 00-Active (L44)(L27) B. Rescind Suspension Date: (L45)28. TERMINATION DATE: 29. INTERMEDIARY/CARRIER NO. 30. REMARKS 00320 (L31) (L28) 31. RO RECEIPT OF CMS-1539 32. DETERMINATION OF APPROVAL DATE (L32) (L33)DETERMINATION APPROVAL



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 \$5587025

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:

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

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

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

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

<u>Informal Dispute Resolution</u> - 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, Program Specialist

Licensing and Certification Program

Kumalu Fiske Downing

Health Regulation Division

Minnesota Department of Health

Kamala.Fiske-Downing@state.mn.us

Telephone: (651) 201-4112 Fax: (651) 215-9697

PRINTED: 01/26/2016 FORM APPROVED OMB NO. 0938-0391

-	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
		245587	B. WING _	·····	12/	30/2015
	PROVIDER OR SUPPLIER ER CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2545 PORTLAND AVENUE SOUTH MINNEAPOLIS, MN 55404		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 000	INITIAL COMMENT	rs	F 00	0		
	as your allegation on Department's accept enrolled in ePOC, year the bottom of the form. Your electron be used as verificate	of correction (POC) will serve of compliance upon the otance. Because you are our signature is not required a first page of the CMS-2567 nic submission of the POC will cion of compliance.				
	on-site revisit of you validate that substa	ur facility may be conducted to notial compliance with the an attained in accordance with				
		ne recertification survey tion were also completed at dard survey.				
F 157 SS=D	completed. The cor		F 15	7		2/8/16
	consult with the res known, notify the re or an interested fan accident involving the injury and has the printervention; a significant physical, mental, or deterioration in hear status in either life to clinical complication significantly (i.e., a existing form of treatments).	ediately inform the resident; ident's physician; and if esident's legal representative mily member when there is an the resident which results in estential for requiring physician ficant change in the resident's epsychosocial status (i.e., a lth, mental, or psychosocial chreatening conditions or ens); a need to alter treatment meed to discontinue an atment due to adverse o commence a new form of				
_ABORATOR\	I Y DIRECTOR'S OR PROVID	DER/SUPPLIER REPRESENTATIVE'S SIGN	NATURE	TITLE		(X6) DATE

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

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			E SURVEY PLETED
		245587	B. WING		12/3	30/2015
	PROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP CO 2545 PORTLAND AVENUE SOUTH MINNEAPOLIS, MN 55404		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 157	the resident from the §483.12(a). The facility must all and, if known, the nor interested family change in room or specified in §483. resident rights under regulations as specified in section. The facility must restrict the address and phologal representative. This REQUIREME by: Based on interview facility failed to ensappointed guardiar falls and medication notification of chance in facility failed: On 12/28/15, at 3:1 interview when R30 was asked if R30 a past several month decline in her mobistaff with a transfer	cision to transfer or discharge ne facility as specified in so promptly notify the resident resident's legal representative member when there is a roommate assignment as 15(e)(2); or a change in er Federal or State law or cified in paragraph (b)(1) of cord and periodically update none number of the resident's er or interested family member. NT is not met as evidenced and document review, the sure 1 of 1 resident (R30) court in had been notified timely after ns changes reviewed for ge. 11 p.m. during a telephone D's court appointed guardian a change in condition within the is, guardian stated R30 had a clity and was dependent on relift. The guardian indicated	F 1	The facility will immediately resident; consult with resider and if known, notify the resid representative or an interest member when there is an accinvolving the resident which injury and has the potential for physician intervention; a significant intervention; a need to alto significant intervention; an end to alto significant intervention.	nt's physician; ent's legal ed family cident results in or requiring nificant sical, mental, a deterioration cocial status in ons or clinical er treatment iscontinue an	
	staff with a transfer she had been appo and prior to her inv admitted to the fac indicated R30 had				iscontinue an le to adverse nce a new sion to ident from the	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPI A. BUILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		245587	B. WING		12/3	30/2015	
	PROVIDER OR SUPPLIER		2	STREET ADDRESS, CITY, STATE, ZIP CODE 2545 PORTLAND AVENUE SOUTH MINNEAPOLIS, MN 55404	,		
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F 157	notified of all medic and any change in the change in cond R30's care plan day was at risk for psycdevelopmental disaverbally communicand need for some The care plan indic R30's affairs and dwas to consult with information and opto During review of R312/1/14, through 12 had several falls with had been indicated primary contact to 8/2/15, R30 had be out of the door of the report had been indicated primary contact "No. too lat day nurse to call." If following the falls affamily or guardian in R30's cognitive loss Assessment (CAA) had triggered secon impairment and presindicated R30 had skills, did not verbal occasion use gestuaddition the CAA id palsy and had mild Review District Coulons.	rations, treatments, accidents condition. Guardian clarified ition was not acute. Red 7/30/14, indicated resident thosocial difficulty related to abilities, had limited ability to ate in her primary language one to make decisions for her. ated R30's guardian handled ecisions her behalf and staff guardian and provide tions for decisions as needed. Red falls/incident reports dated 2/30/15, it was revealed R30 thout injury but on 12/3/14, it as "deferred to next shift" for the property of the end of th	F 157	the resident and, if known, the res legal representative or interested the member when there is a change in or roommate assignment as specitive as a change in resident under Federal or State law or regulations. The guardian of R30 has been upuall changes in medications and/or conditions. By 1/22/16 all licensed and register nurses have been educated of the requirement to immediately notify contacts/guardian of such change. Additional review of condition chan health updates and review of responsty contact information are conducting resident care conferences resident and/or responsible party. Audits are being conducted to enscompliance and will continue for 3 or until ongoing compliance is ach. The director of nursing has oversign this audit process and audit results reported and reviewed at the facili meeting.	amily no room fied in dent or dated of ered primary s. nges, onsible lucted with ure months ieved. ght of s will be		

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES (X1) PROVIDER/SLIPPLIER/CLIA

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	IPLE CONSTRUCTION IG		TE SURVEY MPLETED	
		245587	B. WING _	·····	12	/30/2015
	PROVIDER OR SUPPLIER ER CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CO 2545 PORTLAND AVENUE SOUTH MINNEAPOLIS, MN 55404		
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F 157	R30's diagnoses in retardation, cerebra diplegia, non-morbi presence of cerebration Admission Re On 9/30/15, R30 has been found to have prescribed an oral abut no documentation otified of the infection of the	7/23/15, revealed R30 had pardian. cluded moderate mental all palsy with spastic/ataxia dispensive, epilepsy and ospinal fluid drainage obtained cord dated 8/5/15. and a dentist appointment had a gum infection and was rinse twice daily for 14 days on the guardian had been tion. dietary supplement the discontinued and had and was no documentation of the fied of the changes in	F 15			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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	PROVIDER OR SUPPLIER ER CARE CENTER		2	TREET ADDRESS, CITY, STATE, ZIP CODE 545 PORTLAND AVENUE SOUTH INNEAPOLIS, MN 55404		
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F 157	Continued From pa	ge 4	F 157			
		4 p.m. the nurse practitioner not receive a call back.				
	expected the guard family to be notified changes the director for the reduction. I do being discontinued for." When asked if notify the guardian	4 p.m. when asked if she ian, power of attorney or of medication reductions or or of nursing (DON) stated "not don't think so for medications or started. It depends what it's the staff were supposed to of all the falls DON stated stated the MDS coordinator lan of correction.				
F 176 SS=D	12/2014, indicated party was to be not change in a resider The policy indicated would be notified or family had not been hours, would be not b	on/Notification policy dated the family and/or responsible ified anytime there was a ot's condition or plan of care. If family/responsible party in a timely manner, and if in called during the night time tified the next morning. NT SELF-ADMINISTER ID SAFE	F 176		2/8/16	
	the interdisciplinary	ent may self-administer drugs if team, as defined by as determined that this				
	by: Based on observative review, the facility for practice of self-adm	NT is not met as evidenced ion, interview, and document ailed to determine whether the hinistration of nebulizer e for 1 of 1 residents (R52)		The facility will ensure self-adminis of drugs is done so safely according interdisciplinary team review and recommendation. Unless deemed s	g to	

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F 176	Findings include: On 12/30/15, at 7:0 dressed, opened eyverbal stimulus. A rwas running, no nu supervise the admithe nebulizer tubing had pulled the face nurse (RN)-A who he medication cart near into the room with a hands and a medicunsure if R52 had a order. When asked the medications in medication was the neb tubing, placed the room with the we continuing down to R52 was admitted thad admission diagonal quadriplegia (loss of and several body furth (inability to swallow Record). The significant chartology in	administering medications. 3 a.m. R52 was up in chair yes slightly and responded to nebulized (neb) medication rse was in the room to nistration. R52 had captured g with his right index finger and mask slightly. Registered had been working at the ar the nursing station, walked a cup of thin clear liquid in his ation cup. RN-A stated he was a SAM assessment or a SAM if he was also going to give his hand, RN-A stated "his eneb." RN-A then removed the it on the bedside table and left yater and medication cup,	F1	76	the interdisciplinary team, residents not be allowed to self-administer medication. RN-A were educated at the time of about proper self administration of medicine including R52's plan of care. All nurses were educated about proself administration of medicine by 1 Audits are being conducted with over by the director of nursing and will confor 3 months or until ongoing complist achieved. Audits will be reported and reviewee the monthly QAPI meetings.	survey are. oper /22/16. ersight ontinue liance	

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F 176	and dressing. The significant chardated 10/27/15, ind dementia with behato recognize staff, ranursing home. Reverbally. R52 rarely rarely understands, had an increase with had times when he his mouth. R52 had a Physician Duoneb Solution (behalized four times pulmonary disease.) The care plan dated a self-care deficit at his needs due to less troke and dementing had a decline in swell plan did not indicated medications(s). On 12/29/15, at 3:2 stated R52 has been years she had work unresponsive, with on 12/30/15, at 8:3 not have a SAM, be self-administering, and SAM policy was resulted.	inge Care Area Assessment icated R52 had a diagnosis of vior disturbances, was unable oom, season or that he was in 52 did not communicate makes self-understood and staff anticipate all needs. He h difficulty swallowing and had lets food and fluids run out of m's Order dated 10/28/15, for reathing medication), is a day for chronic obstructive did 11/10/15, indicated R52 had and required staff to meet all it sided hemiplegia, from a. R52 was fed by staff and allowing ability. R52's care in R52 could SAM their open. In the one and 1/2 and here, "but pretty his eyes looking left."	F 1	76		

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			G	(X3) DATE SURVEY COMPLETED	
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F 176 F 226 SS=E	medications. 483.13(c) DEVELO ABUSE/NEGLECT The facility must de policies and proced mistreatment, negle	able to self-administer P/IMPLMENT ETC POLICIES velop and implement written	F 17		2/8/16
	by: Based on interview facility failed to com of 5 employees (E-remployment. This has 122 residents resid worked in multiple at Finding include: New employee persuit E-2, a therapeutic raire date of 10/16/1 conducted or docur E-3, a nursing assis 8/10/15. No referent E-4, a receptionist, reference checks with documented. The administrator has 12 miles and 12 miles and 12 miles and 12 miles and 13 miles and 14 miles and 14 miles and 15 miles an	and the potential to affect 74 of ing at the facility as the staff areas of the facility. sonnel files were reviewed: ecreation staff (TR), had a 5. No reference checks were mented as done. stant (NA), had a hire date of ce checks were conducted. had a hire date of 9/10/15. No		The facility has developed and implemented written policies and procedures that prohibit mistreatmeneglect, and abuse of residents and misappropriation of resident proper. The facility conducts background con all staff prior to employment. The facility also does an additional backcheck which is not required by DHS order to be extra thorough. The facility also does a comprehensive interview of candidate as well as proper licensuchecks prior to employment. The superivors for E-2, E-3 and E-all educated of the expectation to coreference checks prior to offering employment to any candidate. All hiring managers and human respersonnel were educated of the expectation to conduct reference coprior to offering a job to any candidate.	d ty. hecks e tground ility each re were onduct ources hecks

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F 226 F 279 SS=D	at 11:04 a.m. stated them, I'd like them is produce things we have the facility complete staff prior to employ. The facility's Abuse indicated: "Screening 1. All potential estackground check. 2. In addition to employees will receivate the State Board particular practice. 3. Ebenezer Cacontinue to employ documented patient misappropriation of direction to include information from preemployers. 483.20(d), 483.20(k) COMPREHENSIVE A facility must use to to develop, review a comprehensive plant. The facility must deplan for each reside objectives and time medical, nursing, an needs that are iden assessment.	In "It is best practice to do to be done more, but we can't have not done" when asked if ed reference checks for all the yment. Prevention Plan dated 2015, employees will receive a this, all licensed potential sive license status verification of Licensure/Registry for that are Center does not employ or anyone who has a history of tabuse, neglect or property." The policy lacked attempting to obtain evious and/or current and revise the resident's	F 22	The reference check requirement been added to the Human resource checklist. Human resource personnel file aude conducted by the director of huresources for 3 months or until on compliance is achieved. Audits wireported and reviewed at the facili meeting.	dits will man going Il be	2/8/16

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F 279	psychosocial well-b §483.25; and any s be required under § due to the resident' §483.10, including under §483.10, including under §483.10(b)(4). This REQUIREMEI by: Based on interview failed to develop a of 1 resident (R95). Findings include: R95's quarterly Min 12/10/15, indicated and had diagnoses stroke and diabetes indicated R95 displ symptoms directed pushing, scratching others sexually) on seven days. During interview on registered nurse (Fiverified the MDS in directed towards of known behavior for and pushed people have a behavior se	physical, mental, and peing as required under ervices that would otherwise §483.25 but are not provided a exercise of rights under the right to refuse treatment	F 279	A facility uses the results of the assessment to develop, review and the resident's comprehensive plant 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 me and psychosocial needs that are ide in the comprehensive assessment. R95 care plan was updated 12/29/1 reflect behavioral focus and interve & is current. Interdisciplinary team including (RN and (LSW) was educated on 12/30/development and changes to comprehensive care plans in order maintain current documentation and of care. Audits are being conducted with overby the director of nursing and will contains the comprehensive care plans in order maintain current documentation and of care.	ental entified 5 to entions 1)-C 15 on to entions d plans ersight	
		12/30/15, at 12:12 p.m. ker (LSW) said if that was a		for 3 months or until ongoing compl is achieved.		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245587	B. WING _		12	/30/2015
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F 279	would be to have in care plan and ensu place to carry out th	for R95 the facility 's practice terventions in place on the re the staff have the tools in ne interventions.	F 2'	Audits will be reported and retthe monthly QAPI meetings.	∕iewed at	
F 356 SS=C	revised 12/13, instr "Each resident adm Plan begun on adm resident's needs are are met."	y for Admission Care Plan ucted staff: hitted to facility will have a Care hission to ensure each e assessed and all care needs NURSE STAFFING	F 3	56		2/8/16
	a daily basis: o Facility name. o The current date. o The total number by the following cat unlicensed nursing resident care per sh - Registered nu - Licensed prac	rses. tical nurses or licensed as defined under State law). e aides.				
	specified above on of each shift. Data o Clear and readab	ace readily accessible to				
	make nurse staffing	oon oral or written request, g data available to the public not to exceed the community				

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F 356	staffing data for a required by State last required by State last required by State last last required by: Based on observative review, the facility for nursing staff directly was updated daily in this practice had the residents who residents who residents who residents who wished visitors who wished by the Daily Nursing Findings include: During the initial too the Daily Nursing Findings included: During the initial too the Daily Nursing Findings included the facility census, hours of la (RNs), licensed pranursing assistants 12/23/15, which ward 12:33 p.m. The changed for that datour. At 12:44 p.m. infectstated "I did the stated"	aintain the posted daily nurse minimum of 18 months, or as aw, whichever is greater. NT is not met as evidenced tion, interview, and document failed to ensure the report of ty responsible for resident care to reflect actual hours worked. The potential to affect all 122 ded in the facility, family and to view the information. The posting rame, current resident bor for registered nurses actical nurses (LPNs) and (NAs). The posting was dated as five days prior. Daily Nursing Hours had been ay 12/28/15, on a follow up cition control registered nurse aff posting today because the	F 356	,	nours of aff e per sed r State data the ted as	
	coordinator posts it from 7:00 to 10:30 am not sure who ta weekends." Staff vo time of entrance wa	r is out sick today. The staffing to in the morning, anywhere a.m. because her hours vary. I alkes care of it on the erified the posting hanging at as dated 12/23/15.		The facility, upon oral or written requakes nurse staffing data available public for review at a cost not to extend the community standard. The facility maintains the posted data.	to the ceed	

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F 356	nurse approached a supervisor was respected. During interview on director of nursing (department is respected for normally doe nursing did not pick posted wrong from working on a syster problem does not respected wrong from working on a syster problem does not respected wrong from working on a syster problem does not respected wrong from working on a syster problem does not respected wrong from working on a syster problem does not respected wrong from working on a syster problem does not respected wrong from working on a syster problem does not respected wrong from working on a syster problem does not respected wrong from working on a syster problem does not respected wrong from working on a syster problem does not respect to the facility staffer projected wrong from working on a syster problem does not respect to the facility of the facility must of the fa	and stated the nursing consible for posting on the 12/30/15, at 12:04 p.m. the (DON) stated, "the nursing consible the staffing posting. My set it but she has been out sick. It is	F 35	nurse staffing data for a minimum months, or as required by State lawhichever is greater. The posting of staffing information responsibility of the staffing coordi selected designee. Staffing, nurse leadership, nurse monitors and receptionist were all educated on the necessity of daily posting of staffinformation 12/30/15. The receptionist's checklist now in checking for current day staffing information on the posting in order maintain compliance. Audits are being conducted with or by the director of nursing and will of for 3 months or until ongoing complist achieved. Audits will be reported and reviewed the monthly QAPI meetings.	is the nator or he cludes to versight continue bliance	2/8/16
	THIS REQUIRENIE	vi is not met as evidenced				

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F 371	review, the facility is anitary conditions direct contact with In addition, the faci restraints were wor contacting exposed affect 122 of 122 reout of the kitchen. Findings include: During initial kitche a.m. the dietary director white hardened for white hardened, stating "it weekend." On 12/28/15, at 5:3 service the following and around the entand sides of the cardirector (ADD) veri staff wipe it down be service evening metals.	tion, interview, and document failed to ensure safe and for kitchen equipment that had food preparation and storage. lity failed to ensure hair on to effectively keep hair from d food. This had the potential to esidents in the facility who ate on tour on 12/28/15, at 11:54 ector (DD) the following was mixer was covered with plastic g was taken off, there was od splatter and heavy buildup of ebris around the bottom arm, and around the underside of the come in contact with the cified the mixer needed to be was probably used this	F 371	The facility (1) Procures food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Stores, prepar distributes and serves food under conditions. All kitchen staff were educated by 12/29/15 regarding the requireme wear hair restraints and proper us hand sink. The dietary team has redeveloped implemented daily staff cleaning of lists which includes cleaning of the mixer, cleaning of room tray carts (including the 2 South 6-foot close tray cart), cleaning of the red dish cleaning of soup kettle and coveri soup kettles. The dietary supervisor has develously implemented a supervisory check which includes: hair restraint use, inspection of cleanliness for the H mixer, cleanliness of room tray caproper use of the hand sink, clear red dish racks, cleanliness of Rob mixer, cleanliness of soup kettles proper covering of kettles. Audits are being conducted by the manager and will continue for 3 m until ongoing compliance is achieved. Audit results will be reviewed at the QAPI meeting.	nts to e of the d and check e Hobart ed room racks, ng of ped list obart rts, nliness of occupe and e Dietary onths or yed.	

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	PROVIDER OR SUPPLIER		:	STREET ADDRESS, CITY, STATE, ZIP CODE 2545 PORTLAND AVENUE SOUTH MINNEAPOLIS, MN 55404	·	
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F 371	with the debris. During followup kito p.m. with the regist following was obse - On entering the di was observed to be employee hand sinicutout/indentation a had a build up of for After three continuous this food debris was with a paper towel. clean and instructer racks. Clean dishes the leftover food dethe three cycles of During an interview stated staff have sand there was a su "was not being don months, the superview of Ebeneze cleaning and task sa 1/14/13 indicated to Coupe, mixer, soup to initial the assigned have been complet that cleaning had be Review of undated aide daily cleaning/included "clean and included" clean and included	chen tour on 12/29/15, at 2:05 ered dietitian (RD) the rved: ishwashing area, a dish rack exitting on the top of the k. Red dish racks with areas on the sides of racks bod debris in the cutout areas. Ous cycles of wash/rinse cycles is softened and easily removed RD verified the racks were not did the aides to remove all red is would have come in contact obtris that was present prior to washing. If on 12/28/15, at 4:40 p.m. DD pecific duties for each position pervisor checklist but cleaning exprobably not for the past six risor checkoff list is empty." If Care Center daily cooks is chedule with revision date of clean and sanitize Robo to kettle and cover if used and ed cleaning duties after they ed. There was no indication een completed. Ebenezer Care Center dietary task schedule, position four disanitize all carts, including tall as no indication that cleaning	F 371			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245587	B. WING			12/3	30/2015
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP 2545 PORTLAND AVENUE SOUTH MINNEAPOLIS, MN 55404			
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F 431 F 431 SS=E	483.60(b), (d), (e) I LABEL/STORE DF The facility must er a licensed pharmacof records of receip controlled drugs in accurate reconciliar records are in order controlled drugs is reconciled. Drugs and biologic labeled in accordar professional princip appropriate access instructions, and the applicable. In accordance with facility must store a locked compartme controls, and perminave access to the The facility must propermanently affixed controlled drugs list Comprehensive Dr Control Act of 1976 abuse, except whe package drug districts.	DRUG RECORDS, RUGS & BIOLOGICALS Imploy or obtain the services of cist who establishes a system of and disposition of all sufficient detail to enable an tion; and determines that drug er and that an account of all maintained and periodically als used in the facility must be nee with currently accepted oles, and include the cory and cautionary the expiration date when State and Federal laws, the all drugs and biologicals in ints under proper temperature it only authorized personnel to keys. Tovide separately locked, discompartments for storage of ted in Schedule II of the rug Abuse Prevention and and other drugs subject to in the facility uses single unit ibution systems in which the minimal and a missing dose can		131			2/8/16
	This REQUIREME	NT is not met as evidenced					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245587	B. WING		12/:	30/2015	
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZI			
EDENE?	ED CADE CENTED			2545 PORTLAND AVENUE SOUT	Н		
EBENEZ	ER CARE CENTER			MINNEAPOLIS, MN 55404			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		ION SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 431	Based on observareview, facility failed stored at the prope (R40, R95, R101, FR23, R74, R38, R1 refrigerated insuling the facility failed to were properly destricted at the facility failed to were properly destricted. Second North: During tour looking second north unit of licensed practical in temperature of the LPN-A stated the list in the refrigerator as stored between 30-12 Lantus Solosta sugar) total for R40-Six Novolog Flex Psugar) total for R40-Three Humalog Ksugar) for R101 and Two bottles latano pressure in patients solution 0.005% for For the facility, the -20 prefilled influent High dose and, -One vial influenza by registered nurse. During interview or manager stated "the state of the property of the state of the property or manager stated" the state of the property of the property or manager stated the state of the property or manager stated the state of the property or manager stated the state of the property of the property or manager stated the property or manager stated the property of the property or manager stated the property of the property or manager stated the property of the property or manager stated the	tion, interview, and document d to ensure medications were r temperature for 13 residents R123, R60, R69, R7, R132, 04, R59, R54) who received and eye drops. In addition, ensure that fentanyl patches royed for 3 of 3 residents (R27, ent diversion. at medication storage on the on 12/28/15, at 2:00 p.m. nurse (LPN)-A verified the refrigerator was 52 degrees. Sted medications were stored and the medications were to be to 40 degrees. The Pens (used to control blood 10, R95, R123, Pens (used to control blood 10, and R95, wikPen (used to control blood 10, and R95, with open-angle glaucoma) r R60. The medications were: The swith open-angle glaucoma and the medications were: The swith open-angle glaucoma and the control syringes -Fluzone dated open 11/25/15, verified at (RN)-D. The 12/28/15, at 2:15 p.m. dietary the fridge is not working." The degrees verified by dietary degrees verified by dietary	F 4	The facility obtains the solicensed pharmacist who records of receipt and discontrolled drugs in sufficienables an accurate recordetermines that drug recordetermines that drug recordetermines that drug recordetermines that drug recordence and that an account of all is maintained and periodic descepted professional princlude the appropriate and cautionary instructions, and date when applicable. In accordance with State laws, the facility stores all biologicals in locked comproper temperature controlly authorized personner to the keys. The facility provides sepant permanently affixed compatorage of controlled drug Schedule II of the Compatorage of controlled drug Schedule II of the Compatorage of controlled drug Schedule II of the Compatorage of controlled drug subject the when the facility uses sind drug distribution systems quantity stored is minimal dose can be readily detection. Maintenance directioning for the proper functioning for personner functioning for personner functioning for personner functioning for personner functioning for the proper functioning for personner for the proper functioning for the proper function for the proper funct	has a system of sposition of all ent detail which onciliation; and ords are in order I controlled drugs ically reconciled. ed in the facility e with currently inciples, and ccessory and nd the expiration and Federal I drugs and partments under rols, and permits el to have access exactly locked, partments for gs listed in ehensive Drug ontrol Act of 1976 o abuse, except gle unit package in which the I and a missing cted. ordered and north and ector verified all ely		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	IPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
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F 431	was no record of d was supposed to c was not done. Third North: During tour looking third north unit on verified the temper degrees. RN-G stastored in the refriguence to be stored to 14 Lantus Solosta R74, Three vials of Lander of Novolog Flextone Novolog Flextone vial of Novolog Textone prefilled Prevological Properties of Interest of Int	30 p.m. RN-D verified there aily temps. RN-D stated dietary heck the temperature and it at medication storage on the 12/28/15, at 3:10 p.m. RN-G ature of the refrigerator was 56 ted the listed medications were erator and that the medications between 30 to 40 degrees: r Pens total for R69, R7, R23, tus for R38, Pens total for R69, og for R38, Pen total for R7, and R23, renar (a pneumococcal 32 and, sof lorazepam (used for g/ml total for R54, R59, and 15 p.m. it was observed four m were locked in a red box elf in the refrigerator. The shelf of the refrigerator and slid out N-E verified "anyone could walk E verified the last time the hecked was 12/26/15, and the time was 46 degrees.	F 43	maintaining proper temper 12/28/15. Nursing staff is required to refrigerator temps daily. At educated as to this require 1/22/16. All medications from the re 2-north and 3-north were redestroyed and ordered for 12/28/15. This protected at the floors including (R40, IR123, R60, R69, R7, R13; R38, R104, R59, R54) New refrigerators were ord specifically for refrigerated refrigerated narcotic storal placed on units. Until these are placed and put to use, narcotic medications are placed and put to use, narcotic medications are placed in an existing direfrigerator. Fentanyl Patches: RN-H and LPN-B have be to the requirements of proof Fentanyl patches and the for double signatures for an narcotics. All nursing staff were educated the signature requirements of Fentanyl patches by 1/2 Audits are being conducted.	efrigerators on emoved, replacement on ll residents on R95, R101, 2, R23, R74, dered ll medication and ge and will be erefrigerators all refrigerated properly locked louble-locked en educated as per destruction the requirement dministration of eated on proper tiches and for ents for wasting 12/16.	

Facility ID: 00191

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			E SURVEY PLETED
		245587	B. WING		12/:	30/2015
NAME OF PROVIDER OR SUPPLIER EBENEZER CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP 2545 PORTLAND AVENUE SOUTH MINNEAPOLIS, MN 55404	CODE	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	ON SHOULD BE LE APPROPRIATE	(X5) COMPLETION DATE
F 431	asked what the facused patches RN-Fentanyl patches at them out in the cornarcotic book only and none for destruction Received to December 2015 member signed for During review of R. 12/21/15 to 12/27/received the Fentawhich only one nur destruction. First Floor South: On 12/29/15, at 8:0 medication cart wa R48's Fentanyl pat by two nurses whe when a Fentanyl pat by two nurses whe when a Fentanyl pat are to sign it out in half and put it in the MAR from Septem indicated only one removal of Fentanynarcotic book recoit was revealed R4 patch six times, ea documented the de R24's Order Summindicated R24 had 50mcg/hour (hr app MAR from Septem indicated only one removal of Fentanynarcotic fentanynarcotic book recoit was revealed R4 patch six times, ea documented the de R24's Order Summindicated R24 had 50mcg/hour (hr app MAR from Septem indicated only one removal of Fentanynarcotic fentan	tanyl patches for R27. When sility policy was for disposing H stated, they change the at night and one nurse signs inputer. RN-H verified the had signatures for application action. Review of Medication cords (MAR) from September indicated only one staff removal of Fentanyl patch. 27's narcotic book record, from 15, it was revealed R27 had nyl patch three times, each of se had documented the 100 a.m. a tour of the scompleted. LPN-B verified ch had not been double signed in removed. LPN-B stated atch was removed two people the narcotic book and fold it in e sharps container. Review of ber to December 2015 staff member signed for yl patch. During review of R48's rd, from 12/13/15 to 12/28/15, 8 had received the Fentanyl ch of which only one nurse had	F 4	by the director of nursing a for 3 months or until ongoi is achieved. Audit results at the facility QAPI meeting	ng compliance will be reviewed	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED		
		245587	B. WING		12/30)/2015	
NAME OF PROVIDER OR SUPPLIER EBENEZER CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 2545 PORTLAND AVENUE SOUTH MINNEAPOLIS, MN 55404	, .2.00		
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F 431	patch seven times, had documented the During interview or said, "Only one perfentanyl patch and During interview or director of nurses of fold and cut the Fe sharps container." removal and replace we ask for two significant is highly abuse the refrigerator should be degreed. The house notify the nurses if ranges. "Nursing sensure the temperare expected to be include Ativan in the [nurses] are to date open." The DON in assistants, three he staff have access the medications are stopped of the performance	8 had received the Fentanyl, each of which only one nurse he destruction 1 12/29/15, at 10:16 a.m. RN-D rson signs for removal of the they do it on the MAR." 1 12/29/15 at 3:28 p.m. the (DON) said, the nurses are to intanyl patch and put it in the They sign it in the MAR for cement. According to our policy natures, because it is a narcotic ed. The said the temperature in ould be no warmer than 40 sekeepers do a log daily and the temperature was out of the hould be checking the logs to atures are in range. Narcotics ander double lock. That would be third floor fridge. They e multiuse vials when they expected a multiuse vials when they expected a multiuse vials when they expected a multiuse the context of the refrigerators where cored. 1 12/29/15, at 4:00 p.m. vice director stated the context check the temperatures of the esdays.	F 43				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			TE SURVEY MPLETED
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F 441 SS=E	requiring storage in unless otherwise di substances that red within a locked box box must be attach refrigerator." Controlled Substan reviewed October 2 When a Fentanyl premoved/replaced to should be followed used patchF. Doo be signed by personalong with witness destruction log sheur 483.65 INFECTION SPREAD, LINENS The facility must est Infection Control Prosafe, sanitary and control pro	monitoring. Medications a cool place are refrigerated rected on the label. Controlled quire refrigeration are stored within the refrigerator. This ed to the inside of the ce Disposal-Long Term Care 2014, instructed staff: "III. atch needs to be the following procedures for proper destruction of the cumentation of disposal must in disposing of used patch, (licensed staff) on drug et or narcotic book." I CONTROL, PREVENT Atablish and maintain an cogram designed to provide a comfortable environment and development and transmission ction. I Program tablish an Infection Control ch it - introls, and prevents infections rocedures, such as isolation, or an individual resident; and ord of incidents and corrective infections.	F 4			2/8/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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F 441	prevent the spread isolate the resident (2) The facility mus communicable dise from direct contact direct contact will ti (3) The facility mus hands after each dhand washing is in professional practic (c) Linens Personnel must ha	esident needs isolation to of infection, the facility must of infection, the facility must of prohibit employees with a ease or infected skin lesions with residents or their food, if transmit the disease. It require staff to wash their irect resident contact for which dicated by accepted	F 441				
	by: Based on observareview, the facility of the shared razor(s) potential to affect 1 R43, R47, R52, R5 R131). In addition, glucometers were residents (R138, R checks to prevent infection. This had residents who have Findings include: On 12/30/15, at 8:3 noted in the 3 sout # 1. Remington ele	NT is not met as evidenced tion, interview, and document ailed to ensure the standard was disinfected, this had the 2 residents (R14, R28, R32, 44, R58, R59, R85, R96, the facility failed to ensure cleaned properly for 2 of 2 45) who had blood sugar the spread of blood borne the potential to affect 23 a glucometer check.		The facility has established and maintained an Infection Control Prodesigned to provide a safe, sanitar comfortable environment and to he prevent the development and transmission of disease and infection. All razors are currently disinfected between different resident uses. No razors have been ordered for each resident requiring shaving which we for no-longer needing residents to electric razors. Razors will still be pure maintained for infection control pure This includes razors for (R14, R28, R43, R47, R52, R54, R58, R59, R88, R96, R131).	y and elp on. ew ill allow share properly poses. , R32,		

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CENTE	45 FOR MEDICARE	& MEDICAID SERVICES			U	MB NO.	<u>0938-0391</u>
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NAME OF I	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
				2	545 PORTLAND AVENUE SOUTH		
EBENEZ	ER CARE CENTER			N	MINNEAPOLIS, MN 55404		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 441	(RN)-B stated that the entire floor, excuse it themselves a residents that we stare supposed to cleit down and have m RN-B was aware of by microscopic bloowas why we use alcay -At 9:30 the directo expect the razors to residents, accordinat 9:40 nursing as demonstrated clear cleaned with water stated "dries it" (anwith paper towels), NA-D stated he had but had shaved R2 morning, and had le (in pieces). He had razor and could not -At 10:00 the infect shared razors were with alcohol, then firstronger wipes that glucometers [PDA stated that day, ar last used the Blue National Rational	pris inside. Registered nurse they were shared razors for ept for the people who can not have their own razor. The nave use that one, but staff an it in between and we wash sultiple heads [to change out]. It disease that could be spread od particles and stated that cohol to wash it down. It of nursing (DON) stated to be cleaned between go to policy sistant (NA)-D on 3 south, and brush, soap and water, and demonstrated rubbing it dry then cleans with alcohol swab. It not shaved anyone today, and with the razor yesterday eft it to dry on the window sill not used the blue Norelco say who had used it last. It is no control nurse stated the cleaned, and then cleaned urther stated we do have could be used, like on the sanitizing wipes]. It is did not know when he had worelco razor. It he had his own electric razor is purchasing another, because		441	All nurses including RN-I and RN-J educated on proper infection contropractices regarding glucometers by 1/22/16. All nurses and nursing ass including RN-B, NA-D and NA-A we trained on proper disinfection of rat 1/29/16. This training included demonstrations by the participants ensure a thorough understanding. Audits are being conducted with over by the director of nursing and will confor 3 months or until ongoing compis achieved. Audit results will be regard reported at the facility QAPI metallic properties.	ol // sistants ere zors by to // versight ontinue oliance viewed	

-At 1:30 p.m. R54's sister verified use of the

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F 441	shaved 2 own razor razors. R14 was admitted to admission diagnose behavioral disorder of use of 1 side of the Record. The nursing on 12/30/15, directed personal hygiene in R28 was admitted to admission diagnose and major depressing The nursing assistate 12/30/15, directed as shaving as needed. R32 was admitted to admission diagnose arthritis, and type II Record. The nursing on 12/30/15, directed personal hygiene in R32 verified that she electric razor. R43 was admitted to admission diagnosed disorder, anxiety disblood pressure) per nursing assistant cardirected assist of or including shaving.	on the unit, 14 residents were is, and 12 used the shared of the facility on 9/17/12, with ites of vascular dementia with ite, stroke and hemiplegia (loss body) per the Admission grassistant care sheet printed ited assist of one with all cluding shaving. The facility on 3/3/14, with ites of dementia, allergic rhinitis on per the Admission Record. Interest care sheet printed on staff to physically assist with	F 4-	41			

` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	TIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED	
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F 441	kidney disease and Admission Record sheet printed on 12 with all personal hy verified use of the R54 was admitted admission diagnos disorder and major Record. The nursir on 12/30/15, direct with grooming and R54's sister verified R58 was admitted admission diagnos depression, and vit Admission Record sheet printed on 12 one with all groomin needed. R59 was admitted admission diagnos disease and dysphoral distorder sheet printed on 12 of one with groomin RN-B stated some grooming indicated R85 was admitted admission diagnos behavioral disturbation other skin disorder The nursing assist.	es of COPD (lung disease), d high blood pressure per the The nursing assistant care 2/30/15, directed: assist of one regiene including shaving. R47 shared electric razor. Ito the facility on 8/5/12, with es of dementia with behavioral rederession per the Admission ag assistant care sheet printed ed staff to physically assist shave resident as needed. It the use of the shared razor. Ito the facility on 5/11/06, with es of schizophrenia, major ramin D deficiency per the The nursing assistant care 2/30/15, directed: staff assist of ang tasks including shaving as to the facility on 11/2/09, with es of dementia, Alzheimer's agia (difficulty swallowing) per ord. The nursing assistant care 2/30/15, directed staff to assist ang. On 12/30/15, at 9:00 a.m. times assist of one with a shaving as well. Ito the facility on 1/6/09, with es of vascular dementia with ances, lung disease, rash and as per the Admission Record. ant care sheet printed on assist of one with all personal	F 4	41		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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PREFIX (EACH D	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG	PREFIX (EACH CORRECTIVE ACTION SHO		BE	(X5) COMPLETION DATE
admission dementia, Admission sheet print physical as R98 was a admission cardiomyo Admission sheet print with groom special car related to a shared raz R131 was admission disturbanc per the Adcare sheet personal h A razor dis provided. R138's quar R139 had insulin dail During obsused to chat 5:23 p.n placed gluon gloves a	dmitted to diagnose and seboral seboral seboral seboral seist with dmitted to diagnose pathy and Record. Record. Record sed on 12 sing, assire with greationy or on the admitted diagnose e, insommission for directed ygiene in infecting arterly MI and diagnose servation eck bloom servation eck bloom servation eck bloom servation end clear and clear and clear servation end clear servati	o the facility on 10/17/12, with es of Parkinson's disease, orrhea dermatitis per the The nursing assistant care /30/15, indicated R96 received grooming. o the facility on 3/19/10, with es of dementia, d tachycardia per the The nursing assistant care /30/15, indicated independent st of one as needed, and ooming due to risk of infection opathy. R98 verified he used a	F 4	41			

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES (X1) PROVIDER/SLIPPLIER/CLIA

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	PLE CONSTRUCTION IG		COMPLETED		
		245587	B. WING _		1:	2/30/2015	
	EBENEZER CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2545 PORTLAND AVENUE SOUTH MINNEAPOLIS, MN 55404			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 441	and lancet in a cup of the cup in the sh barrier on medication off with a PDI Saniplaced the glucome. During an interview RN-I said, "What is cart to dry or back if for at least three mit and then placed in how the facility tauge. R45's quarterly MD R45 had a diagnost insulin daily. During medication 12/30/15, at 7:27 at and set plastic carrowithout a barrier. Encheck-wiped finger tested blood. RN-J removed test strip a case on top of five carrying case in measked when planned glucometer, RN-J releans them. RN-J alcohol wipe before glucometer needed no it was fine to was that it was ok to have because they have a resident a medicakept under observareturned and surversed.	and disposed of the contents arps container. RN-I placed on cart and wiped glucometer Cloth AF for 40 seconds, then eter in plastic carrier case. You on 12/28/15, at 5:30 p.m. the difference if I put it on the in the container? I won't use it inutes, until it is dry. I scrubbed to in the container." This was ght us to clean the glucometer. You dated 11/25/15, indicated is of diabetes and received administration observation on .m. RN-J entered R45's room ying case on bedside table RN-J performed blood sugar, obtained drop of blood, showed results to R45, and placed glucometer in carry insulin FlexPens and put edication cart. When RN-J was ed on disinfecting the responded that the night shift stated, "I will wipe it off with an extra to a luse it. Asked RN-J if the distoning the pens covers on. RN-J went to give ation. The medication cart was ation until 7:43 a.m. when RN-J yor had to intervene and red disinfected. RN-J agreed					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED		
		245587	B. WING _		12	/30/2015	
	PROVIDER OR SUPPLIER ER CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CO 2545 PORTLAND AVENUE SOUTH MINNEAPOLIS, MN 55404			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 441	case where it was a wiped the glucomet AF wipe. RN-J imm glucometer on the find Glucometer was drawn I stated, "I hav I can put it in the car glucometer was to RN-J said, "I just a does not have to be asked to view the in Sani-Cloth AF wipe stated that it must a minutes. During interview on infection control nube immediately wip with a sani wipe us The glucometer is to the infection control to wipe with alcohologainst blood borned control nurse verified night shift nurse do During interview on director of nurses (to disinfect the glucometer is to disinfect the glucometer in the glucometer in the glucometer is the glucometer in the glucometer is the glucometer in the gl	oved glucometer from carrying sitting on five insulin pens and ter off with a PDI Sani-Cloth rediately placed the top of the medication cart. The property in less than one minute. The towait three minutes before ase." Asked RN-J how long the remain wet with disinfectant. The ed to wipe and air dry. It is visible wet. "RN-J was instructions on the PDI. The package instruction remain visible wet for three are stated glucometers are to red down by the nurse using it ring a three minute wet time. Then placed in the carrier case. The placed in the carrier case of nurse verified it was not ok as it did not disinfect the pathogens. The infection red it was not ok to have the the disinfecting. The pool of the medication can be determined the placed of the pathogens. The infection red it was not ok to have the the disinfecting. The pool of the medication cart. The package instruction are to red down by the nurse using it in the carrier case. The infection red it was not ok to have the the disinfecting. The pool of the medication cart. The package instruction are to visible with a single place of the package of the place of	F 44				

	OF CORRECTION IDENTIFICATION NUMBER		TIPLE CONSTRUCTION NG		E SURVEY MPLETED		
		245587	B. WING		12/	12/30/2015	
	PROVIDER OR SUPPLIER ER CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2545 PORTLAND AVENUE SOUTH MINNEAPOLIS, MN 55404	·		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE	
F 441	other) on the bedsic between the table at 3. After using the disposable gloves, using the appropriate service. 4. If the machine is body fluids clean the cloth to cleanse the disinfect the machin NOTE: This is to be machine out to the 5. Using the top paragraph of the drying. Remove glourse will monitor the contact time and punceessary. NOTE: The treated wet for a full two miness.	r towels (one on top of the de table to create a barrier and the equipment. iagnostic equipment, wearing machine will be disinfected te cleaner wipes at point of visibly soiled with blood or e machine twice; use one e soiled area and one cloth to ne. e done before taking the nurse's cart. uper towel, carry diagnostic e nurse's cart to continue eves and wash hands. The ne machine for continuous wet ut on gloves and re-wipe if surface must remain visible inutes or as directed by additional wipes as needed to	F 4	41			
F 465 SS=D	undated, instructed TO DISINFECT: "soil. Unfold a clean surface. Treated sufor a full three (3) mif needed to ensure contact time. "483.70(h) SAFE/FUNCTIONAE ENVIRON	Germicidal Disposable wipe users: Use a wipe to remove heavy wipe and thoroughly wet urface must remain visibly wet ninutes. Use additional wipe(s) continuous 3 minute wet AL/SANITARY/COMFORTABL ovide a safe, functional, ortable environment for	F 4	65		2/8/16	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
	245587 B. WING		12/30/2015			
	PROVIDER OR SUPPLIER		2	TREET ADDRESS, CITY, STATE, ZIP CODE 545 PORTLAND AVENUE SOUTH MINNEAPOLIS, MN 55404		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 465	This REQUIREME by: Based on observareview, the facility functional and saniresidents (R11, R5 concerns. In additional safe and sanitary dequipment that had preparation and staffect 122 of 122 rout of the kitchen. Findings include: On 12/30/15, at 11 environment tour wenvironmental servations and during the following the following the safe on the left side holes into the wall due to installing ne	-	F 465	The facility provides a safe, function sanitary, and comfortable environmental residents, staff and the public. The holes in the sheetrock in R11's were patched and painted on 12/28. The Blue Dysom and Blue Tape was removed on 12/28/15. The foot grips identified were removed on 12/28/15. The foot grips identified were removed on 12/30/15. Environmental services staff were educated on identifying and reportinon-cleanable surfaces on 12/31/1 housewide audit was conducted or 1/23/16 for identifying non-cleanable surfaces. All findings are entered in CMMS (work-order) system to be completed no later than 2/8/16. An inspection for non-cleanable see has been added to the supervising housekeeper deep-cleaning inspecs schedule. Any findings will be entered.	nent for s room 8/15. as oved on ng 5. A n le n to the ervices etion	
	dysom secured wit exposed the adhes soiled and was not On 12/30/15, at 11 the holes were from not been finished of	et was observed with a blue h blue peeling tape which sive part hanging off it, was a cleanable surface: 51 a.m. ESD verified stated in replacing a grab bar and had off. ESD acknowledged the wall in the sheetrock did create a		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 son 12/31/15.	e or e	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245587	B. WING		12/3	30/2015
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C	•	30,2010
ERENE7	ER CARE CENTER			2545 PORTLAND AVENUE SOUTH		
CDCINCZ	EN CARE CENTER			MINNEAPOLIS, MN 55404		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 465	acknowledged was stated he would rep bar. At 12:37 p.m. voleaned the rooms housekeeping and cleaned daily. Both though the staff cle have been difficulting grab bar as it was too the cleaned daily and not have a policy of the staff cleaned the maintenance staff cleaned the maintenance staff cleaned and indicate staff cleaned and indicate staff cleaned and indicate staff cleaned	o verified the peeling tape and not a cleanable surface. ESD blace it with a textured grab when asked how often the staff the supervisor for laundry stated rooms were her and ESD stated even aned the rooms daily it would to see the peeling tape on the he same color as the plastic g. The supervisor for laundry stated the facility did n cleaning such surfaces. The deed was observed with peeling when asked about the foot he had assumed they had put but thought did not look good. The supervisor for laundry stated the foot grip floor and was not a cleanable do R53 he would remove it supervisor for housekeeping staff were supposed to alert aff of any concerns and would stop in the staff were supposed k order would be initiated for	F 4	An inspection of foot grips hadded to the supervising hodeep cleaning inspection so Audits are in place with ove Maintenance Director. Audit for 3 months or until ongoin is achieved. Audit results wiat the facility QAPI meeting. The clean dish area includir sills was thoroughly cleaned. The dirty dish area table was cleaned including the table, wall and floor. The table caused removed and the floor drain on 12/29/15. The soup kettle, piping, wall perimeter baseboards and was door handle were all thorough 12/30/15. The dietary team has redeven implemented a daily staff cleaned includes cleaning of areas, the soup kettle area, handle and the perimeter baseboard around the legs of equipme. The dietary supervisor check developed and implemented compliance this includes the the soup kettle area, cooler and the perimeter baseboardegs of equipment.	rsight by the swill continue g compliance III be reviewed on 12/29/15. It is thoroughly table legs, alking was replaced II, flooring, walk in cooler ghly cleaned II eloped and eaning check of the dish cooler door aseboards II. It is that been to monitor for el dish areas, door handle rds around the	
	to report and a wor his department to a	k order would be initiated for		developed and implemented compliance this includes the the soup kettle area, cooler and the perimeter baseboar	d to monitor for e dish areas, door handle ds around the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		245587	B. WING			12/3	30/2015
	PROVIDER OR SUPPLIER ER CARE CENTER			2	TREET ADDRESS, CITY, STATE, ZIP CODE 545 PORTLAND AVENUE SOUTH INNEAPOLIS, MN 55404		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 465	kitchen tour with the following was obseted the clean dish are stainless steel table temperature one consituated in a corner this clean dish area four foot windows will below them. Both dirty and splattered a build up of food of the corners of the windshwasher in the ceight foot stainless where the table me four feet of this cautype substance. The food the table was he substance and food table legs and when there was a grimy, debris. The top of the below the dishwash the floor. DD verified be cleaned and the was mold and need replaced by mainter the kitchen the followerified by the DD: Behind the soup with the right of the walk substance. Behind the right of the walk stance is the corner of the walk substance.	54 a.m. during the initial e dietary director (DD) the rved: a contained an eight foot e situated to the left of the high ompartment dishwasher of the kitchen. Directly above a, there were two, three foot by with an eight inch wide window the the windows and sill were with food particles. There was lebris along the back of and in window sill. To the right of the dirty dish area was another steel table with white caulking lets the wall. Approximately alking was black with a mold e wall behind the entire length avily splattered with a brown diparticles. On and around all re the wall meets the floor brown/black buildup of food the floor drain was missing the meets the floor drain was missing the wall was dirty, needed the black caulking most likely ded to be removed and mance. 55 p.m. during a second tour of owing was observed and settle, the piping, wall and by black/brown greasy the same soup kettle and to	F4	465	by the dietary manager with respect kitchen sanitation. Audits conducte resident spaces are overseen by the maintenance director. Audits will confor 3 months or until ongoing complist is achieved. Audits will be reviewed QAPI meeting.	d in ne ontinue lliance	

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		A. BUILDING			(X3) DATE SURVEY COMPLETED			
245587		245587	B. WING			12/30/2015		
	PROVIDER OR SUPPLIER			2545 P	T ADDRESS, CITY, STATE, ZIP CODE ORTLAND AVENUE SOUTH EAPOLIS, MN 55404	,		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE	
F 465	white molding strip brown, sticky subst stainless steel hand brown/black substated. Around the entire the baseboards and equipment there was black/brown grime. During an interview DD stated kitchen seach position and to but cleaning "was refor the past six more list is empty." During an interview cook and DD stated night and that main deep cleaning the fequipment. During an interview registered dietitian cleaning policy for to During an interview administrator stated cleaned in Septemble December. Adminishave liked it cleaned During an interview environmental serve housekeeping was ceilings, walls and the state of the server of the serv	was heavily soiled with a ance. The walk in cooler door die was heavily soiled with ince. perimeter of the kitchen along don and around all legs of as a heavy buildup of and food debris. on 12/28/2015, at 4:40 p.m. staff have specific duties for here is a supervisor checklist not being done, probably not on this, the supervisor check off on 12/29/15, at 2:20 p.m. the die the floor are cleaned every tenance was in charge of loors and behind all on 12/29/15, at 3:30 p.m. stated there was no deep the kitchen. on 12/29/15, at 3:45 p.m. the die the floors were last deep per and due to be cleaned in strator further stated, "I would die before this."	F 4	65				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY MPLETED
		245587	B. WING		12	/30/2015
NAME OF PROVIDER OR SUPPLIER EBENEZER CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2545 PORTLAND AVENUE SOUTH MINNEAPOLIS, MN 55404			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 465	daily cleaning & tas revised 2/14/15 incl tables on clean side floors swept and me cleaned on dirty sid wall, all racks off flobe cleaned and set indication that these completed. Review of the unda indicated "tile and of thoroughly scrubbed clean every two/three completed date and indicated the kitche cleaned 11/6/15, and	nezer Care Center dietary aide k schedule, positions 9-5" uded that all shelves and e be cleaned and sanitized, oped in dish room, walls e, both by tables and opposite for at all times and floor carts up for evening. There was no e cleaning tasks had been ted facility cleaning schedule feramic floor needs to be d. Kitchen duties should be see months. After task is d sign off." The schedule n ceiling and walls had been and the "kitchen/front of coffee r scrub" had been cleaned	F 4	65		

F5587024

PRINTED: 01/28/2016 FORM APPROVED OMB NO. 0938-0391

(X3) DATE SURVEY

(X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING 01 - MAIN BUILDING 01 B. WING 12/29/2015 245587 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 2545 PORTLAND AVENUE SOUTH **EBENEZER CARE CENTER** MINNEAPOLIS, MN 55404 PROVIDER'S PLAN OF CORRECTION (X5) SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (EACH CORRECTIVE ACTION SHOULD BE COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** PREFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) K 000 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

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

TITLE

Electronically Signed

01/25/2016

(X6) DATE

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.

Facility ID: 00191

PRINTED: 01/28/2016 FORM APPROVED OMB NO. 0938-0391

(X3) DATE SURVEY

(X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING 01 - MAIN BUILDING 01 B. WING 12/29/2015 245587 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 2545 PORTLAND AVENUE SOUTH EBENEZER CARE CENTER MINNEAPOLIS, MN 55404 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION SUMMARY STATEMENT OF DEFICIENCIES ID (X4) ID (EACH CORRECTIVE ACTION SHOULD BE **PREFIX** (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX DATE CROSS-REFERENCED TO THE APPROPRIATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) K 000 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

(X2) MULTIPLE CONSTRUCTION

Event ID: KKF421

PRINTED: 01/28/2016 FORM APPROVED OMB NO. 0938-0391

CENTE	13 FOR WEDICARE	& MEDICAID SERVICES					
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01		SURVEY PLETED	
		245587	B. WING_	B. WING		12/29/2015	
	NAME OF PROVIDER OR SUPPLIER EBENEZER CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2545 PORTLAND AVENUE SOUTH MINNEAPOLIS, MN 55404			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE	
K 000	spaces open to the automatic fire depa has a licensed capacensus of 121 at the	corridor, that is monitored for artment notification. The facility acity of 127 beds and had a le time of the survey.	K 00	00			
K 012 SS=F	Building construction	enced by: FETY CODE STANDARD on type and height meets one 9.1.6.2, 19.1.6.3, 19.1.6.4,	K 01	2		2/8/16	
	Based on observa does not meet the type and height.	is not met as evidenced by: tion and interview, this building requirement for construction tice could affect all residents.		The facility has achieved a pass score to remedy this deficiency.	sing FSES		
	On facility tour bety 12/29/2015, observ 3-story, wood fram construction does	ween 9:30 AM and 1:30 PM on vation revealed that this e facility of Type III(200) not meet the minimum ements for a building of this					
		tice was verified by the ervisor at the time of the					
	FSES can establis	cy need not be corrected if an he that the facility has an overall equivalent to that required by					

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(X3) DATE SURVEY

(X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING 01 - MAIN BUILDING 01 B. WING 12/29/2015 245587 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 2545 PORTLAND AVENUE SOUTH **EBENEZER CARE CENTER** MINNEAPOLIS, MN 55404 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION SUMMARY STATEMENT OF DEFICIENCIES ID (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PRFFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) K 012 K 012 | Continued From page 3 the Life Safety Code. 1/13/16 K 038 K 038 NFPA 101 LIFE SAFETY CODE STANDARD SS≍F 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: The facility has achieved a passing Based on observation and staff interview, the FSES score to remedy this deficiency. 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. 1/13/16 K 040 K 040 NFPA 101 LIFE SAFETY CODE STANDARD SS=F 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

Event ID: KKF421

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(X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES COMPLETED **IDENTIFICATION NUMBER:** AND PLAN OF CORRECTION A. BUILDING 01 - MAIN BUILDING 01 B. WING 12/29/2015 245587 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 2545 PORTLAND AVENUE SOUTH **EBENEZER CARE CENTER** MINNEAPOLIS, MN 55404 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION DATE SUMMARY STATEMENT OF DEFICIENCIES ID (X4) ID (EACH CORRECTIVE ACTION SHOULD BE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX CROSS-REFERENCED TO THE APPROPRIATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) K 040 Continued From page 4 K 040 This STANDARD is not met as evidenced by: The facility has achieved a passing FSES Based on observation and interview, the resident score to remedy this deficiency. 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.

(X2) MULTIPLE CONSTRUCTION

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 16768 County Road 160 Cold Spring, MN 56320 320-685-8559 RimholteFiresafe@aol.com



16768 County Road 160 Cold Spring, MN 56320 (320) 685-8559

E-mail: <u>RImholteFiresafe@aol.com</u>

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 S. Indulle

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:

- o 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).

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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/NorthZone 7 – Second Floor NorthZone 2 – Basement SouthZone 8 – Second Floor SouthZone 3 – First Floor CenterZone 9 – Third Floor CenterZone 4 – First Floor NorthZone 10 – Third Floor NorthZone 5 – First Floor SouthZone 11 – Third Floor SouthZone 6 – Second Floor Center

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).

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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.

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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 1%-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.

Zone 2 – Basement Level South:

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 L 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).

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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 ft² 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.

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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.

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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.

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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.

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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.

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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").

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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.

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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 (I) [Value assigned = 1.2]: This zone is one floor height above First Floor.

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- 4. Ratio of Patients to Attendants (7) [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.

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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].

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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.

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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.

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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.

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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*.

		OMP Exemp
ZONE I	OF II	ZONES

FIRE/SMOKE ZONE*	EVALUATION	WORKSHEET	FOR	HEALTH	CARE	FACIL	ITIES

	2000 LIFE SAFETY CODE
FACILITY	BUILDING .
EBENEZER CARE CENTER	01-MAIN BUILDING
ZONE(S) EVALUATED	
BASEMENT - CENTER/NORTH	
PROVIDER/VENDOR NO.	DATE OF SURVEY , ,
245587	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. OCCUPANC	Y RISK PARAM	ETER F	ACTOR	S		
Risk Parameters	Risk Factors Values							
1. Patient Mobility <i>(M)</i>	Mobility Status	Mobile	Limited M	Limited Mobility		t Mobile	Not Movable	
	Risk Factor	1.0	1.6	1.6		3.2	4.5	
2. Patient Density (D)	No. of Patients	1–5	6–10	6–10		11–30	>30	
Density (D)	Risk Factor	1.0	1.2			1.5	2.0	
3. Zone Location <i>(L)</i>	Floor	1 શ	2 nd or 3 nd	4th to 6th		7 th and Above	Basements	
	Risk Factor	1.1	1.2	1.2 1.		1.6	1.6	
Ratio of Patients to	<u>Patients</u> Attendant	<u>1–2</u> 1	<u>3–5</u> 1	<u>6–10</u> 1		<u>>10</u>	One or More None	
Attendants (T)	Risk Factor	1.0	1.1	1.	1.2 1.5		4.0	
5. Patient Average Age (A)	Age	Under 65 Yea		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. OC	CUPANCY	RISK F	ACTOR	CALCUI	ATION	
OCCUPANCY RISK	M 3.2 ×	D X	L 1.6 X	T (O,l	A 1.2 =	F 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)	TABLE 3B. (EXISTING BUILDINGS)
1.0 x = R	$0.6 \times 6.1 = 3.1 = 4$

IRE/SMOKE ZONE is a space separated from all other spaces by floors, horizontal exits, or smoke barriers.							
SURVEYOR SIGNATURE ROBERS & UMAGLE FIRE SAFETY RESOURCES LUC	TITLE PRESIDENT	DATE 01/14/2016					
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	4.			3395		
Safety Parameters	Safety Parameters Values								
1. Construction	Туј		NonCombu Types I a						
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	2	4	
Third	-9	-7	-9	-7		-7 2		4	
4th and Above	-13	-7	-13	-7		-9 -7		4	
2. Interior Finish (Corridors and Exits)	Class C -5(0) ^f	Class B 0(3) ^f		Class A					
3. Interior Finish (Rooms)	Class C	Class B		Class A					
4. Corridor Partitions/Walls	None or Incomplet	e <¹/₂ hour		≥¹/₂ to <1 hour			≥1 hour		
	-10(0)ª	0		1(0	າ)ີ		(2)(0) ^a		
5. Doors to Corridor	No Door	<20 min FF	PR	≥20 min FPR		≥20 min FPR and Auto Clos.			
FIGURE 1	-10	0		(1)(0) ^d		2(0) ^d			
6. Zone Dimensions		Dead End	7			No Dead Ends >30 ft and		Zone Length Is	
	>100 ft	>50 ft to 100 ft	30 ft to	ft to 50 ft >150 f				<100 ft	
	-6(0) ^b	-4(0) ^b	-2(0	-2(0) ^b -2(0) ^c		· (0)		1	
7. Vertical Openings	Open 4 or More	Open 2 or	. 3			osed with Indicated Fire Re		sist.	
	Floors	Floors		<1 hr		≥1 hr to <2 hr		≥2 hr	
	-14	-10		(0)		2(0)°		3(0) ^e	
8. Hazardous Areas		Deficiency				Deficiency		No Deficiencies	
	In Zone	Outside Zo	ne	In Zone		In Adjacent Zone			
	-11	-5		-6		-2		(0)	
9. Smoke Control	No Control	Smoke Bar Serves Zo				sted Systems Zone			
	-5(0)°	0							
10. Emergency	<2 Routes		Multip		Multiple	Routes			
Movement Routes		Deficient	t	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			
				1			(2)		
12. Smoke Detection and Alarm	None	Corridor O	nly	Rooms Only		Corridor and Habit, Spaces		Total Spaces In Zone	
	0(3) ^g	2(3) ³)			(3) ^g	4		5	
13. Automatic Sprinklers	None	Corridor a		Entire Building					
:-	0	8		(10)		1			

NOTE: a Use (0) where parameter 5 is -10.

For SI units: 1 ft = 0.3048 m

^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.

⁹ 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 S₁, S₂, S₃, S₆ to blocks labeled S₁, S₂, S₃, S₆ in Table 7 on page 4 of this sheet.

TA	BLE 5. INDIVIDUAL	SAFETY EVALUAT	IONS	
Safety Parameters	Containment Extinguishment Safety (S ₁) Safety (S ₂)		People Movement Safety (S ₃)	General Safety (S4)
1. Construction	-4	-4		-4
Interior Finish (Corr. and Exit)	3		3	3
3. Interior Finish (Rooms)	-3		English English	-3
4. Corridor Partitions/Walls	2			2
5. Doors to Corridor	1		١	1
6. Zone Dimensions	e de la composition de la composition La composition de la		0	0
7. Vertical Openings	0		0	0
8. Hazardous Areas	0	0		0
9. Smoke Control			0	0
10. Emergency Movement Routes	The second		-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	S1= q	S2= ((S3= ()	S4= 12

MANDATORY S	AFETY REQUIF		LE 6. R USE IN HOSI	PITALS OR NU	IRSING HOME	S)
	Containment (Sa)		Extingui (S		People Movement (S ₀)	
Zone Location	New	Exist.	New	Exist.	New	Exist.
1 st story 2 nd or 3rd story ^b 4 th story or higher	11 15 18	5 9 9	15(12) ^a 17(14) ^a 19(16) ^a	4 ⑥ 6	8(5) ^a 10(7) ^a 11(8) ^a	1 ③ 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_o=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 Sa, Sb, and Sc 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 EQU	IVALENCY EVALUATION	Yes	No
Containment Safety (S ₁)	minus	Mandatory Containment (S _*)	≥ 0	$\begin{bmatrix} S_1 & S_4 & C \\ Q & - & Q \end{bmatrix} = \begin{bmatrix} C & C \\ O & - & C \end{bmatrix}$	J	
Extinguishment Safety (S ₂)	minus	Mandatory Extinguishment (S₀)	≥ 0	$\begin{array}{c ccccccccccccccccccccccccccccccccccc$	1	
People Movement Safety (S ₃)	minus	Mandatory People Movement (S₅)	≥ 0	$\begin{bmatrix} S_3 \\ I_0 \end{bmatrix} - \begin{bmatrix} S_c \\ 3 \end{bmatrix} = \begin{bmatrix} P \\ 1 \end{bmatrix}$	1	
General Safety (S ₄)	minus	Occupancy Risk (R)	≥ 0	$\begin{array}{c ccccccccccccccccccccccccccccccccccc$	/	

	TABLE 8. FACILITY FIRE SAFETY REQUIREMENTS WORKSHEET	Γ		
	mplete one copy of this worksheet for each facility. r each consideration, select and mark the appropriate column.	Met	Not Met	Not Applic.
A.	Building utilities conform to the requirements of Section 9.1.	V		
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.			1
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.	J		
D.	Fuel-burning space heaters and portable electrical space heaters are not used.	1		
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.	1		
G.	Smoking regulations have been adopted and implemented in accordance with 18.7.4 and 19.7.4.	J		
H.	Draperies, upholstered furniture, mattresses, furnishings, and decoration combustibility is limited in accordance with 18.7.5 and 19.7.5.	/		
1.	Fire extinguishers are provided in accordance with the requirements of 18.3.5.4 and 19.3.5.6.	V		
J.	Exit signs are provided in accordance with the requirements of 18.2.10.1 and 19.2.10.	1		
K.	Emergency lighting is provided in accordance with 18.2.9.1 or 19.2.9.	V		
L.	Standpipes are provided in all new high rise buildings as required by 18.4.2.			V

CONCLUSIONS 1. All of the checks in Table 7 are in the "Yes" column. The level of fire safety is at least equivalent to that prescribed by the Life Safety Code.* 2. One of more of the checks in Table 7 are in the "No" column. The level of fire safety is not shown by this system to be equivalent to that prescribed by the Life Safety Code.* *The equivalency covered by this worksheet includes the majority of considerations covered by the Life Safety Code. There are a few considerations that are not evaluated by this method. These must be considered separately. These additional considerations are covered in Table 8, the "Facility Fire Safety Requirements Worksheet." One copy of this separate worksheet is to be completed for each facility.

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

ZONE 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.	DATE OF SURVEY	
24K627	01/3/2016	

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. OCCUPANC	Y RISK PARAMI	ETER F	ACTOR	S			
Risk Parameters		Risk Factors Values							
1. Patient	Mobility Status	Mobile	Limited M	Limited Mobility		t Mobile	Not Movable		
Mobility (M)	Risk Factor	1.0	1.6	1.6		3.2	4.5		
2. Patient	No. of Patients	1–5	6–10	6–10		11–30	>30		
Density (D)	Risk Factor	1.0	1.2		1.5		2.0		
3. Zone	Floor	18	2 nd or 3 nd	or 3 rd 4 th to 6 th 7 th and A		7 th and Above	Basements		
Location (L)	Risk Factor	1.1	1.2	1.2 1.4		1.6	1.6		
4. Ratio of Patients to	<u>Patients</u> Attendant	<u>1–2</u> 1	<u>3–5</u> 1	6-	<u>10</u> I	<u>>10</u>	One or More None		
Attendants (T)	Risk Factor	1.0	1.1	1.	.2	1.5	4.0		
5. Patient	Age	Under 65 Yea	ars and Over 1 year		65 Years and Over 1 Year and Younger				
Average Age <i>(A)</i>	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. OC	CUPAN	CY RISK	FACT	OR CALCU	LATION		
OCCUPANCY RISK	M .	x	L	x x	A =	F = 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)	TABLE 3B. (EXISTING BUILDINGS)
1.0 x = R	0.6 x [1.b] = 1

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

SURVEYOR SIGNATURE	TITLE ~	DATE
LODELS V. CINTETE FIRE SAFERTIRESOURCES LLC	PRESIDENT	01/14/2016
FIRE AUTHORITY SIGNATURE	TITLE Supervisor	DATE 02-18-2016
Thomas Linhoff 12424 / hum from from	Supervisor	02 10-2010

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.

			TABL	E 4.				
Safety Parameters			Saf	ety Param	neters Va	alues		
1. Construction	Ту	Combustible pes III, IV, and V		NonCombu Types I ar				
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	2	4
Third	-9	-7	-9	-7	7	-7	2	4
4th and Above	-13	-7	-13	-7	7	-9	-7	4
Interior Finish (Corridors and Exits)	Class C -5(0) ^f	Class E	3	Clas				
3. Interior Finish (Rooms)	Class C -3(1) ^f	Class E	3	Clas				
4. Corridor	None or Incomplet	e <1/2 hou	r	≥¹/₂ to <			≥1 hour	
Partitions/Walls	-10(0) ^a	0		1(0			(2)0)a	
5. Doors to Corridor	No Door	<20 min F	PR	≥20 mi	n FPR		min FPR and Auto Clos.	
	-10	0		1(0	D) ^d		(2(0)) ^d	
6. Zone Dimensions		Dead End				No Dea	d Ends >30 ft and .	Zone Length Is
	>100 ft			ft to 50 ft >150				<100 ft
	-6(0) ^b	-4(0)b)	-4(0) ^b) -2(-2(0) ^b -2(0) ^c 0		0	1
7. Vertical Openings	Open 4 or More	Open 2 o	r 3		End	losed with	n Indicated Fire Re	sist.
	Floors	Floors			<1 hr		hr to <2 hr	≥2 hr
	-14	-10		0			2(0) ^e	3 (0)°)
8. Hazardous Areas	Double	Deficiency		Single [Deficiency	<i>r</i>	No Deficiencies
	In Zone	Outside Z	one	In Zone		In A	djacent Zone	
	-11	-5		-6		-2		0
9. Smoke Control	No Control	Smoke Ba Serves Zo		Mech. Assisted Systems by Zone		ems		
	-5(0)°	(0)		3				
10. Emergency	<2 Routes			Multiple Routes				
Movement Routes	-	Deficier	nt	1	orizontal kit(s)		Horizontal Exit(s)	Direct Exit(s)
	(-8)	-2			0		1	5
11. Manual Fire Alarm	No Man	ual Fire Alarm			Manua	I Fire Alar	m	
				W/O F.	D. Conn.	V	V/F.D. Conn	
		-4			1		(2)	
12. Smoke Detection and Alarm	None	Corridor C	•	Room	ns Only	1	orridor and bit. Spaces	Total Spaces In Zone
	0(3) ^g	2(3)3)	3	(3) ^g		4	5
13. Automatic Sprinklers	None	Corridor a Habit. Sp			ntire Iding			
	0	8		1	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.

⁹ 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 S₁, S₂, S₃, S₆ to blocks labeled S₁, S₂, S₃, S₆ in Table 7 on page 4 of this sheet.

TA	TABLE 5. INDIVIDUAL SAFETY EVALUATIONS							
Safety Parameters	Containment Safety (S ₁)	Extinguishment Safety (S ₂)	People Movement Safety (S ₃)	General Safety (S4)				
1. Construction	-4	-4		-4				
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	S1= 16	S2= \\	S 3= 5	S4= 13				

MANDATORY S	AFETY REQUIF		LE 6. R USE IN HOSF	PITALS OR NU	IRSING HOMES	S)
esemble and the second	Containment (S _a)		Extingui (S		People Movement (S ₀)	
Zone Location	New	Exist.	New	Exist.	New	Exist.
1 st story 2 nd or 3rd story ^b 4 th story or higher	11 15 18	5 9 9	15(12) ^a 17(14) ^a 19(16) ^a	4 ⑥ 6	8(5) ^a 10(7) ^a 11(8) ^a	1 ③ 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: Sa=7, Sb=10, and Sc=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 Sa, Sb, and Sc 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 EQU	IVALENCY EVALUATION	Yes	No
Containment Safety (S ₁)	minus	Mandatory Containment (S _*)	≥ 0	$\begin{array}{c c} S_1 & S_a & C \\ \hline 16 & 9 & = 7 \end{array}$	1	
Extinguishment Safety (S ₂)	minus	Mandatory Extinguishment (S₀)	≥ 0	$\begin{array}{c c} S_2 & S_b & E \\ \hline 11 & - & 6 & = & 5 \end{array}$	1	e
People Movement Safety (S₃)	minus	Mandatory People Movement (S₅)	≥ 0	S ₃ - S _c P 2	J	
General Safety (S ₄)	minus	Occupancy Risk (R)	≥ 0	$\begin{bmatrix} S_4 & R & G \\ 13 & - & 1 \end{bmatrix} = \begin{bmatrix} I2 \end{bmatrix}$	1	

	TABLE 8. FACILITY FIRE SAFETY REQUIREMENTS WORKSHEET	Г		
1	mplete one copy of this worksheet for each facility. r each consideration, select and mark the appropriate column.	Met	Not Met	Not Applic.
A.	Building utilities conform to the requirements of Section 9.1.	J		
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.			1
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.	7		
D.	Fuel-burning space heaters and portable electrical space heaters are not used.	1		10.00
E.	There are no flue-fed incinerators.	J		
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.	1		
G.	Smoking regulations have been adopted and implemented in accordance with 18.7.4 and 19.7.4.	J		
H.	Draperies, upholstered furniture, mattresses, furnishings, and decoration combustibility is limited in accordance with 18.7.5 and 19.7.5.	J		
l.	Fire extinguishers are provided in accordance with the requirements of 18.3.5.4 and 19.3.5.6.	J		
J.	Exit signs are provided in accordance with the requirements of 18.2.10.1 and 19.2.10.	1		
K.	Emergency lighting is provided in accordance with 18.2.9.1 or 19.2.9.	1		
L.	Standpipes are provided in all new high rise buildings as required by 18.4.2.			/

All of the checks in Table 7 are in the "Yes" column. The level of fire safety is at least equivalent to that prescribed by the Life Safety Code.* 2. One of more of the checks in Table 7 are in the "No" column. The level of fire safety is not shown by this system to be equivalent to that prescribed by the Life Safety Code.* *The equivalency covered by this worksheet includes the majority of considerations covered by the Life Safety Code. There are a few considerations that are not evaluated by this method. These must be considered separately. These additional considerations are covered in Table 8, the "Facility Fire Safety Requirements Worksheet." One copy of this separate worksheet is to be completed for each facility.

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

ZONE	3	OF	1)	ZONES

FIRE/SMOKE ZONE*	EVALUATION	WORKSHEET	FOR HEALTH	CARE FACIL	.ITIES

			2000 LIFE SAFETY CODE
FACILITY		BUILDING	
	EBENEZER CARE CENTER	01-MAIN BUILDING	
ZONE(S) EV	/ALUATED		
	FIRST FLOOR CENTER		
PROVIDER/	VENDOR NO.	DATE OF SURVEY	
	245587	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. OCCUPANC	Y RISK PARAMI	ETER F	ACTOR	3			
Risk Parameters		Risk Factors Values							
1. Patient	Mobility Status	Mobile	Limited M	Limited Mobility		t Mobile	Not Movable		
Mobility (M)	Risk Factor	1.0	1.6	1.6		3.2	4.5		
2. Patient Density (D)	No. of Patients	1–5	6–10)	11–30		>30		
Density (D)	Risk Factor	1.0	1.2	1.2		1.5	2.0		
3. Zone	Floor	1 st	2 nd or 3 nd	4th to 6th		7 th and Above	Basements		
Location (L)	Risk Factor	1.1	1.2	1.4		1.6	1.6		
4. Ratio of Patients to	<u>Patients</u> Attendant	<u>1–2</u> 1	<u>3–5</u> 1	<u>6-</u>	<u>-10</u> <u>>10</u> 1		One or More None		
Attendants (T)	Risk Factor	1.0	1.1	1.2		1.5	4.0		
5. Patient Average	Age	Under 65 Yea	ars and Over 1 year		65 Years and Over 1 Year and Younger				
Age (A)	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. OCC	TABLE 2. OCCUPANCY RISK FACTOR CALCULATION						
	M	D	L	Т	Α	F	
OCCUPANCY RISK	1.b 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)	TABLE 3B. (EXISTING BUILDINGS)
1.0 x =	$0.6 \times \boxed{16.9} = \boxed{10.1} = 11$

* FIRE/SMOKE ZONE is a space separated from all other spaces by floo	ors, horizontal exits, or smoke barriers.	
SURVEYOR SIGNATURE	TITLE	DATE
FIRE AUTHORITY SIGNATURE	TITLE	DATE
Thomas Linhoff 12424 / home down for	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.

	4-2		TABLE					
Safety Parameters			Safe	ty Paran	neters Va	alues		
1. Construction		Combustible Types III, IV, and V			NonComb Types I a			02/00/00/00/00
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	2	4
Third	-9	-7	-9	-7	7	-7	2	4
4th and Above	-13	-7	-13	-7	7	-9	-7	4
2. Interior Finish (Corridors and Exits)	Class C -5(0) ^f	Class B 0(3) ^f		Clas	ss A			
3. Interior Finish	Class C	Class B		Clas				
(Rooms)	-3(1) ^f	1(3) ^f		(3			
4. Corridor	None or Incomplete	<¹/₂ hour	.	≥¹/₂ to <	***************************************		>1 hour	
Partitions/Walls	-10(0) ^a	0		1(0		1	(2(b) ^a	
5. Doors to Corridor	No Door	<20 min FI	PR	>20 mi	n FPR		min FPR and Auto Clos.	
	-10	0		220 Milli FFR		1	2(0) ^d	
6. Zone Dimensions	Dead End					No Doa		'one I ength Is
o. Zorio Zimonolorio	>100 ft	>50 ft to 100 ft	30 ft	ft to 50 ft >150 f			d Ends >30 ft and Z	<100 ft
	-6(0)b)	-4(0) ^b		2(0) ^b	-2(0		0	1
7. Vertical Openings	Open 4 or More	Open 2 or		(-)	L		h Indicated Fire Res	
,	Floors	Floors		<1 hr			hr to <2 hr	>2 hr
	-14	-10		(0	(°)		2(0) ^e	3(0) ^e
8. Hazardous Areas	Double	Deficiency			Single I	Deficiency	,	No Deficiencies
	In Zone	Outside Zo	ne	In Zone		In A	djacent Zone	
	-11	-5		-6			-2	(0)
9. Smoke Control	No Control	Smoke Bar Serves Zo		Mech. Assisted Systems by Zone		ems		
	-5(0)°	(0)	(0)		3			
10. Emergency	<2 Routes		- L	**************************************	Multipl	e Routes		
Movement Routes		Deficient	t	W/O Horizontal Exit(s)			Horizontal Exit(s)	Direct Exit(s)
	(-8)	-2			0	1	1	5
11. Manual Fire Alarm	No Manu	al Fire Alarm			Manua	Fire Alar	m	PRAISE
				W/O F.	D. Conn.	V	V/F.D. Conn	
		-4			1		(2)	
12. Smoke Detection and Alarm	None	Corridor O	nly	Room	ns Only	1	prridor and bit. Spaces	Total Spaces In Zone
	0(3) ^g	2(3) ³)		3((3) ^g		4	5
13. Automatic Sprinklers	None	Corridor a Habit. Spa	386.00	Er	ntire Iding			
	0	8		7	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.

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 S₁, S₂, S₃, S₆ to blocks labeled S₁, S₂, S₃, S₆ in Table 7 on page 4 of this sheet.

TA	BLE 5. INDIVIDUAL	SAFETY EVALUAT	IONS	
Safety Parameters	Containment Safety (S ₁)	Extinguishment Safety (S ₂)	People Movement Safety (S ₃)	General Safety (S₄)
1. Construction	-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	1.0	1	l
6. Zone Dimensions			0	0
7. Vertical Openings	0		0	0
8. Hazardous Areas	0	0		O
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	S1= (7	S2= 13	S3= 4	S4= 11

MANDATORY S	AFETY REQUI	15.00	LE 6. R USE IN HOSI	PITALS OR NU	JRSING HOME	S)			
	Containment (S _a)		J					People Moveme (S _c)	
Zone Location	New	Exist.	New	Exist.	New	Exist.			
1 st story	11	(<u>5</u>)	15(12) ^a	4	8(5) ^a	1			
2 nd 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: Sa=7, Sb=10, and Sc=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 Sa, Sb, and Sc 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 _*)	≥ 0	$\begin{array}{c c} S_1 & S_a & C \\ \hline 17 & - & 5 \end{array} = \begin{array}{c} C \\ \hline 12 \end{array}$	1	
Extinguishment Safety (S ₂)	minus	Mandatory Extinguishment (S₀)	≥ 0	$\begin{bmatrix} S_2 \\ V_3 \end{bmatrix} - \begin{bmatrix} S_b \\ 4 \end{bmatrix} = \begin{bmatrix} Q \end{bmatrix}$	1	
People Movement Safety (S ₃)	minus	Mandatory People Movement (S₅)	≥ 0	$\begin{bmatrix} S_3 \\ 4 \end{bmatrix} - \begin{bmatrix} S_c \\ J \end{bmatrix} = \begin{bmatrix} P \\ 3 \end{bmatrix}$	1	
General Safety (S ₄)	minus	Occupancy Risk (R)	≥ 0	$\begin{array}{c ccccccccccccccccccccccccccccccccccc$	1	

	TABLE 8. FACILITY FIRE SAFETY REQUIREMENTS WORKSHEE	Г		
Stone	mplete one copy of this worksheet for each facility. r each consideration, select and mark the appropriate column.	Met	Not Met	Not Applic.
A.	Building utilities conform to the requirements of Section 9.1.	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.			J
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.	1		
D.	Fuel-burning space heaters and portable electrical space heaters are not used.	1		
E.	There are no flue-fed incinerators.	1		
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.	1		
G.	Smoking regulations have been adopted and implemented in accordance with 18.7.4 and 19.7.4.	J		
H.	Draperies, upholstered furniture, mattresses, furnishings, and decoration combustibility is limited in accordance with 18.7.5 and 19.7.5.	J		
I.	Fire extinguishers are provided in accordance with the requirements of 18.3.5.4 and 19.3.5.6.	J		
J.	Exit signs are provided in accordance with the requirements of 18.2.10.1 and 19.2.10.	1		
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.			V

1. All of the checks in Table 7 are in the "Yes" column. The level of fire safety is at least equivalent to that prescribed by the Life Safety Code.* 2. One of more of the checks in Table 7 are in the "No" column. The level of fire safety is not shown by this system to be equivalent to that prescribed by the Life Safety Code.* *The equivalency covered by this worksheet includes the majority of considerations covered by the Life Safety Code. There are a few considerations that are not evaluated by this method. These must be considered separately. These additional considerations are covered in Table 8, the "Facility Fire Safety Requirements Worksheet." One copy of this separate worksheet is to be completed for each facility.

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

ZONE 4 OF 11 ZONES

FIRE/SMOKE ZONE* EVALUATION WORKSHEET FOR HEALTH CARE FACILITIES

			2000 LIFE SAFETY CODE
FACILITY	- 4	BUILDING	
501 St. 104 SCHOOL ST. 100 St.	EBENEZER CARE CENTER	01- MAIN BUILDING	
ZONE(S) EVA	LUATED		
The second secon	FIRST FLOOR NORTH		
PROVIDER/V		DATE OF SURVEY / /	

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 Status	Mobile	Limited M	Limited Mobility		t Mobile	Not Movable	
Mobility (M)	Risk Factor	1.0	1.6	1.6		3.2	4.5	
2. Patient Density (D)	No. of Patients	1–5 6–10		11–30		>30		
Defisity (D)	Risk Factor	1.0	1.2		1.5		2.0	
3. Zone	Floor	1 st	2 nd or 3 nd	4 th to 6 th		7th and Above	e Basements	
Location (L)	Risk Factor	1.1	1.2	1.4		1.6	1.6	
4. Ratio of Patients to	<u>Patients</u> Attendant	<u>1–2</u> 1	<u>3–5</u> 1	<u>6</u> 1	10 <u>>10</u> 1		One or More None	
Attendants (T)	Risk Factor	1.0	1.1	1.1 1.2		1.5	4.0	
5. Patient Average	Age	Under 65 Yea	ars and Over 1 year	5)	65 Years and Over 1 Year and Younger			
Age (A)	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. OC	CUPANO	Y RISK	FACTOR	CALCUI	ATION	
OCCUPANCY RISK	M	D	L	T	A	F
	3.2 X	2,0 X	i.i x	1.5 X	1,2 =	12.1

- 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)	TABLE 3B. (EXISTING BUILDINGS)
1.0 X = =	$ \begin{array}{ccc} \mathbf{F} & \mathbf{R} \\ 0.6 \times 127 & = 7.6 & = 8 \end{array} $

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

SURVEYOR SIGNATURE

TITLE

PRESIDENT

DATE

OI 14/2016

TITLE

DATE

OA 18 2016

Supervisor

Form CMS-2786T (02/2013)

Thomas Linhoff 12424

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	E 4.				
Safety Parameters			Safe	ty Param	neters Va	lues		
1. Construction	Ту	Combustible Types III, IV, and V			NonCombus Types I an			
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	2	4
Third	-9	-7	-9	-7	7	-7	2	4
4th and Above	-13	-7	-13	-7	7	-9	-7	4
Interior Finish (Corridors and Exits)	Class C -5(0) ^f	Class B		Clas				
3. Interior Finish (Rooms)	Class C	Class B		Clas				
4. Corridor	None or Incomplet		r	≥¹/₂ to <			>1 hour	
Partitions/Walls	-10(0) ^a	0		≥'/₂ to <			≥1 hour (2(0) ^a	
5. Doors to Corridor	No Door	<20 min F	PR	>20 mi	n FPR		min FPR and Auto Clos.	
	-10	0				2(0) ^d		
6. Zone Dimensions	Dead End				Ĺ	No Dea	d Ends >30 ft and 2	one Lenath Is
This bush of the first of the Control of the Contro	>100 ft	>50 ft to 100 ft	30 ft	ft to 50 ft >150		~~~	100 ft to 150 ft	<100 ft
	-6(0) ^b)	-4(0) ^b	-2	-2(0) ^b -2(0))°	0	1
7. Vertical Openings	Open 4 or More	Open 2 or	r 3		Enc	losed with	n Indicated Fire Res	sist.
1000 1000	Floors	Floors		<1 hr		≥1	hr to <2 hr	≥2 hr
	-14	-10		0			2(0) ^e)	3(0) ^e
8. Hazardous Areas	Double	Deficiency		Single Deficie		Deficiency	,	No Deficiencies
	In Zone	Outside Zo	one	In Zone		In A	djacent Zone	
	-11	-5		-6		-2		
9. Smoke Control	No Control	Smoke Bar Serves Zo		Mech. Assisted Systems by Zone		ems		
	-5(0)°	(0)		3				
10. Emergency	<2 Routes			Multiple Routes				
Movement Routes		Deficien	t		orizontal :it(s)		Horizontal Exit(s)	Direct Exit(s)
	(-8)	-2			0		1	5
11. Manual Fire Alarm N		ual Fire Alarm			Manual	Fire Alar	m	
				W/O F.	D. Conn.	V	V/F.D. Conn	
		-4			1		2	
12. Smoke Detection and Alarm	News	0	um la c	5	- 0-1		orridor and	Total Spaces
and Alami	None	Corridor O	rity	Rooms Only		Hal	oit. Spaces	In Zone
40.4	0(3) ^g	2(3) ^g)			(3) ^g	-	4	5
13. Automatic Sprinklers	None	Corridor a Habit. Spa		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.

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.

⁹ 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 S₁, S₂, S₃, S₆ to blocks labeled S₁, S₂, S₃, S₆ 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 (S₄)			
1. Construction	-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	and the second s	0	0			
8. Hazardous Areas	0	0		0			
9. Smoke Control			0	0			
10. Emergency Movement Routes			~ <u>&</u>	-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	S1= [7	S2= 13	S3= 4	S4= 4			

MANDATORY S	AFETY REQUI	0.0 (0.00)	LE 6. R USE IN HOS	PITALS OR NU	JRSING HOME	S)
		inment S₃)	Extingui (S			Novement S _c)
Zone Location	New	Exist.	New	Exist.	New	Exist.
1st story 2nd or 3rd story ^b	11 15	(<u>5</u>)	15(12) ^a 17(14) ^a	<u>4</u> 6	8(5) ^a 10(7) ^a	① 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: Sa=7, Sb=10, and Sc=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 Sa, Sb, and Sc 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 (S₄)	≥ 0	$\begin{array}{c c} S_1 & S_a & C \\ \hline 17 & - & 5 & = & \boxed{12} \end{array}$	1	
Extinguishment Safety (S ₂)	minus	Mandatory Extinguishment (S₀)	≥ 0	$\begin{bmatrix} S_2 \\ J_3 \end{bmatrix} - \begin{bmatrix} S_b \\ L_1 \end{bmatrix} = \begin{bmatrix} E \\ Q \end{bmatrix}$	J	
People Movement Safety (S ₃)	minus	Mandatory People Movement (S₀)	≥ 0	$\begin{bmatrix} S_3 & S_c & P \\ 4 & - 1 & 3 \end{bmatrix}$	J	
General Safety (S ₄)	minus	Occupancy Risk (R)	≥ 0	$\begin{bmatrix} S_4 & R & G \\ I4 & - & B \end{bmatrix} = \begin{bmatrix} G & G \\ G & G \end{bmatrix}$	/	

	TABLE 8. FACILITY FIRE SAFETY REQUIREMENTS WORKSHEET	Γ		
1	mplete one copy of this worksheet for each facility. r each consideration, select and mark the appropriate column.	Met	Not Met	Not Applic.
A.	Building utilities conform to the requirements of Section 9.1.	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.			1
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.	J		
D.	Fuel-burning space heaters and portable electrical space heaters are not used.	1		
E.	There are no flue-fed incinerators.	1		
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.	J		7. P. Ser
G.	Smoking regulations have been adopted and implemented in accordance with 18.7.4 and 19.7.4.	1		
H.	Draperies, upholstered furniture, mattresses, furnishings, and decoration combustibility is limited in accordance with 18.7.5 and 19.7.5.	1		
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.	J,		
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.			V

CONCLUSIONS 1. All of the checks in Table 7 are in the "Yes" column. The level of fire safety is at least equivalent to that prescribed by the *Life Safety Code*.* 2. One of more of the checks in Table 7 are in the "No" column. The level of fire safety is not shown by this system to be equivalent to that prescribed by the *Life Safety Code*.* *The equivalency covered by this worksheet includes the majority of considerations covered by the *Life Safety Code*. There are a few considerations that are not evaluated by this method. These must be considered separately. These additional considerations are covered in Table 8, the "Facility Fire Safety Requirements Worksheet." One copy of this separate worksheet is to be completed for each facility.

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

ZONE 5 OF II 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	
	DATE OF SURVEY
245587	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 Status	Mobile	Limited I	Limited Mobility		t Mobile	Not Movable			
Mobility <i>(M)</i>	Risk Factor	1.0	(1.0	1.6		3.2	4.5			
2. Patient Density (D)	No. of Patients	1–5	6-	6–10		11–30 >				
Density (D)	Risk Factor	1.0	1.:	1.2		1.5	2.0			
3. Zone	Floor	1 st	2 nd or 3 nd	4 th to	o 6 th	7th and Abov	e Basements			
Location (L)	Risk Factor	1.1	1.2	1.	.4	1.6	1.6			
4. Ratio of Patients to	<u>Patients</u> Attendant	<u>1–2</u> 1	<u>3–5</u> 1	6-	<u>10</u> I	<u>>10</u> 1	One or More None			
Attendants (T)	Risk Factor	1.0	1.1	1	.2	1.5	4.0			
5. Patient Average	Age	Under 65 Yea	ars and Over 1 yea	ſ	65 Years and Over 1 Year and Younger					
Age (A)	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							
OCCUPANCY RISK	M	D	L	T	A	F	
	1.b >	X 1.5 X	J.I X	4.0 X	1.2 =	12,1	

- 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)	TABLE 3B. (EXISTING BUILDINGS)
1.0 X = =	$ \begin{array}{ccc} & & & & & & & & & & & & & & & & & $

rine/smoke zone is a space separated from all other spaces by no	015, 1101120	intal exits, of silloke partiers.	
SURVEYOR SIGNATURE	TITLE	5	DATE / /
Robert & Unitalt FIRE SAFETA RESOURCES, LIC		PRESIDENT	01/14/2016
FIRE AUTHORITY SIGNATURE	TITLE	Supervisor	DATE 02-18-2016
Thomas Linhoff 12424	1	Supervisor	02-10-2010

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.

	The second secon			TABLE	Ξ 4.					
Safety Parameters				Safe	ety Param	eters	Values			
1. Construction	Ту	Combustible pes III, IV, and			The state of the s			D. PARK MAR MINISTER	nCombustible /pes I and II	
Floor or Zone	000	111		200	211 + 2HH		000	111	222, 332, 433	
First	-2	0	0 (-2)		0		0	2	2	
Second	-7	-2	-2 -4		-2		-2	2	4	
Third	-9	-7		-9	-7		-7	2	4	
4th and Above	-13	-7	-7 -13		-7		-9	-7	4	
Interior Finish (Corridors and Exits)	Class C -5(0) ^f		ass B		Clas					
3. Interior Finish (Rooms)	Class C -3(1) ^f		ass B		Clas	s A			***************************************	
4. Corridor	None or Incomplet		hour		≥¹/₂ to <	<u> </u>		≥1 hour		
Partitions/Walls	-10(0) ^a		0)		1(0			2(0) ^a		
5. Doors to Corridor	No Door	<20 r	nin FP	R	<u>≥</u> 20 mi	≥20 min FP		min FPR and Auto Clos.		
	-10		0		(1)(D) ^d			2(0) ^d		
6. Zone Dimensions		Dead End					No Dea	d Ends >30 ft and	Zone Length Is	
	>100 ft	>50 ft to 10	0 ft	30 fl	to 50 ft		>150 ft	100 ft to 150 ft	<100 ft	
	-6(0) ^b)	-4(0) ^b		-	2(0) ^b		-2(0)°	0	1	
7. Vertical Openings	Open 4 or More	Open 2 or 3		3			Enclosed wit	h Indicated Fire R	esist.	
	Floors	FI	Floors		<1 hr		<u>></u>	1 hr to <2 hr	≥2 hr	
	-14		-10		0			2(0) ^e	3(0)	
8. Hazardous Areas	Double	e Deficiency			Single		gle Deficienc	y	No Deficiencies	
	In Zone	Outsi	Outside Zone		In Zone		In A	Adjacent Zone		
	-11		-5		-6		-2		\bigcirc	
9. Smoke Control	No Control		e Barr es Zon			Mech. Assisted Systems by Zone				
	-5(0)°		0)							
10. Emergency	<2 Routes					M	ultiple Routes			
Movement Routes		De	ficient		W/O H	orizont it(s)	al	Horizontal Exit(s)	Direct Exit(s)	
	(-8)		-2			0		1	5	
11. Manual Fire Alarm	No Man	ual Fire Alarm	1			Ma	nual Fire Ala	rm		
					W/O F.I	D. Con	n. \	N/F.D. Conn		
		-4				1		(2)		
12. Smoke Detection and Alarm	None	Corrie	dor On	nly	Room	s Only	1	orridor and bit. Spaces	Total Spaces In Zone	
	0(3) ⁹	2	2(3) ³)		3(3) ^g		4	5	
13. Automatic Sprinklers	None		idor an			tire ding				
	0		8		(1	0)				

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.

⁹ 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 S₁, S₂, S₃, S₆ to blocks labeled S₁, S₂, S₃, S₆ 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 (S₄)				
1. Construction	-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	Ō		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	io	10	10 ÷2=5	10				
Total Value	S1= 15	S2= 13	S 3= 4	S4= 12				

TABLE 6. MANDATORY SAFETY REQUIREMENTS (FOR USE IN HOSPITALS OR NURSING HOMES)									
Containment Extinguishment People Movement (Sa) (Sb) (Sc)									
Zone Location	New Exist. New Exist. New								
1 st story 2 nd or 3rd story ^b 4 th story or higher	11 15 18	(5) 9 9	15(12) ^a 17(14) ^a 19(16) ^a	4) 6 6	8(5) ^a 10(7) ^a 11(8) ^a	(1) 3 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 Sa, Sb, and Sc 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							
Containment Safety (S ₁)	minus	Mandatory Containment (S _*)	≥ 0	$\begin{bmatrix} S_1 \\ 15 \end{bmatrix} - \begin{bmatrix} S_a \\ 5 \end{bmatrix} = \begin{bmatrix} C \\ 10 \end{bmatrix}$	1			
Extinguishment Safety (S ₂)	minus	Mandatory Extinguishment (S₅)	≥ 0	$\begin{bmatrix} S_2 \\ J_3 \end{bmatrix} - \begin{bmatrix} S_b \\ 4 \end{bmatrix} = \begin{bmatrix} E \\ q \end{bmatrix}$	1			
People Movement Safety (S₃)	minus	Mandatory People Movement (S₀)	≥ 0	$\begin{bmatrix} S_3 \\ 4 \end{bmatrix} - \begin{bmatrix} S_c \\ 1 \end{bmatrix} = \begin{bmatrix} P \\ 3 \end{bmatrix}$	J			
General Safety (S ₄)	minus	Occupancy Risk (R)	≥ 0	$\begin{bmatrix} S_4 \\ 12 \end{bmatrix} - \begin{bmatrix} R \\ 8 \end{bmatrix} = \begin{bmatrix} G \\ \lambda_4 \end{bmatrix}$	J			

	TABLE 8. FACILITY FIRE SAFETY REQUIREMENTS WORKSHEET	7		
1	mplete one copy of this worksheet for each facility. r each consideration, select and mark the appropriate column.	Met	Not Met	Not Applic.
A.	Building utilities conform to the requirements of Section 9.1.	\checkmark		
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.	J		
D.	Fuel-burning space heaters and portable electrical space heaters are not used.	$\sqrt{}$		
E.	There are no flue-fed incinerators.	1		
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.	J		
G.	Smoking regulations have been adopted and implemented in accordance with 18.7.4 and 19.7.4.	1		
H.	Draperies, upholstered furniture, mattresses, furnishings, and decoration combustibility is limited in accordance with 18.7.5 and 19.7.5.	$\sqrt{}$		
I.	Fire extinguishers are provided in accordance with the requirements of 18.3.5.4 and 19.3.5.6.	V		
J.	Exit signs are provided in accordance with the requirements of 18.2.10.1 and 19.2.10.	J,		
K.	Emergency lighting is provided in accordance with 18.2.9.1 or 19.2.9.	$\sqrt{}$		
L.	Standpipes are provided in all new high rise buildings as required by 18.4.2.			1

1. All of the checks in Table 7 are in the "Yes" column. The level of fire safety is at least equivalent to that prescribed by the *Life Safety Code*.* 2. One of more of the checks in Table 7 are in the "No" column. The level of fire safety is not shown by this system to be equivalent to that prescribed by the *Life Safety Code*.* *The equivalency covered by this worksheet includes the majority of considerations covered by the *Life Safety Code*. There are a few considerations that are not evaluated by this method. These must be considered separately. These additional considerations are covered in Table 8, the "Facility Fire Safety Requirements Worksheet." One copy of this separate worksheet is to be completed for each facility.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is o938-0242. The time required to complete this information collection is estimated to average 5 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, Attn: PRA Reports Clearance Officer, 7500 Security Boulevard, Baltimore, Maryland 21244-1850.

ONE _____OF___I__ZONE

			20	NE	Or		20
FIRE/SMOKE ZONE*	FVALUATION	WORKSHEET	FOR HEALT	H CAR	E FACIL	ITIES	

			2000 LIFE SAFETY CODE
FACILITY	F 2 2	BUILDING	
	EBENEZER CARE CENTER	01-MAIH BUILDING	
ZONE(S) EVA	ALUATED	•	
	SECOND FLOOR CENTER		
PROVIDER/V		DATE OF SURVEY	
	245587	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 Status	Mobile	Limited M	Limited Mobility		t Mobile	Not Movable			
Mobility (M)	Risk Factor	1.0	1.6	1.6		3.2	4.5			
2. Patient Density (D)	No. of Patients	1–5	6–10	6–10		11–30	>30			
Defisity (D)	Risk Factor	1.0	1.2	.2		1.5	2.0			
3. Zone	Floor	1 st	2 nd or 3 nd	2 nd or 3 rd 4 th to		7 th and Above	Basements			
Location (L)	Risk Factor	1.1	1.2	1.4		1.6	1.6			
4. Ratio of Patients to	<u>Patients</u> Attendant	<u>1–2</u> 1	<u>3–5</u> 1	<u>6-</u> 1	6 <u>–10</u>		One or More None			
Attendants (T)	Risk Factor	1.0	1.1	1.	2	1.5	4.0			
5. Patient Average	Age	Under 65 Yea	ars and Over 1 year		65 Years and Over 1 Year and Younger					
Age (A)	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. OC	CUPANC	Y RISK	FACTOR	CALCU	LATION	
	М	D	L	Т	Α	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)	TABLE 3B. (EXISTING BUILDINGS)
1.0 x = R	$0.6 \times 10.4 = 6.2 = 7$

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

FIRE AUTHORITY SIGNATURE
Thomas Linhoff 12424

TITLE

Supervisor

DATE

02-18-2010

DATE

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

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

			TABLE						
Safety Parameters			Safe	ty Param	neters Va	lues			
1. Construction	Ту	Combustible pes III, IV, and V					NonCombustible Types I and II		
Floor or Zone	000	111	200	211 + 2HH		000	111	222, 332, 43	
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	7	-9	-7	4	
Interior Finish (Corridors and Exits)	Class C -5(0) ^f	Class E	3	Clas	ss A				
3. Interior Finish	Class C	Class E		Clas					
(Rooms)	-3(1) ^f	1(3) ^f		(3					
4. Corridor	None or Incomplet	e <1/2 hou	r	≥¹/₂ to <	1 hour		≥1 hour		
Partitions/Walls	-10(0) ^a	0	<u>'</u>	1(0			(2(0) ^a		
5. Doors to Corridor	No Door	<20 min F	PR	>20 mi	n FPR		min FPR and Auto Clos.		
	-10	0		(1)0		<u> </u>	2(0) ^d		
6. Zone Dimensions		Dead End			, 	No Doo		7	
			30 ft	ft to 50 ft >150		~~~~~~~~~~	d Ends >30 ft and 2	<100 ft	
	-6(0) ⁶)	-4(0) ^b		-2(0) ^b -2(0			0	1	
7. Vertical Openings	Open 4 or More	Open 2 o	1	-(-/			I Indicated Fire Res		
	Floors Floors		i i	<1 hr			hr to <2 hr	>2 hr	
	-14	-10		C)		2(0) ^e	3(0)°)	
8. Hazardous Areas	Double	Double Deficiency		AND LONG TO A STATE OF THE STAT	Single [Deficiency	,	No Deficiencies	
	In Zone	Outside Zo	one	In Z	one	In A	djacent Zone		
	-11	-5		-6			-2	(O)	
9. Smoke Control	No Control	Smoke Bar Serves Zo			Mech. Assi by	sted Syst Zone	ems		
	-5(0)°	-5(0)°		3					
10. Emergency	<2 Routes				Multipl	e Routes			
Movement Routes		Deficien	t		orizontal it(s)	T	Horizontal Exit(s)	Direct Exit(s)	
	(-8)	-2		0		1		5	
11. Manual Fire Alarm	No Man	ual Fire Alarm			Manual	Fire Alar	m		
			Γ	W/O F.I	D. Conn.	V	V/F.D. Conn		
		-4			1		(2)		
12. Smoke Detection and Alarm	None	Corridor O	inly	Rooms Only			orridor and pit. Spaces	Total Spaces In Zone	
	0(3) ^g	2(3)3)			(3) ^g		4	5	
13. Automatic Sprinklers	None	Corridor a Habit. Spa		En	itire Iding				
	0	8		71	10)	1			

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.

⁹ 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 S₁, S₂, S₃, S_G to blocks labeled S₁, S₂, S₃, 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 (S₄)				
1. Construction	-4	-4		-4				
Interior Finish (Corr. and Exit)	3		3	3				
3. Interior Finish (Rooms)	3			3				
4. Corridor Partitions/Walls	2		er in Frankling (Frankling)	2				
5. Doors to Corridor	1		1	(
6. Zone Dimensions			0	0				
7. Vertical Openings	0		0	0				
8. Hazardous Areas	0	0		0				
9. Smoke Control			0	٥				
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	IO				
Total Value	S1= 15	S2= \\	S 3= 4	S4= 12				

TABLE 6. MANDATORY SAFETY REQUIREMENTS (FOR USE IN HOSPITALS OR NURSING HOMES)							
Containment Extinguishment (Sa) (Sb)						lovement Sc)	
Zone Location	New	Exist.	New	Exist.	New	Exist.	
1 st story 2 nd or 3rd story ^b 4 th story or higher	11 15 18	5 9 9	15(12) ^a 17(14) ^a 19(16) ^a	4 ⑥ 6	8(5) ^a 10(7) ^a 11(8) ^a	1 3 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: Sa=7, Sb=10, and Sc=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 Sa, Sb, and Sc 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 S	SAFETY EQU	IVALENCY EVALUATION	Yes	No
Containment Safety (S ₁)	minus	Mandatory Containment (S _a)	≥ 0	$\begin{array}{c c} S_1 & S_a & C \\ \hline (G) & - & Q & = & G \end{array}$	1	
Extinguishment Safety (S ₂)	minus	Mandatory Extinguishment (S _s)	≥ 0	$\begin{array}{c c} S_2 & S_b & E \\ \hline 11 & - & b & = & 5 \end{array}$	1	
People Movement Safety (S₃)	minus	Mandatory People Movement (S₀)	≥ 0	$\begin{bmatrix} S_3 & S_c & P \\ 4 & - 3 & = 1 \end{bmatrix}$	J	
General Safety (S ₄)	minus	Occupancy Risk (R)	≥ 0	$\begin{bmatrix} S_4 & R & G \\ 12 & 7 & = 5 \end{bmatrix}$	J	

	TABLE 8. FACILITY FIRE SAFETY REQUIREMENTS WORKSHEET	Γ		
	mplete one copy of this worksheet for each facility. r each consideration, select and mark the appropriate column.	Met	Not Met	Not Applic.
A.	Building utilities conform to the requirements of Section 9.1.	J		
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.			1
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.	1		
D.	Fuel-burning space heaters and portable electrical space heaters are not used.	1		
E.	There are no flue-fed incinerators.	J		
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.	1		
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.	7		
I.	Fire extinguishers are provided in accordance with the requirements of 18.3.5.4 and 19.3.5.6.	7	13116	
J.	Exit signs are provided in accordance with the requirements of 18.2.10.1 and 19.2.10.	V.		
K.	Emergency lighting is provided in accordance with 18.2.9.1 or 19.2.9.	1		
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 <i>Life Safety Code</i> .*
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 <i>Life Safety Code</i> .*
*The equivalency covered by this worksheet includes the majority of considerations covered by the <i>Life Safety Code</i> . There are a few considerations that are not evaluated by this method. These must be considered separately. These additional considerations are covered in Table 8, the "Facility Fire Safety Requirements Worksheet." One copy of this separate worksheet is to be completed for each facility.

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

ZONE	7	OF	11	ZONES

FIRE/SMOKE ZONE* EVALUATION WORKSHEET FOR HEALTH CARE FACILITIES

2000 LIFE SAFETY CODE
BUILDING
01-MAIN BUILDING
W.
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. OCCUPANC	Y RISK PARAM	ETER F	ACTOR	3		
Risk Parameters		Risk F	actors Values				*	
1. Patient	Mobility Status	Mobile	Limited M	Limited Mobility		t Mobile	Not Movable	
Mobility <i>(M)</i>	Risk Factor	1.0	1.6	1.6		3.2	4.5	
2. Patient Density (D)	No. of Patients	1–5	-5 6 -10 11 -30		>30			
Density (D)	Risk Factor	1.0	1.2			1.5	2.0	
3. Zone	Floor	1ઘ	2 nd or 3 nd	4 th to 6 th		7 th and Above	e Basements	
Location (L)	Risk Factor	1.1	1.2	2) 1.4		1.6	1.6	
4. Ratio of Patients to	<u>Patients</u> Attendant	<u>1–2</u> 1	<u>3–5</u> 1	6-	-10 <u>>10</u>		One or More None	
Attendants (T)	Risk Factor	1.0	1.1	1.2		1.5	4.0	
5. Patient Average	Age	Under 65 Yea	ars and Over 1 year		65 Years and Over 1 Year and Younger			
Age (A)	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								
OCCUPANCY RISK	M	D	L	T	A	F		
	3.2 X	1.5 X	1.2 X	1.5 X	[1.2] =	\0,4		

- 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)	TABLE 3B. (EXISTING BUILDINGS)
1.0 x = =	$0.6 \times 104 = 10.2 = 7$

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

SURVEYOR SIGNATURE	TITLE T	DATE (,
Robert J. Umbotte FIRE SAFER RESOURCES, 1	LLC, PRESIDENT	01/14/2016
FIRE AUTHORITY SIGNATURE	TITLE .	DATE 02 19 2016
Thomas Linhoff 12424 / hum from	Supervisor Supervisor	02-16-2016

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			Safe	ty Param	neters Va	lues			
1. Construction	Ту	Combustible pes 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	2	4	
Third	-9	-7	-9	-7	7	-7	2	4	
4th and Above	-13	-7	-13	-7	7	-9	-7	4	
2. Interior Finish (Corridors and Exits)	Class C -5(0) ^f	Class E	3	Clas			*		
3. Interior Finish	Class C	Class E		Clas	ss A				
(Rooms)	-3(1) ^f	1(3) ^f		(3					
4. Corridor	None or Incomple	te <1/2 hou	r	≥¹/₂ to <	1 hour		≥1 hour	THE PARTY AND ADDRESS OF THE PARTY AND ADDRESS	
Partitions/Walls	-10(0) ^a	0		1(0			(2)0)a		
5. Doors to Corridor	No Door	<20 min F	PR	≥20 mi	n FPR		min FPR and Auto Clos.		
	-10	0		(10)			2(0) ^d		
6. Zone Dimensions		Dead End				No Dea	d Ends >30 ft and 2	one Length Is	
	>100 ft	>50 ft to 100 ft	30 ft	to 50 ft	>150		100 ft to 150 ft	<100 ft	
	-6(0)b)	-4(0) ^b	-2	2(0) ^b	-2(0)°	0	1	
7. Vertical Openings	Open 4 or More	Open 2 o	r 3		Enc	losed with	n Indicated Fire Res	sist.	
	Floors	Floors		<1 hr		<u>></u> 1	hr to <2 hr	≥2 hr	
	-14	-10		C)		2(0)°)	3(0) ^e	
8. Hazardous Areas	Double	e Deficiency		***************************************	Single [Deficiency	1	No Deficiencies	
	In Zone	Outside Zo	one	In Z	Zone	In A	djacent Zone		
	-11	-5		_	6		-2	(0)	
9. Smoke Control	No Control	Smoke Ba Serves Zo	100.00		Mech. Assi by	sted Syst Zone	ems		
	-5(0)°	0				3			
10. Emergency	<2 Routes		~~~		Multipl	e Routes			
Movement Routes		Deficier	ıt		orizontal tit(s)		Horizontal Exit(s)	Direct Exit(s)	
	(-8)	-2			0		1	5	
11. Manual Fire Alarm	No Mar	ual Fire Alarm			Manua	Fire Alar	m		
				W/O F.	D. Conn.	V	V/F.D. Conn		
		-4			1		2		
12. Smoke Detection and Alarm	None	Corridor C	only	Room	ns Only		orridor and bit. Spaces	Total Spaces In Zone	
	0(3) ^g	2(3)		3((3) ^g		4	5	
13. Automatic Sprinklers	None	Corridor a Habit. Spa		Er	ntire Iding				
	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.

⁹ 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 S₁, S₂, S₃, S_G to blocks labeled S₁, S₂, S₃, S_G in Table 7 on page 4 of this sheet.

TA	BLE 5. INDIVIDUAL	SAFETY EVALUAT	IONS	70
Safety Parameters	Containment Safety (S ₁)	Extinguishment Safety (S ₂)	People Movement Safety (S ₃)	General Safety (S₄)
1. Construction	-4	-4	e restantante.	-4
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			l
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	S1= 15	S2= \\	S3= Lt	S4= 12

MANDATORY SA	AFETY REQUIR		LE 6. R USE IN HOS	PITALS OR NU	IRSING HOMES	S)
		inment Sa)	Extingui (S			lovement
Zone Location	New	Exist.	New	Exist.	New	Exist.
1 st story 2 nd or 3rd story ^b 4 th story or higher	11 15 18	5 ⑨ 9	15(12) ^a 17(14) ^a 19(16) ^a	4 ⑥ 6	8(5) ^a 10(7) ^a 11(8) ^a	1 ③ 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: Sa=7, Sb=10, and Sc=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 Sa, Sb, and Sc 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 EQU	IVALENCY EVALUATION	Yes	No
Containment Safety (S ₁)	minus	Mandatory Containment (S _*)	≥ 0	$\begin{array}{c c} S_1 & S_a & C \\ \hline 15 & - & q & = & b \end{array}$	1	
Extinguishment Safety (S ₂)	minus	Mandatory Extinguishment (S₅)	≥ 0	$\begin{array}{c c} S_2 & S_b & E \\ \hline JJ & - & G & = & 5 \end{array}$	1	
People Movement Safety (S ₃)	minus	Mandatory People Movement (S₅)	≥ 0	S ₃ S _c P 1	J	
General Safety (S ₄)	minus	Occupancy Risk (R)	≥ 0	$\begin{array}{c cccc} S_4 & R & G \\ \hline & 12 & - & 7 & = & 5 \end{array}$	J	

	TABLE 8. FACILITY FIRE SAFETY REQUIREMENTS WORKSHEET	Γ		
	mplete one copy of this worksheet for each facility. r each consideration, select and mark the appropriate column.	Met	Not Met	Not Applic.
A.	Building utilities conform to the requirements of Section 9.1.	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.			1
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.	J		
D.	Fuel-burning space heaters and portable electrical space heaters are not used.	1		
E.	There are no flue-fed incinerators.	1		
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.	J	V	
G.	Smoking regulations have been adopted and implemented in accordance with 18.7.4 and 19.7.4.	1	NAMES OF A STREET	
H.	Draperies, upholstered furniture, mattresses, furnishings, and decoration combustibility is limited in accordance with 18.7.5 and 19.7.5.	J	THE CONTRACTOR OF THE CONTRACT	
1.	Fire extinguishers are provided in accordance with the requirements of 18.3.5.4 and 19.3.5.6.	V		
J.	Exit signs are provided in accordance with the requirements of 18.2.10.1 and 19.2.10.	V		
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 <i>Life Safety Code.</i> *
	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 <i>Life Safety Code</i> .*
	*The equivalency covered by this worksheet includes the majority of considerations covered by the <i>Life Safety Code</i> . There are a few considerations that are not evaluated by this method. These must be considered separately. These additional considerations are covered in Table 8, the "Facility Fire Safety Requirements Worksheet." One copy of this separate worksheet is to be completed for each facility.
-	

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

FACILITY

ZONE 8 OF 11 ZONES

FIRE/SMOKE ZONE* EVALUATION WORKSHEET FOR HEALTH CARE FACILITIES

		2000 LIFE SAFETY CODE
+ 1 1	BUILDING	
EBENEZER CARE CENTER	01-MAIH BUILDING	
ATED		

ZONE(S) EVALUATED

SECOND FLOOR SOUTH

PROVIDER/VENDOR NO.

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. OCCUPANC	Y RISK PARAMI	ETER F	ACTOR	3			
Risk Parameters Risk Factors Values									
1. Patient	Mobility Status	Mobile	Limited M	Limited Mobility		t Mobile	Not Movable		
Mobility <i>(M)</i>	Risk Factor	1.0	1.6	1.6		3.2	4.5		
2. Patient Density (D)	No. of Patients	1–5	6–10	6–10		11–30	>30		
Density (D)	Risk Factor	1.0	1.2	1.2		1.5	2.0		
3. Zone	Floor	1 st	2 nd or 3 rd	4 th to 6 th		7 th and Above	e Basements		
Location (L)	Risk Factor	1.1	1.2	1.	4	1.6	1.6		
4. Ratio of Patients to	<u>Patients</u> Attendant	<u>1–2</u> 1	<u>3–5</u> 1	<u>6–10</u> 1		<u>>10</u> 1	One or More None		
Attendants (T)	Risk Factor	1.0	1.1	1.2		1.5	4.0		
5. Patient	Age	Under 65 Yea	ars and Over 1 year		65 Years and Over 1 Year and Younger				
Average Age (A)	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								
OCCUPANCY RISK	M	D	L	T	A	F		
	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)	TABLE 3B. (EXISTING BUILDINGS)
1.0 x = =	$6.6 \times 10.4 = 6.2 = 7$

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

SURVEYOR SIGNATURE	TITLE ~	DATE , ,
Robert U. Unitale FIRE SAFERIALESOURCES, LIC	PRESIDENT	01/14/2016
FIRE AUTHORITY SIGNATURE	TITLE _	DATE 02-18-2016
Thomas Linhoff 12424 how from	Supervisor	02-10-2010

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	1.					
Safety Parameters			Safety	/ Param	neters Va	lues	***************************************		
1. Construction	Ту	Combustible pes III, IV, and V	***************************************				NonCombus Types I and		
Floor or Zone	000	111	200	211 +	2HH	000	111	222, 332, 433	
First	-2	0	-2	0	1	0	2	2	
Second	-7	-2	(4)	-2	2	-2	2	4	
Third	-9	-7	-9	-7	7	-7	2	4	
4th and Above	-13	-7	-13	-7	7	-9	-7	4	
Interior Finish (Corridors and Exits)	Class C -5(0) ^f	Class B 0(3) ^f		Clas					
3. Interior Finish (Rooms)	Class C -3(1) ^f	Class B		Clas	ss A			#	
4. Corridor Partitions/Walls	None or Incomplet	e <1/2 hour		≥¹/₂ to <	1 hour		≥1 hour		
	-10(0) ^a	0		1(0	J) ~	-	(2)(0) ^a		
5. Doors to Corridor	No Door	<20 min FI	PR	≥20 mi			min FPR and Auto Clos.		
	-10	0		(1)	D) ^d	2(0) ^d			
6. Zone Dimensions		Dead End	·			No Dea	d Ends >30 ft and 2	d Zone Length Is	
	>100 ft			50 ft	>150) ft 100 ft to 150 ft		<100 ft	
	-6(0) ^b)	-4(0) ^b	-2(0)) ^b	-2(0	0)° 0		1	
7. Vertical Openings	Open 4 or More	Open 2 or	3	Enclosed with Indicate		h Indicated Fire Res	sist.		
		Floors Floors		<1 hr		≥′	1 hr to <2 hr	≥2 hr	
	-14	-10		C)		2(0) ^e	3(0)	
8. Hazardous Areas		Deficiency			Single D	Deficiency	4	No Deficiencies	
	In Zone	Outside Zo	ne	In Zone		In A	Adjacent Zone		
	-11	-5			6		-2		
9. Smoke Control	No Control	Smoke Bar Serves Zo			Mech. Assi by	sted Syst Zone	tems		
	-5(0)°	-5(0)°		3					
10. Emergency	<2 Routes				Multiple	e Routes			
Movement Routes		Deficient		W/O Horizontal Exit(s)		Horizontal Exit(s)		Direct Exit(s)	
	(-8)	-2			0	1		5	
11. Manual Fire Alarm	No Man	ual Fire Alarm			Manual	Fire Alar	m		
				W/O F.	D. Conn.	V	V/F.D. Conn		
		-4			1		(2)		
12. Smoke Detection and Alarm	None	Corridor O	nly	Rooms Only			orridor and bit. Spaces	Total Spaces In Zone	
	0(3) ^g	2(3)g)		3(3) ^g			4	5	
13. Automatic Sprinklers	None	Corridor a Habit. Spa			ntire Iding				
	0	8		P	(0)	1			

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.

⁹ 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 S₁, S₂, S₃, S₆ to blocks labeled S₁, S₂, S₃, S₆ 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 (S₄)						
1. Construction	-4	-4		-4						
Interior Finish (Corr. and Exit)	3		3	3						
3. Interior Finish (Rooms)	3			3						
4. Corridor Partitions/Walls	2			2						
5. Doors to Corridor)			J						
6. Zone Dimensions			0	O						
7. Vertical Openings	0		0	0						
8. Hazardous Areas	0	0		0						
9. Smoke Control			0	0						
10. Emergency Movement Routes			- B	-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	S1= 15	S2= \	S 3=4	S4= \2						

TABLE 6. MANDATORY SAFETY REQUIREMENTS (FOR USE IN HOSPITALS OR NURSING HOMES)									
Containment Extinguishment People Movement (Sa) (Sb) (Sc)									
Zone Location	New	Exist.	New	Exist.	New	Exist.			
1 st story 2 nd or 3rd story ^b 4 th story or higher	11 15 18	5 <u>9</u> 9	15(12) ^a 17(14) ^a 19(16) ^a	4 6 6	8(5) ^a 10(7) ^a 11(8) ^a	1 ③ 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: Sa=7, Sb=10, and Sc=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 Sa, Sb, and Sc 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.

	Yes	No				
Containment Safety (S ₁)	minus	Mandatory Containment (S _*)	≥ 0	$\begin{array}{c c} S_1 & S_a & C \\ \hline 15 & - & q & = & 6 \end{array}$	J	
Extinguishment Safety (S ₂)	minus	Mandatory Extinguishment (S₅)	≥ 0	$\begin{array}{c c} S_2 & S_b & E \\ \hline 11 & - & 6 & = & 5 \end{array}$	J	
People Movement Safety (S ₃)	minus	Mandatory People Movement (S₀)	≥ 0	$\begin{bmatrix} S_3 \\ L_4 \end{bmatrix} - \begin{bmatrix} S_c \\ 3 \end{bmatrix} = \begin{bmatrix} P \\ 1 \end{bmatrix}$	1	
General Safety (S ₄)	minus	Occupancy Risk (R)	≥ 0	S ₄ R G F F F F F F F F F	1	

	TABLE 8. FACILITY FIRE SAFETY REQUIREMENTS WORKSHEET	Γ		
1	mplete one copy of this worksheet for each facility. r each consideration, select and mark the appropriate column.	Met	Not Met	Not Applic.
A.	Building utilities conform to the requirements of Section 9.1.	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.			1
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.	J		
D.	Fuel-burning space heaters and portable electrical space heaters are not used.	1		
E.	There are no flue-fed incinerators.	1		
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.	1		
G.	Smoking regulations have been adopted and implemented in accordance with 18.7.4 and 19.7.4.	1		
H.	Draperies, upholstered furniture, mattresses, furnishings, and decoration combustibility is limited in accordance with 18.7.5 and 19.7.5.	1		
I.	Fire extinguishers are provided in accordance with the requirements of 18.3.5.4 and 19.3.5.6.	1		
J.	Exit signs are provided in accordance with the requirements of 18.2.10.1 and 19.2.10.	1		
K.	Emergency lighting is provided in accordance with 18.2.9.1 or 19.2.9.	1		
L.	Standpipes are provided in all new high rise buildings as required by 18.4.2.			\

CONCLUSIONS 1. All of the checks in Table 7 are in the "Yes" column. The level of fire safety is at least equivalent to that prescribed by the Life Safety Code.* 2. One of more of the checks in Table 7 are in the "No" column. The level of fire safety is not shown by this system to be equivalent to that prescribed by the Life Safety Code.* *The equivalency covered by this worksheet includes the majority of considerations covered by the Life Safety Code. There are a few considerations that are not evaluated by this method. These must be considered separately. These additional considerations are covered in Table 8, the "Facility Fire Safety Requirements Worksheet." One copy of this separate worksheet is to be completed for each facility.

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

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	
THRO FLOOR CENTER	
	DATE OF SURVEY
245587	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 PARAMI	ETER F	ACTORS	3		
Risk Parameters Risk Factors Values								
1. Patient	Mobility Status	Mobile	Limited M	Limited Mobility		t Mobile	Not Movable	
Mobility (M)	Risk Factor	1.0	1.6	1.6		3.2	4.5	
2. Patient	No. of Patients	1–5	6–10	6–10		11–30	>30	
Density (D)	Risk Factor	1.0	1.2	1.2		1.5	2.0	
3. Zone	Floor	1 ជ	2 nd or 3 nd	4 th to 6 th		7 th and Abov	e Basements	
Location (L)	Risk Factor	1.1	1.2	1.4		1.6	1.6	
4. Ratio of Patients to	<u>Patients</u> Attendant	<u>1–2</u> 1	<u>3–5</u> 1	3–5 1 6–10 1		<u>>10</u> 1	One or More None	
Attendants (T)	Risk Factor	1.0 1.1		1,2		1.5	4.0	
5. Patient	Age	Under 65 Yea	ars and Over 1 year		65 Yea	ars and Over 1 Y	ear and Younger	
Average Age <i>(A)</i>	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						
OCCUPANCY RISK	M 3.2	D X 1.5 X	<u>L</u> 1,2	T X [15] X	A 12 =	F 10.4

Step 3: Compute Adjusted Building Status (R) - Use Table 2.

Form CMS-2786T (02/2013)

- 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)	TABLE 3B. (EXISTING BUILDINGS)
1.0 X = =	$ \begin{array}{ccc} & \mathbf{F} & \mathbf{R} \\ & 0.6 \times 0.4 & = 6.2 & = 7 \end{array} $

* FIRE/SMOKE ZONE is a space separated from all other spaces by floors, horizontal exits, or smoke barriers.								
SURVEYOR SIGNATURE ROLLY & Undrolle FIRE SAFER	TRESOURCES LLC	TITLE	RESIDENT	ATE 01/14/201				
FIDE AUTHODITY CICALATURE		TITLE		A				

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.

			TABL	E 4.						
Safety Parameters		Safety Parameters Values								
1. Construction	Ту	Combustible Types III, IV, and V				NonCombi Types I a				
Floor or Zone	000	111	200	211 +	211 + 2HH		111	222, 332, 433		
First	-2	0	-2	0		0	2	2		
Second	-7	-2	-4	-2	2	-2	2	4		
Third	-9	-7	(-9)	-7	7	-7	2	4		
4th and Above	-13	-7	-13	-7	7	-9	-7	4		
Interior Finish (Corridors and Exits)	Class C -5(0) ^f	Class B 0(3) ^f		Clas		-		- 1 mg		
3. Interior Finish (Rooms)	Class C -3(1) ^f	Class B		Clas						
4. Corridor	None or Incomplet		r	≥¹/₂ to <			>1 hour	.1		
Partitions/Walls	-10(0) ^a	0		1(0			(2)0)a			
5. Doors to Corridor	No Door	<20 min F	PR	≥20 mi			min FPR and Auto Clos.			
	-10	0		(1)(D) ^d		2(0) ^d			
6. Zone Dimensions		Dead End				No Dea	d Ends >30 ft and 2	Zone Length Is		
	>100 ft >50 ft to 100 ft		30 ft to 50 ft		>150	>150 ft 100 ft to 150 ft		<100 ft		
*	-6(0) ^b)	-4(0) ^b		-2(0) ^b	-2(0)°	0	1		
7. Vertical Openings	Open 4 or More Open 2 or 3		r 3			losed wit	h Indicated Fire Re	sist.		
	Floors	Floors			<1 hr		1 hr to <2 hr	≥2 hr		
	-14	-10		0			2(0) ^e	3(0)		
8. Hazardous Areas	Double	e Deficiency			Single I	Deficiency	/	No Deficiencies		
	In Zone	Outside Zo	one	In Zone		In A	djacent Zone			
	-11	-5		-	-6		-2	(0)		
9. Smoke Control	No Control	Smoke Bar Serves Zo			Mech. Assi by	isted Syst Zone	ems			
	-5(0)°	(0)					244-200-2			
10. Emergency	<2 Routes				Multip	le Routes				
Movement Routes		Deficien	t	W/O Horiz Exit(s)				Direct Exit(s)		
	(-8)	-2			0		1	5		
11. Manual Fire Alarm	No Man	ual Fire Alarm		1	Manua	l Fire Alaı	m			
				W/O F.	D. Conn.	ν	V/F.D. Conn			
		-4			1		2			
12. Smoke Detection and Alarm	None	Corridor C	only	Rooms Only		1	orridor and bit. Spaces	Total Spaces In Zone		
	0(3) ^g	2(3) ^g)		3	(3) ^g		4	5		
13. Automatic Sprinklers	None	Corridor a Habit. Spa			ntire ilding					
	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.

⁹ 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 S1, S2, S3, SG to blocks labeled S1, S2, S3, SG 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 (S₄)			
1. Construction	-9	-9		-9			
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	١			
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	S1= (0	S2= 6	S3=4	S4= 7			

TABLE 6. MANDATORY SAFETY REQUIREMENTS (FOR USE IN HOSPITALS OR NURSING HOMES)								
		inment Sa)	Extingui (S		People Movement (S _c)			
Zone Location	New	Exist.	New	Exist.	New	Exist.		
1 st story 2 nd or 3rd story ^b 4 th story or higher	11 15 18	5 9 9	15(12) ^a 17(14) ^a 19(16) ^a	4 ⑥ 6	8(5) ^a 10(7) ^a 11(8) ^a	3 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: Sa=7, Sb=10, and Sc=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 Sa, Sb, and Sc 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.

	Yes	No				
Containment Safety (S ₁)	minus	Mandatory Containment (S _*)	≥ 0	$\begin{bmatrix} S_1 \\ \downarrow \bigcirc \end{bmatrix} - \begin{bmatrix} S_a \\ q \end{bmatrix} = \begin{bmatrix} C \\ \downarrow \end{bmatrix}$	1	
Extinguishment Safety (S ₂)	minus	Mandatory Extinguishment (S₀)	≥ 0	$\begin{array}{c ccccccccccccccccccccccccccccccccccc$	J	
People Movement Safety (S ₃)	minus	Mandatory People Movement (S₀)	≥ 0	$\begin{bmatrix} S_3 \\ L_4 \end{bmatrix} - \begin{bmatrix} S_c \\ 3 \end{bmatrix} = \begin{bmatrix} P \\ 1 \end{bmatrix}$	J	-
General Safety (S ₄)	minus	Occupancy Risk (R)	≥ 0	$\begin{bmatrix} S_4 & R & G \\ \hline 7 & - & 7 & = & \bigcirc \end{bmatrix}$	J	

	TABLE 8. FACILITY FIRE SAFETY REQUIREMENTS WORKSHEET	Г		
	mplete one copy of this worksheet for each facility. r each consideration, select and mark the appropriate column.	Met	Not Met	Not Applic.
A.	Building utilities conform to the requirements of Section 9.1.	$\sqrt{}$	t .	
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.	1		
D.	Fuel-burning space heaters and portable electrical space heaters are not used.	J		
E.	There are no flue-fed incinerators.	1		
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.	J		
G.	Smoking regulations have been adopted and implemented in accordance with 18.7.4 and 19.7.4.	1		(Co. 9)
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.	1		
J.	Exit signs are provided in accordance with the requirements of 18.2.10.1 and 19.2.10.	V,		
K.	Emergency lighting is provided in accordance with 18.2.9.1 or 19.2.9.	1		
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 <i>Life Safety Code</i> .*
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 <i>Life Safety Code</i> .*
*The equivalency covered by this worksheet includes the majority of considerations covered by the <i>Life Safety Code</i> . There are a few considerations that are not evaluated by this method. These must be considered separately. These additional considerations are covered in Table 8, the "Facility Fire Safety Requirements Worksheet." One copy of this separate worksheet is to be completed for each facility.

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

OF

ZONE 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 MORTH	
PROVIDER/VENDOR NO.	DATE OF SURVEY
245587	01/13/2016
COMPLETE THE MODIFICATION FACILITIES IN	

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 Status	Mobile	Limited M	Limited Mobility		t Mobile	Not Movable		
Mobility <i>(M)</i>	Risk Factor	1.0	1.6	1.6		3.2	4.5		
2. Patient Density (D)	No. of Patients	1–5 6–10		11–30		>30			
Definity (D)	Risk Factor	1.0	1.2	1.2		1.5	2.0		
3. Zone	Floor	111	2 rd or 3 rd	4 th to	o 6 th	7 th and Above	e Basements		
Location (L)	Risk Factor	1.1	1.2	1.4		1.6	1.6		
4. Ratio of Patients to	<u>Patients</u> Attendant	<u>1–2</u> 1	<u>3–5</u> 1	<u>6–10</u> 1		<u>>10</u> 1	One or More None		
Attendants (T)	Risk Factor	1.0	1.1	1.	.2	1.5	4.0		
5. Patient	Age	Under 65 Yea		65 Years and Over 1 Year and Younger					
Average Age <i>(A)</i>	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							
OCCUPANCY RISK	M 3.2 ×	D 1.5 X	L 1,2 ×	T 1.5 X	A 1.2 =	F 104	

- 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.
 - 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)	TABLE 3B. (EXISTING BUILDINGS)					
1.0 x = =	$0.6 \times 10.4 = 6.2 = 7$					

* FIRE/SMOKE ZONE is a space separated from all other spaces by floo	rs, horizontal exits, or smoke barriers.	
SURVEYOR SIGNATURE	TITLE ~	DATE , ,
Robert S. Vindalte FIRE SAFER KESOVERES, LLC	PRESIDENT	01/14/2016
FIRE AUTHORITY SIGNATURE	TITLE .	DATE 02-18-2016
Thomas Liphoff 12/12/1	Supervisor	02-18-2016

Thomas Linnoit 12424 / Form CMS-2786T (02/2013)

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	Ξ 4.					
Safety Parameters			Safe	ety Param	eters Va	lues			
1. Construction	Ту	Combustible Types III, IV, and V				NonCombi Types I a			
Floor or Zone	000	111	111 200		211 + 2HH		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	
Interior Finish (Corridors and Exits)	Class C -5(0) ^f	Class B		Clas					
3. Interior Finish	Class C	Class B		Clas					
(Rooms)	-3(1) ^f	1(3) ^f		(3		-			
4. Corridor	None or Incomplet		r	≥¹/₂ to <		1	≥1 hour		
Partitions/Walls	-10(0) ^a	e < 1/2 nou		≥'/2 to <		+	≥1 nour (2)(0) ^a		
5. Doors to Corridor	No Door	<20 min F	DD	•			min FPR and Auto Clos.		
	-10	0	1 17	≥20 min FPR		-	2(0) ^d		
6. Zone Dimensions	-10	Dead End			, , , , , , , , , , , , , , , , , , ,	No Dec	L	7	
6. Zone Dimensions	>100 ft >50 ft to 100 ft		30 f	ft to 50 ft >150			d Ends >30 ft and 100 ft to 150 ft	<pre><pre>< doi: 100 ft</pre></pre>	
	-6 (0) ⁶)	-4(0) ^b		·2(0) ^b			0	1	
7 Vertical Openings				2(0)		-2(0)° 0 Enclosed with Indicated Fire			
7. Vertical Openings	Open 4 or More Open 2 or 3 Floors Floors		3	<1 hr			n indicated Fire Re	esist. ≥2 hr	
	-14 -10			0		-	2(0)°)	3(0) ^e	
8. Hazardous Areas		Deficiency		Single De		Deficiency		No Deficiencies	
0. Hazardoda 7 iroda	In Zone		Outside Zone		one only i		Adjacent Zone	No Deliciencies	
	-11	-5	3110	-6		 	-2	(0)	
9. Smoke Control	No Control	Smoke Bar	rrier		Mech Ass	sted Systems			
or ormano	THE CONTROL	Serves Zo				Zone			
	-5(0)°	0)° (0)							
10. Emergency	<2 Routes			<u> </u>	Multip	le Routes			
Movement				W/O H	orizontal		Horizontal	**************************************	
Routes	-	Deficien	t	Exit(s)			Exit(s)	Direct Exit(s)	
	(-8)	-2			0	1		5	
11. Manual Fire Alarm	No Man	ual Fire Alarm			Manua	I Fire Alaı	rm		
				W/O F.	D. Conn.	V	V/F.D. Conn		
		-4		1			(2)		
12. Smoke Detection							orridor and	Total Spaces	
and Alarm	None	Corridor C	nly	Room	ns Only	На	bit. Spaces	In Zone	
	0(3) ^g	2(3) ^g)		3(3) ^g			4	5	
13. Automatic Sprinklers	None	Corridor a Habit. Spa			ntire Iding				
	0	8		(10)		1			

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")

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.

⁹ 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 S₁, S₂, S₃, S_G to blocks labeled S₁, S₂, S₃, 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 (S₄)				
1. Construction	-9	_q		-9				
Interior Finish (Corr. and Exit)	3		3	3				
3. Interior Finish (Rooms)	3			3				
4. Corridor Partitions/Walls	2			2				
5. Doors to Corridor	l			J				
6. Zone Dimensions	e e nga sa a		0	0				
7. Vertical Openings	0		0	0				
8. Hazardous Areas	Ò	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	jo				
Total Value	S1= 10	S2= 6	S3= 4	S4=7				

TABLE 6. MANDATORY SAFETY REQUIREMENTS (FOR USE IN HOSPITALS OR NURSING HOMES)								
	Containment Extinguishment People Movement (Sa) (Sb) (Sc)							
Zone Location	New	Exist.	New Exis		New	Exist.		
1 st story 2 nd or 3rd story ^b 4 th story or higher	11 15 18	5 9 9	15(12) ^a 17(14) ^a 19(16) ^a	4 ⑥ 6	8(5) ^a 10(7) ^a 11(8) ^a	1 3 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: Sa=7, Sb=10, and Sc=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 Sa, Sb, and So 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.

	IVALENCY EVALUATION	Yes	No			
Containment Safety (S ₁)	minus	Mandatory Containment (S ₄)	≥ 0	$\begin{array}{c c} S_1 & S_a & C \\ \hline 10 & - & q & = & 1 \end{array}$	7	
Extinguishment Safety (S ₂)	minus	Mandatory Extinguishment (S₅)	≥ 0	$\begin{array}{c c} S_2 & S_b & E \\ \hline b & - b & = 0 \end{array}$	J	
People Movement Safety (S₃)	minus	Mandatory People Movement (S₀)	≥ 0	$\begin{bmatrix} S_3 \\ 4 \end{bmatrix} - \begin{bmatrix} S_c \\ 3 \end{bmatrix} = \begin{bmatrix} 1 \end{bmatrix}$	7	
General Safety (S ₄)	minus	Occupancy Risk (R)	≥ 0	$\begin{bmatrix} S_4 & R & G \\ 7 & -7 & = 0 \end{bmatrix}$	1	

	TABLE 8. FACILITY FIRE SAFETY REQUIREMENTS WORKSHEET								
	mplete one copy of this worksheet for each facility. r each consideration, select and mark the appropriate column.	Met	Not Met	Not Applic.					
A.	Building utilities conform to the requirements of Section 9.1.	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.			J					
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.	, 1							
D.	Fuel-burning space heaters and portable electrical space heaters are not used.	1							
E.	There are no flue-fed incinerators.	J							
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.	J							
G.	Smoking regulations have been adopted and implemented in accordance with 18.7.4 and 19.7.4.	7							
H.	Draperies, upholstered furniture, mattresses, furnishings, and decoration combustibility is limited in accordance with 18.7.5 and 19.7.5.	J							
1.	Fire extinguishers are provided in accordance with the requirements of 18.3.5.4 and 19.3.5.6.	J							
J.	Exit signs are provided in accordance with the requirements of 18.2.10.1 and 19.2.10.	J							
K.	Emergency lighting is provided in accordance with 18.2.9.1 or 19.2.9.	1							
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 <i>Life Safety Code</i> .*	
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 <i>Life Safety Code</i> .*	
*The equivalency covered by this worksheet includes the majority of considerations covered by the <i>Life Safety Code</i> . There are a few considerations that are not evaluated by this method. These must be considered separately. These additional considerations are covered in Table 8, the "Facility Fire Safety Requirements Worksheet." One copy of this separate worksheet is to be completed for each facility.	

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

ZONE (I OF II 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.	DATE OF SURVEY
245587	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 Status	Mobile	Limited M	Limited Mobility		t Mobile	Not Movable		
Mobility (M)	Risk Factor	1.0	1.6	1.6		3.2	4.5		
2. Patient Density (D)	No. of Patients	1–5	6–10	6–10		11–30	>30		
Defisity (D)	Risk Factor	1.0	1.2	1.2		1.5	2.0		
3. Zone	Floor	1 st	2 nd or 3 nd	4th to	o 6 th	7 th and Abov	e Basements		
Location (L)	Risk Factor	1.1	1.2	1.	.4 1.6		1.6		
4. Ratio of Patients to	<u>Patients</u> Attendant	<u>1–2</u> 1	<u>3–5</u> 1	6-	<u>10</u> I	<u>>10</u> 1	One or More None		
Attendants (T)	Risk Factor	1.0	1.1	1.	1.2 (1.5)		4.0		
5. Patient Average	Age	Under 65 Yea	ars and Over 1 year		65 Years and Over 1 Year and Younger				
Age (A)	Risk Factor		(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							
OCCUPANCY RISK	M 3.2 X	D 15 X	1,2	T X 1.5 X	A 1,2 =	F 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)	TABLE 3B. (EXISTING BUILDINGS)
1.0 X = =	$ \begin{array}{ccc} \mathbf{F} & \mathbf{R} \\ 0.6 \times 0.4 & = 6.2 & = 7 \end{array} $

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

ŞURVEYOR SIGNATURE	TITLE	DATE
Kobers U. Sindatte, FIRE SAFETY RESOURCES, LL	PRESIDENT	01/14/2016
FIRE AUTHORITY SIGNATURE	TITLE	DATE 02 19 2016
Thomas Linhoff 12424 / hum hand for	Supervisor	02-16-2016

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	E 4.				
Safety Parameters			Safe	ety Param	neters Va	lues		
1. Construction	Ту	Combustible pes III, IV, and V		NonCombi Types I a				
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	2	4
Third	-9	-7	(-9)	-7	7	-7	2	4
4th and Above	-13	-7	-13	-7	7	-9	-7	4
Interior Finish (Corridors and Exits)	Class C -5(0) ^f	Class E	3	Clas				
3. Interior Finish	Class C	Class E	3	Clas	ss A			
(Rooms)	-3(1) ^f	1(3) ^f		(3		1		
4. Corridor	None or Incomplet	e <¹/₂ hou	r	≥¹/₂ to <	1 hour		≥1 hour	
Partitions/Walls	-10(0) ^a	0		1(0			(2)0)a	
5. Doors to Corridor	No Door	<20 min F	PR	≥20 mi	n FPR		min FPR and Auto Clos.	
	-10 0		72	(1)0	D) ^d	2(0) ^d		
6. Zone Dimensions	Dead End				No Dea	d Ends >30 ft and	Zone Length Is	
	>100 ft >50 ft to 100 ft		30 f	ft to 50 ft >15		ft 100 ft to 150 ft		<100 ft
	-6 (0) ^b)	-4(0) ^b		-2(0) ^b -2)°	0	1
7. Vertical Openings	Open 4 or More Open 2 or 3		r 3		Enc	losed with	h Indicated Fire Re	esist.
NA.	Floors	Floors	Floors		<1 hr		I hr to <2 hr	≥2 hr
	-14	-10	-10		0 2(0) ^e		2(0) ^e	3 (6)®
8. Hazardous Areas	Double Deficiency				Single [Deficiency	/	No Deficiencies
	In Zone	Outside Z	Outside Zone		In Zone		djacent Zone	
	-11	-5	**************	-6			-2	0
9. Smoke Control	No Control		Smoke Barrier Serves Zone		Mech. Assisted Systems by Zone		tems	
	-5(0)°	-5(0)°						
10. Emergency	<2 Routes				Multipl	le Routes		
Movement Routes		Deficier	nt	W/O Horizontal Exit(s)			Horizontal Exit(s)	Direct Exit(s)
	(-8)	-2		0			1	5
11. Manual Fire Alarm	No Mar	ual Fire Alarm				l Fire Alaı	m	
				W/O F.	D. Conn.	V	V/F.D. Conn	
		-4			1		(2)	
12. Smoke Detection and Alarm	None	Corridor C	Only	Roon	ns Only		orridor and bit. Spaces	Total Spaces In Zone
	0(3) ^g	2(3)9		3	(3) ^g		4	5
13. Automatic Sprinklers	None	Corridor a			ntire ilding			
	0	8		(10)	1		

NOTE: ^a Use (0) where parameter 5 is -10.

For SI units: 1 ft = 0.3048 m

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.

⁹ 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 S₁, S₂, S₃, S₆ to blocks labeled S₁, S₂, S₃, S₆ 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	der strame carac	-9				
Interior Finish (Corr. and Exit)	3		3	3				
3. Interior Finish (Rooms)	3		And the second of the second o	3				
4. Corridor Partitions/Walls	2			2				
5. Doors to Corridor)		I	1				
6. Zone Dimensions	44		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	en er er fall formelle som Statut som til 1800 som etter som til statut i statut i	2				
12. Smoke Detection and Alarm		3	3	3				
13. Automatic Sprinklers	10	10	10 ÷2=5	10				
Total Value	S1= 10	S2=6	S₃= 4	S4=7				

TABLE 6. MANDATORY SAFETY REQUIREMENTS (FOR USE IN HOSPITALS OR NURSING HOMES)							
Containment Extinguishment (S _a) (S _b)			People Movement (S _c)				
Zone Location	New	Exist.	New	Exist.	New	Exist.	
1 st story 2 nd or 3rd story ^b 4 th story or higher	11 15 18	5 9 9	15(12) ^a 17(14) ^a 19(16) ^a	4 ⑥ 6	8(5) ^a 10(7) ^a 11(8) ^a	1	

<sup>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</sup> requirement values set specified in the table, the following mandatory values set shall be permitted to be used: Sa=7, Sb=10, and Sc=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 Sa, Sb, and Sc 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 S	SAFETY EQU	IVALENCY EVALUATION	Yes	No
Containment Safety (S ₁)	minus	Mandatory Containment (S _a)	≥ 0	$\begin{array}{c c} S_1 & S_a \\ \hline 10 & - & q & = & 1 \end{array}$	/	
Extinguishment Safety (S ₂)	minus	Mandatory Extinguishment (S₀)	≥ 0	$\begin{array}{c c} S_2 & S_b & E \\ \hline b & - & b & = 0 \end{array}$	1	
People Movement Safety (S ₃)	minus	Mandatory People Movement (S₀)	≥ 0	S ₃ - S _c P	1	
General Safety (S ₄)	minus	Occupancy Risk (R)	≥ 0	$ \begin{array}{c c} S_4 & R & G \\ \hline $	1	

	TABLE 8. FACILITY FIRE SAFETY REQUIREMENTS WORKSHEET	Γ		
	mplete one copy of this worksheet for each facility. r each consideration, select and mark the appropriate column.	Met	Not Met	Not Applic.
A.	Building utilities conform to the requirements of Section 9.1.	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.			J
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.	1		
D.	Fuel-burning space heaters and portable electrical space heaters are not used.	1		
E.	There are no flue-fed incinerators.	J		
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.	1		
G.	Smoking regulations have been adopted and implemented in accordance with 18.7.4 and 19.7.4.	1		
H.	Draperies, upholstered furniture, mattresses, furnishings, and decoration combustibility is limited in accordance with 18.7.5 and 19.7.5.	7		
I.	Fire extinguishers are provided in accordance with the requirements of 18.3.5.4 and 19.3.5.6.	1		
J.	Exit signs are provided in accordance with the requirements of 18.2.10.1 and 19.2.10.	√		
K.	Emergency lighting is provided in accordance with 18.2.9.1 or 19.2.9.	√		
L.	Standpipes are provided in all new high rise buildings as required by 18.4.2.			

CONCLUSIONS 1. All of the checks in Table 7 are in the "Yes" column. The level of fire safety is at least equivalent to that prescribed by the Life Safety Code.* 2. One of more of the checks in Table 7 are in the "No" column. The level of fire safety is not shown by this system to be equivalent to that prescribed by the Life Safety Code.* *The equivalency covered by this worksheet includes the majority of considerations covered by the Life Safety Code. There are a few considerations that are not evaluated by this method. These must be considered separately. These additional considerations are covered in Table 8, the "Facility Fire Safety Requirements Worksheet." One copy of this separate worksheet is to be completed for each facility.

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

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

F5587024

PRINTED: 01/28/2016 FORM APPROVED OMB NO. 0938-0391

(X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING 02 - BLDG TWO **B WING** 12/29/2015 245587 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 2545 PORTLAND AVENUE SOUTH EBENEZER CARE CENTER MINNEAPOLIS, MN 55404 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION SUMMARY STATEMENT OF DEFICIENCIES ID (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** DATE PREFIX CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) K 000 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:

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

TITLE

Electronically Signed

01/25/2016

(X6) DATE

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.



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 <u>only a suggestion</u> 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

Ebenezer Care Center January 15, 2016 Page 2

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, Program Specialist

Licensing and Certification Program

Kumala Fiske Downing

Health Regulation Division
Minnesota Department of Health

Kamala.Fiske-Downing@state.mn.us

Telephone: (651) 201-4112

Fax: (651) 215-9697

Ebenezer Care Center January 15, 2016 Page 3

PRINTED: 01/26/2016 FORM APPROVED

(X6) DATE

Minnesota Department of Health

STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00191	B. WING		12/3	0/2015
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE	•	
EBENEZ	ER CARE CENTER		TLAND AVE OLIS, MN 5:	NUE SOUTH 5404		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPERTION OF T	D BE	(X5) COMPLETE DATE
2 000	0 Initial Comments		2 000			
	****ATTE	NTION*****				
	NH LICENSING	CORRECTION ORDER				
	144A.10, this correct pursuant to a surver found that the deficiency found that the deficiency form of corrected shall with a schedule of the Minnesota Department of the Minnesota Department of the Minnesota Department of the number and MN Ru When a rule contain comply with any of lack of compliance. re-inspection with a result in the assess that was violated ducorrected.	nether a violation has been compliance with all erule provided at the tagule number indicated below. In several items, failure to the items will be considered Lack of compliance upon ny item of multi-part rule will ment of a fine even if the item uring the initial inspection was				
	that may result from orders provided tha the Department with	hearing on any assessments non-compliance with these t a written request is made to hin 15 days of receipt of a ent for non-compliance.				
	receipt of State lice the Minnesota Depa Informational Bullet http://www.health.si	participate in the electronic nsure orders consistent with artment of Health in 14-01, available at tate.mn.us/divs/fpc/profinfo/inf e licensing orders are				

Minnesota Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

01/25/16 **Electronically Signed**

TITLE

STATE FORM 6899 KKF411 If continuation sheet 1 of 39

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		00191	B. WING		12/3	30/2015
	PROVIDER OR SUPPLIER	2545 POF	DRESS, CITY, S RTLAND AVEI POLIS, MN 55			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 000	Department of Hea you electronically. Is necessary for State enter the word "corn text. You must then State licensure proceompletion date, the corrected prior to el Minnesota Departm On December 28, 2 surveyors of this Deabove provider and orders are issued. electronic plan of coreviewed these ordethey will be completed Minnesota Departmente State Licensing federal software. Ta assigned to Minnesota Nursing Homes. The assigned tag in column entitled "ID statute/rule out of completed and replaces the "Tocorrection order. The findings which are in after the statement, evidence by." Followare the Suggested Time period for Corplease DISREGA FOURTH COLUMN	Althorders being submitted to Although no plan of correction ate Statutes/Rules, please rected" in the box available for indicate in the electronic cess, under the heading e date your orders will be lectronically submitting to the nent of Health. 2015 through 12/30/15, epartment's staff, visited the the following correction Please indicate in your correction that you have ers, and identify the date when ted. The health is documenting Correction Orders using ag numbers have been onto state statutes/rules for umber appears in the far left or Prefix Tag." The state ompliance is listed in the ent of Deficiencies" column to Comply" portion of the his column also includes the n violation of the state statute are wing the surveyors findings method of Correction and crection. ARD THE HEADING OF THE WHICH STATES,	2 000			
		N OF CORRECTION." THIS				

Minnesota Department of Health

STATE FORM 6899 KKF411 If continuation sheet 2 of 39

STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00191	B. WING		12/3	80/2015
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE	•	
EBENEZ	ER CARE CENTER		TLAND AVE	NUE SOUTH 5404		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
2 000	Continued From pa	ge 2	2 000			
	THIS WILL APPEAR ON EACH PAGE.					
	THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.					
2 265	MN Rule 4658.0085 Notification of Chg in Resident Health Status		2 265			2/8/16
	policies to guide sta physicians, physicia practitioners, and if legal representative member of a reside accident, or death. nursing services, ar attending physician development of the	ast develop and implement aff decisions to consult an assistants, and nurse known, notify the resident's or an interested family ent's acute illness, serious. At a minimum, the director of and the medical director or an must be involved in the se policies. The policies must address at least the tion times for:				
		involving the resident which has the potential for requiring on;				
	physical, mental, o example, a deterior	change in the resident's r psychosocial status, for ation in health, mental, or in either life-threatening al complications;				
	example, a need to	ter treatment significantly, for discontinue an existing form adverse consequences, or to f treatment;				
	D. a decision t resident from the nu	o transfer or discharge the ursing home; or				

Minnesota Department of Health

STATE FORM 6899 KKF411 If continuation sheet 3 of 39

Minnesc	ta Department of He	alth				
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE S COMPL	
		00191	B. WING 12/			0/2015
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
EBENEZ	ER CARE CENTER		TLAND AVE OLIS, MN 5	NUE SOUTH 5404		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETE DATE
2 265	Continued From pa	ge 3	2 265			
	E. expected an	d unexpected resident deaths.				
	by: Based on interview facility failed to ensiappointed guardian falls and medication notification of change. Findings include: On 12/28/15, at 3:1 interview when R30 was asked if R30 a past several month decline in her mobil staff with a transfer had been appointed summer and prior to been admitted to the Guardian indicated and disability thus sometified of all medicand any change in the change in condition of the change in condition. R30's diagnoses incretardation, cerebrated diplegia, non-morbin presence of cerebraterom Admission Reference of cerebraterom Admission Reference of cerebraterom Admission Reference of Control of the change in conditions and the change in conditions are considered as a condition of the change in conditions and the change in conditions are conditions.	1 p.m. during a telephone b's court appointed guardian change in condition within the s, guardian stated R30 had a lity and was dependent on lift. Guardian indicated she d as the guardian this last o her involvement R30 had e facility for rehabilitation. R30 had a language barrier she was the person who was ations, treatments, accidents condition. Guardian clarified lition was not acute. cluded moderate mental al palsy with spastic/ataxia d obesity, epilepsy and beginal fluid drainage obtained cord dated 8/5/15. litt Fourth Judicial District alth Division letter for 7/23/15, revealed R30 had		The facility has developed and implemented policies to guide stat decisions to consult physicians, plassistants, and nurse practitioners known, notify the resident's legal representative or an interested far member of a resident's acute illne serious accident, or death. At a m the director of nursing services, and medical director or an attending plis involved in the development of the policies. The policies have criterial address at least the appropriate notification times for: A. an accident involving the residence results in injury and has the potent requiring physician intervention; B. a significant change in the residence results in injury and has the potent requiring physician intervention; C. a need to alter treatment signification for example, a need to discontinue existing form of treatment due to a consequences, or to begin a new treatment; D. a decision to transfer or dischalting the state of the sta	nysician s, and if mily ss, inimum, nd the hysician chese which ent which tial for dent's status, alth, either cal cantly, e an adverse form of	

STATE FORM 6899 If continuation sheet 4 of 39 KKF411

resident from the nursing home; or

TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) 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	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
EBENEZER CARE CENTER 2545 PORTLAND AVENUE SOUTH MINNEAPOLIS, MN 55404 (X4) ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 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 (X5) E. expected and unexpected resident deaths.			00191	B. WING		12/3	0/2015
PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 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 PREFIX TAG (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) E. expected and unexpected resident deaths.			2545 POR	TLAND AVE	NUE SOUTH		
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	PREFIX	(EACH DEFICIENCY	/ MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO	_D BE	COMPLETE
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 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	2 265	During review of R3 12/1/14, through 12 had several falls with had been indicated primary contact to be 8/2/15, R30 had be out of the door of he report had been indicated ay nurse to call." If following the falls la family or guardian he documentation of the change of the change. On 11/13/15, R30's medications had be changed but there we guardian being notion treatments/medications had be changed but there were found to have prescribed an oral report but no documentation of the infection of th	30 falls/incident reports dated 2/30/15, it was revealed R30 thout injury but on 12/3/14, it as "deferred to next shift" for one updated. In addition on en found crying and crawling er room and on the incident dicated for contacting primary er to call family, left note for the Review of all progress notes acked documentation either the nad been updated on the falls. Imment review the following atted 12/11/15, R30's cation for acid reflux) had been alligrams (mg) but no ne guardian being notified of a dietary supplement sen discontinued and had and was no documentation of the fied of the changes in ions. In ad a dentist appointment had a gum infection and was rinse twice daily for 14 days on the guardian had been tion. In addition of the change of the guardian had been dated 5/14/15, indicated R30 and and you severe cognitive esence of behaviors. The CAA mpaired decision making lize needs to staff but will on	2 265		lent	

Minnesota Department of Health

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ,	E CONSTRUCTION		E SURVEY PLETED
		00191	B. WING		12/:	30/2015
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
EBENEZ	ER CARE CENTER		TLAND AVE OLIS, MN 5	NUE SOUTH 5404		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETE DATE
2 265	care plan dated 7/3 risk for psychosocial developmental disal verbally communication and need for some of The care plan indication. R30's affairs and developmental was to consult with information and option of 12/30/15, at 3:1 manager (RN)-F verbad been notified for thought the staff has acknowledged there RN-F also verified for ders either medication changed or decrease the guardian being "definitely we should on any changes with condition." On 12/30/15, at 4:2 was called and did On 12/30/15, at 4:3 expected the guard notified of medication director of nursing should be defined by the staff were suppalled the falls DON states the MDS coordinate correction. Change Of Condition 12/2014, indicated the staff were suppalled the falls DON states and the MDS coordinate correction.	ge 5 0/14, indicated resident was at al difficulty related to abilities, had limited ability to ate in her primary language one to make decisions for her. ated R30's guardian handled ecisions her behalf and staff guardian and provide ions for decisions as needed. 0 p.m. registered nurse erified the primary contact(s) or the falls. RN-F stated she d contacted R30's family but e was no documentation. R30 also some medications eations had been discontinued, sed and no documentation of notified. RN-F stated d notify the family or guardian h resident treatment and 4 p.m. the nurse practitioner not receive a call back. 4 p.m. when asked if she be an eductions or changes the estated "not for the reduction. I edications being discontinued ds what it's for." When asked if osed to notify the guardian of eated "yes." DON further stated or was working on a plan of eated in anytime there was a	2 265			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		00191	B. WING		12/3	0/2015	
NAME OF F	PROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, S	STATE, ZIP CODE			
EBENEZ	ER CARE CENTER		TLAND AVE OLIS, MN 5	NUE SOUTH 5404			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPROFICIENCY)	D BE	(X5) COMPLETE DATE	
2 265	The policy indicated would be notified or family had not been hours, would be not SUGGESTED MET The director of nurs develop policies and resident's represent changes in condition treatments. The DC all appropriate staff and monitor to ensure TIME PERIOD FOR	ge 6 It's condition or plan of care. If family/responsible party in a timely manner, and if it called during the night time itified the next morning. HOD OF CORRECTION: Iting (DON) or designee could did procedures to ensure each tative is promptly notified of all in and/or changes in DN or designee could educate on the policies/procedures, are ongoing compliance. R CORRECTION: Twenty One	2 265				
2 560	Plan of Care; Contents comprehensive plan objectives and time long- and short-tern and mental and psy identified in the comassessment. The comust include the increquired by Minness subdivision 14, para This MN Requirements: Based on interview failed to develop a content of the content of t	of plan of care. The n of care must list measurable tables to meet the resident's n goals for medical, nursing, rchosocial needs that are aprehensive resident comprehensive plan of care dividual abuse prevention plan ota Statutes, section 626.557,	2 560	The facility will ensure that compre plans of care list measurable object and timetables to meet the resident and short term goals for medical, rand mental and psychosocial need.	ctives nt's long nursing,	2/8/16	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING	LE CONSTRUCTION :	(X3) DATE S COMPL		
		00191	B. WING		12/3	0/2015
-	PROVIDER OR SUPPLIER ZER CARE CENTER SUMMARY STA	2545 POR		STATE, ZIP CODE ENUE SOUTH 55404 PROVIDER'S PLAN OF CORRECTI		(X5)
PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	COMPLETE DATE
2 560	R95's quarterly Min 12/10/15, indicated and had diagnoses stroke and diabetes indicated R95 displayments symptoms directed pushing, scratching others sexually) one seven days. During interview on registered nurse (R verified the MDS indirected towards of known behavior for and pushed people have a behavior sestated, "These behaplanned." During interview on licensed social world be to have in care plan and ensure plan and ensure place to carry out the The facility's policy revised 12/13, instruction in the second resident's needs are met." SUGGESTED MET The director of nurse staff to develop a call interventions for all	imum Data Set (MDS) dated R95 was cognitively intact of lung and colon cancer, s. The quarterly MDS also ayed physical behavioral toward others (hitting, kicking, grabbing, and abusing to three times in the last 12/29/15, at 3:09 p.m. N)-C, MDS coordinator dicated R95 had behaviors hers. RN-C stated, it was a R95 that R95 joked around. RN-C verified R95 did not ction in R95's care plan. RN-C aviors should have been care 12/30/15, at 12:12 p.m. ker (LSW) said if that was a for R95 the facility's practice terventions in place on the re the staff have the tools in the interventions.	2 560	are identified in the comprehensive resident assessment. The comprehensive resident assessment. The comprehensive care includes the individual prevention plan. R95 care plan was updated 12/29 reflect behavioral focus and intervals is current. Interdisciplinary team including (Fland (LSW)) was educated on 12/3 development and changes to comprehensive care plans in ordermaintain current documentation and focus of care. Audits are being conducted with only the director of nursing and will for 3 months or until ongoing comis achieved. Audits will be reported and review monthly QAPI meetings.	ehensive al abuse 1/15 to ventions RN)-C 10/15 on er to er to end plans eversight continue pliance	

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	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	ATE SURVEY DMPLETED	
		00191	B. WING	1	2/30/2015
	PROVIDER OR SUPPLIER	2545 POR		STATE, ZIP CODE NUE SOUTH 5404	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 560	to assure ongoing a interventions in resp	ge 8 and effective care plan conse to resident care needs. R CORRECTION: Twenty One	2 560		
21134	MN RULE 4658.06 Sanitation, storage	70 Supb. 2. Dishwashing;	21134		1/29/16
	must be thoroughly surfaces of utensils given sanitization tr in such a manner a contamination. Cle	e. All utensils and equipment cleaned, and food-contact s and equipment must be eatment and must be stored s to be protected from aned and sanitized equipment be handled in a way that contamination.			
	by: Based on observati review, the facility fa sanitary conditions direct contact with f In addition, the facil restraints were work contacting exposed	ent is not met as evidenced on, interview and document ailed to ensure safe and for kitchen equipment that had ood preparation and storage. ity failed to ensure hair in to effectively keep hair from food. This had the potential to sidents in the facility who ate		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.	e e
		n tour on 12/28/15, at 11:54 ector (DD) the following was		All kitchen staff were educated by 12/29/15 regarding the requirements to wear hair restraints and proper use of th hand sink.	e
	- Hobart Stand up n	nixer was covered with plastic		The dietary team has redeveloped and implemented daily staff cleaning check	

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE : COMPI	
			,			
		00191	B. WING		12/3	0/2015
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	ORESS, CITY, S	STATE, ZIP CODE		
EBENEZ	ER CARE CENTER		TLAND AVE OLIS, MN 5	NUE SOUTH 5404		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETE DATE
21134	bag. When the bag white hardened foo white/brown food de backside and on an mixer. Food would debris. The DD veri cleaned, stating "it weekend." On 12/28/15, at 5:3 service the following and debris on and a and around the enti and sides of the cardirector (ADD) verif staff wipe it down be service evening meneded cleaning, "it after each meal." Fewith the debris. During followup kitch p.m. with the registe following was observed to be employee hand sink cutout/indentation a had a build up of for After three continuous this food debris was	was taken off, there was d splatter and heavy buildup of abris around the bottom arm, and around the underside of the come in contact with the fied the mixer needed to be was probably used this O p.m. during dinner meal g was observed: If foot closed room tray cart to of brown, white food splatter around the inside tray holders are outside bottom of the unit of the cart was dirty and had before filling it with the room al. DD verified the cart is supposed to be wiped down bood would come in contact when tour on 12/29/15, at 2:05 ared dietitian (RD) the	21134	lists which includes cleaning of the mixer, cleaning of room tray carts (including the 2 South 6-foot close tray cart), cleaning of the red dish cleaning of the Robocoupe mixer, cleaning of soup kettle and coverisoup kettles. The dietary supervisor has develo implemented a supervisory check which includes: hair restraint use, inspection of cleanliness for the H mixer, cleanliness of room tray ca proper use of the hand sink, clean red dish racks, cleanliness of Rob mixer, cleanliness of soup kettles proper covering of kettles. Audits are being conducted by the manager and will continue for 3 m until ongoing compliance is achieved Audit results will be reviewed at the QAPI meeting.	ed room racks, ng of ped list obart rts, lliness of occupe and e Dietary onths or	
	racks. Clean dishes	d the aides to remove all red would have come in contact bris that was present prior to washing.				

	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X) A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		00191	B. WING		12/3	0/2015	
NAME OF F	PROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, S	STATE, ZIP CODE	•		
EBENEZ	ER CARE CENTER		TLAND AVE OLIS, MN 5	NUE SOUTH 5404			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE	
21134	Continued From pa	ge 10	21134				
	stated staff have spand there was a superwas not being done months, the supervalue Review of Ebeneze cleaning and task so 1/14/13 indicated to Coupe, mixer, soup to initial the assigned have been complete that cleaning had be Review of undated aide daily cleaning/stages.	Ebenezer Care Center dietary task schedule, position four					
	bus cart." There wa had been complete SUGGESTED MET The dietary director been educated and reporting maintenar could be conducted quality committee for	THOD OF CORRECTION: could ensure all staff have are following cleaning and nce issues policies. Audits I and the results brought to the or review.					
	(14) days.	R CORRECTION: Fourteen					
21385	MN Rule 4658.0800 Staff assistance) Subp. 3 Infection Control;	21385			2/8/16	
	Personnel must be infection control pro the residents and n	istance with infection control. assigned to assist with the ogram, based on the needs of ursing home, to implement icedures of the infection					

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Minnesc	ta Department of He	ealth				
	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE COMPI	SURVEY LETED
		00191	B. WING		12/3	0/2015
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
EBENEZ	ER CARE CENTER		OLIS, MN 5	NUE SOUTH 5404		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE COM		(X5) COMPLETE DATE
21385	Continued From pa	ge 11	21385			
	by: Based on observation review, the facility for the shared razor(s) potential to affect 1 R43, R47, R52, R5 R131). In addition, glucometers were considents (R138, R4 checks to prevent to infection. This had residents who have residents who have residents who have findings include: On 12/30/15, at 8:3 noted in the 3 south # 1. Remington electromate # 2. Phillips Noreloctromate RN)-B stated that the entire floor, excluse it themselves a residents that we share supposed to cleated down and have many RN-B was aware of by microscopic bloowas why we use allowas why we wanted the why why why why why	on, interview and document ailed to ensure the standard was disinfected, this had the 2 residents (R14, R28, R32, 4, R58, R59, R85, R96, the facility failed to ensure cleaned properly for 2 of 2 (45) who had blood sugar he spread of blood borne the potential to affect 23 a glucometer check. O a.m. electric razors were a nursing station window seal. ctric razor that was in pieces. O (blue handle) that had a pris inside. Registered nurse they were shared razors for ept for the people who can and have their own razor. The nave use that one, but staff ean it in between and we wash aultiple heads [to change out]. It disease that could be spread and particles and stated that cohol to wash it down. It of nursing (DON) stated to be cleaned between g to policy sistant (NA)-D on 3 south, and of razor, disassembled, and brush, soap and water, did demonstrated rubbing it dry then cleans with alcohol swab.		All razors are currently disinfected between different resident uses. No razors have been ordered for each resident requiring shaving which we for no longer needing residents to electric razors. Razors will still be maintained for infection control put This includes razors for (R14, R28, R43, R47, R52, R54, R58, R59, R8131). All nurses including RN-I and RN-educated on proper infection contribution practices for glucometers by 1/22/nursing assistants and nurses included RN-B, NA-A and NA-D were trained proper disinfection of razors 1/29/straining included demonstrations be participants to ensure a thorough understanding. Audits are being conducted with orby the director of nursing and will of for 3 months or until ongoing complications are discovered. Audit results will be reand reported at the facility QAPI manufacture.	lew share properly rposes. B, R32, 85, R96, U were rol 16. All uding ed on 16. This by the versight continue oliance eviewed	

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STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00191	B. WING		12/3	0/2015
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		.,
EBENEZ	ER CARE CENTER			NUE SOUTH		
		MINNEAP TEMENT OF DEFICIENCIES	OLIS, MN 5		ON	0.5-1
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
21385	5 Continued From page 12		21385			
	but had shaved R26 morning, and had le (in pieces). He had razor and could not -At 10:00 the infecti shared razors were with alcohol, then fustronger wipes that glucometers [PDAs -At 11:30 NA-A stat anyone that day, ar last used the Blue N-At 1:00 R25 stated and had considered he "would never she" would never she-At 1:05 R98 stated 1st floorAt 1:10 R32 verifie -At 109, R47 verifie	ed that he had not shaved ad did not know when he had Norelco razor. he had his own electric razor of purchasing another, because are a razor." he used the shared razor on the use of a shared razor of the use of a shared razor. sister verified use of the				
	Of the 24 residents on the unit, 14 residents were shaved 2 own razors, and 12 used the shared razors.					
	admission diagnose behavioral disorder of use of 1 side of b Record. The nursin	o the facility on 9/17/12, with es of vascular dementia with , stroke and hemiplegia (loss body) per the Admission g assistant care sheet printed ed assist of one with all cluding shaving.				
	admission diagnose and major depressi The nursing assista	o the facility on 3/3/14, with es of dementia, allergic rhinitis on per the Admission Record. Int care sheet printed on staff to physically assist with				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00191	B. WING		12/3	30/2015
-	PROVIDER OR SUPPLIER	2545 POF	DRESS, CITY, S RTLAND AVEI POLIS, MN 55			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
21385	shaving as needed. R32 was admitted to admission diagnose arthritis, and type II Record. The nursing on 12/30/15, directed personal hygiene in R32 verified that she electric razor. R43 was admitted to admission diagnosed disorder, anxiety disolood pressure) per nursing assistant conditional diagnosed disorder and admission diagnosed kidney disease and Admission Record. Sheet printed on 12 with all personal hyverified use of the second. The nursing on 12/30/15, directed with grooming and R54's sister verified. R58 was admitted to admission diagnosed disorder and major Record. The nursing on 12/30/15, directed with grooming and R54's sister verified. R58 was admitted to admission diagnosed depression, and vital Admission Record.		21385			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		00191	B. WING		12/3	0/2015
NAME OF	PROVIDER OR SUPPLIER		, ,	STATE, ZIP CODE		
EBENEZ	ER CARE CENTER		OLIS, MN 5	NUE SOUTH 5404		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
21385	Continued From pa	ige 14	21385			
	one with all groomineeded.	ng tasks including shaving as				
	admission diagnose disease and dysphathe Admission Reconstruction 12 of one with grooming RN-B stated somet grooming indicated R85 was admitted the admission diagnose behavioral disturbation other skin disorders The nursing assistat 12/30/15, directed: hygiene including states.	to the facility on 1/6/09, with es of vascular dementia with nces, lung disease, rash and sper the Admission Record. ant care sheet printed on assist of one with all personal having.				
	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.					
	admission diagnose cardiomyopathy an Admission Record. sheet printed on 12 with grooming, assi special care with gr	d tachycardia per the The nursing assistant care ½/30/15, indicated independent ist of one as needed, and rooming due to risk of infection ropathy. R98 verified he used a				
	admission diagnose	I to the facility on 4/8/15, with es of dementia with behavioral nia and vitamin D deficiency				

Minnesota Department of Health

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00191	B. WING		10/2	0/2015
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE	12/3	0/2015
				NUE SOUTH		
EBENEZ	ER CARE CENTER	MINNEAP	OLIS, MN 5	5404		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
21385	Continued From page 15		21385			
	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					
	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.					
	RN-I said, "What is cart to dry or back i for at least three mi it and then placed if	on 12/28/15, at 5:30 p.m. the difference if I put it on the n the container? I won't use it inutes, until it is dry. I scrubbed t in the container." This was ght us to clean the glucometer.				
		S dated 11/25/15, indicated is of diabetes and received				
	12/30/15, at 7:27 a.	administration observation on m. RN-J entered R45's room ying case on bedside table				

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PRINTED: 01/26/2016 FORM APPROVED

Minnesota Department of Health

AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: COMPLETED 00191 B. WING 12/30/2015	Minnesota Department of He		T			
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2545 PORTLAND AVENUE SOUTH MINNEAPOLIS, MN 55404 (X4) ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 21385 Continued From page 16 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	STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	` ′			
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2545 PORTLAND AVENUE SOUTH MINNEAPOLIS, MN 55404 (X4) ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 21385 Continued From page 16 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	AND I DAY OF COTTLECTION	IDENTIFICATION NOMBER.	A. BUILDING:		OOWII	LLILD
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2545 PORTLAND AVENUE SOUTH MINNEAPOLIS, MN 55404 (X4) ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 21385 Continued From page 16 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						
EBENEZER CARE CENTER 2545 PORTLAND AVENUE SOUTH MINNEAPOLIS, MN 55404 (X4) ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 21385 Continued From page 16 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		00191	B. WING		12/3	0/2015
(X4) ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 21385 Continued From page 16 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	NAME OF PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
(X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 21385 Continued From page 16 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		2545 POR	TLAND AVE	NUE SOUTH		
PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) 21385 Continued From page 16 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	EBENEZER CARE CENTER	MINNEAP	OLIS, MN 5	5404		
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	PREFIX (EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI	D BE	COMPLETE
check-wiped finger, obtained drop of blood, tested blood. RN-J showed results to R45, removed test strip and placed glucometer in carry	21385 Continued From pa	Continued From page 16				
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.	without a barrier. For check-wiped finger tested blood. RN-J removed test strip a case on top of five carrying case in masked when planned glucometer, RN-J releans them. RN-J alcohol wipe before glucometer needed no it was fine to wathat it was ok to have because they have a resident a medical kept under observateurned and surverequest glucometer to do so. RN-J removed the glucometer to do so. RN-J immoglucometer on the follucometer was drawn-J stated, "I have I can put it in the cate glucometer was to RN-J said, "I just in does not have to be asked to view the in Sani-Cloth AF wipe stated that it must in minutes. During interview on infection control nube immediately wip with a sani wipe usi	RN-J performed blood sugar, obtained drop of blood, showed results to R45, and placed glucometer in carry insulin FlexPens and put edication cart. When RN-J was ed on disinfecting the esponded that the night shift stated, "I will wipe it off with an e I use it. Asked RN-J if the I to disinfect it now. RN-J said it until need to use it again and we it touching the pens covers on. RN-J went to give ation. The medication cart was ation until 7:43 a.m. when RN-J yor had to intervene and be disinfected. RN-J agreed oved glucometer from carrying sitting on five insulin pens and the off with a PDI Sani-Cloth hediately placed the top of the medication cart. It is in less than one minute. It is the towait three minutes before ase." Asked RN-J how long the remain wet with disinfectant. The ed to wipe and air dry. It is visible wet. "RN-J was instructions on the PDI. The package instruction remain visible wet for three as stated glucometers are to ed down by the nurse using it ing a three minute wet time.	21303			

Minnesota Department of Health

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STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION	(1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		A. BUILDING:			
	00191	B. WING		12/3	0/2015
NAME OF PROVIDER OR SUPPLIER	STREET ADI	ORESS, CITY, S	STATE, ZIP CODE		
EBENEZER CARE CENTER		TLAND AVE OLIS, MN 5	NUE SOUTH 5404		
PREFIX (EACH DEFICIENCY MU	MENT OF DEFICIENCIES UST BE PRECEDED BY FULL IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
against blood borne parcontrol nurse verified in night shift nurse do the night shift nurse do the director of nurses (DC to disinfect the glucomaccording to the director of nurses (DC to disinfect the glucomaccording to the director of nurses (DC to disinfect the glucomaccording to the director of nurses (DC to disinfect the glucomaccording to the director of nurses of the cleaner to the lood of the pathogen of the lood borne pathogen of the lood b	ad as it did not disinfect bathogens. The infection it was not ok to have the e disinfecting. 2/29/15, at 3:28 p.m. the DN) stated the nurses were neters using the PDI wipes tion on the wipe. Blood Glucose Monitor and 7/12, instructed staff: Monitor/INR machine will be fiter each use with prevent the spread of its. In ent. In owels (one on top of the table to create a barrier of the equipment, wearing achine will be disinfected cleaner wipes at point of sibly soiled with blood or machine twice; use one poiled area and one cloth to the control of the entry of the entr	21385			

Minnesota Department of Health

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Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X3 A. BUILDING:			3) DATE SURVEY COMPLETED	
			A. BUILDING.				
		00191	B. WING	· · · · · · · · · · · · · · · · · · ·	12/3	0/2015	
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE			
EBENEZ	ER CARE CENTER		TLAND AVE OLIS, MN 5	NUE SOUTH 5404			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE	
21385	Continued From page 18		21385				
	undated, instructed TO DISINFECT: "U soil. Unfold a clean surface. Treated su for a full three (3) m	Germicidal Disposable wipe users: se a wipe to remove heavy wipe and thoroughly wet rface must remain visibly wet ninutes. Use additional wipe(s) continuous 3 minute wet					
	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 Twenty-One (21) Da						
21426	MN St. Statute 144. Prevention And Cor	A.04 Subd. 3 Tuberculosis ntrol	21426			2/8/16	
	maintain a compreh infection control pro- current tuberculosis issued by the Unite Control and Preven Tuberculosis Elimin Morbidity and Morta This program must infection control pla unpaid employees, residents, and volun	e provider must establish and nensive tuberculosis ogram according to the most infection control guidelines d States Centers for Disease tion (CDC), Division of nation, as published in CDC's ality Weekly Report (MMWR). include a tuberculosis in that covers all paid and contractors, students, inteers. The Department of etechnical assistance					

Minnesota Department of Health

STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE COMP	
71112 1 27111	or confidence	ISEITTII TOTTI TOTTI TOTTI TE	A. BUILDING:			
		00191	B. WING		12/3	0/2015
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	ORESS, CITY, S	STATE, ZIP CODE		
EBENEZ	ER CARE CENTER		TLAND AVE OLIS, MN 5	NUE SOUTH 5404		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROFILE DEFICIENCY)	D BE	(X5) COMPLETE DATE
21426	Continued From paregarding implement (b) Written compliate be maintained by the This MN Requirement by: Based on interview facility failed to door tuberculosis (TB) short 5 of 5 residents reviewed for TB scribing include: R21 was admitted the R21's admission Mineral R21's immunization given the first step read results was not TST was given on the R53's admission Mineral R53's admission M	ge 19 Intation of the guidelines. Ince with this subdivision must be nursing home. Interest is not met as evidenced and document review, the ument complete results of the kin test (TST) that was given (R21, R47, R107, R53, R100) reening. In the facility on 11/29/15, per inimum Data Set (MDS). In record revealed R21 was TST on 11/30/15. The date of documented. The second 12/30/15 with results pending. In the facility on 10/10/15, per DS. R53's immunization 3 was given the first step TST e second step TST on a did not have the date read	21426	The facility has established and maintained a comprehensive tube infection control program accordin most current tuberculosis infection guidelines. Verified R53, R100, R107, R47 TE results were 0 millimeters induration through communication with test results were documentation pla resident's immunization record channels immunization record channels immunization through the factor of TB reading by 1/22/16. Audits are in place with oversight the director of nursing and will continue months or until ongoing compliance achieved. Audits results will be reversed.	rculosis g to the control ton ead ced in arts by acility . by the e for 3 ee is	
	T100's admission Nature revealed R100 was 10/14/15, and the s	to the facility on 10/14/15, per MDS immunization record given the first step TST on econd step TST on 10/20/15. ave the date read results		at the facility QAPI meeting.		

6899

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		00191	B. WING		12/3	0/2015	
	PROVIDER OR SUPPLIER	2545 POR		STATE, ZIP CODE NUE SOUTH 5404			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE	
21426	R107 was admitted R107's admission of record revealed R1. TST on 11/5/15, and 11/15/15. Both tests results documented R47 was admitted to R47's admission of R47 was admission of R47's of duration document of R47's admission of R47's admissio	to the facility on 11/5/15, per MDS. R107's immunization 07 was given the first step d the second step TST on a did not have the date read d. o the facility on 9/23/15, per DS. R47's immunization 7 was given the first step TST second step TST on 8/9/15. did not have the date read d. In addition, both first and did not have millimeters (mm) inted. 48 p.m. infection control nurse or TST results for residents formation. ICN stated she sees read TB results they both negative results and mm osis screening - resident irrected "upon admission: all sessed for symptoms of and reculosis and have a 2-step se indicated. Factors that estep TST are: admitted from ospital or nursing facility with ST administered at that facility inths." HOD OF CORRECTION: The or designee, could estep on resident and employee and perform audits to	21426				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00191	B. WING		12/3	0/2015
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
EBENEZ	ER CARE CENTER		OLIS, MN 5	NUE SOUTH 5404		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE
21426	Continued From pa	ge 21	21426			
	TIME PERIOD FOR (21) days.	R CORRECTION: Twenty-one				
21565	MN Rule 4658.1325 Medications Self Ac	5 Subp. 4 Administration of Imin	21565			1/29/16
	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.					
	by: Based on observati review, the facility fa practice of self-adm medication was saf	ent is not met as evidenced on, interview and document ailed to determine whether the inistration of nebulizer e for 1 of 1 residents (R52) administering medications.		The facility will ensure residents a allowed to self-administer medicat their assessment and comprehens of care reflect that they are safe to RN-A and RN-B were educated at of survey about proper self admini of medicine including R52's plan of	ions if sive plan do so. the time stration	
	dressed, opened ey verbal stimulus. An was running, no nur supervise the admir the nebulizer tubing had pulled the face nurse (RN)-A who he medication cart near into the room with a hands and a medical unsure if R52 had a order. When asked the medications in he medication was the	3 a.m. R52 was up in chair res slightly and responded to ebulized (neb) medication rese was in the room to nistration. R52 had captured with his right index finger and mask slightly. Registered had been working at the arthe nursing station, walked a cup of thin clear liquid in his ation cup. RN-A stated he was a SAM assessment or a SAM if he was also going to give his hand, RN-A stated "his neb." RN-A then removed the t on the bedside table and left		All nurses were educated about pr self administration of medicine by Audits are being conducted with or by the director of nursing and will of for 3 months or until ongoing comp is achieved. Audits will be reported and reviewed monthly QAPI meetings.	roper 1/22/16. versight continue bliance	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				ATE SURVEY OMPLETED	
			7.1. 20125.110.1				
		00191	B. WING		12/3	0/2015	
NAME OF	PROVIDER OR SUPPLIER		, ,	STATE, ZIP CODE			
EBENEZ	ER CARE CENTER		TLAND AVE OLIS, MN 5	NUE SOUTH 5404			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE	
21565	the room with the woontinuing down to R52 was admitted thad admission diagquadriplegia (loss of and several body furth (inability to swallow Record. The significant character of the significant character of the system of the significant character of the significant character of the significant character of two stands and dressing. The significant character of two stands and dressing.	vater and medication cup, the end of the hall. to the facility on 8/30/05, and gnoses of dementia, functional of body control for all four limbs unctions) and dysphagia thin liquids) per the Admission and Market assessment R52 was never or rarely ding to staff assessment R52 arem and long term memory erely impaired cognition epression, evidenced by poor experience for transfers, extensive taff for toilet use, bed mobility, ange Care Area Assessment licated R52 had a diagnosis of avior disturbances, was unable from, season or that he was in 52 did not communicate and makes self-understood and staff anticipate all needs. He the difficulty swallowing and had lets food and fluids run out of an's Order dated 10/28/15, for	21565				
	nebulized four time pulmonary disease The care plan dates	reathing medication), s a day for chronic obstructive d 11/10/15, indicated R52 had nd required staff to meet all					
		ft sided hemiplegia, from					

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Minnesota Department of Health
STATEMENT OF DEFICIENCIES (X1)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 1			ATE SURVEY OMPLETED	
7.1.12 . 27.11	0. 0020		A. BUILDING:		00		
		00191	B. WING		12/3	0/2015	
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	ORESS, CITY, S	STATE, ZIP CODE			
EBENEZ	ER CARE CENTER		TLAND AVE OLIS, MN 5	NUE SOUTH 5404			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE	
21565	Continued From pa	ge 23	21565				
	stroke and dementi had a decline in sw	a. R52 was fed by staff and allowing ability. R52's care e R52 could SAM their					
	stated R52 has bee	0 p.m. nursing assistant-C en like this in the one and 1/2 sed here, "but pretty his eyes looking left."					
	not have a SAM, be	0 a.m. RN-B stated, R52 does ecause he was not capable of so he had not been assessed. not found by RN-B.					
	stated she would exwith a patient receive	0 a.m. the director of nursing xpect the staff nurse to stay ving a nebulized medication, if able to self-administer					
	The director of nurs current for SAM, ar trained. Residents assessed, and a sy could be devised.	THOD OF CORRECTION: sing could ensure policies are ad licensed staff have been who wish to SAM could be stem for indicating this to staff Audits could be conducted at nes, and the results brought to see for review.					
	TIME PERIOD FOR (14) days.	R CORRECTION: Fourteen					
21615	MN Rule 4658.1340 Preparation Area;S	O Subp. 2 MedicineCabinet & cheduleII	21615			1/22/16	
	nursing home must	of Schedule II drugs. A provide separately locked manently affixed to the					

Minnesota Department of Health

wiinnesc	ita Department of He	ailli				
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
		00191	B. WING		12/3	0/2015
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS CITY	STATE, ZIP CODE		
NAME OF	TIOVIDEIT OIT SOLT EIEIT			ENUE SOUTH		
EBENEZ	ER CARE CENTER		OLIS, MN 5			
	OLIMAN DV OTA		1			0.50
(X4) ID PREFIX		TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL	-	(X5) COMPLETE
TAG		SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROI		DATE
				DEFICIENCY)		
21615	Continued From pa	ge 24	21615			
	•					
		edication cart for storage of				
		ted in Minnesota Statutes,				
	section 152.02, sul	odivision 3.				
						ı
	This MN Requireme	ent is not met as evidenced				1
	by:	one to not mot do oridonoca				
		on interview and document		The facility provides separately loc	cked	
	review facility failed	to ensure medications were		compartments, permanently affixe		
		r temperature for 13 residents		physical plant or medication cart for		
	(R40, R95, R101, F	R123, R60, R69, R7, R132,		storage of controlled drugs.		
		04, R59, R54) who received				1
	refrigerated insulin'	s and eye drops.		New thermometers were ordered		1
				placed in refrigerators 2-north and	3-north.	1
	Findings include:			Maintenance director verified all		1
				refrigerators to be properly		ı
	Second North:			functioning/operating order and		1
		at medication storage on the		maintaining proper temperatures		1
		n 12/28/15, at 2:00 p.m. urse (LPN)-A verified the		12/28/15.		1
		refrigerator was 52 degrees.		Nursing staff is required to check		1
		sted medications were stored		refrigerator temps daily. All nursing	ด พลร	1
		nd the medications were to be		educated as to this requirement by		1
	stored between 30			1/22/16.	,	
		Pens (used to control blood		,,,,,		ı
	sugar) total for R40	`		All medications from the refrigerat	ors on	ı
	-Six Novolog FlexP	ens (used to control blood		2-north and 3-north were removed	1 ,	
	sugar) total for R40	, and R95,		destroyed and ordered for replace	ment on	ı
		vikPen (used to control blood		12/28/15. This protected all reside		
	sugar) for R101 and			the floors including (R40, R95, R1		ı
		orost (reducing intraocular		R123, R60, R69, R7, R132, R23,	R74,	
	•	with open-angle glaucoma)		R38, R104, R59, R54).		ı
	solution 0.005% for			Navo vafida avatava vosus avalava d		
	For the facility, the			New refrigerators were ordered	rigaratad	
		za vaccine syringes -Fluzone		specifically for medication and refr	•	
	High dose and,	dated open 11/25/15, verified		narcotic storage and will be placed units. Until these refrigerators are		
	by registered nurse			and put to use, all refrigerated nar		
	by registered fluise	(1114) D.		medications are properly locked a		
	During interview on	12/28/15, at 2:15 p.m. dietary		stored in an existing double-locked		
		. = =, . = , = =	II.		- '	i

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00191	B. WING		12/3	0/2015
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
EBENEZ	ER CARE CENTER		TLAND AVE OLIS, MN 5	NUE SOUTH 5404		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
21615	Continued From pa	ge 25	21615			
21615	manager stated "the Temperature of 66 manager using digit On 12/28/15, at 4:3 was no record of dawas supposed to chwas not done. Third North: During tour looking third north unit on 1 verified the temperadegrees. RN-G stat stored in the refrige were to be stored b -14 Lantus Solostar R74, -Three vials of Lant -One Novolog Flext -One vial of Novolog -11 Humalog Kwik -One prefilled Prevevaccine) 13 for R13 -Four-30 ml bottles anxiety-Ativan) 2mg R104. On 12/28/15, at 3:1 bottles of lorazepanattached to the she was not attached to	e fridge is not working." degrees verified by dietary tal probe. 0 p.m. RN-D verified there ally temps. RN-D stated dietary neck the temperature and it at medication storage on the 2/28/15, at 3:10 p.m. RN-G ature of the refrigerator was 56 ted the listed medications were erator and that the medications etween 30 to 40 degrees: r Pens total for R69, R7, R23, rus for R38, Pens total for R69, g for R38, Pens total for R7, and R23, Penar (a pneumococcal se and, of lorazepam (used for g/ml total for R54, R59, and 5 p.m. it was observed four n were locked in a red box If in the refrigerator. The shelf of the refrigerator and slid out	21615	refrigerator. All nursing staff were educated or destruction of Fentanyl patches at double signature requirements for of Fentanyl patches by 1/22/16. Audits are being conducted with oby the director of nursing and will for 3 months or until ongoing com is achieved. Audit results will be reat the facility QAPI meeting.	nd for wasting oversight continue pliance	
	away with it." RN-E temperature was chemperature at that During interview on said, "Only one persons of the said o	I-E verified "anyone could walk verified the last time the necked was 12/26/15, and the time was 46 degrees. 12/29/15, at 10:16 a.m. RN-D son signs for removal of the they do it on the MAR."				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00191	B. WING	·····	12/3	0/2015
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	ORESS, CITY, S	STATE, ZIP CODE	•	
FBENEZER CARE CENTER			TLAND AVE	NUE SOUTH		
(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 CROSS-REFERENCED TO THE APPROFIDEFICIENCY)	D BE	(X5) COMPLETE DATE
21615	Continued From pa	ge 26	21615			
	During interview on director of nurses (I fold and cut the Fer sharps container. Tremoval and replace we ask for two signs that is highly abuse the refrigerator should degrees. The house notify the nurses if tranges. "Nursing sensure the temperature expected to be include Ativan in the [nurses] are to date open. "The DON in nursing assistants, dietary staff have as where medications." During interview on environmental servinous ekeepers only refrigerators on Tues. Storage of Medications red "XI. Medications red "temperature betwee degrees Fahrenheit are kept in a refrige allow temperature requiring storage in unless otherwise di substances that red within a locked box	12/29/15 at 3:28 p.m. the DON) said, the nurses are to ntanyl patch and put it in the hey sign it in the MAR for ement. According to our policy atures, because it is a narcotic d. The said the temperature in uld be no warmer than 40 ekeepers do a log daily and the temperature was out of the should be checking the logs to a tures are in range. Narcotics under double lock. That would be third floor fridge. They multiuse vials when they indicated 17 nurses, 25 three housekeepers and six cocess to the refrigerators are stored. 12/29/15, at 4:00 p.m. ice director stated the check the temperatures of the esdays.				

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00191 B. WING 12/3		0/2015		
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE	•	
FBENEZER CARE CENTER			TLAND AVE OLIS, MN 5	NUE SOUTH 5404		
(X4) ID PREFIX TAG			D BE	(X5) COMPLETE DATE		
21615	Controlled Substan reviewed October 2 When a Fentanyl premoved/replaced to should be followed used patchF. Doo be signed by personalong with witness of destruction log sheen SUGGESTED MET. The director of nursuall appropriate staff.	ce Disposal-Long Term Care 2014, instructed staff: "III. atch needs to be he following procedures for proper destruction of the sumentation of disposal must in disposing of used patch, (licensed staff) on drug et or narcotic book." HOD OF CORRECTION: sing or designee could educate members on the processes. sing or designee could develop to ensure ongoing	21615			2/8/16
	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					

STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMPI	
		00191	B. WING		12/30/2015	
	PROVIDER OR SUPPLIER	2545 POR	TLAND AVE	STATE, ZIP CODE NUE SOUTH		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 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,			NUE SOUTH	D BE PRIATE	(X5) COMPLETE DATE	
	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:			to the requirements of proper dest of Fentanyl patches and the requirements for administration of the requirements for administration of the requirements for administration of the requirements for o	proper nd for wasting versight continue pliance	

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
	00191	B. WING		12/3	0/2015	
NAME OF PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE			
EBENEZER CARE CENTER		TLAND AVE OLIS, MN 5	NUE SOUTH 5404			
PREFIX (EACH DEFICIENCY	FEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	TION SHOULD BE COMPLET THE APPROPRIATE DATE		
R48's Fentanyl patch by two nurses when when a Fentanyl pat are to sign it out in the half and put it in the MAR from Septembe indicated only one si removal of Fentanyl narcotic book record it was revealed R48 patch six times, each documented the des R24's Order Summa indicated R24 had a 50mcg/hour (hr appl MAR from Septembe indicated only one si removal of Fentanyl narcotic book record it was revealed R48 patch seven times, each documented the During interview on said, "Only one persfentanyl patch and the During interview on director of nurses (D fold and cut the Fentisharps container. The removal and replace we ask for two signathat is highly abused Controlled Substance.	a completed. LPN-B verified h had not been double signed removed. LPN-B stated tch was removed two people he narcotic book and fold it in sharps container. Review of er to December 2015 taff member signed for patch. During review of R48's d, from 12/13/15 to 12/28/15, had received the Fentanyl h of which only one nurse had struction. Tary Report printed 12/30/15, an order for Fentanyl patch ly every 72 hours. Review of er to December 2015 taff member signed for patch. During review of R24's d, from 12/13/15 to 12/28/15, had received the Fentanyl each of which only one nurse e destruction 12/29/15, at 10:16 a.m. RN-D son signs for removal of the hey do it on the MAR." 12/29/15 at 3:28 p.m. the DON) said, the nurses are to tanyl patch and put it in the ney sign it in the MAR for ement. According to our policy atures, because it is a narcotic d." The Disposal-Long Term Care 1014, instructed staff: "III.	21630				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		00191	B. WING		12/30/2015	
	PROVIDER OR SUPPLIER	2545 POR		STATE, ZIP CODE NUE SOUTH 5404		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
21630	removed/replaced to should be followed used patchF. Doo be signed by person along with witness (destruction log shed SUGGESTED MET The pharmacist and in-service all staff reneed to secure medications accord policy/procedure.	the following procedures for proper destruction of the umentation of disposal must in disposing of used patch, licensed staff) on drug et or narcotic book." HOD OF CORRECTION: d/or director of nursing could esponsible for medications the lications and follow disposal of	21630			
21695	Subp. 4. Houseke provide housekeepi necessary to mainta comfortable interior ceilings, registers, f and furnishings. This MN Requirements: Based on observati review, the facility functional and sanitary concerns. In additions afe and sanitary of equipment that had preparation and sto	eping. A nursing home must ng and maintenance services ain a clean, orderly, and including walls, floors, ixtures, equipment, lighting, ent is not met as evidenced ons, interview and document ailed to ensure a safe, ary environment for 2 of 2 environment for 2 of 3 environment for 2 of 2 environment for 3 environme	21695	The facility provides housekeeping maintenance services as necessa maintain a clean, orderly and cominterior. The holes in the sheetrock in R11' were patched and painted on 12/2 The Blue Dysom and Blue Tape w removed on 12/28/15.	ry to fortable s room 8/15.	2/8/16

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	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	LE CONSTRUCTION .	(X3) DATE S	
			A. BUILDING	:		
		00191	B. WING		12/30	0/2015
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY,	STATE, ZIP CODE		
EBENEZ	ER CARE CENTER			ENUE SOUTH		
	0.000		OLIS, MN 5		~	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
21695	Continued From pa	age 31	21695			
	Findings include:			The foot grips identified were remainded 12/30/15.	oved on	
	On 12/30/15, at 11: environment tour wenvironmental serv supervisor for house and during the folloom. R11's bathroom on room observations bar on the left side holes into the wall sidue to installing new sanded down or fillibar next to the toile dysom secured with exposed the adhessoiled and was not. On 12/30/15, at 11: the holes were from not been finished on had holes/groves in rough surface. ESD acknowledged was stated he would report at 12:37 p.m. At 12:37	247 a.m. to 12:34 p.m. an as conducted with the ice director (ESD) and the sekeeping and laundry (SHK) wing were reviewed. 12/28/15, at 3:21 p.m. during the wall to the left of a grab of the sink was observed with sheetrock which appeared was w grab bar but was never ed. In addition the right grab of the sekeeping tape which ive part hanging off it, was a cleanable surface. 251 a.m. ESD verified stated in replacing a grab bar and had ff. ESD acknowledged the wall in the sheetrock did create a coverified the peeling tape and anot a cleanable surface. ESD place it with a textured grab when asked how often the staff the supervisor for laundry stated rooms were her and ESD stated even aned the rooms daily it would to see the peeling tape on the the same color as the plastic g. The supervisor for laundry stated the facility did in cleaning such surfaces.		Environmental services staff were educated on identifying and report non-cleanable surfaces on 12/31/housewide audit was conducted on 1/23/16 for identifying non-cleanable surfaces. All findings are entered in CMMS (work-order) system to be completed no later than 2/8/16. An inspection for non-cleanable set has been added to the supervising housekeeper deep-cleaning inspesschedule. 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 son 12/31/15. An inspection of foot grips has been added to the supervising houseked deep cleaning inspection scheduled with oversight in Maintenance Director. Audits will for 3 months or until ongoing comits achieved. Audit results will be reat the facility QAPI meeting. The clean dish area including the sills was thoroughly cleaned on 12 sills w	ting 15. A n ole in to the ervices ction ered into as e or e surfaces en eper e) by the continue pliance eviewed window	
	Foot Grip R53's floor by the b	ped was observed with peeling		The dirty dish area table was thore cleaned including the table, table I	oughly	

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		00191	B. WING		12/30/2015	
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		0, = 0.10
EDENE7	ER CARE CENTER			NUE SOUTH		
EDENEZ	EN CANE CENTEN	MINNEAP	OLIS, MN 5	5404		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE
21695	5 Continued From page 32		21695			
	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.			and floor. The table caulking was and the floor drain was replaced o 12/29/15.		
	supervisor for hous was peeling off the surface. ESD stated and replaced. The sand laundry stated	09 p.m. ESD and the ekeeping verified the foot grip floor and was not a cleanable d to R53 he would remove it supervisor for housekeeping staff were supposed to alert aff of any concerns and would		The soup kettle, piping, wall, floori perimeter baseboards and walk in door handle were all thoroughly cle 12/30/15. The dietery team has redeveloped implemented a daily staff cleaning list. This includes cleaning of the	cooler eaned and check	
	On 12/30/15, at 3:3 did not have a specidentified and indica	5 p.m. ESD stated the facility ific policy to the concerns ated the staff were supposed order would be initiated for ddress.		areas, the soup kettle area, cooler handle and the perimeter baseboa around the legs of equipment. The dietary supervisor check list h developed and implemented to mo compliance this includes the dish at the soup kettle area, cooler door hand the perimeter baseboards aro	as been onitor for areas, andle	
	kitchen tour with the following was observed: - the clean dish are stainless steel table temperature one consituated in a corner this clean dish area four foot windows will below them. Bot dirty and splattered a build up of food dithe corners of the windshwasher in the deight foot stainless where the table me	54 a.m. during the initial edietary director (DD) the rved: a contained an eight foot esituated to the left of the high empartment dishwasher of the kitchen. Directly above, there were two, three foot by with an eight inch wide window h the windows and sill were with food particles. There was ebris along the back of and in window sill. To the right of the irty dish area was another steel table with white caulking ets the wall. Approximately lking was black with a mold		legs of equipment. Audits are being conducted with or by the dietary manager with respektichen sanitation. Audits conducteresident spaces are overseen by traintenance director. Audits will of for 3 months or until ongoing complis achieved. Audits will be reviewe QAPI meeting.	ct to ed in he ontinue oliance	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00191	B. WING		12/3	0/2015
	PROVIDER OR SUPPLIER	2545 POR		STATE, ZIP CODE NUE SOUTH 5404		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
21695	type substance. The of the table was her substance and food table legs and when there was a grimy, I debris. The top of the below the dishwash the floor. DD verifies to be cleaned and the was mold and need replaced by mainter on 12/29/15, at 2:00 the kitchen the followerified by the DD: - Behind the soup ke flooring had a heave substance. Behind the right of the walk approximate two into white molding strip brown, sticky substantless steel hand brown/black substance. Around the entire the baseboards and equipment there was black/brown grime as the position and the but cleaning "was not the past six more list is empty."	e wall behind the entire length avily splattered with a brown a particles. On and around all the the wall meets the floor brown/black buildup of food the floor drain was missing the where water drained into the drained was dirty, needed the black caulking most likely led to be removed and mance. 5 p.m. during a second tour of wing was observed and the same soup kettle and to the in cooler door and the wide by three feet in long was heavily soiled with a lance. The walk in cooler door alle was heavily soiled with a lance. The walk in cooler door alle was heavily soiled with nace. perimeter of the kitchen along of an and around all legs of land food debris. on 12/28/2015, at 4:40 p.m. staff have specific duties for here is a supervisor checklist of being done, probably not on the supervisor check off	21695			
		on 12/29/15, at 2:20 p.m. the				

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	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		00191	B. WING		12/3	0/2015	
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE			
FBENEZER CARE CENTER			TLAND AVE OLIS, MN 5:	NUE SOUTH 5404			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE	
21695	Continued From pa	ge 34	21695				
	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.						
	daily cleaning & tas revised 2/14/15 incl tables on clean side floors swept and me cleaned on dirty sid wall, all racks off flo be cleaned and set	nezer Care Center dietary aide k schedule, positions 9-5" uded that all shelves and e be cleaned and sanitized, oped in dish room, walls e, both by tables and opposite for at all times and floor carts up for evening. There was no e cleaning tasks had been					
	indicated "tile and of thoroughly scrubbe clean every two/thre completed date and indicated the kitche cleaned 11/6/15, and	ted facility cleaning schedule eramic floor needs to be d. Kitchen duties should be ee months. After task is d sign off." The schedule n ceiling and walls had been de the "kitchen/front of coffeers scrub" had been cleaned					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '			(3) DATE SURVEY COMPLETED	
71112 1 27111	01 001112011011	BENTH TO THE TOTAL BETTE	A. BUILDING:				
		00191	B. WING		12/3	0/2015	
NAME OF P	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE			
EBENEZE	ER CARE CENTER		TLAND AVE	NUE SOUTH 5404			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE	
22000	The administrator of schedule which inclining the walk-in around the stove/hor conducted periodical assurance committed. TIME PERIOD FOF (21) days. MN St. Statute 626 Reporting - Maltreated. Subd. 14. Abuse facility, except homogersonal care attenestablish and enfort prevention plan. The assessment of the penvironment, and it factors which may early and a statement of to minimize the risk comply with any rule promulgated by the (b) Each facility, agency and person providers, shall dever prevention plan for residing there or reconstruction of the plan shall contains assessment of: (1) abuse by other individual adults; (2)	THOD OF CORRECTION: ould develop a cleaning uded all areas of the building, in freezers and the areas pod. An audit could be ally and report to the quality ee at the quarterly meetings. R CORRECTION: Twenty-one described in the control of the co	21695	DEFICIENCY)		2/8/16	

STATEMEN	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:					3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED		
		00191	B. WING		12/30/2015		
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE			
EBENEZ	ER CARE CENTER		TLAND AVE OLIS, MN 5	NUE SOUTH 5404			
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22000	risk of abuse to that adults. For the purp term "abuse" includ (c) If the facility, and personal care a knows that the vuln violent crime or an atoward others, the inplan must detail the minimize the risk the reasonably be expefacility and persons unsupervised. Undo fa vulnerable adurisconduct or physical information from authority or through another facility, and	t person and other vulnerable boses of this paragraph, the	22000				
	by: Based on interview facility failed to come of 5 employees (E-2 employment. This has 122 residents residing worked in multiple at Finding include: New employee person	and the potential to affect 74 of ing at the facility as the staff		The facility has an abuse prevention. The facility has hiring practices the include efforts to review background references of candidates in an efform abuse prevention. The facility conducts background on all staff prior to employment. The facility also does an additional background conducts which is not required by DH order to be extra thorough. The facility also does a comprehensive interview of	at index and ort in aid ort in aid ort in aid ort in aid ort orthogonal ortho		

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00191	B. WING		12/3	0/2015
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
EBENEZ	ER CARE CENTER		TLAND AVE OLIS, MN 5	NUE SOUTH 5404		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
22000	Continued From pa	ge 37	22000			
	hire date of 10/16/15. No reference checks were conducted or documented as done.			candidate as well as proper licens checks prior to employment.	ure	
	8/10/15. No referen	stant (NA), had a hire date of ace checks were conducted. had a hire date of 9/10/15. No were conducted or		The superivors for E-2, E-3 and E all educated of the expectation to reference checks prior to offering employment to any candidate. All hiring managers and human re	conduct	
	back without the reat 11:04 a.m. stated them, I'd like them produce things we	nanded the employee files ferences check on 12/30/15, d "It is best practice to do to be done more, but we can't have not done" when asked if ed reference checks for all the		personnel were educated of the expectation to conduct reference of prior to offering a job to any candid. The reference check requirement been added to the Human resource checklist.	date. has	
	staff prior to employ The facility's Abuse indicated: "Screening 1. All potential of background check. 2. In addition to employees will receiverification via the Sticensure/Registry 3. Ebenezer Cacontinue to employ history of documen misappropriation of direction to include	employees will receive a this, all licensed potential sive license status State Board of for that particular practice. are Center does not employ or		Human resource personnel file au be conducted by the director of huresources for 3 months or until on compliance is achieved. Audits wireported and reviewed at the facili meeting.	man going II be	
	nursing (DON) coul to ensure the abuse implemented as wr	of Correction: The director of d work with the administrator prohibiton policy was itten to meet Federal then could educate staff. The				

Minnesota Department of Health

STATE FORM 6899 KKF411 If continuation sheet 38 of 39

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00191	B. WING		12/3	0/2015
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
EBENEZ	ER CARE CENTER		OLIS, MN 5	NUE SOUTH 5404		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
22000	Continued From pa	ge 38	22000			
	DON or designee or ensure reports to the timeframes.	ould also perform audits to se SA occurred in the requried				
	Time Period for Cordays.	rrection: Twenty-one (21)				

Minnesota Department of Health

PRINTED: 01/26/2016 FORM APPROVED

(X6) DATE

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		00191	B. WING		12/3	0/2015
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
EBENEZ	ER CARE CENTER		RTLAND AVE POLIS, MN 5	NUE SOUTH 5404		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
3 000	INITIAL COMMENT	-S	3 000			
	****ATTENTIC	DN*****				
	BOARDING CAF LICENSING CORR					
	144A.10, this correct pursuant to a surve found that the defic herein are not corrected shall	Minnesota Statute, section ction order has been issued y. If, upon reinspection, it is iency or deficiencies cited ected, a fine for each violation be assessed in accordance ines promulgated by rule of artment of Health.				
	corrected requires of requirements of the number and MN Ru When a rule contain comply with any of lack of compliance. re-inspection with a result in the assess	nether a violation has been compliance with all rule provided at the tag alle number indicated below. In several items, failure to the items will be considered Lack of compliance upon my item of multi-part rule will ment of a fine even if the item uring the initial inspection was				
	that may result from orders provided tha the Department witl	hearing on any assessments non-compliance with these tawritten request is made to nin 15 days of receipt of a nt for non-compliance.				
	receipt of State lice the Minnesota Depa Informational Bullet http://www.health.si	participate in the electronic nsure orders consistent with				

Minnesota Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

01/25/16 **Electronically Signed**

TITLE

STATE FORM 6899 KKF411 If continuation sheet 1 of 25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00191	B. WING		12/3	30/2015
	PROVIDER OR SUPPLIER	2545 POF	DRESS, CITY, S RTLAND AVEI POLIS, MN 55			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
3 000	delineated on the at Department of Heat you electronically. Is necessary for State enter the word "context. You must then State licensure proceompletion date, the corrected prior to elements of the Minnesota Departments." On December 28, 2 surveyors of this Deabove provider and orders are issued. electronic plan of correviewed these ordethey will be completed they will be completed. Minnesota Departments of the State Licensing federal software. To assigned to Minnesota Departments of the State Licensing federal software. To assigned to Minnesota Departments of the State Licensing federal software. To assigned to Minnesota Departments of the State Licensing federal software. To assigned to Minnesota Departments of the State	ttached Minnesota Ith orders being submitted to Although no plan of correction ate Statutes/Rules, please rected" in the box available for indicate in the electronic cess, under the heading e date your orders will be lectronically submitting to the nent of Health. 2015 through 12/30/15, epartment's staff, visited the the following correction Please indicate in your correction that you have ers, and identify the date when ted. The Health is documenting Correction Orders using ag numbers have been sota state statutes/rules for umber appears in the far left or Prefix Tag." The state ompliance is listed in the ent of Deficiencies" column or Comply" portion of the nis column also includes the n violation of the state statute wing the surveyors findings Method of Correction and				
	FOURTH COLUMN					

Minnesota Department of Health

STATE FORM 6899 KKF411 If continuation sheet 2 of 25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		, ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00191	B. WING		12/3	30/2015
NAME OF I	PROVIDER OR SUPPLIER		, ,	STATE, ZIP CODE		
EBENEZ	ER CARE CENTER		TLAND AVE	NUE SOUTH 5404		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
3 000	Continued From pa	ge 2	3 000			
		RAL DEFICIENCIES ONLY. R ON EACH PAGE.				
	PLAN OF CORREC	QUIREMENT TO SUBMIT A CTION FOR VIOLATIONS OF E STATUTES/RULES.				
3 601	MN St. Statute 144 Prevention And Cor	.56 Subp. 2c Tuberculosis htrol	3 601			2/8/16
	maintain a compreh control program acc tuberculosis infectic issued by the Unite Control and Preven Division of Tuberculosis Elin CDC's Morbidity an Report (MMWR). T tuberculosis infectic that covers all paid and contractors, studen volunteers. The Department of assistance regardin of The guidelines.	nination, as published in d Mortality Weekly his program must include a on control plan unpaid employees, ts, residents, and Health shall provide technical ag implementation				
	(b) Written compliate be maintained by the care home.	nce with this subdivision must ne boarding				
	This MN Requireme	ent is not met as evidenced				

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STATE FORM 6899 KKF411 If continuation sheet 3 of 25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00191	B. WING		12/3	0/2015
-	PROVIDER OR SUPPLIER	2545 POR		STATE, ZIP CODE ENUE SOUTH 5404		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
3 601	by: Based on interview facility failed to doct tuberculosis (TB) sl for 5 of 5 residents reviewed for TB scr Findings include: R21 was admitted the R21's admission MR21's immunization given the first step read results was not TST was given on TST was given on R53's admission MR23's admission MR	and document review, the ument complete results of the kin test (TST) that was given (R21, R47, R107, R53, R100) reening. To the facility on 11/29/15, per inimum Data Set (MDS). The cord revealed R21 was TST on 11/30/15. The date of documented. The second 12/30/15 with results pending. To the facility on 10/10/15, per DS. R53's immunization 3 was given the first step TST resecond step TST on a did not have the date read did. To the facility on 10/14/15, per MDS immunization record given the first step TST on econd step TST on 10/20/15. ave the date read results To the facility on 11/5/15, per MDS. R107's immunization 07 was given the first step d the second step TST on a did not have the date read results	3 601	The facility has established and maintained a comprehensive tube infection control program according most current tuberculosis infection guidelines. Verified R53, R100, R107, R47 Thresults were 0 millimeters indurate through communication with test nurses. Proper documentation playersident's immunization record chall nurses were educated on the foreign protocol for TB reading by 1/22/16. Audits are in place with oversight director of nursing and will continumenths or until ongoing compliant achieved. Audits results will be reat the facility QAPI meeting.	B test ion read aced in harts. acility by the ue for 3 ce is	

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STATE FORM 6899 KKF411 If continuation sheet 4 of 25

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X3) A. BUILDING:			B) DATE SURVEY COMPLETED	
		00191	B. WING		12/3	0/2015	
NAME OF F	PROVIDER OR SUPPLIER			STATE, ZIP CODE			
EBENEZ	ER CARE CENTER		TLAND AVE OLIS, MN 5	NUE SOUTH 5404			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETE DATE	
3 601	The first step TST or results documented second step TST's of duration docume On 12/30/15, at 12: (ICN) confirmed the lacked complete infexpected when nurshould be entering of induration. The facility tubercul policy dated 8/15, does risk factors for tube TST unless otherwimay preclude the 2 another qualified he documentation of T within the last 3 more	second step TST on 8/9/15. did not have the date read d. In addition, both first and did not have millimeters (mm) nted. 48 p.m. infection control nurse e TST results for residents formation. ICN stated she ses read TB results they both negative results and mm osis screening - resident irected "upon admission: all sessed for symptoms of and rculosis and have a 2-step se indicated. Factors that -step TST are: admitted from ospital or nursing facility with ST administered at that facility	3 601				
31120	Subp. 3. Refrige other medications r kept in a specially ke	O Subp. 3 Medicine Cabinet; ations rated drugs. Biologicals and equiring refrigeration shall be ocked, securely attached, and container in a general use	31120			1/29/16	
	by:	ent is not met as evidenced on interview and document		Biologicals and other medications			

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Minnesota Department of Health						
	IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:	·	COMP	LETED
		00191	B. WING		12/2	0/2015
		00191			12/3	0/2013
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
EDENEZ	ED CADE CENTED	2545 POR	TLAND AVE	NUE SOUTH		
EDENEZ	ER CARE CENTER	MINNEAP	OLIS, MN 5	5404		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	ON	(X5)
PREFIX		MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOUL		COMPLETE
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROF	PRIATE	DATE
				22.18.21.6.1		
31120	Continued From pa	ge 5	31120			
	review facility failed	to ensure medications were		requiring refrigeration are to be ke	nt in a	
		r temperature for 13 residents		specially locked, securely attached		
		R123, R60, R69, R7, R132,		labeled, impervious container in a		
		04, R59, R54) who received		use refrigerator.	gonora	
	refrigerated insulin's			ger and in		
	· ·	,		New thermometers were ordered	and	
	Findings include:			placed in refrigerators 2-north and	3-north.	
	-			Maintenance director verified all		
	Second North:			refrigerators to be properly		
	During tour looking	at medication storage on the		functioning/operating order and		
	second north unit o	n 12/28/15, at 2:00 p.m.		maintaining proper temperatures.		
	licensed practical n	urse (LPN)-A verified the		12/28/15.		
		refrigerator was 52 degrees.				
		sted medications were stored		Nursing staff is required to check		
		nd the medications were to be		refrigerator temps daily. All nursing was		
	stored between 30			educated as to this requirement by	/	
		Pens (used to control blood		1/22/16.		
	sugar) total for R40			AH 11 11 11 11 11 11 11 11 11 11 11 11 11		
		ens (used to control blood		All medications from the refrigerat		
	sugar) total for R40			2-north and 3-north were removed		
		wikPen (used to control blood		destroyed and ordered for replace		
	sugar) for R101 and	prost (reducing intraocular		12/28/15. This protected all reside the floors including (R40, R95, R1		
		s with open-angle glaucoma)		R123, R60, R69, R7, R132, R23, I		
	solution 0.005% for			R38, R104, R59, R54)	17 4,	
	For the facility, the			1.00, 1.101, 1.00, 1.04)		
		za vaccine syringes -Fluzone		New refrigerators were ordered		
	High dose and,			specifically for medication and nar	cotic	
		dated open 11/25/15, verified		storage and will be placed on units		
	by registered nurse			these refrigerators are placed and		
	, 0	,		use, all narcotic medications are p		
	During interview on	12/28/15, at 2:15 p.m. dietary		locked and stored in an existing	. ,	
		e fridge is not working."		double-locked refrigerator.		
		degrees verified by dietary				
	manager using digi	tal probe.		Audits are being conducted with or		
				by the director of nursing and will of		
		0 p.m. RN-D verified there		for 3 months or until ongoing comp		
		aily temps. RN-D stated dietary		is achieved. Audit results will be re	eviewed	
		neck the temperature and it		at the facility QAPI meeting.		
	was not done.					

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-	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00191	B. WING		12/3	0/2015
NAME OF	PROVIDER OR SUPPLIER		, ,	STATE, ZIP CODE		
EBENEZ	ER CARE CENTER		TLAND AVE	NUE SOUTH 5404		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
31120	Continued From pa	ge 6	31120			
	third north unit on 1 verified the tempera degrees. RN-G star stored in the refrige were to be stored b -14 Lantus Solostar R74, -Three vials of Lant -One Novolog Flext -One vial of Novolo -11 Humalog KwikF -One prefilled Previous of R13 -Four-30 ml bottles	Pens total for R69, g for R38, Pen total for R7, and R23, enar (a pneumococcal				
	time the temperatu	5 p.m. RN-E verified the last re was checked was 12/26/15, e at that time was 46 degrees.				
	director of nurses (temperature in the warmer than 40 de log daily and notify was out of the rang checking the logs to	12/29/15 at 3:28 p.m. the DON) said, the said the refrigerator should be no grees. The housekeepers do a the nurses if the temperature es. "Nursing should be pensure the temperatures are ses] are to date multiuse vials				
	environmental serv housekeepers only refrigerators on Tue	•				
	Storage of Medicat	ions-Long Term Care reviewed				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
	00191		B. WING		12/30/2015	
NAME OF I	PROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, S	STATE, ZIP CODE	•	
FBENEZER CARE CENTER			TLAND AVE OLIS, MN 5	NUE SOUTH 5404		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROFIDENCY)	D BE	(X5) COMPLETE DATE
31120	12/2014 instructed "XI. Medications red" temperature betwee degrees Fahrenheit are kept in a refrige allow temperature requiring storage in unless otherwise di substances that red within a locked box box must be attacher refrigerator." TIME PERIOD FOR (14) days.		31120 31165			2/8/16
31100	Subp. 3. Record of such destruction medication, and pre recorded on the res Such destruction sh notation signed by the This MN Requirements. Based on observation review facility failed were properly destroiced were properly destroiced were properly destroiced. R24, R48) to prevent Findings include: Second Floor North On 12/29/15, at 9:1	ling of disposition. A notation giving date, quantity, name of escription number shall by sident's personal care record. In all be witnessed and the both persons. The property of the proper	31165	The facility will ensure that medica are properly disposed including provided witnesses and documentation. Fentanyl Patches: RN-H and LPN-B have been educt to the requirements of proper dest of Fentanyl patches and the requirements for double signatures for administration.	ated as ruction ement	2/8/16

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STATEME	NT OF DEFICIENCIES N OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ,	E CONSTRUCTION	(X3) DATE COMPI		
		00191	B. WING		12/3	12/30/2015	
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE			
EBENEZ	ZER CARE CENTER		TLAND AVE	NUE SOUTH 5404			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE	
31165	the tour inside the ropened box of Fentasked what the faci used patches RN-Fentanyl patches at them out in the comparcotic book only hand none for destruction. Administration Rece to December 2015 member signed for During review of R2 12/21/15 to 12/27/1 received the Fentar which only one nursidestruction. First Floor South: On 12/29/15, at 8:0 medication cart was R48's Fentanyl patch by two nurses where when a Fentanyl patch by two nurses where when a Fentanyl patch by two nurses where when a Fentanyl patch sign it out in thalf and put it in the MAR from Septemble indicated only one stremoval of Fentanyl narcotic book recordit was revealed R48 patch six times, each documented the decomposition of Fentanyl NAR from Septemble indicated only one stremoval of Fentanyl one stremoval of Fentanyl of Fen	parcotic box was observed an anyl patches for R27. When lity policy was for disposing I stated, they change the anight and one nurse signs apputer. RN-H verified the nad signatures for application action. Review of Medication ords (MAR) from September indicated only one staff removal of Fentanyl patch. 27's narcotic book record, from 5, it was revealed R27 had anyl patch three times, each of se had documented the secompleted. LPN-B verified the had not been double signed a removed. LPN-B stated atch was removed two people the narcotic book and fold it in a sharps container. Review of staff member signed for I patch. During review of R48's d, from 12/13/15 to 12/28/15, 8 had received the Fentanyl ch of which only one nurse had	31165	narcotics. All nursing staff were educated on destruction of Fentanyl patches are double signature requirements for of Fentanyl patches by 1/22/16. Audits are being conducted with oby the director of nursing for 3 mountil ongoing compliance is achieved Audits will be reported to the facility meeting.	versight nths or		

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_	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00191	B. WING		12/3	0/2015
NAME OF F	PROVIDER OR SUPPLIER		, ,	STATE, ZIP CODE		
EBENEZ	ER CARE CENTER		TLAND AVE OLIS, MN 5	NUE SOUTH 5404		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
31165	Continued From page 9		31165			
		B had received the Fentanyl each of which only one nurse the destruction				
	said, "Only one pers	12/29/15, at 10:16 a.m. RN-D son signs for removal of the they do it on the MAR."				
	director of nurses (I fold and cut the Fer sharps container. T removal and replac	12/29/15, at 3:28 p.m. the DON) said, the nurses are to ntanyl patch and put it in the they sign it in the MAR for ement. According to our policy atures, because it is a narcotic d."				
	reviewed October 2 When a Fentanyl paremoved/replaced to should be followed used patchF. Doo be signed by person along with witness of	ce Disposal-Long Term Care 2014, instructed staff: "III. atch needs to be the following procedures for proper destruction of the cumentation of disposal must in disposing of used patch, (licensed staff) on drug et or narcotic book."				
	TIME PERIOD FOR (21) days.	R CORRECTION: Twenty-one				
31240	MN Rule 4655.8520 Requirements;Sani		31240			2/8/16
	Dietary staff:					
		cedures and conditions shall e operation of the dietary nes.				

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Minnesota Department of He	alln				
STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
AND PLAN OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPI	-EIED
	00191	B. WING		12/3	0/2015
NAME OF PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
	2545 POR	TLAND AVE	NUE SOUTH		
EBENEZER CARE CENTER	MINNEAP	OLIS, MN 5	5404		
PREFIX (EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE
31240 Continued From pa	ge 10	31240			
This MN Requireme	ent is not met as evidenced				ı
by: Based on observation review, the facility fasanitary conditions direct contact with function, the facility restraints were work contacting exposed affect 122 of 122 recout of the kitchen. Findings include: During initial kitcher a.m. the dietary directors observed: - Hobart Stand up in bag. When the bag white hardened foor white/brown food debackside and on an mixer. Food would debris. The DD vericleaned, stating "it weekend." On 12/28/15, at 5:3 service the following and debris on and a and around the enticular and sides of the cardirector (ADD) verificatiff wipe it down be service evening me	on, interview and document ailed to ensure safe and for kitchen equipment that had ood preparation and storage. ity failed to ensure hair not effectively keep hair from food. This had the potential to esidents in the facility who ate on tour on 12/28/15, at 11:54 ector (DD) the following was enixer was covered with plastic was taken off, there was displatter and heavy buildup of ebris around the bottom arm, and around the underside of the come in contact with the field the mixer needed to be was probably used this		Sanitary procedures and condition maintained in the operation of the department at all times. All kitchen staff were educated by 12/29/15 regarding the requirement wear hair restraints and proper usthand sink. The dietary team has redeveloped implemented daily staff cleaning clists which includes cleaning of the mixer, cleaning of room tray carts (including the 2 South 6-foot close tray cart), cleaning of the red dish cleaning of the Robocoupe mixer, cleaning of soup kettle and covering soup kettles. The dietary supervisor has develog implemented a supervisory checkly which includes: hair restraint use, inspection of cleanliness for the Homixer, cleanliness of room tray can proper use of the hand sink, clean red dish racks, cleanliness of Robomixer, cleanliness of soup kettles proper covering of kettles. Audits are being conducted with or by the dietary manager with respektichen sanitation. Audits conducter resident spaces are overseen by the maintenance director. Audits will of for 3 months or until ongoing compis achieved. Audits will be reviewed QAPI meeting.	nts to e of the I and heck Hobart d room racks, ng of ped and ist obart rts, liness of occupe and versight ct to ed in he ontinue oliance	

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
			7.1. 20.22.1.10.1			
		00191	B. WING		12/3	0/2015
NAME OF	PROVIDER OR SUPPLIER		, ,	STATE, ZIP CODE		
EBENEZ	EBENEZER CARE CENTER 2545 POI			NUE SOUTH 5404		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
31240	after each meal." F with the debris. During followup kitc p.m. with the regist following was obse - On entering the di was observed to be employee hand sincutout/indentation a had a build up of for After three continuous this food debris was with a paper towel. clean and instructer racks. Clean dishes the leftover food dethe three cycles of the three cycles of the three was a su "was not being don months, the superviolent Review of Ebeneze cleaning and tasks 1/14/13 indicated to Coupe, mixer, soup to initial the assigned have been complete that cleaning had been complete whad been complete whad been complete what observed the complete with the complet	chen tour on 12/29/15, at 2:05 ered dietitian (RD) the rved: ishwashing area, a dish rack e sitting on the top of the k. Red dish racks with areas on the sides of racks bod debris in the cutout areas. Ous cycles of wash/rinse cycles is softened and easily removed RD verified the racks were not did the aides to remove all red is would have come in contact ebris that was present prior to washing. If on 12/28/15, at 4:40 p.m. DD pecific duties for each position pervisor checklist but cleaning e, probably not for the past six risor checkoff list is empty." If Care Center daily cooks is chedule with revision date of clean and sanitize Robo to kettle and cover if used and ed cleaning duties after they ed. There was no indication een completed. Ebenezer Care Center dietary it is an indication that cleaning tall as no indication that cleaning				

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Millineso	Minnesota Department of Health						
	IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED		
		00191	B. WING		12/3	0/2015	
NAME OF I		CTDEET ADI		STATE, ZIP CODE			
NAIVIE OF I	PROVIDER OR SUPPLIER						
EBENEZ	ER CARE CENTER			NUE SOUTH			
		MINNEAP	OLIS, MN 5	5404			
(X4) ID		TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL)		(X5) COMPLETE	
PREFIX TAG		/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO THE APPROP		DATE	
		,		DEFICIENCY)			
31240	Continued From page 12		31240				
31240	Continued From pa	ge 12	31240				
	(21) days.						
	() 9 -						
31455	MN Rule 4655.9000	0 Subp. 1 Housekeeping;	31455			2/8/16	
	General Requireme						
	•						
		eral 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 unassig	ned areas is prohibited.					
	This MN Requireme	ent is not met as evidenced					
	by:						
		ons, interview and document		The entire facility, including walls,	floors,		
	review, the facility fa	ailed to ensure a safe ,		ceilings, registers, fixtures, equipm	ent,		
	functional and sanit	ary environment for 2 of 2		and furnishings are maintained in	a clean,		
	residents (R11, R53	B) reviewed for environmental		sanitary, and orderly condition thro	ughout		
		on, the facility failed to ensure		and are kept free from offensive of	dors,		
		onditions for kitchen		dust, rubbish, and safety hazards.			
		direct contact with food					
		rage. This had the potential to		The holes in the sheetrock in R11's			
		esidents in the facility who ate		were patched and painted on 12/2			
	out of the kitchen.			The Blue Dysom and Blue Tape was removed on 12/28/15.	as		
	Findings include:			Tellioved off 12/26/15.			
	i maniga melade.			The foot grips identified were remo	oved on		
	On 12/30/15, at 11:	47 a.m. to 12:34 p.m. an		12/30/15.	7700 011		
	environment tour was conducted with the						
		ice director (ESD) and the		Environmental services staff were			
		ekeeping and laundry (SHK)		educated on identifying and report	ing		
		wing were reviewed.		non-cleanable surfaces on 12/31/1			
				housewide audit was conducted or			
		12/28/15, at 3:21 p.m. during		1/23/16 for identifying non-cleanab			
		the wall to the left of a grab		surfaces. All findings are entered i	n to the		
	bar on the left side	of the sink was observed with		CMMS (work-order) system to be			

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STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION) DATE SURVEY COMPLETED	
		00191	B. WING		12/30/2015		
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE	1 12/0	0/2013	
				NUE SOUTH			
EBENEZ	ER CARE CENTER	MINNEAP	OLIS, MN 5	5404			
(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 SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	LD BE COMPLETE		
31455	Continued From page 13		31455				
	due to installing new sanded down or fille bar next to the toile dysom secured with exposed the adhes soiled and was not On 12/30/15, at 11: the holes were from not been finished or had holes/groves in rough surface. ESD acknowledged was stated he would rep bar. At 12:37 p.m. voleaned the rooms housekeeping and cleaned daily. Both though the staff cle have been difficult to grab bar as it was toloth it was securing housekeeping and	aundry stated rooms were her and ESD stated even aned the rooms daily it would o see the peeling tape on the ne same color as the plastic g. The supervisor for aundry stated the facility did		completed no later than 2/8/16. An inspection for non-cleanable set has been added to the supervising housekeeper deep-cleaning inspeschedule. Any findings will be enterthe 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 son 12/31/15. An inspection of foot grips has been added to the supervising houseked deep cleaning inspection schedule. Audits are in place with oversight I Maintenance Director. Audits will of for 3 months or until ongoing complication is achieved. Audit results will be reat the facility QAPI meeting.	ction cred into as ce cor e surfaces en eper e) by the continue pliance		
	root 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.			The clean dish area including the sills was thoroughly cleaned on 12 The dirty dish area table was thorocleaned including the table, table I and floor. The table caulking was and the floor drain was replaced of 12/29/15. The soup kettle, piping, wall, flooriperimeter baseboards and walk in door handle were all thoroughly cleaned to 12/30/15. The dietary team has redeveloped	2/29/15. bughly egs, wall removed in ing, cooler eaned		

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STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00191	B. WING		12/3	0/2015
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
EBENEZ	ER CARE CENTER			NUE SOUTH		
			OLIS, MN 5		N	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE
31455	Continued From page 14		31455			
	On 12/30/15, at 3:3 did not have a specidentified and indicato report and a work his department to a On 12/28/15, at 11: kitchen tour with the following was obserthe clean dish are stainless steel table temperature one cosituated in a corner this clean dish area four foot windows will below them. Bot dirty and splattered a build up of food dithe corners of the windishwasher in the deight foot stainless where the table me four feet of this cautype substance. The of the table was he substance and food table legs and where there was a grimy, debris. The top of the below the dishwash the floor. DD verifies to be cleaned and the was mold and need replaced by mainter on 12/29/15, at 2:0	5 p.m. ESD stated the facility effic policy to the concerns ated the staff were supposed to order would be initiated for ddress. 54 a.m. during the initial edietary director (DD) the red: a contained an eight foot esituated to the left of the high empartment dishwasher of the kitchen. Directly above, there were two, three foot by with an eight inch wide window he the windows and sill were with food particles. There was ebris along the back of and in window sill. To the right of the irry dish area was another steel table with white caulking ets the wall. Approximately liking was black with a mold er wall behind the entire length avily splattered with a brown a particles. On and around all the the wall meets the floor brown/black buildup of food the floor drain was missing the ware water drained into the day are was dirty, needed the black caulking most likely led to be removed and mance. 5 p.m. during a second tour of		implemented a daily staff cleaning list. This includes cleaning of the careas, the soup kettle area, cooler handle and the perimeter baseboa around the legs of equipment. The dietary supervisor check list he developed and implemented to me compliance this includes the dish at the soup kettle area, cooler door hand the perimeter baseboards arolegs of equipment. Audits are being conducted with or by the dietary manager with respektichen sanitation. Audits conducter resident spaces are overseen by the maintenance director. Audits will confor 3 months or until ongoing compis achieved. Audits will be reviewed QAPI meeting.	as been onitor for areas, andle und the versight ct to ed in he ontinue oliance	
		5 p.m. during a second tour of wing was observed and				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		00191	B. WING		12/3	30/201 5
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
EBENEZ	ERENEZER CARE CENTER		RTLAND AVE POLIS, MN 5	NUE SOUTH 5404		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
31455	- Behind the soup of flooring had a heave substance. Behind the right of the walk approximate two in white molding strip brown, sticky substation stainless steel hand brown/black substation and the entire the baseboards and equipment there was black/brown grime. During an interview DD stated kitchen seach position and the but cleaning "was refor the past six more list is empty." During an interview cook and DD stated night and that main deep cleaning the frequipment. During an interview registered dietitian cleaning policy for the past six more list is empty."	kettle, the piping, wall and by black/brown greasy the same soup kettle and to a in cooler door an ch wide by three feet in long was heavily soiled with a rance. The walk in cooler door dle was heavily soiled with ance. perimeter of the kitchen along do n and around all legs of as a heavy buildup of and food debris. You on 12/28/2015, at 4:40 p.m. staff have specific duties for here is a supervisor checklist not being done, probably not on this, the supervisor check off You on 12/29/15, at 2:20 p.m. the did the floor are cleaned every stenance was in charge of floors and behind all You on 12/29/15, at 3:30 p.m. stated there was no deep the kitchen. You on 12/29/15, at 3:45 p.m. the did the floors were last deep ber and due to be cleaned in strator further stated, "I would did before this."	31455			

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE COMP	SURVEY LETED
		00191	B. WING		12/3	0/2015
NAME OF F	PROVIDER OR SUPPLIER			STATE, ZIP CODE	1 / U	
EBENEZ	ER CARE CENTER		TLAND AVE	NUE SOUTH		
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROIDEFICIENCY)	D BE	(X5) COMPLETE DATE
31455	Continued From pa	ge 16	31455			
	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.					
	daily cleaning & tas revised 2/14/15 incl tables on clean side floors swept and me cleaned on dirty sid wall, all racks off flo be cleaned and set	nezer Care Center dietary aide k schedule, positions 9-5" luded that all shelves and e be cleaned and sanitized, oped in dish room, walls e, both by tables and opposite for at all times and floor carts up for evening. There was no e cleaning tasks had been				
	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 FOF (21) days.	R CORRECTION: Twenty-one				
31830	MN Rule 144.651 S of HCF Bill of Right	Subd. 10 Patients & Residents s	31830			2/8/16
	Subd. 10. Parti notification of family	cipation in planning treatment; members.				
	the planning of their includes the opport	have the right to participate in r health care. This right unity to discuss treatment and dividual caregivers, the				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00191	B. WING		12/3	0/2015
	PROVIDER OR SUPPLIER	2545 POR		STATE, ZIP CODE NUE SOUTH 5404		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
31830	opportunity to reque care conferences, a family member or o both. In the event t present, a family me chosen by the reside conferences. (b) If a resident w unconscious or con communicate, the efforts as required to either a family mem writing by the reside an emergency that admitted to the facil family member to p planning, unless the to believe the reside directive to the cont specified in writing to member included in notifying a family m family member to p planning, the facility efforts, consistent w practice, to determi executed an advance Resident's health co of this paragraph, "In (1) examining the resident; (2) examining the resident in the poss (3) inquiring of ar family member con- whether the resider directive and wheth	ge 17 est and participate in formal and the right to include a ther chosen representative, or hat the resident cannot be ember or other representative ent may be included in such who enters a facility is natose or is unable to facility shall make reasonable under paragraph (c) to notify there or a person designated in ent as the person to contact in the resident has been lity. The facility shall allow the articipate in treatment efacility knows or has reason ent has an effective advance errary or knows the resident has that they do not want a family in treatment planning. After ember but prior to allowing a articipate in treatment which make reasonable with reasonable medical ne if the resident has ce directive relative to the are decisions. For purposes reasonable efforts" include: the personal effects of the ession of the facility; my emergency contact or tacted under this section at has executed an advance er the resident normally goes for the resident normally goes for	31830			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			7. BOILDING.			
		00191	B. WING		12/3	0/2015
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	ORESS, CITY, S	STATE, ZIP CODE		
EBENEZ	ER CARE CENTER		TLAND AVE OLIS, MN 5:	NUE SOUTH 5404		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
31830	(4) inquiring of the resident normally gowhether the resider directive. If a facilite designated emerge member to participal accordance with this liable to resident for the notification of the emergency contact family member was patient 's privacy ries (c) In making reast family member or designated the medical recompossession of the facility shall attest members or a designative examining the persuand the medical recompossession of the facility a family memergency contact admission, the facil social service agency that the residentifying and notification designated emerges service agency or least the facility is a facility subdivision is not liad damages on the grather family member.	e physician to whom the ces for care, if known, at has executed an advance y notifies a family member or ncy contact or allows a family ate in treatment planning in a paragraph, the facility is not redamages on the grounds that the family member or or the participation of the simproper or violated the ghts. Isonable efforts to notify a esignated emergency contact, ampt to identify family gnated emergency contact by conal effects of the resident cords of the resident in the acility. If the facility is unable ember or designated within 24 hours after the ity shall notify the county cy or local law enforcement ident has been admitted and a unable to notify a family ated emergency contact. The re agency and local law y shall assist the facility in ying a family member or ncy contact. A county social local law enforcement agency y in implementing this able to the resident for counds that the notification of or emergency contact or the family member was improper	31830			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
	00191	B. WING		12/3	0/2015
NAME OF PROVIDER OR SUPPLIER	R STREET AD	DRESS, CITY,	STATE, ZIP CODE		
EBENEZER CARE CENTER		TLAND AVE	ENUE SOUTH 55404		
PREFIX (EACH DEFICIENCE	FATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPERTION OF T	D BE	(X5) COMPLETE DATE
by: Based on intervier facility failed to en appointed guardia falls and medication notification of cha Findings include: On 12/28/15, at 3 interview when R3 was asked if R30 past several mont decline in her most staff with a transfe had been appoint summer and prior been admitted to Guardian indicate and disability thus notified of all med and any change in the change in con R30's diagnoses i retardation, cereb diplegia, non-mort presence of cereb from Admission R Review District Corprobate-Mental H guardianship date been assigned a gent of the control of the contr	nent is not met as evidenced w and document review, the sure 1 of 1 resident (R30) court in had been notified timely after ons changes reviewed for nge. 11 p.m. during a telephone 80's court appointed guardian a change in condition within the hs, guardian stated R30 had a bility and was dependent on er lift. Guardian indicated she ed as the guardian this last to her involvement R30 had the facility for rehabilitation. d R30 had a language barrier she was the person who was ications, treatments, accidents in condition. Guardian clarified dition was not acute. Included moderate mental ral palsy with spastic/ataxia bid obesity, epilepsy and prospinal fluid drainage obtained ecord dated 8/5/15. Durt Fourth Judicial District ealth Division letter for d 7/23/15, revealed R30 had	31830	The facility will properly notify family members after falls, medication of or changes of condition. The guardian of R30 has been upuall changes in medications and/or conditions. By 1/22/16 all licensed and register nurses have been educated of the requirement to immediately notify contacts/guardian of such change. Additional review of condition charm health updates and review of resperty contact information are conduring resident care conferences are resident and/or responsible party. Audits are being conducted to enscompliance and will continue for 3 or until ongoing compliance is ach. The director of nursing has oversign this audit process and audit results reported and reviewed at the facili meeting.	dated of ered eprimary s. enges, onsible lucted with eure months ieved. ght of s will be	

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	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00191	B. WING		12/30/2015	
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
FBENEZER CARE CENTER		TLAND AVE OLIS, MN 5	NUE SOUTH 5404			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETE DATE
31830	primary contact to be 8/2/15, R30 had be out of the door of he report had been indicated an urse to call." If following the falls la family or guardian he documentation of the change. -Physician Order documentation of the change. -On 11/13/15, R30's medications had be changed but there is guardian being notion treatments/medicated no 9/30/15, R30 he been found to have prescribed an oral ribut no documentation of the infection	be updated. In addition on en found crying and crawling er room and on the incident licated for contacting primary et to call family, left note for the Review of all progress notes cked documentation either the had been updated on the falls. In the following atted 12/11/15, R30's eation for acid reflux) had been liligrams (mg) but no he guardian being notified of a dietary supplement then discontinued and had and was no documentation of the fied of the changes in ions. In additional and was inse twice daily for 14 days on the guardian had been	31830			

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	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		00191	B. WING		12/3	30/2015	
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE	-		
EBENEZ	ER CARE CENTER		TLAND AVE	NUE SOUTH 5404			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE	
31830	and need for some The care plan indic R30's affairs and do was to consult with information and opt On 12/30/15, at 3:1 manager (RN)-F vehad been notified for thought the staff ha acknowledged there RN-F also verified forders either medic changed or decreas the guardian being "definitely we shoul on any changes wit condition." On 12/30/15, at 4:2 was called and did On 12/30/15, at 4:3 expected the guard notified of medication director of nursing some don't think so for mor started. It depends the staff were suppall the falls DON state MDS coordinate correction. Change Of Condition 12/2014, indicated the policy indicated would be notified or other the staff was to be noticed the policy indicated would be notified or the policy indicat	ge 21 one to make decisions for her. ated R30's guardian handled ecisions her behalf and staff guardian and provide ions for decisions as needed. O p.m. registered nurse erified the primary contact(s) or the falls. RN-F stated she d contacted R30's family but e was no documentation. R30 also some medications ations had been discontinued, sed and no documentation of notified. RN-F stated d notify the family or guardian h resident treatment and 4 p.m. the nurse practitioner not receive a call back. 4 p.m. when asked if she ian, POA or family to be on reductions or changes the stated "not for the reduction. I edications being discontinued ds what it's for." When asked if osed to notify the guardian of ated "yes." DON further stated or was working on a plan of on/Notification policy dated the family and/or responsible ified anytime there was a at's condition or plan of care. It family/responsible party in a timely manner, and if in called during the night time	31830				

Minnesota Department of Health

STATE FORM 6899 KKF411 If continuation sheet 22 of 25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		00191	B. WING		12/3	30/2015
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
EBENEZ	ER CARE CENTER		TLAND AVE OLIS, MN 5	NUE SOUTH 5404		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
31830	Continued From pa	ge 22	31830			
	hours, would be not	tified the next morning.				
	TIME PERIOD FOR (21) Days.	R CORRECTION: Twenty One				
32000	MN Rule 626.557 S Maltreatment of Vul		32000			2/8/16
	Subd. 14. Abuse	e prevention plans.				
	and personal care a shall establish and abuse prevention pl assessment of the penvironment, and it which may encoura statement of specifi minimize the risk of	s population identifying factors ge or permit abuse, and a ic measures to be taken to abuse. The plan shall comply rning the plan promulgated by				
	agency and personal providers, shall developer prevention plan for there or receiving sushall contain an independent the person's susception of the person's risk of adults; and (3) states measures to be taken abuse to that person for the purposes of "abuse" includes see					
		except home health agencies attendant services providers,				

Minnesota Department of Health										
STATEMENT OF DEFICIENCIES		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPL	EIEU				
		00191	B. WING		12/30	/2015				
NAME OF I	PROVIDER OR SUPPLIER	STREET AN	DRESS, CITY, STATE, ZIP CODE							
IVAIVIL OI I	TIOVIDEIT OIT SOLT EIEIT									
EBENEZER CARE CENTER 2545 PORTLAND AVENUE SOUTH MINNEAPOLIS, MN 55404										
	0111414171/074		-		- · ·					
(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 SHOUL CROSS-REFERENCED TO THE APPROF	JLD BE COMPLETE					
32000	Continued From page 23		32000							
	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 facility failed to com of 5 employees (E-remployment. This has 122 residents resid worked in multiple at Finding include: New employee persection of 10/16/1 conducted or docured or docured. The second of 10/15 is a nursing assis 8/10/15. No reference of 10/15 is a nursing assis 8/10/15.	and document review, the applete references checks for 3 2, E-3, E-4) prior to add the potential to affect 74 of ing at the facility as the staff areas of the facility. sonnel files were reviewed: ecreation staff (TR), had a 5. No reference checks were		The facility will ensure reference of are included as part of the hiring period to contribute to abuse prevention. The facility conducts background on all staff prior to employment. The facility also does an additional backeck which is not required by DH order to be extra thorough. The factores a comprehensive interview of candidate as well as proper licens checks prior to employment. The supervisors for E-2, E-3 and E all educated of the expectation to reference checks prior to offering employment to any candidate. All hiring managers and human re	checks ne kground S in cility f each ure					
	reference checks w documented.			personnel were educated of the expectation to conduct reference of						

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		00191	B. WING		12/3	0/2015					
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2545 PORTLAND AVENUE SOUTH MINNEAPOLIS, MN 55404											
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE					
32000	The administrator heack without the refat 11:04 a.m. stated them, I'd like them to produce things we have the facility complete staff prior to employ. The facility's Abuse indicated: "Screening 1. All potential estackground check. 2. In addition to employees will receive the State Board particular practice. 3. Ebenezer Cacontinue to employ documented patient misappropriation of direction to include information from preemployers.	randed the employee files ferences check on 12/30/15, do "It is best practice to do to be done more, but we can't have not done" when asked if ed reference checks for all the yment. Prevention Plan dated 2015, employees will receive a status verification of Licensure/Registry for that the care Center does not employ or anyone who has a history of	32000	prior to offering a job to any candi. The reference check requirement been added to the Human resource checklist. Human resource personnel file aube conducted by the director of huresources for 3 months or until on compliance is achieved. Audits wireported and reviewed at the facili meeting.	has ces udits will uman going Il be						