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

ID: KLV3
Facility ID: 00917

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245376**

2.STATE VENDOR OR MEDICAID NO.
(L2) **766119300**

3. NAME AND ADDRESS OF FACILITY
(L3) **ZUMBROTA CARE CENTER**
(L4) **433 MILL STREET**
(L5) **ZUMBROTA, MN** (L6) **55992**

4. TYPE OF ACTION: 7 (L8)

1. Initial
2. Recertification
3. Termination
4. CHOW
5. Validation
6. Complaint
7. On-Site Visit
9. Other
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9) **12/17/2003**

6. DATE OF SURVEY **11/04/2015** (L34)

8. ACCREDITATION STATUS: ___ (L10)

0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

12.Total Facility Beds **50** (L18)

13.Total Certified Beds **50** (L17)

10.THE FACILITY IS CERTIFIED AS:

X A. In Compliance With Program Requirements Compliance Based On:
____1. Acceptable POC

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

And/Or Approved Waivers Of The Following Requirements:

__ 2. Technical Personnel
__ 3. 24 Hour RN
__ 4. 7-Day RN (Rural SNF)
__ 5. Life Safety Code
__ 6. Scope of Services Limit
__ 7. Medical Director
__ 8. Patient Room Size
__ 9. Beds/Room

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	50			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Lisa Carey, HFE NE II 09/25/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 11/19/2015 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
12/01/1986
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30)

VOLUNTARY 00
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal

INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
00220
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
11/10/2015
(L33)

DETERMINATION APPROVAL

C&T REMARKS - CMS 1539 FORM **STATE AGENCY REMARKS**

CCN- 24 5376

On November 4, 2015 a Post Certification Revisit (PCR) was completed to verify the facility achieved substantial compliance with deficiencies issued pursuant to the standard survey completed September 17, 2015. We presumed based on the facility's plan of correction that the facility had corrected the deficiencies as of October 16, 2015. Based on our PCR we have determined the facility has corrected the deficiencies issued at the standard survey completed on September 17, 2015. The deficiency cited at K0072 have been determined compliant as a result of the FSES.

See attached Fire Safety Evaluation System (FSES) dated October 27, 2015 for the Life Safety Code results. Refer to the CMS-2567b for the results of the Health PCR.

Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 245376

November 17, 2015

Ms. Krista Siddiqui, Administrator
Zumbrota Care Center
433 Mill Street
Zumbrota, MN 55992

Dear Ms. Siddiqui:

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

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

Effective October 16, 2015 the above facility is certified for:

50 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all50 skilled nursing facility beds.

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

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

Please contact me if you have any questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing, Program Specialist
Licensing and Certification Program
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 Minnesotans

Electronically delivered
November 17, 2015

Ms. Krista Siddiqui, Administrator
Zumbrota Care Center
433 Mill Street
Zumbrota, MN 55992

RE: Project Number S5376024

Dear Ms. Siddiqui:

On October 5, 2015, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on September 17, 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 November 4, 2015, the Minnesota Department of Health completed a Post Certification Revisit (PCR) and on November 17, 2015 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 September 17, 2015. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of October 16, 2015. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on September 17, 2015, effective October 16, 2015 and therefore remedies outlined in our letter to you dated October 5, 2015, will not be imposed.

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

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

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

Department of Health and Human Services
Centers for Medicare & Medicaid Services

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

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

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245376	A. Building B. Wing	11/4/2015

Name of Facility	Street Address, City, State, Zip Code
ZUMBROTA CARE CENTER	433 MILL STREET ZUMBROTA, MN 55992

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

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix F0164 Reg. # 483.10(e), 483.75(l)(4) LSC	10/16/2015	ID Prefix F0253 Reg. # 483.15(h)(2) LSC	10/16/2015	ID Prefix F0278 Reg. # 483.20(g) - (j) LSC	10/16/2015
ID Prefix F0279 Reg. # 483.20(d), 483.20(k)(1) LSC	10/16/2015	ID Prefix F0280 Reg. # 483.20(d)(3), 483.10(k)(2) LSC	10/16/2015	ID Prefix F0282 Reg. # 483.20(k)(3)(ii) LSC	10/16/2015
ID Prefix F0309 Reg. # 483.25 LSC	10/16/2015	ID Prefix F0312 Reg. # 483.25(a)(3) LSC	10/16/2015	ID Prefix F0314 Reg. # 483.25(c) LSC	10/16/2015
ID Prefix F0319 Reg. # 483.25(f)(1) LSC	10/16/2015	ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	GPN/kfd	11/17/2015		11/4/2015
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on: 9/17/2015

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

Department of Health and Human Services
Centers for Medicare & Medicaid Services

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

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

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245376	A. Building 01 - MAIN BUILDING 01 B. Wing	11/17/2015

Name of Facility	Street Address, City, State, Zip Code
ZUMBROTA CARE CENTER	433 MILL STREET ZUMBROTA, MN 55992

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

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix Reg. # NFPA 101 LSC K0025	10/16/2015	ID Prefix Reg. # NFPA 101 LSC K0072	10/16/2015	ID Prefix Reg. # NFPA 101 LSC K0144	10/16/2015
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	TL/kfd	11/17/2015	12424	11/17/2015

Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
9/18/2015			

Department of Health and Human Services
Centers for Medicare & Medicaid Services

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

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

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction A. Building B. Wing	(Y3) Date of Revisit
245376	02 - 2014 ADDTION	11/17/2015

Name of Facility	Street Address, City, State, Zip Code
ZUMBROTA CARE CENTER	433 MILL STREET ZUMBROTA, MN 55992

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

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix Reg. # NFPA 101 LSC K0062	10/16/2015	ID Prefix Reg. # NFPA 101 LSC K0144	10/16/2015	ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	TL/kfd	11/17/2015	12424	11/17/2015
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? YES NO
9/18/2015	

Whitney, Marian (DPS)

From: Linhoff, Tom (DPS)
Sent: Friday, November 13, 2015 12:28 PM
To: rochi_lsc@cms.hhs.gov; Dehler, Robert (MDH); Dietrich, Shellae (MDH); Henderson, Mary (MDH); Fiske-Downing, Kamala (MDH); Johnston, Kate (MDH); Leach, Colleen (MDH); Meath, Mark (MDH); Whitney, Marian (DPS)
Cc: ksiddiqui@zhs.sfhs.org
Subject: Zumbrota Care Center (245376) 2015 FSES for K72 Previously Approved - No Changes

This is to inform you that I am accepting the FSES report that was conducted on 10/27/2015 for Zumbrota care center regarding K-072.
The exit date of the survey was 9/18/2015.

Tom Linhoff
Fire Safety Supervisor

MN State Fire Marshal Division
445 Minnesota Street, Suite 145
St. Paul, MN 55101-5145
Phone: 651.430.3012
Fax: 651.430.3012
Cell: 651-769-7778
Email: Tom.Linhoff@state.mn.us
Web: www.fire.state.mn.us

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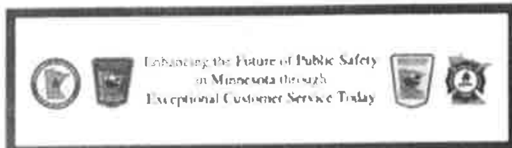

REPORT OF CONSULTANT FSES FINDINGS

Zumbrota Care Center
433 Mill Street
Zumbrota, MN 55992

Provider No. 245376

Date of Survey: October 27, 2015

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

Fire Safety Resources, LLC
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E-mail: RImholteFiresafe@aol.com

October 30, 2015

Ms. Krista Siddiqui
Administrator
Zumbrota Care Center
433 Mill Street
Zumbrota, Minnesota 55992

RE: FSES at Zumbrota Care Center

Dear Ms. Siddiqui:

Enclosed please find the survey information relating to the fire safety evaluation of Zumbrota Care Center, 433 Mill Street in Zumbrota, MN conducted on 10/27/2015. This evaluation was conducted in accordance with the Fire Safety Evaluation System (FSES) specified in Chapter 4 of NFPA 101A(01), *Guide to Alternative Approaches to Life Safety*.

As you're aware, the FSES is a rating system designed to evaluate the level of fire/life safety in health care facilities and serves as a method to demonstrate alternative compliance with the 2000 edition of the *Life Safety Code*® (NFPA 101). An FSES was made necessary in this case because of a corridor obstruction (K072) deficiency cited during a state fire/life safety recertification survey conducted on 09/18/2015.

A review of the Statement of Deficiencies from the 09/18/2015 fire/life safety recertification survey revealed that Zumbrota Care Center was surveyed as two buildings: Building 01 – Main Building, consisting of the 1964 original building and 1968 addition, and Building 02, the 2014 resident wing addition known as Mill River. Because Building 01 (Main Building) and Building 02 (2014 Addition) are not separated from each other by a minimum 2-hour-rated fire barrier wall, this evaluation covers both buildings.

The following factors served as the basis for this evaluation:

- Because the original building and addition were constructed prior to 03/11/2003, Building 01 (Main Building) was considered an existing building.
- Because it was constructed after 03/11/2003, Building 02 (2014 Addition) was considered a new building.
- Building 01 (Main Building) is one story in height and has a partial basement. For purposes of this FSES, the two occupied building levels were divided into four (4) separate smoke zones.
- Building 02 (2014 Addition) is two (2) stories in height and has no basement. For purposes of this FSES, each level was treated as a separate smoke zone. Because the building is on a sloping grade, both the upper and lower levels of the building have direct access to the exterior at grade level. In accordance with NFPA 101A(01), Sec. 4.5.3.2, therefore, each level was scored as a first floor zone for purposes of this FSES.

Based on conditions found between 0825 hours and 1520 hours on 10/27/2015, calculations show that Zumbrota Care Center does **not** pass the FSES.

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

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

Based on conditions found during the 10/27/2015 on-site visit to the facility, calculations show:

1. A negative score in the category People Movement Safety in one (1) of the four (4) zones evaluated in Building 01 (Main Building). This occurred because the door opening installed in the smoke barrier wall separating the West Wing from the main level lobby area as part of the remodeling of the facility administrator's office was not equipped with self-closing or automatic-closing hardware as required by NFPA 101(00), Sections 18.3.7.6 and 19.3.7.6. As a result, the score for Parameter 9, *Smoke Control*, in Table 4 of the FSES worksheets for Zone 4 (Main Level West Wing) was assigned a score of -5, "No Control".
2. A negative score in the category General Safety in one (1) of the two (2) zones evaluated in Building 02 (2014 Addition). This occurred because it was reported that the nurse station in Zone 2 (Upper Level) is not staffed on a 24-hour basis. As a result, the score for Parameter 4, *Ratio of Patients to Attendants (T)*, in Table 1 of the FSES worksheets for Zone 2 (Upper Level) was assigned a score of 4.0, "One or More over None".

Again, because of the negative score assigned to Parameter 9 in Table 4 of the Worksheets for Building 01 (Main Building) Zone 4 and the score assigned to Parameter 4 in Table 1 of the FSES worksheets for Building 02 (2014 Addition) Zone 2, Zumbrota Care Center has currently **not** achieved a passing FSES score. It must be noted, however, that a score of zero (0) or better **can** be achieved in all six (6) zones evaluated and in all four (4) of the categories in Table 7 of the FSES worksheets provided that, at a minimum, the following corrections are made:

1. If the newly installed door opening in the Main Level West Wing smoke barrier wall were arranged to be self-closing or automatic-closing on detection of smoke as required by NFPA 101(00), Sections 18.3.7.6, 19.3.7.6, 18.2.2.2.6 and 19.2.2.2.6, the score for Parameter 9 in Table 4 of the Worksheets for Building 01 (Main Building) Zone 4 would change from -5 to 0.
2. If the nurse station on the Upper Level of Mill River were staffed on a 24-hour basis, the score for Parameter 4 in Table 1 of the FSES worksheets for Building 02 (2014 Addition) Zone 2 would change from 4.0 to 1.5.

As shown in the Table of Alternates attached to the FSES worksheets for Building 01 (Main Building) Zone 4 and Building 02 (2014 Addition) Zone 2, these scoring changes will result in Zumbrota Care Center achieving a passing score of zero (0) or better in all four categories in Table 7 of the FSES worksheets for both buildings.

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

Wishing you a safe day!

Robert L. Imholte
President
Fire Safety Resources, LLC

Enclosures

RLI/rli

Report of Consultant FSES Findings

Zumbrota Care Center
433 Mill Street
Zumbrota, MN 55992

Provider No. 245376

Building 01 – Main Building

Date of Survey: October 27, 2015

Form Approved
OMB Exempt

ZONE 1 OF 4 ZONES

FIRE/SMOKE ZONE* EVALUATION WORKSHEET FOR HEALTH CARE FACILITIES

2000 LIFE SAFETY CODE

FACILITY: Zumbrota Care Center | BUILDING: 01 - Main Building

ZONE(S) EVALUATED: Basement

PROVIDER/VENDOR NO.: 245376 | DATE OF SURVEY: 10/27/2015

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

Step 1: Determine Occupancy Risk Parameter Factors - Use Table 1.

A. For each Risk Parameter in Table 1, select and circle the appropriate risk factor value. Choose only one for each of the five Risk Parameters.

TABLE 1. OCCUPANCY RISK PARAMETER FACTORS

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

Step 2: Compute Occupancy Risk Factor (F) - Use Table 2.

A. Transfer the circled risk factor values from Table 1 to the corresponding blocks in Table 2.

B. Compute F by multiplying the risk factor values as indicated in Table 2.

TABLE 2. OCCUPANCY RISK FACTOR CALCULATION

OCCUPANCY RISK M [ ] x D [ ] x L [ ] x T [ ] 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)

1.0 X F [ ] = R [ ]

TABLE 3B. (EXISTING BUILDINGS)

0.6 X F [1.6] = R [1]

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

SURVEYOR SIGNATURE	TITLE	DATE
[signature] Fire Safety Resources, LLC	President	10/30/2015
FIRE AUTHORITY SIGNATURE	**TITLE**	**DATE**
[signature] State Fire Marshal Division	Fire Safety Supervisor	11-13-2015

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

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

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

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

TABLE 5. INDIVIDUAL SAFETY EVALUATIONS

Safety Parameters	Containment Safety (S_1)	Extinguishment Safety (S_2)	People Movement Safety (S_3)	General Safety (S_4)
1. Construction	-2	-2		-2
2. Interior Finish (Corr. and Exit)	3		3	3
3. Interior Finish (Rooms)	3			3
4. Corridor Partitions/Walls	0			0
5. Doors to Corridor	1		1	1
6. Zone Dimensions			1	1
7. Vertical Openings	0		0	0
8. Hazardous Areas	0	0		0
9. Smoke Control			0	0
10. Emergency Movement Routes			0	0
11. Manual Fire Alarm		2		2
12. Smoke Detection and Alarm		3	3	3
13. Automatic Sprinklers	10	10	10 ÷ 2 = 5	10
Total Value	S_1= 15	S_2= 13	S_3= 13	S_4= 21

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

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

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

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

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ZONE 2 OF 4 ZONES

FIRE/SMOKE ZONE* EVALUATION WORKSHEET FOR HEALTH CARE FACILITIES

2000 LIFE SAFETY CODE

FACILITY: Zumbrota Care Center
BUILDING: 01-Main Building
ZONE(S) EVALUATED: Main Level North Wing & Lobby Area
PROVIDER/VENDOR NO.: 245376
DATE OF SURVEY: 10/27/2015

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

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

TABLE 1. OCCUPANCY RISK PARAMETER FACTORS

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

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 [1.5] X L [1.1] X T [1.5] X A [1.2] = F [9.5]

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 F [ ] = R [ ]	0.6 X F [9.5] = R [5.7] ≈ 6

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

SURVEYOR SIGNATURE	TITLE	DATE
[signature] Fire Safety Resources, LLC	President	10/30/2015

FIRE AUTHORITY SIGNATURE	TITLE	DATE
[signature] State Fire Marshal Division	Fire Safety Supervisor	11-13-2015

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

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

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

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

TABLE 5. INDIVIDUAL SAFETY EVALUATIONS

Safety Parameters	Containment Safety (S_1)	Extinguishment Safety (S_2)	People Movement Safety (S_3)	General Safety (S_4)
1. Construction	0	0		0
2. Interior Finish (Corr. and Exit)	0		0	0
3. Interior Finish (Rooms)	3			3
4. Corridor Partitions/Walls	0			0
5. Doors to Corridor	1		1	1
6. Zone Dimensions			0	0
7. Vertical Openings	0		0	0
8. Hazardous Areas	0	0		0
9. Smoke Control			0	0
10. Emergency Movement Routes			-2	-2
11. Manual Fire Alarm		2		2
12. Smoke Detection and Alarm		3	3	3
13. Automatic Sprinklers	10	10	10 ÷ 2 = 5	10
Total Value	S_1= 14	S_2= 15	S_3= 7	S_4= 17

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

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

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

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

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ZONE 3 OF 4 ZONES

FIRE/SMOKE ZONE* EVALUATION WORKSHEET FOR HEALTH CARE FACILITIES

2000 LIFE SAFETY CODE

FACILITY Zumbrota Care Center	BUILDING 01-Main Building
ZONE(S) EVALUATED Main Level South Wing Dayroom	
PROVIDER/VENDOR NO. 245376	DATE OF SURVEY 10/27/2015

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

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

TABLE 1. OCCUPANCY RISK PARAMETER FACTORS

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

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 [1.5] X L [1.1] X T [1.5] X A [1.2] = F [9.5]

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 F [ ] = R [ ]	0.6 X F [9.5] = R [5.7] = 6

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

SURVEYOR SIGNATURE	TITLE	DATE
[signature] Fire Safety Resources, LLC	President	10/30/2015
FIRE AUTHORITY SIGNATURE	TITLE	DATE
[signature] State Fire Marshal Division	Fire Safety Supervisor	11-13-2015

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

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

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

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

TABLE 5. INDIVIDUAL SAFETY EVALUATIONS

Safety Parameters	Containment Safety (S_1)	Extinguishment Safety (S_2)	People Movement Safety (S_3)	General Safety (S_4)
1. Construction	0	0		0
2. Interior Finish (Corr. and Exit)	3		3	3
3. Interior Finish (Rooms)	3			3
4. Corridor Partitions/Walls	0			0
5. Doors to Corridor	1		1	1
6. Zone Dimensions			1	1
7. Vertical Openings	0		0	0
8. Hazardous Areas	0	0		0
9. Smoke Control			0	0
10. Emergency Movement Routes			-2	-2
11. Manual Fire Alarm		2		2
12. Smoke Detection and Alarm		3	3	3
13. Automatic Sprinklers	10	10	10 ÷ 2 = 5	10
Total Value	S_1= 17	S_2= 15	S_3= 11	S_4= 21

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

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

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

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

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ZONE 4 OF 4 ZONES

FIRE/SMOKE ZONE* EVALUATION WORKSHEET FOR HEALTH CARE FACILITIES

2000 LIFE SAFETY CODE

FACILITY	BUILDING
Zumbrota Care Center	01-Main Building
ZONE(S) EVALUATED: Main Level West Wing	
PROVIDER/VENDOR NO. 245376	DATE OF SURVEY 10/27/2015

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

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

TABLE 1. OCCUPANCY RISK PARAMETER FACTORS

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

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

TABLE 2. OCCUPANCY RISK FACTOR CALCULATION

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

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

TABLE 3A. (NEW BUILDINGS)	TABLE 3B. (EXISTING BUILDINGS)
1.0 X F [ ] = R [ ]	0.6 X F [7.6] = R [4.6] = 5

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

SURVEYOR SIGNATURE	TITLE	DATE
[signature] Fire Safety Resources, LLC	President	10/30/2015
FIRE AUTHORITY SIGNATURE	TITLE	DATE
[signature] State Fire Marshal Division	Fire Safety Supervisor	11-13-2015

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

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

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

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

TABLE 5. INDIVIDUAL SAFETY EVALUATIONS

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

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

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

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

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

Table 5 Alternate Facility ZUMBROTA CARE CENTER - BLDG 01 - #245376 Zone # 4 Date: 10/27/2015

Safety Parameters	As Is				Alt. 1				Alt. 2				Alt. 3			
	Containment (S_1)	Extinguishment (S_2)	People Movement (S_3)	General Safety (S_G)	Containment (S_1)	Extinguishment (S_2)	People Movement (S_3)	General Safety (S_G)	Containment (S_1)	Extinguishment (S_2)	People Movement (S_3)	General Safety (S_G)	Containment (S_1)	Extinguishment (S_2)	People Movement (S_3)	General Safety (S_G)
1. Construction	0	0		0	0	0		0								
2. Interior Finish (Corr.& Exit)	0		0	0	0		0	0								
3. Interior Finish (Rooms)	3			3	3			3								
4. Corridor Partitions/Walls	0			0	0			0								
5. Doors to Corridor	1		1	1	1		1	1								
6. Zone Dimensions			0	0			0	0								
7. Vertical Openings	0		0	0	0		0	0								
8. Hazardous Areas	0	0		0	0	0		0								
9. Smoke Control			-5	-5			0	0								
10. Emergency Movement Routes			-2	-2			-2	-2								
11. Manual Fire Alarm		2		2		2		2								
12. Smoke Detection & Alarm		0	0	0		0	0	0								
13. Automatic Sprinklers	10	10	5 ½	10	10	10	5 ½	10			½				½	
A. Total Value	14	12	-1	9	14	12	4	14								
B. Mandatory Values	5	4	1	5	5	4	1	5								
C. Difference Between A & B	9	8	-2	4	9	8	3	9								
D. If C is 0 or more, check box	√	√		√	√	√	√	√								

FIRE SAFETY EVALUATION

BUILDING 01 – MAIN BUILDING

Name of Facility: Zumbrota Care Center
Address: 433 Mill Street, Zumbrota, MN 55992
Phone: 507-732-8400
Licensed capacity: 50
Census at time of survey: 47

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 0825 hours and 1520 hours on 10/27/2015. 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, Zumbrota Care Center Building 01 (Main Building) has not achieved a passing score on the FSES.

In addition to observations made and documentation review conducted during the 10/27/2015 on-site visit, the findings outlined herein are based on:

- o Information provided by Mr. Ray Goranson, Director of Environmental Services; and
- o A review of the Statement of Deficiencies (Form CMS-2567) from a fire/life safety recertification survey conducted on 09/18/2015.

Initial Comments:
A review of the Statement of Deficiencies from the 09/18/2015 fire/life safety recertification survey revealed that Zumbrota Care Center was surveyed as two buildings: Building 01 – Main Building, consisting of the 1964 original building and 1968 addition, and Building 02, the 2014 resident wing addition known as Mill River.

Building 01 (Main Building) was originally constructed in 1964 as a single story building with a partial basement. In 1968 a one-story addition with no basement was added to the west of the original building. The original building and 1968 addition were determined to be constructed of masonry exterior bearing walls and a steel roof deck supported by steel bar joists. The roof/ceiling assembly is protected by a suspended-grid acoustical tile ceiling. Because no documentation was available certifying that the acoustical tile ceiling assembly carries a fire resistance rating of one hour or better, the building was assigned a Type II(000) construction type in accordance with NFPA 220(99), Sec. 3-2 and Table 3-1.

At the northeast end of Building 01 (Main Building), the nursing home is connected to a senior assisted living facility called Bridges of Zumbrota. Because Bridges of Zumbrota is not used for purposes of housing, treatment or customary access by the facility's residents and because it is separated from the nursing home by a 2-hour-rated fire barrier, this building was not included in this evaluation.

Because Building 01 (Main Building) was constructed prior to 03/11/03, it is considered an existing building for federal certification purposes and was, therefore, treated as such for assigning values on the FSES worksheets.

Building 01 (Main Building) has an addressable manual fire alarm system, which is monitored for automatic fire department notification. In addition, automatic smoke detectors are provided for door release service at the smoke barrier doors and other doors allowed to be held open in accordance with NFPA 101(00), Sections 19.2.2.2.6 and 7.2.1.8.2. Based on documentation review, the fire alarm system and smoke detectors are being inspected, tested and maintained in accordance with NFPA 72.

The facility is protected throughout by a supervised, wet-pipe automatic fire sprinkler system. Zones 1, 2 and 3 are protected with quick-response sprinklers. Based on documentation review, the system is being inspected, tested and maintained in accordance with NFPA 25.

Based on review of the facility's Life Safety drawings and interview with the Director of Environmental Services, the smoke compartments for the main level of Building 01 (Main Building) have been modified with the construction of Building 02 (2014 addition). This has resulted in a reduction from four (4) smoke compartments to three (3) as follows:

- The west smoke compartment has remained unchanged.
- The north smoke compartment has been expanded and now consists of the North Wing and main level lobby area. For purposes of this FSES, therefore, the cross-corridor doors into the North Wing were treated as control doors only.
- The south smoke compartment is now included with the smoke compartment containing Building 02 (2014 addition). For purposes of this FSES, therefore, the South Wing, with the exception of the South Wing dayroom space, was surveyed as part of Building 02 (2014 addition). A review of the facility's Life Safety drawings revealed the newly created compartment to be 20,891 ft^2 in size and observations revealed that it meets the requirements of NFPA 101(00), Sec. 18.3.7.
- The South Wing dayroom space is now designated as a separate smoke compartment.

For purposes of this FSES, the two building levels in Building 01 (Main Building) were divided into four (4) separate smoke zones as follows:

Zone 1 – Basement
Zone 2 – Main Level North Wing and Lobby Area
Zone 3 – Main Level South Wing Dayroom
Zone 4 – Main Level West Wing

This report is intended to serve as an explanation of the scores entered on Tables 1, 4 and 8 of the FSES worksheets (i.e. Forms CMS-2786T) for Building 01 (Main Building) as it was found on 10/27/2015. The score assigned to each item is noted in brackets ([ ]). It must be noted that numbers were rounded to the nearest tenth of a point and that measurements of over one-half inch were rounded to the nearest inch. To ensure that the FSES addresses the "worst-case scenario", the product of the multiplication in Table 3B (i.e. value of "R") was rounded up to the nearest whole number. Code references are provided where appropriate. Codes referenced include the 2001 edition of NFPA 101A and the 2000 edition of the *Life Safety Code*® (NFPA 101).

With the exception of Table 8, which applies to all zones, this narrative will address each of the four (4) zones in Building 01 (Main Building) separately.

<u>All Zones – TABLE 8. FACILITY FIRE SAFETY REQUIREMENTS WORKSHEET</u>

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. Because Building 01 (Main Building) is an existing facility and does not meet the definition of a high rise, Items B and L were checked 'Not Applicable'.

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

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

  Surveyor Note: A review of the Statement of Deficiencies from the 09/18/2015 fire/life safety recertification survey revealed that the facility was cited because a review of the monthly generator logs revealed that the monthly generator run tests did not meet the requirements of NFPA 110(99), Sec. 6-4.2 (see data tag K144). Staff interview and documentation review conducted during this FSES survey revealed that, as allowed by NFPA 110(99), Sec. 6-4.2.2, Ziegler Power Systems conducted a 2-hour load bank test of the diesel-operated emergency generator on 09/28/2015.
- No incinerator or space heaters were found.
- The facility's evacuation plan and fire drill records was reviewed and appeared to be in order.
- The facility's smoking regulations were reviewed and appeared to be in order. Zumbrota Care Center is a smoke-free facility.
- Documentation review showed all draperies, cubicle curtains, upholstered furniture, mattresses and decorations to be in accordance with NFPA 101(00), Sec. 19.7.5.
- Documentation was provided certifying that the plantscapes (e.g faux trees) installed in the facility's public spaces are either flame resistant when tested in accordance with NFPA 701 and/or carry a Class A (25 or less) flame spread rating.
- Portable fire extinguishers, EXIT signage and emergency lighting appeared to be provided in accordance with applicable requirements.

Zone 1 – Basement Level:

TABLE 1. OCCUPANY RISK PARAMETER FACTORS

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

TABLE 4. SAFETY PARAMETERS and SAFETY PARAMETER VALUES

1. Construction [Score: -2]:
   The building was assigned a Type II(000) construction type.
2. Interior Finish (Corridors and Exits) [Score: +3]:
   Walls in corridors and exits were determined to be of masonry and plaster. Documentation was provided certifying that the acoustical ceiling tile carries a Class A (25 or less) flame spread rating.
3. Interior Finish (Rooms) [Score: +3]:
   While most walls in rooms were determined to be of masonry and gypsum wallboard, wood paneling was found on some walls. Documentation was provided certifying that:
   - The wood paneling was treated with Flame Control Fire Retardant Coating 40-40A to achieve a Class A (25 or less) flame spread rating, and
   - The acoustical ceiling tile carries a Class A (25 or less) flame spread rating.

4. Corridor Partitions/Walls [Score: 0]:
   Corridor walls were determined to be constructed of glazed masonry block and plaster, but terminate at the acoustical tile ceiling. For this reason, NFPA 101A(01), Sec. 4.6.4.2 requires that they be graded as "<½ hour".
5. Doors to Corridor [Score: +1]:
   Corridor doors in this zone were found to be of 1¾-inch-thick solid wood construction mounted in metal frames.
6. Zone Dimensions [Score: +1]:
   This zone measures approximately 94 feet in length and has no dead ends.
7. Vertical Openings [Score: 0]:
   This score was assigned per Footnote *e* to this Table – Parameter 1 is based on a Type II(000) construction type. Vertical openings were found to be enclosed with construction providing a minimum 1-hour fire resistance.
8. Hazardous Areas [Score: 0]:
   No hazardous area deficiencies were found in this zone.
9. Smoke Control [Score: 0]:
   A smoke barrier serves this zone.
10. Emergency Movement Routes [Score: 0]:
    There are two remote exits from this zone.
11. Manual Fire Alarm [Score: +2]:
    Manual fire alarm pull stations are provided in accordance with NFPA 101(00), Sec. 19.3.4.2. The fire alarm system is monitored by USA Central Station Alarm Corporation.
12. Smoke Detection and Alarm [Score: +3]:
    This score was assigned per instruction in Footnote *g* to this Table. The zone is protected with quick-response sprinklers.
13. Automatic Sprinklers [Score: +10]:
    The entire facility is protected by a supervised, wet-pipe automatic fire sprinkler system.

Zone 2 – Main Level North Wing and Lobby Area:

TABLE 1. OCCUPANY RISK PARAMETER FACTORS

1. Resident Mobility (*M*) [Value assigned = 3.2]: It was reported that some residents in this zone may need assistance with evacuation.
2. Patient Density (*D*) [Value assigned = 1.5]: There is bed capacity for up to nine (9) residents in the North Wing. The zone also contains the facility's main lobby. It was reported that there are a maximum of 15 residents in the lobby area at any one time.
3. Zone Location (*L*) [Value assigned = 1.1]: This zone is less than one-half floor height above grade.
4. Ratio of Patients to Attendants (*T*) [Value assigned = 1.5]: This score was assigned to ensure that the FSES addresses the "worst-case scenario". It was reported that there are three (3) staff persons on duty on the night shift, but one staff person makes rounds in the Mill River addition 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: 0]:
   The building was assigned a Type II(000) construction type.

2. Interior Finish (Corridors and Exits) [Score: 0]:
   Walls in corridors and exits were determined to be of masonry and plaster. Documentation was provided certifying that:
   - Most wall and ceiling finishes [i.e. aesthetics ("home front facades")] in the North Wing carry a Class A (25 or less) flame spread rating, while some of the wood finishes were treated with Flame Control Fire Retardant Coating to achieve a Class B (26 - 75) flame spread rating, and
   - The acoustical ceiling tile carries a Class A (25 or less) flame spread rating.
3. Interior Finish (Rooms) [Score: +3]:
   Walls in rooms were determined to be of masonry, plaster and gypsum wallboard. Documentation was provided certifying that the acoustical ceiling tile carries a Class A (25 or less) flame spread rating.
4. Corridor Partitions/Walls [Score: 0]:
   Corridor walls were determined to be constructed of glazed block and plaster, but terminate at the acoustical tile ceiling. For this reason, NFPA 101A(01), Sec. 4.6.4.2 requires that they be graded as "<½ hour".
5. Doors to Corridor [Score: +1]:
   Corridor doors in this zone were found to be of 1¾-inch-thick solid wood construction.
6. Zone Dimensions [Score: 0]:
   This zone measures approximately 110 feet in length and has no dead ends.
7. Vertical Openings [Score: 0]:
   This score was assigned per Footnote *e* to this Table – Parameter 1 is based on a first floor zone. Vertical openings were found to be enclosed with construction providing a minimum 1-hour fire resistance.
8. Hazardous Areas [Score: 0]:
   No hazardous area deficiencies were found in this zone.
9. Smoke Control [Score: 0]:
   A smoke barrier serves this zone.

   Surveyor Note: A review of the Statement of Deficiencies from the 09/18/2015 fire/life safety recertification survey revealed that the facility was cited because open penetrations were found above the suspended ceiling in the smoke barrier wall by the nursing station (see data tag K025). Documentation review revealed that the facility has subsequently submitted a Plan of Correction stating that the penetrations were sealed with fire caulk and larger openings were sheetrocked and closed on both sides. At the time of this FSES survey, a visual check of both sides of the smoke barrier wall revealed no unprotected penetrations of the wall.
10. Emergency Movement Routes [Score: -2]:
   A review of the Statement of Deficiencies from the 09/18/2015 fire/life safety recertification survey revealed that Zumbrota Care Center was cited for the presence of interior finish materials mounted on the corridor walls in the North Wing that diminished the width of the existing corridors resulting in a reduction of corridor width from 84¾ inches to 75¾ inches along the entire length of the corridor (see data tag K072). While the resulting clear width of the corridors still exceeds the 4 ft clear width required by NFPA 101(00), Sec. 19.2.3.3, the reduction of the original 84¾-inch corridor width does not meet the requirements of NFPA 101(00), Sec. 4.6.7.
11. Manual Fire Alarm [Score: +2]:
   Manual fire alarm pull stations are provided in accordance with NFPA 101(00), Sec. 19.3.4.2. The fire alarm system is monitored by USA Central Station Alarm Corporation.

12. Smoke Detection and Alarm [Score: +3]:
    This score was assigned per instruction in Footnote *g* to this Table. The zone is protected with quick-response sprinklers. Automatic smoke detectors provided for door release service were found at the smoke barrier doors and other doors allowed to be held open in accordance with NFPA 101(00), Sections 19.2.2.2.6 and 7.2.1.8.2.
13. Automatic Sprinklers [Score: +10]:
    The entire facility is protected by a supervised, wet-pipe automatic fire sprinkler system.

Zone 3 – Main Level South Wing Dayroom:

TABLE 1. OCCUPANY RISK PARAMETER FACTORS

1. Resident Mobility (*M*) [Value assigned = 3.2]: It was reported that some residents in this zone may need assistance with evacuation.
2. Patient Density (*D*) [Value assigned = 1.5]: There are no sleeping rooms in this zone; it is used as a day room, chapel and activity space. It was reported that there are a maximum of 20 residents in the 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 = 1.5]: This score was assigned to ensure that the FSES addresses the "worst-case scenario". It was reported that there is at least one (1) staff person on duty when residents are 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: 0]:
   The building was assigned a Type II(000) construction type.
2. Interior Finish (Corridors and Exits) [Score: +3]:
   Walls in corridors and exits were determined to be of masonry, gypsum wallboard and plaster. Documentation was provided certifying that the acoustical ceiling tile carries a Class A (25 or less) flame spread rating.
3. Interior Finish (Rooms) [Score: +3]:
   Walls in this room were determined to be of masonry, plaster and gypsum wallboard. Documentation was provided certifying that the acoustical ceiling tile carries a Class A (25 or less) flame spread rating.
4. Corridor Partitions/Walls [Score: 0]:
   Corridor walls were determined to be constructed of glazed masonry block and plaster and gypsum wallboard on metal studs, but terminate at the acoustical tile ceiling. For this reason, NFPA 101A(01), Sec. 4.6.4.2 requires that they be graded as "<½ hour".
5. Doors to Corridor [Score: +1]:
   Corridor doors in this zone were found to be of 1¾-inch-thick solid wood construction mounted in metal frames.
6. Zone Dimensions [Score: +1]:
   This zone measures approximately 40 feet in length and has no dead ends.
7. Vertical Openings [Score: 0]:
   This score was assigned per Footnote *e* to this Table – Parameter 1 is based on a first floor zone. Vertical openings were found to be enclosed with construction providing a minimum 1-hour fire resistance.

8. Hazardous Areas [Score: 0]:
   No hazardous area deficiencies were found in this zone.
9. Smoke Control [Score: 0]:
   A smoke barrier serves this zone.
10. Emergency Movement Routes [Score: -2]:
    A review of the Statement of Deficiencies from the 09/18/2015 fire/life safety recertification survey revealed that Zumbrota Care Center was cited for the presence of interior finish materials mounted on the corridor walls in the South Wing through which this room exits that diminished the width of the existing corridors resulting in a reduction of corridor width from 84¾ inches to 75¾ inches along the entire length of the corridor (see data tag K072). While the resulting clear width of the corridors still exceeds the 4 ft clear width required by NFPA 101(00), Sec. 19.2.3.3, the reduction of the original 84¾-inch corridor width does not meet the requirements of NFPA 101(00), Sec. 4.6.7.
11. Manual Fire Alarm [Score: +2]:
    Manual fire alarm pull stations are provided in accordance with NFPA 101(00), Sec. 19.3.4.2. The fire alarm system is monitored by USA Central Station Alarm Corporation.
12. Smoke Detection and Alarm [Score: +3]:
    This score was assigned per instruction in Footnote *g* to this Table. The zone is protected with automatic smoke detection and quick-response sprinklers.
13. Automatic Sprinklers [Score: +10]:
    The entire facility is protected by a supervised, wet-pipe automatic sprinkler system.

Zone 4 – Main Level West Wing:

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 17 residents in this zone.
3. Zone Location (*L*) [Value assigned = 1.1]: This zone is less than one-half floor height above grade.
4. Ratio of Patients to Attendants (*T*) [Value assigned = 1.2]: This score was assigned to ensure that the FSES addresses the "worst-case scenario". It was reported that there are three (3) staff persons on duty on the night shift, but one staff person makes rounds in the Mill River addition 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: 0]:
   The building was assigned a Type II(000) construction type.
2. Interior Finish (Corridors and Exits) [Score: 0]:
   Walls in corridors and exits were determined to be of gypsum wallboard. Documentation was provided certifying that:
   - Most wall and ceiling finishes [i.e. aesthetics ("home front facades")] in the zone carry a Class A (25 or less) flame spread rating, while some of the wood finishes were treated with Flame Control Fire Retardant Coating to achieve a Class B (26 - 75) flame spread rating, and
   - The acoustical ceiling tile carries a Class A (25 or less) flame spread rating.

3. Interior Finish (Rooms) [Score: +3]:
   Walls in rooms were determined to be of gypsum wallboard. While most ceilings in rooms were found to be gypsum wallboard, acoustical ceiling tile was found in some rooms. Documentation was provided certifying that the acoustical ceiling tile carries a Class A (25 or less) flame spread rating.
4. Corridor Partitions/Walls [Score: 0]:
   Corridor walls were determined to be constructed of gypsum wallboard on metal studs, but terminate at the acoustical tile ceiling. For this reason, NFPA 101A(01), Sec. 4.6.4.2 requires that they be graded as " <½ hour".
5. Doors to Corridor [Score: +1]:
   Corridor doors in this zone were found to be of 1¾-inch-thick solid wood construction mounted in metal frames.
6. Zone Dimensions [Score: 0]:
   This zone measures approximately 100 feet in length and has no dead ends.
7. Vertical Openings [Score: 0]:
   This score was assigned per Footnote *e* to this Table – Parameter 1 is based on a first floor zone. Vertical openings were found to be enclosed with construction providing a minimum 1-hour fire resistance.
8. Hazardous Areas [Score: 0]:
   No hazardous area deficiencies were found in this zone.
9. Smoke Control [Score: -5]:
   A smoke barrier serves this zone; however, another door opening has been created in the smoke barrier wall as part of the remodeling of the facility administrator's office. The door was found to carry a 90-minute fire protection rating, but was not equipped with self-closing or automatic-closing hardware as required by NFPA 101(00), Sections 18.3.7.6 and 19.3.7.6.
   See Table of Alternates: *If the newly installed door into the facility administrator's office were equipped with self-closing or automatic-closing hardware as required by NFPA 101(00), Sections 18.3.7.6 and 19.3.7.6, the score for this Parameter would change to 0.*
10. Emergency Movement Routes [Score: -2]:
    A review of the Statement of Deficiencies from the 09/18/2015 fire/life safety recertification survey revealed that Zumbrota Care Center was cited for the presence of interior finish materials mounted on the corridor walls in this zone that diminished the width of the existing corridors resulting in a reduction of corridor width from 84¾ inches to 75¾ inches along the entire length of the corridor (see data tag K072). While the resulting clear width of the corridors still exceeds the 4 ft clear width required by NFPA 101(00), Sec. 19.2.3.3, the reduction of the original 84¾-inch corridor width does not meet the requirements of NFPA 101(00), Sec. 4.6.7.
11. Manual Fire Alarm [Score: +2]:
    Manual fire alarm pull stations are provided in accordance with NFPA 101(00), Sec. 19.3.4.2. The fire alarm system is monitored by USA Central Station Alarm Corporation.
12. Smoke Detection and Alarm [Score: 0]:
    Automatic smoke detectors provided for door release service were found at the smoke barrier doors and other doors allowed to be held open in accordance with NFPA 101(00), Sections 19.2.2.2.6 and 7.2.1.8.2. Per the instruction in NFPA 101A(01), Sec. 4.6.12.1 and because the zone is protected with standard spray sprinklers, this parameter was required to be scored as "None".
13. Automatic Sprinklers [Score: +10]:
    The entire facility is protected by a supervised, wet-pipe automatic sprinkler system.

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

It must be noted that the scores and values assigned to the parameters in the tables on the FSES worksheets are based on conditions found between 0825 hours and 1520 hours on 10/27/2015. Any changes in those conditions after those dates could affect these scores and values, either positively or negatively. Again, based on this evaluation, Zumbrota Care Center Building 01 (Main Building) **has not** achieved a passing score on the FSES. No other assessment of the level of safety in this facility is either intended or implied by *Fire Safety Resources, LLC.*

Report of Consultant FSES Findings

Zumbrota Care Center

433 Mill Street

Zumbrota, MN 55992

Provider No. 245376

Building 02 – 2014 Addition

Date of Survey: October 27, 2015

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

Form Approved
OMB Exempt

ZONE 1 OF 2 ZONES

FIRE/SMOKE ZONE* EVALUATION WORKSHEET FOR HEALTH CARE FACILITIES

2000 LIFE SAFETY CODE

FACILITY	ZUMBROTA CARE CENTER	BUILDING	02-2014 ADDITION
ZONE(S) EVALUATED	LOWER LEVEL		
PROVIDER/VENDOR NO.	245376	DATE OF SURVEY	10/27/2015

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

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

TABLE 1. OCCUPANCY RISK PARAMETER FACTORS

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

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

TABLE 2. OCCUPANCY RISK FACTOR CALCULATION

	M		D		L		T		A		F
OCCUPANCY RISK	3.2	X	1.0	X	1.1	X	1.0	X	1.2	=	4.2

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

TABLE 3A. (NEW BUILDINGS)

	F		R	
1.0 X	4.2	=	4.2	=5

TABLE 3B. (EXISTING BUILDINGS)

	F		R
0.6 X	.	=	.

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

SURVEYOR SIGNATURE [signature], FIRE SAFETY RESOURCES, LLC	TITLE PRESIDENT	DATE 10/30/2015
FIRE AUTHORITY SIGNATURE [signature] STATE FIRE MARSHAL DIVISION	TITLE FIRE SAFETY SUPERVISOR	DATE 11-13-2015

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

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

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

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

TABLE 5. INDIVIDUAL SAFETY EVALUATIONS

Safety Parameters	Containment Safety (S_1)	Extinguishment Safety (S_2)	People Movement Safety (S_3)	General Safety (S_4)
1. Construction	0	0		0
2. Interior Finish (Corr. and Exit)	3		3	3
3. Interior Finish (Rooms)	3			3
4. Corridor Partitions/Walls	2			2
5. Doors to Corridor	1		1	1
6. Zone Dimensions			-2	-2
7. Vertical Openings	0		0	0
8. Hazardous Areas	0	0		0
9. Smoke Control			0	0
10. Emergency Movement Routes			0	0
11. Manual Fire Alarm		2		2
12. Smoke Detection and Alarm		3	3	3
13. Automatic Sprinklers	10	10	10 ÷ 2 = 5	10
Total Value	S_1= 19	S_2= 15	S_3= 10	S_4= 22

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

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

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

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

ZONE 2 OF 2 ZONES

FIRE/SMOKE ZONE* EVALUATION WORKSHEET FOR HEALTH CARE FACILITIES

2000 LIFE SAFETY CODE

FACILITY: Zumbrota Care Center
BUILDING: 02-2014 Addition
ZONE(S) EVALUATED: Upper Level
PROVIDER/VENDOR NO.: 245376
DATE OF SURVEY: 10/27/2015

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

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

TABLE 1. OCCUPANCY RISK PARAMETER FACTORS

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

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

TABLE 2. OCCUPANCY RISK FACTOR CALCULATION

OCCUPANCY RISK: M [3.2] X D [2.0] X L [1.1] X T [4.0] X A [1.2] = F [33.8]

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 F [33.8] = R [33.8] ≈ 34	0.6 X F [ ] = R [ ]

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

SURVEYOR SIGNATURE	TITLE	DATE
[signature], Fire Safety Resources, LLC	President	10/30/2015
FIRE AUTHORITY SIGNATURE	**TITLE**	**DATE**
[signature] State Fire Marshal Division	Fire Safety Supervisor	11-13-2015

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

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

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

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

TABLE 5. INDIVIDUAL SAFETY EVALUATIONS

Safety Parameters	Containment Safety (S_1)	Extinguishment Safety (S_2)	People Movement Safety (S_3)	General Safety (S_4)
1. Construction	0	0		0
2. Interior Finish (Corr. and Exit)	3		3	3
3. Interior Finish (Rooms)	3			3
4. Corridor Partitions/Walls	0			0
5. Doors to Corridor	1		1	1
6. Zone Dimensions			-2	-2
7. Vertical Openings	0		0	0
8. Hazardous Areas	0	0		0
9. Smoke Control			0	0
10. Emergency Movement Routes			-2	-2
11. Manual Fire Alarm		2		2
12. Smoke Detection and Alarm		3	3	3
13. Automatic Sprinklers	10	10	10 ÷ 2 = 5	10
Total Value	S_1= 17	S_2= 15	S_3= 8	S_4= 18

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

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

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

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

Table 5 Alternate Facility ZUMBROTA CARE CENTER - BLDG 02 - #245376 Zone # 2 Date: 10/27/2015

Safety Parameters	As Is				Alt. 1				Alt. 2				Alt. 3			
	Containment (S_1)	Extinguishment (S_2)	People Movement (S_3)	General Safety (S_G)	Containment (S_1)	Extinguishment (S_2)	People Movement (S_3)	General Safety (S_G)	Containment (S_1)	Extinguishment (S_2)	People Movement (S_3)	General Safety (S_G)	Containment (S_1)	Extinguishment (S_2)	People Movement (S_3)	General Safety (S_G)
1. Construction	0	0		0	0	0		0								
2. Interior Finish (Corr.& Exit)	3		3	3	3		3	3								
3. Interior Finish (Rooms)	3			3	3			3								
4. Corridor Partitions/Walls	0			0	0			0								
5. Doors to Corridor	1		1	1	1		1	1								
6. Zone Dimensions			-2	-2			-2	-2								
7. Vertical Openings	0		0	0	0		0	0								
8. Hazardous Areas	0	0		0	0	0		0								
9. Smoke Control			0	0			0	0								
10. Emergency Movement Routes			-2	-2			-2	-2								
11. Manual Fire Alarm		2		2		2		2								
12. Smoke Detection & Alarm		3	3	3		3	3	3								
13. Automatic Sprinklers	10	10	5 ½	10	10	10	5 ½	10			½				½	
A. Total Value	17	15	8	18	17	15	8	18								
B. Mandatory Values	11	15	8	34	11	15	8	13								
C. Difference Between A & B	6	0	0	-16	6	0	0	5								
D. If C is 0 or more, check box	✓	✓	✓		✓	✓	✓	✓								

FIRE SAFETY EVALUATION

BUILDING 02 – 2014 ADDITION

Name of Facility: Zumbrota Care Center
Address: 433 Mill Street, Zumbrota, MN 55992
Phone: 507-732-8400
Licensed capacity: 50
Census at time of survey: 47

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 0825 hours and 1520 hours on 10/27/2015. 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, Zumbrota Care Center Building 02 (2014 Addition) has not achieved a passing score on the FSES.

In addition to observations made and documentation review conducted during the 10/27/2015 on-site visit, the findings outlined herein are based on:

- Information provided by Mr. Ray Goranson, Director of Environmental Services and Mr. Scott Jackson, Director of Projects and Community Services, St. Francis Health Services; and
- A review of the Statement of Deficiencies (Form CMS-2567) from a fire/life safety recertification survey conducted on 09/18/2015.

Initial Comments:
A review of the Statement of Deficiencies from the 09/18/2015 fire/life safety recertification survey revealed that Zumbrota Care Center was surveyed as two buildings: Building 01 – Main Building, consisting of the 1964 original building and 1968 addition, and Building 02, the 2014 resident wing addition known as Mill River.

Construction of Building 02 (2014 Addition) commenced in 2013; the building was occupied in 2014. Because the building was constructed after 03/11/03, it is considered a new building for federal certification purposes and was, therefore, treated as such for assigning values on the FSES worksheets.

Building 02 (2014 Addition) is directly attached to the east side of the South Wing of Building 01 (Main Building). It is two (2) stories in height and has no basement. Because the building is on a sloping grade, both the upper and lower levels of the building have direct access to the exterior at grade level. In accordance with NFPA 101A(01), Sec. 4.5.3.2, therefore, each level was scored as a first floor zone for purposes of this FSES.

The Lower Level of Building 02 (2014 Addition) was found to be a mixed use occupancy – health care and educational. A preschool occupancy, located at the south end of the Lower Level, occupies approximately one-third of that level of the building. The preschool occupancy is not used for purposes of housing, treatment or customary access by the facility's residents. Based on observation, interview of the Environmental Services Director and review of building construction drawings, the health care and educational occupancies are separated from each other by construction having a fire resistance rating of at least 2 hours. For purposes of this FSES, the preschool occupancy was treated as a suite as allowed by NFPA 101(00), Sec. 18.2.5.

Based on observation, interview of the Environmental Services Director and review of the Code Summary attached to the building construction drawings, Building 02 (2014 Addition) was assigned a Type II(111) construction type – the building was determined to be constructed of masonry exterior bearing walls, a precast concrete plank floor assembly supported by steel I-beams with spray-on fireproofing, and a steel roof deck supported by steel bar joists. In accordance with NFPA 101(00), Sections 18.1.6.2 and 8.2.1, however, the building was assigned a Type II(000) construction type for purposes of this FSES, because it is not separated from Building 01 (Main Building) by a minimum 2-hour-rated fire barrier wall.

Building 02 (2014 Addition) has an addressable fire alarm system with automatic smoke detection in the corridors and spaces open to corridors that is monitored for automatic fire department notification. The resident sleeping rooms in the Mill River Wing are equipped with single station smoke alarms. Based on documentation review, the fire alarm system is being inspected, tested and maintained in accordance with NFPA 72.

Building 02 (2014 Addition) is protected throughout by a supervised, wet-pipe automatic fire sprinkler system consisting of quick-response sprinklers. Based on documentation review, the system is being inspected, tested and maintained in accordance with NFPA 25.

> ***Surveyor Note:*** A review of the Statement of Deficiencies from the 09/18/2015 fire/life safety recertification survey revealed that the facility was cited because observation revealed that the dry fire sprinkler heads in the walk-in cooler and freezer on the Lower Level of Building 02 (2014 Addition) had clear fluid in them (see data tag K062). Documentation review revealed that the facility has subsequently submitted a Plan of Correction stating that Olson Fire Protection was contacted to replace the heads. Upon inspection, however, the contractor determined that the sprinklers were not defective – the fluid in the sprinklers is a light yellow, not clear, indicating a temperature rating of 175-225 degrees F [see NFPA 13(99), Sec. 3-2.5.2 and Table 3-2.5.1]. At the time of this FSES survey, a visual check of the fire sprinklers in question confirmed that the fluid in the sprinklers is a light yellow.

For purposes of this FSES, the two building levels in Building 02 (2014 Addition) were divided into two (2) separate smoke zones as follows:

Zone 1 – Lower Level
Zone 2 – Upper Level

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 Building 02 (2014 Addition) as it was found on 10/27/2015. The score assigned to each item is noted in brackets ([ ]). It must be noted that numbers were rounded to the nearest tenth of a point and that measurements of over one-half inch were rounded to the nearest inch. To ensure that the FSES addresses the "worst-case scenario", the product of the multiplication in Table 3A (i.e. value of "R") was rounded up to the nearest whole number. Code references are provided where appropriate. Codes referenced include the 2001 edition of NFPA 101A and the 2000 edition of the *Life Safety Code*® (NFPA 101).

With the exception of Table 8, which applies to all zones, this narrative will address each of the two (2) zones in Building 02 (2014 Addition) separately.

All Zones – TABLE 8. FACILITY FIRE SAFETY REQUIREMENTS WORKSHEET

In accordance with NFPA 101A(01), Sec. 4.7, Step 8, only one copy of this table is required to be filled out for each building. For convenience, however, this table was filled out on the worksheets for both zones evaluated. All items in Table 8 could be checked 'Met' with the exception of Item L. Because Building 02 (2014 Addition) does not meet the definition of a high rise, Item L was checked 'Not Applicable'.

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

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

  Surveyor Note: A review of the Statement of Deficiencies from the 09/18/2015 fire/life safety recertification survey revealed that the facility was cited because a review of the monthly generator logs revealed that the monthly generator run tests did not meet the requirements of NFPA 110(99), Sec. 6-4.2 (see data tag K144). Staff interview and documentation review conducted during this FSES survey revealed that, as allowed by NFPA 110(99), Sec. 6-4.2.2, Ziegler Power Systems conducted a 2-hour load bank test of the diesel-operated emergency generator on 09/28/2015.
- No incinerator or space heaters were found.
- The facility's evacuation plan and fire drill records was reviewed and appeared to be in order.
- The facility's smoking regulations were reviewed and appeared to be in order. Zumbrota Care Center is a smoke-free facility.
- Documentation review showed all draperies, cubicle curtains, upholstered furniture, mattresses and decorations to be in accordance with NFPA 101(00), Sec. 19.7.5.
- The facility has documentation showing that the plantscapes (e.g faux plants and trees) installed in the facility's public spaces are either flame resistant when tested in accordance with NFPA 701 and/or carry a Class A (25 or less) flame spread rating.
- Portable fire extinguishers, EXIT signage and emergency lighting appeared to be provided in accordance with applicable requirements.

Zone 1 – Lower Level:

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 = 1.0]: There are no sleeping rooms in this zone; it houses an OT/PT suite, the facility's main kitchen and a preschool occupancy. It was reported that there are a maximum of three (3) residents in this zone at any one time.
3. Zone Location (*L*) [Value assigned = 1.1]: This value was assigned per the instruction in NFPA 101A(01), Sec. 4.5.3.2. Although the facility is two stories in height, it sits on a sloping grade. As a result, this zone has direct access to the exterior at grade level.
4. Ratio of Patients to Attendants (*T*) [Value assigned = 1.0]: It was reported that there is at least one (1) staff person for each resident 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: 0]:
   The building was assigned a Type II(000) construction type.
2. Interior Finish (Corridors and Exits) [Score: +3]:
   Walls in corridors and exits were determined to be of masonry and gypsum wallboard. Documentation was provided certifying that the acoustical ceiling tile carries a Class A (25 or less) flame spread rating.
3. Interior Finish (Rooms) [Score: +3]:
   Walls in rooms were determined to be of masonry and gypsum wallboard. Documentation was provided certifying that the acoustical ceiling tile carries a Class A (25 or less) flame spread rating.
4. Corridor Partitions/Walls [Score: +2]:
   Corridor walls were determined to be constructed of masonry and gypsum wallboard installed on both sides of steel studs.
5. Doors to Corridor [Score: +1]:
   Corridor doors in this zone were found to be a mixture of labeled 45-minute, 60-minute and 90-minute doors.
6. Zone Dimensions [Score: -2]:
   This zone measures approximately 155 feet in length and has no dead ends.
7. Vertical Openings [Score: 0]:
   This score was assigned per Footnote *e* to this Table – Parameter 1 is based on a first floor zone. Based on observation, interview of the Environmental Services Director and review of building construction drawings, the exit stairway located at the east end of the building is enclosed with construction providing a minimum 2-hour fire resistance. Vertical openings in Building 01 (Main Building), however, were found to be enclosed with construction providing a minimum 1-hour fire resistance. Because Building 01 (Main Building) serves as part of the means of egress from Building 02 (2014 Addition) and the two buildings are not separated by a minimum 2-hour-rated fire barrier wall, this Parameter was scored as "≥1 hr to <2 hr".
8. Hazardous Areas [Score: 0]:
   No hazardous area deficiencies were found in this zone.
9. Smoke Control [Score: 0]:
   A smoke barrier serves this zone.
10. Emergency Movement Routes [Score: 0]:
    There are two remote exits from this zone.
11. Manual Fire Alarm [Score: +2]:
    Manual fire alarm pull stations are provided in accordance with NFPA 101(00), Sec. 18.3.4.2. The fire alarm system is monitored by USA Central Station Alarm Corporation.
12. Smoke Detection and Alarm [Score: +3]:
    This score was assigned per instruction in Footnote *g* to this Table. The zone is protected with corridor smoke detection and quick-response sprinklers.
13. Automatic Sprinklers [Score: +10]:
    The entire facility is protected by a supervised, wet-pipe automatic sprinkler system.

Zone 2 – Upper Level:

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]: This score was assigned to ensure that the FSES addresses the "worst-case scenario". This zone consists of the 2014 addition and the South Wing of the existing building, with the exception of the South Wing dayroom space. There is bed capacity for up to 24 residents in this zone. The zone also contains the facility's main dining room, which has an occupant load of 40.
3. Zone Location (*L*) [Value assigned = 1.1]: This value was assigned per the instruction in NFPA 101A(01), Sec. 4.5.3.2. Although the facility is two stories in height, it sits on a sloping grade. As a result, this zone has direct access to the exterior at grade level.
4. Ratio of Patients to Attendants (*T*) [Value assigned = 4.0]: This score was assigned to ensure that the FSES addresses the "worst-case scenario". It was reported that the nurse station in this zone is not staffed on a 24-hour basis, but there are at least four (4) staff persons present when residents are in the dining room and one of the three (3) staff persons on duty at the nurse station in Building 01 (Main Building) on the night shift makes rounds in this zone every 2 hours. Because the zone is not constantly attended, this Parameter was scored as "One or More over None".

   See Table of Alternates: *If the nurse station in this zone were staffed on a 24-hour basis, the score for this Parameter would change to 1.5.*
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: 0]:
   The building was assigned a Type II(000) construction type.
2. Interior Finish (Corridors and Exits) [Score: +3]:
   Based on interview and observation, it was determined that the wall and ceiling finishes [i.e. aesthetics ("home front facades") and wooden structure (archway) at the set of cross-corridor doors leading from Mill River to the South Wing of the existing building] in this zone are constructed of noncombustible material (e.g. metal and cement board). The acoustical ceiling tile carries a Class A (25 or less) flame spread rating.
3. Interior Finish (Rooms) [Score: +3]:
   Walls in rooms were determined to be of masonry, plaster and gypsum wallboard. Documentation was provided certifying that the acoustical ceiling tile carries a Class A (25 or less) flame spread rating.
4. Corridor Partitions/Walls [Score: 0]:
   Corridor walls were determined to be constructed of glazed masonry block, plaster and gypsum wallboard. Three (3) non-fire-rated glass vision panels were found in the corridor wall at the nurse station. As a result, the corridor walls were graded as "<½ hour".
5. Doors to Corridor [Score: +1]:
   Corridor doors in this zone were found to be of 1¾-inch-thick solid wood construction mounted in metal frames.
6. Zone Dimensions [Score: -2]:
   This zone measures approximately 190 feet in length and has no dead ends.

7. Vertical Openings [Score: 0]:
   This score was assigned per Footnote *e* to this Table – Parameter 1 is based on a first floor zone. Based on observation, interview of the Environmental Services Director and review of building construction drawings, the exit stairway located at the east end of the building is enclosed with construction providing a minimum 2-hour fire resistance. Vertical openings in Building 01 (Main Building), however, were found to be enclosed with construction providing a minimum 1-hour fire resistance. Because Building 01 (Main Building) serves as part of the means of egress from Building 02 (2014 Addition) and the two buildings are not separated by a minimum 2-hour-rated fire barrier wall, this Parameter was scored as "≥1 hr to <2 hr".
8. Hazardous Areas [Score: 0]:
   No hazardous area deficiencies were found in this zone.
9. Smoke Control [Score: 0]:
   A smoke barrier serves this zone.
10. Emergency Movement Routes [Score: -2]:
    This score was assigned for the following reasons:
    - Access to the southwest exit from this zone is through the day room, which does not meet the requirements of NFPA 101(00), Sections 18.2.5.9 and 19.2.5.9.
    - A review of the Statement of Deficiencies from the 09/18/2015 fire/life safety recertification survey revealed that Zumbrota Care Center was cited for the presence of interior finish materials mounted on the corridor walls in the South Wing of the existing building that diminished the width of the existing corridors resulting in a reduction of corridor width from 84¾ inches to 75¾ inches along the entire length of the corridor – see data tag K072 cited against Building 01 (Main Building).
11. Manual Fire Alarm [Score: +2]:
    Manual fire alarm pull stations are provided in accordance with NFPA 101(00), Sections 18.3.4.2 and 19.3.4.2. The fire alarm system is monitored by USA Central Station Alarm Corporation.
12. Smoke Detection and Alarm [Score: +3]:
    This score was assigned per instruction in Footnote *g* to this Table. The zone is protected with corridor smoke detection and quick-response sprinklers.
13. Automatic Sprinklers [Score: +10]:
    The entire facility is protected by a supervised, wet-pipe automatic sprinkler system.

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

It must be noted that the scores and values assigned to the parameters in the tables on the FSES worksheets are based on conditions found between 0825 hours and 1520 hours on 10/27/2015. Any changes in those conditions after those dates could affect these scores and values, either positively or negatively. Again, based on this evaluation, Zumbrota Care Center Building 02 (2014 Addition) **has not** achieved a passing score on the FSES. No other assessment of the level of safety in this facility is either intended or implied by *Fire Safety Resources, LLC.*

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

ID: KLV3
Facility ID: 00917

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245376**
2.STATE VENDOR OR MEDICAID NO.
(L2) **766119300**

3. NAME AND ADDRESS OF FACILITY
(L3) **ZUMBROTA CARE CENTER**
(L4) **433 MILL STREET**
(L5) **ZUMBROTA, MN**　(L6) **55992**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9) **12/17/2003**
6. DATE OF SURVEY **09/17/2015** (L34)
8. ACCREDITATION STATUS: ___ (L10)
0 Unaccredited　1 TJC
2 AOA　3 Other

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
09/30

11. .LTC PERIOD OF CERTIFICATION
From (a) :
To (b) :
12.Total Facility Beds **50** (L18)
13.Total Certified Beds **50** (L17)

10.THE FACILITY IS CERTIFIED AS:
A. In Compliance With Program Requirements Compliance Based On:
____1. Acceptable POC

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	50			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE　Date :
Denise Erickson, HFE NE II　10/22/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL　Date:
Kamala Fiske-Downing, Enforcement Specialist　11/10/2015 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
12/01/1986
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal

INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
00220
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered
October 5, 2015

Ms. Krista Siddiqui, Administrator
Zumbrota Care Center
433 Mill Street
Zumbrota, Minnesota 55992

RE: Project Number S5376024

Dear Ms. Siddiqui:

On September 17, 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 your facility to be widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

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

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

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

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

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

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

DEPARTMENT CONTACT

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

Gail Anderson, Unit Supervisor
Minnesota Department of Health
1505 Pebble Lake Road #300
Fergus Falls, Minnesota 56537
gail.anderson@state.mn.us
Telephone: (218) 332-5140 Fax: (218) 332-5196

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 October 27, 2015, the Department of Health will impose the following remedy:

• State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by October 27, 2015 the following remedy will be imposed:

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

- Address how corrective action will be accomplished for those residents found to have

been affected by the deficient practice;

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

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

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

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

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

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by December 17, 2015 (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 March 17, 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 electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm

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

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

Gary L. Schroeder – Interim Fire Safety Supervisor
Health Care / Adult Foster Care / Corrections
Minnesota State Fire Marshal Division
445 Minnesota Street, Suite 145
St. Paul, MN 55101-5145
gary.schroeder@state.mn.us
Office/Cell: 507-361-6204 Fax: 507-282-7899

Feel free to contact me if you have questions.

Sincerely,

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

POC NOT FINAL

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245376	A. BUILDING ______ B. WING ______	09/17/2015

NAME OF PROVIDER OR SUPPLIER: **ZUMBROTA CARE CENTER**

STREET ADDRESS, CITY, STATE, ZIP CODE: **433 MILL STREET, ZUMBROTA, MN 55992**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 164 SS=D	483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS The resident has the right to personal privacy and confidentiality of his or her personal and clinical records. Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility. The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law.	F 164		10/16/15

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 10/15/2015

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

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F 164	Continued From page 1 The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident. This REQUIREMENT is not met as evidenced by: Based on observation and interview the facility failed to ensure resident medical records were stored in a safe and secure environment. This had the potential to affect all current residents and discharged residents in the facility. Findings include: On 9/15/15, at 8:00 a.m. an observation of the hallway in the basement of the facility revealed four banker boxes and one brown cardboard box were stacked to the left side of the hallway on top of each other. One stack held three bankers boxes and the second stack held a brown cardboard box and one banker box. The boxes were labeled with the following information: -Banker box on bottom of the three tall stack was labeled "vulnerable adult (VA) reports from 2012 to 2013." - Banker box in the middle of the stack was labeled, "narcotic book destruction, skin logs May, June and July 2012." -Banker box on the top of the stack was labeled, "skin and incident reports 2010-2014." - Banker box on the bottom of the second stack	F 164	All medical information contained in the resident records is kept confidential. The Record Retention and Destruction policy/procedure was reviewed by the Administrator/designee. Per the policy St. Francis Health Services maintains a comprehensive record and information retention and destruction system designed to meet privacy and regulatory compliance. All active resident records are kept in an area behind the nursing station until the time of discharge. At that time they are moved to the Medical Record room which is a locked area in the basement. Thinned and/or purged records will be handled per the Record Retention and Destruction policy/procedure. Environmental audits will be done to include all areas of the facility accessible to staff, visitors and residents. A log will be kept by the Administrator/Director of Maintenance/designee directing the specific areas, items and individual responsible for the audit as well as the frequency for each area. Audits will be brought to the QAPI Committee for review and recommendations.	

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F 164	Continued From page 2 was unlabeled and the brown cardboard box on the top of the bankers box was also unlabeled. The banker box was observed to be full, contained individual resident incident reports. The brown cardboard box was observed to be full, contained individual resident medical records. On 9/16/15 at 7:07 a.m. and 9/17/15 at 8:01 a .m. the 4 banker boxes and 1 cardboard box of resident medical information remained in the hallway of the basement. On 9/17/15, at 8:15 a.m. the maintenance director was observed in the hallway of the basement bringing equipment to a room which was also housed in the basement of the facility, the boxes of resident medical information remained in the hallway. On 9/1715, at 11:59 a.m. the facility administrator confirmed the basement of the facility was not locked and was accessible to all staff, visitors and also the residents of the assisted living facility. The administrator confirmed the 5 boxes in the basement contained resident medical records. The adminstrator stated the boxes had been in the director of nurses office and were temporarily stored in the hallway before moving to the medical record storage room which was housed in the basement. The administrator also stated the medical records had been in the basement for a week and were not usually stored in an unsecured location.	F 164	The administrator/designee is responsible for assuring on-going compliance for the Plan of Correction.	
F 253 SS=E	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a	F 253		10/16/15

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F 253	Continued From page 3 sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to maintain a clean and sanitary kitchen in the facility and failed to maintain effective maintenance services in resident living spaces in a for 6 of 9 residents (R5, R6, R42, R46, R53,R70) reviewed Findings include: During the Initial kitchen tour with Cook (C-B) at 9/14/15, at 5:20 p.m. the following was observed: -tile grout was observed black throughout the entire kitchen. C-B stated maintenance used a floor scrubber machine to clean the kitchen floor every Wednesday, otherwise dietary mopped the kitchen floor on the other days. She stated the facility had been unsuccessful at removing the dirt. C-B stated maintenance had only been using the floor scrubber for about a month. She stated before that, dietary only mopped until they realized it was not removing the dirt build up. She stated since maintenance started using the floor scrubber it had been getting better. - the clean end of the stainless steel dishwashing table had a white pipe set on top of a small metal grated drain on the floor. The pipe and the drain was surrounded by standing water with 3 water soaked maroon rags on top of the drain. C-B removed the dripping, soaked wet rags from the drain and after the wet rags were removed, standing water remained which surrounded the drain. Rust colored stains were observed on the	F 253	The facility will provide housekeeping and maintenance services necessary to maintain a sanitary, orderly and comfortable interior. The pipe in the kitchen was repaired to extend into the drain eliminating the excess water that was spilling over to the kitchen floor. The grout in the kitchen will be cleaned with a bleach solution once daily. R 70¿s bathroom door was repaired removing several long gouges. R 5¿s bathroom door was repaired. R 42¿s wall in the bathroom was painted and repaired. R 6¿s damaged walls were repaired to include the sheetrock above the soap dispenser. The floor around the toilet was cleaned and repaired to include the grout. An environmental audit will be completed by the Administrator/designee to assure that resident rooms and the facility in general is in compliance by maintaining a sanitary, orderly and comfortable interior. The audit will include the following: resident rooms, kitchen, tub rooms, utility rooms and dining & serving areas. A log will kept by the Director of Maintenance/designee assigning specific areas, frequency of the audit, problem areas identified and plan for any repairs necessary with a specific date of completion. The Administrator and Director of Maintenance will be responsible for	

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F 253	Continued From page 4 tile grout and on the floor board lip below the wall and a black, wet substance between the tiles. C-B confirmed the findings and stated she wasn't sure why the rags had been placed on the drain. On 9/14/15, at 5:30 p.m., DA-A confirmed the wet rags and the standing water surrounding the drain, and stated he put the rags there to soak up the water that leaked from the pipe. On 9/16/15, at 2:28 p.m. the dietary director (DD) stated she felt when dietary staff did a lot of dishes, the drain couldn't take all the water, and the standing water was related to how the water hit the drain from the pipe. She confirmed the wet floor area was 3 feet by 5 feet. She also confirmed the black, moist tile grout. She stated dietary staff should not have layed towels on top of the drain to soak up the water, and she would expect them to mop up or wipe up the water as they go, and to keep track of it. She stated the water splattered when they doing an extra push of dishes, and she noticed this a couple of months ago. She stated she told the ESD a couple months ago and he was looking at some options to fix the drain and the pipe. She confirmed the dirty kitchen tile . She stated she thought maintenance had started using the floor scrubber machine in June of this year, but before that dietary staff had mopped the floor. She stated that as long as the actual tiles were clean, that is what she looked at. She stated she felt the floor scrubber got some of the black dirt out of the tile. On 9/17/15, at 10:45 a.m., during follow-up interview, the DD confirmed the rust and wet dirty tile in the standing water area, and the dirty tile throughout the kitchen. She stated she thought the tile was black in the cracks from dirt that they	F 253	ongoing compliance. Audit results will be brought to the QAPI Committee for review and further recommendations.	

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F 253	Continued From page 5	F 253		

couldn ' t get out. She stated it is getting better, but stated she felt the dirt and lint in the tile crevices would not come out.

An environmental tour was completed on 9/17/15, at 2:30 p.m. with the environmental services director (ESD). During the environmental tour, the following findings were confirmed by the ESD:

-R53' room- a 1.5 inch (") and (2) 1" gouge on the wall behind the TV which exposed the sheetrock.

-R46's room- a 6" gouge and a 12" gouge in the wall just above the foot of the the bed, one on top of the other and exposed the sheetrock. ESD stated the bed used to face the other way, and the bed scratched the wall. He stated the wall should have been repaired after they changed the position of the bed.

-R70' room- several long, horizontal gouges to the bottom of the bathroom door.

-R5's room- several long, horizontal gouges to the bottom of the bathroom door. He stated he felt the door had been gouged by the wheelchair of the resident next door, who shared a bathroom with R5.

-R42's room- 3 areas of missing paint above the soap dispenser in the resident bathroom which measured .5", 1" and 1.5" with the sheetrock exposed in this area.

-R6's room- a chipped area with sheetrock exposed above the soap dispenser which measured 1.5". The wall was damaged above the towel bar that included a 1" gouge, 1-1/4" hole in

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F 253	Continued From page 6 the wall, a 6" horizontal area of peeled, chipped paint. An area with chipped paint and a 1" diameter hole in the wall below the mounted paper towel dispenser. Next to the toilet grab bar there were two 6" dark scrapes in the paint and a 2"x 1" dirt spot next to it. There was a large dark green painted, patched area along the bottom of the wall and had 3 scratches revealing cream colored paint underneath, and had dark gray scuffs below it, 3 holes 2", 1", .5", and 3 horizontal dark scuffs to the wall each about 4" long. Behind R6's toilet a dark brown substance was observed on the floor and in the grout of the tile around the back and sides of the toilet that extended about 2.5 " The dark brown substance appeared wet and sticky. ESD stated R6's bathroom had not been looked at since last fall and stated R6's bathroom needed new paint, the holes in the wall repaired, and the tile surrounding and behind the toilet needed to be cleaned using a scrub machine, and also cleaned by hand with a scrub brush remove the dark sticky substance. He stated the entire room needed to repaired. He stated the dark substance on the tile could have been mold, but stated he felt it was from soap dripping onto the floor from the wall mounted soap dispenser. He stated he felt the black stuff in the tile grout could be dirt and lint, and he stated it had been there for awhile. He stated they do what they can do to get it out. During the tour, ESD confirmed the facility did not have a system in place and did not record any cleaning or maintenance of resident rooms. He stated he was not aware of the findings and indicated the usual facility practice was for staff to write down areas that needed repairs in the maintenance To do list book or during spring cleaning. He confirmed identified repairs and	F 253		

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F 253	Continued From page 7 stated all repairs needed to be fixed right away. He stated he would have gotten to the resident rooms when they did, "Spring cleaning." He also stated they don't record what rooms they repair, or when they were done. He stated spring cleaning started each January, and they try to get through all the resident rooms once a year, whenever they can. On 9/17/15, at 2:40 p.m. ESD confirmed the dirty kitchen tile. He stated he thought it would come out, and the dietary staff were responsible for cleaning it. He stated the kitchen tile was black and dirty because the dietary staff didn't put enough elbow grease into cleaning it, and they had started using the floor scrubber once per week now. He stated it was usual for the dietary staff to have rags on top of the drain to soak up the standing water from the malfunctioning pipe and drain. He stated the amount of standing water was directly related to the amount of dishes dietary staff did at one time. He stated the drain couldn't handle that much water because the pipe was on top of drain and not inside it. He stated he knew about the water on the floor but he felt it was not urgent and was not his priority. He then stated it should have been a priority but it wasn't. He stated the DD had told him about the standing water a couple times, and the last time was about a month ago. He confirmed the rust on the drain cover, the rusty floor tiles, and the black, wet material in the tile grout and stated the dietary department was responsible for cleaning that area. On 09/17/15, at 3:43 p.m. the administrator stated the facility did not have an environmental policy for how to maintain resident rooms or the physical environment. She also confirmed the	F 253		

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F 253	Continued From page 8 facility did not have a policy for cleaning the kitchen floors, but a cleaning list was posted in dietary work area.	F 253		
F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the	F 278	R 66 and R 72¿s toileting programs	10/16/15

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F 278	Continued From page 9 facility failed to accurately code the Minimum Data Set (MDS) to reflect toileting programs for 2 of 5 residents (R66, R72) residents reviewed in the sample. Findings include: R66's admission MDS dated 4/20/15, identified R66 had diagnoses which included, obstructed uropathy and dementia. The MDS identified R66's assistance needs for activities of daily living were variable from supervision to extensive assist, had an indwelling Foley catheter and an external condom catheter, and was always continent of urine. R66's 14 day perspective payment system (PPS) MDS dated 4/27/15, identified R66's assistance needs for activities of daily living were variable form supervision to extensive assist, did not have any urinary devices, was occasionally incontinent of urine and was not on a toileting program. R66's facility form titled Bowel and Bladder Detailed Report-Last 7 days (an assessment which directed staff to document R66's hourly toileting pattern) dated 7/15/15 to 7/21/15, identified the following: 7/15/15, No documentation of incontinence or toilet use. 7/16/15, urinated at 9:56 a.m. ,and urinated and bowel movement at 8:41 a.m. 7/17/15, urinated at 12:21 p.m. 7/18/19, no documentation of incontinence or toilet use. 7/19/15, no documentation of urination, bowel movement at 2:31 p.m. and 3:00 p.m. 7/20/15, urinated at 12:55 p.m., urinated and bowel movement at 8:36 p.m. 7/21/15, urinated at 1:24 p.m. and 8:29 p.m. The form lacked complete documentation of R66's toileting pattern; however, the assessment	F 278	were reviewed by the DON/MDS Coordinator/designee. The care plans and toileting programs were adjusted to reflect their current assessments. Modifications were made to R66¿s MDS dated 7/21/15 and R72¿s MDS dated 6/22/15 to reflect accurate coding of toileting programs. An audit was conducted by the MDS coordinator to identify other residents whose current assessments do not match either their current care plan and/or care guides as it relates to Bowel and Bladder status. Any resident identified as needing a re-assessment and/or revision of their current toileting program were re-assessed to include a 72 hour diary and care plan and care guides adjusted as per assessment results. The Urinary Incontinence Program policy and procedure was reviewed and revised prn by the DON and MDS coordinator. . Education was provided to staff as well as additional education for the Nurse Managers to assure understanding of Toileting Plans that meet coding requirements. Random Audits will be conducted by the DON/ designee to assure compliance with resident toileting programs 2XweekX2, then weekly thereafter. Audit results will be presented at QAPI meeting for review and recommendations.	

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F 278 Continued From page 10 F 278

did identify R66 was continent of urine and bowel when the documentation was completed.

R66's quarterly MDS dated 7/21/15, documented R66 had a trial of a toileting program (e.g., scheduled toileting, prompted voiding, or bladder training) on admission/reentry or since urinary incontinence was noted in this facility. And a current toileting program or trial was currently being implemented.

Review of R66 care plan, revised 8/14/15, identified R66 was at risk for bladder incontinence related to BPH (enlarged prostate) and history of urinary retention with a goal for R66 to remain continent of bladder. R66's care plan listed interventions for bladder program on demand and assist of one to toilet as requested. R66's care plan also identified R66 was at risk for bowel incontinence related to diverticulosis and the goal for R66 was to remain continent of bowel. The care plan listed the intervention on demand.

R66's comprehensive assessment dated 7/21/15, identified the following: The resident [R66] had a urinary catheter on admission for urinary retention. The catheter had been removed and the resident has been doing well without the catheter. The resident is presently continent of bowel and bladder. The resident B/B (bowel and bladder program) at present is to continue continence of bowel and bladder.

During observations on 9/16/2015, at 7:07 a.m. R66 was in his room alone, in bed with eyes closed and the lights off. R66's blankets covered his lower half of body,oxygen cannula in his nose, and the wheel chair next to the bed at an

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ZUMBROTA CARE CENTER	433 MILL STREET ZUMBROTA, MN 55992

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F 278	Continued From page 11	F 278		

angle. No staff member was observed to walk by or enter R66's room.

At 7:39 a.m. R66 was seated in a wheelchair in the room with the lights on. R66 propelled the wheelchair into the bathroom, no staff were present in the room.

At 7:56 a.m. R66 propelled self from the bathroom with out clothing on. A facility staff walked by the room at this time and pulled the door shut but did not enter the room nor offer assistance to R66. At 8:07 a.m. R66's bed call light appeared on the marque of the facility. At 8:08 a.m. NA-D entered R66's room. R66 was seated in the wheel chair wearing a T-shirt and underwear. R66 stated "I got this far I can't get my stockings on."

During an interview on 9/16/2015, at 8:50 a.m. R66 verified he performed his usual morning routine as follows: awoke independently, transferred self to wheel chair, independently used the bathroom, independently washed self including body, brushed teeth and dress as much as he was able. R66 indicated assistance was needed with donning shoes and pants. R66 stated, "so I called for staff."

During an interview on 9/16/2015, at 12:06 p.m. nursing assistant (NA)-C identified R66 required supervision with all areas of daily living with exception of needing hands on assistance to dress the lower half of his body. NA-C further identified R66 required encouragement to complete things independently, for example getting in to bed and then scooting up in the bed. NA-C verified R66 was able to independently

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F 278	Continued From page 12 move around the inside and outside of the nursing facility, managed his day, going to meals and toileting self. NA-C verified R66 did not use incontinent products, was able to independently recognize the need to urinate and independently take himself to the toilet. NA-C indicated R66 would activate the call light if assistance was needed to pull up and fasten pants. NA-C verified staff did not remind or offer R66 the use of the toilet. During interview on 9/16/2015, at 12:55 p.m. NA-D verified R66's usual routine was to independently awake and get out of bed, use the bathroom, wash self, dress and brush teeth. NA-D verified R66 would activate the call light when staff were needed to assist with donning stockings shoes and pants. NA-D verified R66's ability to manage his toileting needs independently was not new. R66 has taken himself to the bathroom with no reminders or help needed since his urinary catheter had been removed, NA-D stated, "a long time ago." During interview on 9/16/2015, at 1:53 p.m. licensed practical nurse (LPN)-A verified responsibility of completing the MDS process with the nurse managers completed resident assessments. LPN-A verified R66's MDS was coded that R66 was on a toileting plan and continent of bowel and bladder. LPN-A did not answer when questioned regarding what a toileting program was. During interview on 9/16/2015, at 2:28 p.m. registered nurse (RN)-A verified R66 was independent in his room with use of a wheel chair	F 278		

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and independent with toileting. RN-A identified R66's MDS was coded as being on a toileting plan. RN-A stated "we want to make sure they are all on something." RN-A indicated a resident that requested to be assisted to the toilet would be considered to be on a toileting plan "on demand." RN-A stated "indirectly it is a program. For us it would be a program." RN-A further explained the facility staff would intervene if a resident became incontinent in order to assist the resident to regain continence; therefor, it would be considered a toileting program.

During interview on 9/17/2015, at 2:49 p.m. RN-A verified R66's MDS had been incorrectly coded. RN-A indicated R66 was on a maintenance program not a toileting program.

During interview on 9/17/2015, at 2:56 p.m. the director of nursing (DON) indicated correct MDS coding regarding toileting programs had been addressed at facility meetings.

R72's admission Minimum Data Set (MDS) dated 6/22/15, identified R72 had diagnoses which included depression and anxiety. The MDS identified R72 was independent in activities of daily living, including toileting, was continent of urine and was on a toileting program.

R72's 14 day perspective payment system (PPS) MDS dated 6/29/15, identified R72 was independent in ADL's, including toileting, was

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continent of urine and was on a toileting program.

R72's 72 hour bladder diary (an assessment which directed staff to document R72's hourly toileting pattern) dated 6/16/15, 6/17/15, and 6/18/15, lacked complete documentation of R72's toileting pattern. However, the assessment did identify R72 was continent of urine when the documentation was completed.

R72's care plan dated 9/16/15, (undated during survey) revealed R72 was independent in toileting.

On 9/16/15, at 1:55 p.m. during interview, R72 denied needing assistance with toileting and stated he/she did not have a concern with urinary incontinence. R72 also stated staff did not offer prompts to toilet.

On 9/16/15, at 2:15 p.m. nursing assistant (NA)-E stated R72 was independent in toileting and was continent of urine. NA-E also stated R72 did not receive prompting to use the bathroom.

On 9/16/15, at 2:22 p.m. registered Nurse (RN)-C confirmed R72 was continent of urine and did not receive prompting from staff. RN-C also stated R72 was independent in ADL's.

On 9/17/15, at 11:07 a.m. licensed practical nurse (LPN)-B confirmed R72 was independent with ADL's including toileting and was continent of urine.

On 9/17/15, at 1:45 p.m. LPN-A confirmed R72's admission MDS dated 6/22/15, and R72's 14-day PPS MDS dated 6/29/15, identified R72 was on a

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toileting program. LPN-A stated that the information for the MDS was obtained from the nurse managers and entered by LPN - A. LPN-A also stated the nurse managers develop resident toileting programs for each resident.

On 9/17/15, at 2:03 p.m. RN-B confirmed R72 had been considered to be on a toileting program. RN-B confirmed R72 did not meet the criteria for coding a toileting program on the MDS. RN-B confirmed R72's toileting pattern had not been established and staff was not monitoring R72's toileting. RN-B also confirmed R72 was independent in toileting, continent of urine and was not a risk for incontinence. RN-B confirmed R72's admission MDS dated 6/22/15, and 14-day PPS MDS dated 6/19/15, were incorrectly coded for a toileting program.

The facility policy titled MDS 3.0 Assessment dated amended 5/11/15, identified the purpose was to ensure residents are assessed, using comprehensive assessment process, in order to identify care needs and to develop an interdisciplinary care plan. And to ensure the MDS Assessment Coordinator and the interdisciplinary team follow the required processes for submitting, validating and correcting MDS Assessments.

According to the Long Term Care Facility Resident Assessment Instrument User's Manual version 3.0 dated October 2014, the following criteria must be for a resident to be on a toileting program;

-Establishment of a voiding pattern

-establishment of a goal

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F 278	Continued From page 16 -implementation of a toileting plan -monitoring of the toileting plan. -evaluation of the toileting plan. A policy was requested regarding toileting programs, one was not provided.	F 278		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to develop care planning	F 279	R 68¿s care plan was reviewed by the DON/designee. The care plan was	10/16/15

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F 279	Continued From page 17 interventions for 1 of 1 resident (R68) with depression and difficulty adjusting. Findings include: R68's admission Minimum Data Set (MDS), dated 6/20/15, identified R68 had severe cognitive impairment and required extensive assistance with all activities of daily living (ADLs). R68's diagnoses included diabetes and stroke. The MDS also identified R68 had mild depression and took antidepressant medication. R68's symptoms of depression included; little interest or pleasure in doing things, feeling down or depressed, hopeless, feeling tired and having little energy for half of more of the days. R68's quarterly MDS, dated 9/1/15, identified R68 had severe cognitive impairment and required extensive assistance with all activities of daily living (ADLs). R68's diagnoses included diabetes, stroke and dementia. The MDS also identified R68 had worsening, moderate depression and took antidepressant medication. R68's symptoms of depression included; little interest or pleasure in doing things, trouble falling or staying asleep, or sleeping too much, feeling tired and had little energy, and trouble concentrating nearly everyday. R68's care plan, dated 9/1/15 identified R68 had limited socialization, preferred to stay in his room, did not pursue independent activities, had the potential for inability to verbally communicate his needs, and was vulnerable because of his physical and cognitive condition. The care plan failed to identify R68 had depression, was receiving anti-depressant medication, did not include any interventions for mood, and failed to	F 279	updated to include the diagnosis of depression with identified symptoms, and goals and interventions to address those symptoms, also any difficulty with adjusting to the facility. A review of all care plans of residents with a diagnosis of depression was done by SW/designee to assure that all residents have a social service care plan to include identified symptoms of depression, interventions for, and effectiveness (and SE monitoring) of antidepressant medications. Appropriate mental health services will be provided as needed to all residents. The facility Care Plan Policy was reviewed and revised prn by the DON/ SW /designee. Audits will be conducted of to include all care plans by day 21 following admission, to assure that on-going social service concerns regarding symptoms of depression and difficulty adjusting are addressed. Audits results will be presented at the QAPI Committee meetings for review and further recommendations. The Administrator and DON will be responsible for on-going compliance of the Plan of Correction.	

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include any monitoring of signs and symptoms of worsening depression for R68.

On 09/15/15, at 2:21 p.m. family member (FM-A) was very tearful, and choked up while talking during interview. FM-A stated R68 was depressed because of multiple, recent, significant losses in his life. She stated over the last year R68's wife passed away, he had a stroke, lost his ability to care for himself, moved into a different nursing home after he was discharged from the hospital after his stroke and due to neglect of care at the previous nursing home he developed significant health implications, and finally transferred to this nursing home, and had lost his independence. She stated R68 continued to sleep a lot due to his depression, and it has been difficult for R68 to adjust moving into the nursing home to live with a bunch of other people, when he is used to being independent, living in his own home, and taking care of his wife.

On 09/17/15, at 8:34 a.m. the activities director (AD) stated she also shared the social services duties with the clinical coordinator (CC). She stated over the last year R68 had lost his wife, had a stroke, and moved to the nursing home. She stated whenever they asked him how he was doing, he would just say everything is ok, he had a "whatever," type demeanor, no facial expression, and would never want to talk. She stated they feel that's just the way he is. She stated he liked to go to bed early, sleep in, and nap throughout the day. She confirmed R68's activities assessment, identifying R68 enjoyed arts and crafts, music, radio, watching TV and movies, hunting, fishing, outdoors and visiting. She confirmed R68's CP and it identified R68 did not like groups, would refuse activities, wanted to

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F 279	Continued From page 19 stay in his room and would not pursue independent activities. She stated she would know if his depression got worse if his participation in activities decreased, and stated all refusals to activity invitations would be documented on his activity record. She stated R68 received an antidepressant medication as the only intervention for R68's depression. She stated it was the responsibility of either CC or herself to develop R68's social services care plan, and it had not been done. On 09/17/15, at 9:23 a.m. the CC stated she shared the social services duties with the AD. She stated R68 had recently lost his wife, had a stroke and was admitted to the nursing home. She stated, "He'll never ask for help, he'd love to lay in bed all the time if he could." She confirmed 20 mg of Celexa (antidepressant medication) was the facilities only intervention for R68's depression. She stated the dose had not changed since admission, so she felt it was effective. She confirmed R68's CP including the absence of a social services care plan, interventions and monitoring for R68's depression and anti-depressant medication. She stated it was the responsibility of either the AD, clinical manager (CM-A) or herself to develop R68's care plan, and it had not been done. She stated R68 spends most of his day in bed. She said he naps after breakfast until lunch, takes another nap after lunch, and is in bed from 7:00 p.m. to 8:30 a.m. She stated she would know if R68's depression got worse if he showed a lack of interest, or if he became weepy. She stated staff would let her know if they saw these behaviors. She stated she was unaware of any concerns related to R68's depression.	F 279		

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F 279	Continued From page 20 On 09/17/15, at 11:37 a.m. the CM-A stated it was their standard of practice if a resident received a psychoactive drug and had a change in mood they would inform the physician and the family. She confirmed R68's 9/1/15 MDS which identified R68's depression was worse. She said she was not aware of his mood, and the physician and family had not been notified. She stated she expected R68's care plan to to include social services interventions and monitoring of R68's depression and medication. She stated staff should encourage R68 to come out of his room more, encourage him to self-propel in his wheelchair, and help dress himself to help manage his depression. She stated she felt he was doing better, and that his sleepiness was partly related to his stroke. She confirmed staff would not know how to monitor or what to do for R68's depression because it is not on his care plan. On 09/17/15, at 1:54 p.m. nursing assistant (NA-A) and NA-B both stated R68 spends most of his time in bed sleeping, and felt he doesn't want to get up to do anything. They stated they felt R68 was depressed because his wife died. They confirmed the nursing assistant care guide, utilized by the facility, and R68's care plan and stated R68's care plan did not direct them to do anything for R68's depression, and they were not aware of anything special they could do for R68's depression or what symptoms to watch for. On 9/29/15, at 5:15 p.m. director of nurses (DON), confirmed the facility did not have a social services policy, and provided a copy of the social services designees job description. After review of the job description dated 6/14/12, it revealed they would provide individual services to improve	F 279		

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F 279	Continued From page 21 social functioning and reduce psychological problems of residents, contribute to an environment designed to enhance the positive self-images of residents and preserve their human dignity, and assist residents as necessary to find appropriate mental health resources. Review of the facilities Care Plans policy, it identified every resident would have a social services care plan that included social services problems or concerns, evaluation/goals/outcomes and interventions. The policy further identified social services made social related assessments, developed social services related goals, implements plans, and evaluated social services goals.	F 279		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.	F 280		10/16/15

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F 280	Continued From page 22 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to revise the plan of care after a mental health professional recommended a psychotherapy treatment plan for 1 of 1 resident (R39) who had anxiety and depression. Findings include: R39's quarterly Minimum Data Set (MDS), dated 7/6/15 identified R39 had diagnoses that included CVA (stroke), Parkinson's disease and anxiety. MDS also identified R39 was cognitively intact, had minimal depression, was on anti-depressant medication, had no behaviors, and required extensive assistance with all activities of daily living (ADLs) except for eating. R39's Care Plan dated 9/15/15 identified R39's daily decision making ability was severely impaired. R39's goal was to have no further decline in activity participation due to isolation. The care plan revealed R39 declined activity invitations, had repetitive health complaints, anxiety, depression, was on anti-anxiety medication, had excessive call light use, had been isolating herself and called out for help. R39's care plan listed various interventions which included to use distraction, music, puzzles, puzzle books, TV in room, quiet environment and use a calm gentle voice to decrease R39's attention seeking behavior. Review of R39's psychotherapy session note dated 8/13/15 identified R39 had an adjustment	F 280	R 39¿s care plan was reviewed by the DON/designee and updated to reflect non-pharm interventions as recommended by the psychotherapist . DON/designee will conduct an audit of all residents seeing the to ensure psychotherapist recommendations made are on the resident¿s care plan. Audits will be conducted on a weekly basis, for any residents seen by the Psychotherapist, after their visit, to ensure the care plan includes their recommendations Audit results will be presented at the QAPI meeting for review and recommendations.	

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F 280	Continued From page 23 disorder with mixed anxiety and depression, anxiety and chronic pain syndrome. The mental health practitioner noted R39 was irritable, agitated, her affect was depressed, made only some eye contact and was not engaged in the session. The mental health practitioner identified a treatment plan for R39 which included exercise, make mobilization efforts, participate in activities, and receive support for practice relaxation (diaphragmatic breathing and visualization) at least twice daily to manage health and emotional status. On 9/16/15, at 1:00 p.m. during interview, R39 stated she goes to very few activities because she can't go by herself and she had a lot of anxiety. She stated she is not invited by staff to activities, but has a calendar to look at. She stated, " I'm wild, and nervous and I can't go to activities." R39 was observed to be physically agitated, furrowed brow, hand wringing and in a gruff voice said, " I just want to sleep." She stated she doesn't know why she has so much anxiety, and said, "You tell me and we'll both know," using an angry voice and had an angry expression on her face. On 9/16/15, at 1:54 p.m. during interview NA-F and NA-E stated R39 will come out of her room when she feels good. They stated R39 had a history of eating meals in her room, and complained of not feeling good. They stated R39 did not do much for activities other than puzzles in her room. On 9/17/15, at 11:59 a.m. clinical manager (CM)-A stated she was unaware that R39 had a psychotherapy consult, and had not seen the	F 280		

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F 280	Continued From page 24	F 280		

treatment plan. She stated she was unsure of how the facility received consult documentation, or where it went. She stated these documents don't come to us in a timely manner, and didn't know when they received it. She stated clinical coordinator (CC) should have received the report, and confirmed the treatment plan after the consult. She stated the CC did not sign off on the report, or confirm the treatment plan so she must not have received it.

On 9/17/15, at 12:09 p.m. during follow-up interview of the CC and CM, CC confirmed the date on the fax was from 8/31/15, and she never received the report and was unaware R39 had a prescribed treatment plan. She stated this was due to a miscommunication problem. CC stated she should have received it, communicated with the CM, and the CM should have updated R39's care plan to implement the recommendations. They confirmed R39's care plan, and stated it had not been updated to include the prescribed treatment plan. CM stated she did not update R39's care plan but should have. CC indicated she felt R39 would know what to do and do it by herself.

Review of the facility care plans policy, dated 9/1/15 it identified the NM/charge nurse makes nursing assessments, develops nursing goals, implements plans and evaluates the nursing goals of the care plan. The policy further identified care plans are updated on an ongoing basis as needed by the member of the interdisciplinary team responsible for working on those specific goals.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION	(X5) COMPLETION DATE
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN	F 282		10/16/15

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F 282	Continued From page 25 The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to follow the written plan of care for 1 of 4 residents (R32) who required assistance with toileting and 1 of 4 resident (R32) at risk for the development of pressure ulcers. Findings include: R32's current care plan dated 4/25/14, identified R32 was at risk for skin break down related to incontinence and decreased mobility. The care plan directed staff to change R32's position every two hours and for comfort as needed with extensive assist of two staff to reposition and to off load heels when in bed. The care plan further directed staff to check/change R32 every two hours with extensive assist of two staff and to monitor skin for redness or discoloration, blistering, shearing, and blanching and report abnormal's to physicians assistant, nurse practitioner or medical doctor. During continual observation on 9/16/15 at 7:13 a.m. to 10:02 a.m. At 7:13 a.m. R32 was observed lying on her back in bed, with her upper body slightly tilted to the left, eyes closed and her head off the pillow. R32 was alone in her room with the head of the bed elevated approximately 30 degrees, and covered with a blanket which came up to her mid chest area. Trained	F 282	R32¿s care plan was reviewed and revised by DON with attention to turning/repositioning schedule. Education provided to nurses and CNA¿s on turning and repositioning schedules and facility protocols for prevention of pressure ulcers. DON/designee will audit all care plans and care guides for residents that are at risk for pressure ulcers to assure appropriate repositioning schedules. Audits of the care plan/care guides will be completed weekly by DON/designee to assure that appropriate turning and repositioning plans are updated. Audit results will be presented at the QAPI Committee meeting for review and recommendations.	

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F 282	Continued From page 26	F 282		

medication aid (TMA)-A entered the room, woke R32 up, elevating the head of the bed slightly up and gave R32 a drink of water and her medication. At approximately 7:20 a.m. TMA-A left room, did not offer to reposition or assist with toileting for R32. R32 remained in the same position lying on her back in bed, with her upper body slightly tilted to the left and her head off the pillow, elevated approximately 30 degrees, until 10:02 a.m.

-At 9:55 a.m. nursing assistant (NA)-F entered R32's room and asked R32 if she was ready to get up R32 stated "not yet." NA-F then stated to R32 "I will give you another half hour, we need to reposition you."
-At 9:57 a.m. NA-F proceed by gloving both hands, lowered the head of the bed, and then raised the bed to a working position.
-At 9:58 a.m. NA-F removed R32's blankets and she was lying on a white cloth incontinent pad. R32 wore white socks on both of her feet and both R32's heels rested directly on the mattress.
-At 10:02 a.m. NA-F rolled R32 to her left side, changed her brief and provided peri cares. NA-F confirmed R32 was incontinent at this time. During the observation R32's coccyx area was noted to be reddish/purple in color around the coccyx area and extended out approximately five centimeters (cm) around the area with no open areas noted. NA-F then rolled R32 to her left side and placed a pillow under her head, rolled up a blanket and placed under her feet, covered her up, lowered the bed, placed call light, elevated head of bed slightly, raised side rail, then left the room.
R32 had not been provided services for incontinence from 7:13 a.m. until 10:02 a.m., a total of 2 hours and 49 minutes. R32 was unable

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F 282	Continued From page 27	F 282		

to reposition herself independently and was not assisted by staff to be checked or changed for incontinence every two hours per her current care plan.

During interview on 9/16/15 at 10:04 a.m. NA-F confirmed R32 was routinely incontinent of bowel and bladder and needed to be repositioned every two hours and checked/changed. NA-F indicated R32 had not been repositioned or checked/changed since around 6:00 a.m. this morning and stated "this is the first time I have been in there all morning, I hate to say it but it's true."

During interview on 9/16/15 at 10:12 a.m. NA-G confirmed R32 was routinely incontinent of bowel and bladder and needed to be repositioned every two hours, off load heels while in bed and checked/changed. NA-G indicated R32 had not been repositioned or checked/changed since around 6:00 a.m. this morning and stated "she has not been done by me, so no she was not repositioned until NA-F did it."

During interview on 9/16/15 at 1:56 p.m. nurse (RN)-A confirmed R32 was routinely incontinent of bowel and bladder and needed to be repositioned every two hours and checked/changed. RN-A confirmed R32 was at risk for pressure ulcers, confirmed R32's current care plan and stated "she would expect staff to follow the care plan."

During interview on 9/17/15 at 8:49 a.m. NA-F verified R32 was to have her heels floated while in bed and stated " care sheets say off load heels while in bed." At 12:00 p.m. NA-F verified that

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F 282	Continued From page 28	F 282		

lifting the head of the bed up slightly is not repositioning and stated "you need to off load their bottom or side to side or back."

During interview on 9/17/15 at 11:44 a.m. director of nursing (DON) confirmed R32 was at risk for the development of pressure ulcers, confirmed R32's current care plan and indicated she would expect staff to follow the care plan by off loading and repositioning every two hours, off loading her heels and to be checking resident to see if she was incontinent and to check/change her and stated "staff should be following the care plan. DON also indicated she did not consider elevating the head of the bed up as repositioning and stated "repositioning, you have to off load and lifting the head of the bed is not off loading to patient."

During interview on 9/17/15 at 12:07 p.m. TMA-A confirmed R32 was routinely incontinent of bowel and bladder and needed to be repositioned every two hours and checked/changed. TMA-A verified that R32 was not repositioned by her today and indicated that lifting the head of the bed up is not repositioning and stated "I personally do not consider that repositioning."

Review of facility policy, titled Skin Ulcer Protocol revised on 2/1/5 indicated any resident identified at moderate to high risk by the Braden scale will have a comprehensive pressure ulcer risk assessment completed to determine appropriate, individualized interventions for prevention and treatment of pressure/skin ulcers. (pressure relief mattress, pressure relief cushion in chair, turning and repositioning schedule and heel lifts).

Review of facility policy, titled Care Plans revised

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F 282	Continued From page 29 on 9/1/15 indicated staffs approach to meeting the identified goals, including the care and services that must be provided to meet those goals, the frequency of these services provided.	F 282		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to implement a physician prescribed psychotherapy treatment plan for 1 of 1 resident (R39) who had anxiety and depression. Findings include: R39's quarterly Minimum Data Set (MDS), dated 7/6/15 identified R39 had diagnoses that included CVA (stroke), Parkinson's disease and anxiety. MDS also identified R39 was cognitively intact, had minimal depression, was on anti-depressant medication, had no behaviors, and required extensive assistance with all activities of daily living (ADLs) except for eating. R39's Care Area Assessment (CAA) dated 7/6/15 identified R39 had generalized anxiety disorder with depression and mild atrophy of the brain. The CAA identified R39 is calmer, was less	F 309	R 39¿s treatment plan was reviewed by DON and Clinical Coordinator. Recommendations re non-pharm interventions were reviewed and the care plan was updated to include psychotherapist treatment plan and non-pharm interventions. All residents who have a Psychotherapy Treatment Plan will be identified and care plans will be reviewed and revised prn for non- pharm interventions. The Provider Regulatory SNF visit form was changed to include the PHQ-9 score and per our Medical Director this was changed in the Mayo Clinic system for all geriatric MD/ CNP rounds, as well. The system for receiving fax reports from the psychotherapist was reviewed and revised to ensure Clinical Coordinator will receive them and update the care plan on	10/16/15

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F 309	Continued From page 30 anxious and had no behaviors. R39's Care Plan dated 9/15/15 identified R39's daily decision making ability was severely impaired. R39's goal was to have no further decline in activity participation due to isolation. The care plan revealed R39 declined activity invitations, had repetitive health complaints, anxiety, depression, was on anti-anxiety medication, had excessive call light use, had been isolating herself and called out for help. R39's care plan listed various interventions which included to use distraction, music, puzzles, puzzle books, TV in room, quiet environment and use a calm gentle voice to decrease R39's attention seeking behavior. R39's active orders were provided by the DON 9/17/15, at 2:53 p.m. and identified she had been taking 10 milligrams (mg) of Paxil (anti-anxiety medication) daily at 8:00 a.m. for depression, and 0.5 mg of clonazepam (anti-anxiety medication) twice a day at 8:00 a.m. and 2:00 p.m. for anxiety. Review of R39's psychotherapy session note dated 8/13/15 identified R39 had an adjustment disorder with mixed anxiety and depression, anxiety and chronic pain syndrome. The mental health practitioner noted R39 was irritable, agitated, her affect was depressed, made only some eye contact and was not engaged in the session. The mental health practitioner identified a treatment plan for R39 which included exercise, make mobilization efforts, participate in activities, and receive support for practice relaxation (diaphragmatic breathing and visualization) at least twice daily to manage health and emotional	F 309	a timely basis. Audits will be conducted by the DON/designee on a weekly basis, for any residents seen by the Psychotherapist, after their visit, to ensure the care plan includes their recommendations. Audit result will be presented at quarterly QAPI meetings for review and recommendations.	

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F 309	Continued From page 31 status. Progress Notes reviewed from 7/27/15 to 9/17/15 revealed the following: -On 7/27/15, at 5:22 p.m. R39 refused to be weighed. No documentation of any non-pharmacological interventions tried. No further intervention or follow up noted. -On 8/1/15, at 11:48 p.m. R39 became weak during transfer and was lowered to the floor by staff. R68 was then to be transferred with a mechanical lift at all times. -On 8/4/15, at 5:51 p.m. R39 reported increased anxiety at 4 p.m. every day. Anxiety medication changed from 4:00 p.m. to 2:00 p.m. daily. No documentation of any non-pharmacological interventions or medication administration for anxiety. -On 8/5/15, at 4:14 p.m. R39 reported no change in her degree of anxiety at 4:00 p.m. with medication change. No documentation of any non-pharmacological interventions, medication administration or further follow up for R68's anxiety. -On 8/13/15, at 11:09 a.m. physical therapy documented R39 reported pain was so nervous and very weak she didn't think she was going to be able to walk. No documentation of any non-pharmacological interventions attempted for R39's anxiety. -On 8/19/15, at 4:07 p.m. R68 felt she did not need PT anymore. R39 was discharged from PT this date. No documentation of any	F 309		

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non-pharmacological interventions tried for redirection or encouragement.

-On 9/7/15, at 9:50 a.m. R39 refused to take a bath 3 times, and stated she does not feel up to getting a bath. No documentation of any non-pharmacological interventions tried.

On 9/16/15, at 8:25 a.m. during observation R39 was in her room in bed awake while clinical manager (CM-A) assisted her with a nebulizer treatment. R39 appeared physically anxious and was fidgeting with her fingers during the treatment.

On 9/16/15, at 9:27 a.m. R39 was observed up in her recliner. R39's face was grimaced, appeared frustrated, irritable, anxious and agitated. R39 was short of breath, both hands were shaking and stated, " I hurt all the time and I can't breathe."

On 9/16/15, at 1:00 p.m. during interview, R39 stated she goes to very few activities because she can't go by herself and she had a lot of anxiety. She stated she is not invited by staff to activities, but has a calendar to look at. She stated, " I'm wild, and nervous and I can't go to activities." R39 was observed to be physically agitated, furrowed brow, hand wringing and in a gruff voice said, " I just want to sleep." She stated she doesn't know why she has so much anxiety, and said, "You tell me and we'll both know," using an angry voice and had an angry expression on her face.

On 9/16/15, at 1:54 p.m. during interview NA-F and NA-E stated R39 will come out of her room when she feels good. They stated R39 had a

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F 309	Continued From page 33	F 309		

history of eating meals in her room, and complained of not feeling good. They stated R39 did not do much for activities other than puzzles in her room.

On 9/17/15, at 11:59 a.m. clinical manager (CM)-A stated she was unaware that R39 had a psychotherapy consult, and had not seen the treatment plan. She stated she was unsure of how the facility received consult documentation, or where it went. She stated she felt these documents don't come to facility in a timely manner, and didn't know when they received it. She stated clinical coordinator (CC) should have received the report, and confirmed the treatment plan after the consult. She stated the CC did not sign off on the report, or confirm the treatment plan so she must not have received it.

On 9/17/15, at 12:09 p.m. during follow-up interview of the CC and CM, CC confirmed the date on the fax was from 8/31/15, and she never received the report and was unaware R39 had a prescribed treatment plan. She stated this was due to a miscommunication problem. CC stated she should have received it, communicated with the CM, and the CM should have updated R39's care plan to implement the recommendations. They confirmed R39's care plan, and stated it had not been updated to include the prescribed treatment plan. CM stated she did not update R39's care plan but should have. CC indicated she felt R39 would know what to do and do it by herself.

On 9/17/15, at 3:00 p.m. DON stated she was unable to find a facility policy related to following

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F 309	Continued From page 34 physicians orders.	F 309		
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to provide timely services to maintain good personal hygiene for 1 of 4 residents (R32) reviewed for activities of daily living. Findings include: R32's quarterly Minimum Data Set (MDS), dated 6/12/15, identified R32 had severe cognitive impairment with diagnoses which included: dementia, anemia, and chronic pain. The MDS identified R32 required extensive assist of two staff for bed mobility, transferring and toileting. The MDS also identified R32 was always incontinent of bladder, frequently incontinent of bowel and was currently on a trial toileting program for bladder and not on a bowel toileting program. R32's bowel and bladder assessment dated 9/9/15, indicated R32 had stress/functional urinary incontinence and required routine scheduled toileting with incontinent products changed frequent. R32 was always incontinent of	F 312	It is the policy of this facility to provide the necessary services to provide good personal hygiene r/t incontinence care. Resident R 32¿s care plan was reviewed by the DON/designee. The resident is incontinent of bowel and bladder due to dementia and functional limitations. The resident requires extensive assist of two and is checked and changed every 2 hours and brief changed per incontinent product protocol with Desitin to bottom and perineum. In-service training was provided to all direct care nursing staff regarding R32¿s care plan and state and federal requirements as it relates to provision of personal hygiene (incontinence care). All residents with incontinence care needs were identified and care plans /care guides were reviewed and updated prn by DON/designee. Observational audits of incontinence care will be conducted 2Xweek x2, then weekly thereafter. Audit results reports will be brought to	10/16/15

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F 312	Continued From page 35 bowel/bladder and scored fifteen on the bowel and bladder assessment indicating R32 had minimal restorative potential to restore her bowel and bladder function. R32's care area assessment (CAA) dated 3/25/15, indicated R32 was frequently incontinent of bladder, occasionally incontinent of bowel and required a scheduled toileting plan to check an change every 2 hours, needed extensive assist of 2 for toileting and desitin to bottom and perineum. R32's current care plan dated 4/25/14, identified R32 was at risk for skin break down related to incontinence and decreased mobility. The care plan directed staff to check/change R32 every two hours with extensive assist of two staff and to monitor skin for redness or discoloration, blistering, shearing, and blanching and report abnormal's to physicians assistant, nurse practitioner or medical doctor. During continual observation on 9/16/15 at 7:13 a.m. to 10:02 a.m. At 7:13 a.m. R32 was observed lying on her back in bed, with her upper body slightly tilted to the left, eyes closed and her head off the pillow. R32 was alone in her room with the head of the bed elevated approximately 30 degrees, and covered with a blanket which came up to her mid chest area. Trained medication aid (TMA)-A entered the room, woke R32 up, elevating the head of the bed slightly up and gave R32 a drink of water and her medication. At approximately 7:20 a.m. TMA-A left room, did not offer to reposition or assist with toileting for R32. R32 remained in the same position lying on her back in bed, with her upper body slightly tilted to the left and her head off the pillow, elevated approximately 30 degrees, until	F 312	the QAPI Committee meeting for review and recommendations. DON /Administrator will be responsible for sustaining compliance of the Plan of Correction.	

POC NOT FINAL

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	245376	A. BUILDING ______ B. WING ______	09/17/2015

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F 312	Continued From page 36	F 312		

10:02 a.m.

-At 9:55 a.m. nursing assistant (NA)-F entered R32's room and asked R32 if she was ready to get up R32 stated "not yet." NA-F then stated to R32 "I will give you another half hour, we need to reposition you."
-At 9:57 a.m. NA-F proceed by gloving both hands, lowered the head of the bed, and then raised the bed to a working position.
-At 9:58 a.m. NA-F removed R32's blankets and she was lying on a white cloth incontinent pad. R32 wore white socks on both of her feet and both R32's heels rested directly on the mattress.
-At 10:02 a.m. NA-F rolled R32 to her left side, changed her brief and provided peri cares. NA-F confirmed R32 was incontinent at this time.
During the observation R32's coccyx area was noted to be reddish/purple in color around the coccyx area and extended out approximately five centimeters (cm) around the area with no open areas noted. NA-F then rolled R32 to her left side and placed a pillow under her head, rolled up a blanket and placed under her feet, covered her up, lowered the bed, placed call light, elevated head of bed slightly, raised side rail, then left the room.
R32 had not been provided services for incontinence from 7:13 a.m. until 10:02 a.m., a total of 2 hours and 49 minutes. R32 was unable to reposition herself independently and was not assisted by staff to be checked or changed for incontinence every two hours per her current care plan.

During interview on 9/16/15 at 10:04 a.m. NA-F confirmed R32 was routinely incontinent of bowel and bladder and needed to be repositioned every two hours and checked/changed. NA-F indicated

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F 312	Continued From page 37	F 312		

R32 had not been repositioned or checked/changed since around 6:00 a.m. this morning and stated "this is the first time I have been in there all morning, I hate to say it but it's true."

During interview on 9/16/15 at 10:12 a.m. NA-G confirmed R32 was routinely incontinent of bowel and bladder and needed to be repositioned every two hours, off load heels while in bed and checked/changed. NA-G indicated R32 had not been repositioned or checked/changed since around 6:00 a.m. this morning and stated "she has not been done by me, so no she was not repositioned until NA-F did it."

During interview on 9/16/15 at 1:56 p.m. nurse (RN)-A confirmed R32 was routinely incontinent of bowel and bladder and needed to be repositioned every two hours and checked/changed. RN-A confirmed R32 was at risk for pressure ulcers, confirmed R32's current care plan and stated "she would expect staff to follow the care plan."

During interview on 9/17/15 at 8:49 a.m. NA-F verified R32 was to have her heels floated while in bed and stated " care sheets say off load heels while in bed." At 12:00 p.m. NA-F verified that lifting the head of the bed up slightly is not repositioning and stated "you need to off load their bottom or side to side or back."

During interview on 9/17/15 at 11:44 a.m. director of nursing (DON) confirmed R32 was at risk for the development of pressure ulcers, confirmed R32's current care plan and indicated she would expect staff to follow the care plan by off loading and repositioning every two hours, off loading her

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F 312	Continued From page 38 heels and to be checking resident to see if she was incontinent and to check/change her and stated staff should be following the care plan. During interview on 9/17/15 at 12:07 p.m. TMA-A confirmed R32 was routinely incontinent of bowel and bladder and needed to be repositioned every two hours and checked/changed. TMA-A verified that R32 was not repositioned when she assisted R32 with her medications. Review of facility policy, titled Care Plans revised on 9/1/15 indicated staffs approach to meeting the identified goals, including the care and services that must be provided to meet those goals, the frequency of these services provided.	F 312		
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure timely repositioning for 1 of 1 resident (R32) identified at risk for pressure ulcers. Findings include:	F 314	Per the facility protocol residents will not develop pressure sores/skin ulcers unless it is clinically unavoidable and appropriate care and services will be provided to prevent, treat, and monitor progress of all healing ulcer(s).	10/16/15

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F 314	Continued From page 39 R32's quarterly Minimum Data Set (MDS), dated 6/12/15, identified R32 had severe cognitive impairment with diagnoses which included: dementia, anemia, and chronic pain. In addition, the MDS identified R32 required extensive assist of two staff for bed mobility and transferring. The MDS also identified R32 was at risk for the development of pressure ulcers and listed various treatments which included turning and repositioning and utilized a pressure reducing device on R32's bed and chair. R32's care area assessment (CAA) dated 3/25/15, indicated R32 had a Braden score of 14 which indicated at risk for developing pressure related to skin incidents. The CAA identified R32 continued to transfer with assist of two staff using a front wheeled walker and was on a every 2 hour repositioning schedule, had a pressure reducing wheel chair cushion and mattress and to off load heels while in bed. The CAA also indicated R32 was frequently incontinent of bladder, occasionally incontinent of bowel and required a scheduled toileting plan to check an change every 2 hours, needed extensive assist of 2 for toileting and desitin to bottom and perineum. R32's Braden Scale for Prediction Pressure Sore Risk form, dated 9/9/15 identified R32 was high risk for the development of pressure ulcers, skin was constantly moist, was chairfast, had very limited mobility, and a problem of friction and shearing. R32's current care plan dated 4/25/14, identified R32 was at risk for skin break down related to incontinence and decreased mobility. The care plan directed staff to change R32's position every	F 314	R (39)¿s skin assessment and care plan was reviewed. A tissue tolerance test was initiated and turning and repositioning schedule was adjusted per results. The care plan was revised to include the change in T/R schedule. All residents at risk for skin breakdown were identified and care plans/care guides were reviewed to ensure all residents¿ are being turned and repositioned per results of their skin assessment to include tissue tolerance testing. The facility Skin Ulcer Protocol and resident¿s care plan was reviewed by the DON/designee. Skin assessments are done at time of admission, quarterly and with any change of condition. Skin assessments should include an evaluation of the skin integrity and tissue tolerance to assess resident at risk of developing pressure ulcers. A tissue tolerance will be done upon admission, with any change in condition (including becoming dependent on staff or development of a pressure ulcer) and annually. All residents will be assessed for skin issues per protocol with preventive measures as indicated. Education was provided to nursing staff on R39¿s skin care plan, the facility Skin Protocol and tissue tolerance assessment review. Observational Audits of T/R for residents at risk of skin breakdown will be conducted 2xweekX2, then weekly thereafter, by DON/Nurse Manager/designee. Audit results will be presented at the QAPI Committee meeting for review and further direction.	

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F 314	Continued From page 40 two hours and for comfort as needed with extensive assist of two staff to reposition and to off load heels when in bed. The care plan further directed staff to monitor skin for redness or discoloration, blistering, shearing, and blanching and report abnormal's to physicians assistant, nurse practitioner or medical doctor. During continual observation on 9/16/15 at 7:13 a.m. to 10:02 a.m. At 7:13 a.m. R32 was observed lying on her back in bed, with her upper body slightly tilted to the left, eyes closed and her head off the pillow. R32 was alone in her room with the head of the bed elevated approximately 30 degrees, and covered with a blanket which came up to her mid chest area. Trained medication aid (TMA)-A entered the room, woke R32 up, elevating the head of the bed slightly up and gave R32 a drink of water and her medication. At approximately 7:20 a.m. TMA-A left room, did not offer to reposition or assist with toileting for R32. R32 remained in the same position lying on her back in bed, with her upper body slightly tilted to the left and her head off the pillow, elevated approximately 30 degrees, until 10:02 a.m. -At 9:55 a.m. nursing assistant (NA)-F entered R32's room and asked R32 if she was ready to get up R32 stated "not yet." NA-F then stated to R32 "I will give you another half hour, we need to reposition you." -At 9:57 a.m. NA-F proceed by gloving both hands, lowered the head of the bed, and then raised the bed to a working position. -At 9:58 a.m. NA-F removed R32's blankets and she was lying on a white cloth incontinent pad. R32 wore white socks on both of her feet and both R32's heels rested directly on the mattress.	F 314	Administrator and DON are responsible for sustained compliance of POC.	

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F 314	Continued From page 41	F 314		

-At 10:02 a.m. NA-F rolled R32 to her left side, changed her brief and provided peri cares. NA-F confirmed R32 was incontinent at this time. During the observation R32's coccyx area was noted to be reddish/purple in color around the coccyx area and extended out approximately five centimeters (cm) around the area with no open areas noted. NA-F then rolled R32 to her left side and placed a pillow under her head, rolled up a blanket and placed under her feet, covered her up, lowered the bed, placed call light, elevated head of bed slightly, raised side rail, then left the room.
R32 had not been repositioned from 7:13 a.m. until 10:02 a.m., a total of 2 hours and 49 minutes. R32 was unable to reposition herself independently and was not assisted by staff to be checked or changed for incontinence every two hours per her current care plan.

During interview on 9/16/15 at 10:04 a.m. NA-F confirmed R32 was routinely incontinent of bowel and bladder and needed to be repositioned every two hours and checked/changed. NA-F indicated R32 had not been repositioned or checked/changed since around 6:00 a.m. this morning and stated "this is the first time I have been in there all morning, I hate to say it but it's true."

During interview on 9/16/15 at 10:12 a.m. NA-G confirmed R32 was routinely incontinent of bowel and bladder and needed to be repositioned every two hours, off load heels while in bed and checked/changed. NA-G indicated R32 had not been repositioned or checked/changed since around 6:00 a.m. this morning and stated "she has not been done by me, so no she was not repositioned until NA-F did it."

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F 314	Continued From page 42 During interview on 9/16/15 at 1:56 p.m. nurse (RN)-A confirmed R32 was routinely incontinent of bowel and bladder and needed to be repositioned every two hours and checked/changed. RN-A confirmed R32 was at risk for pressure ulcers, confirmed R32's current care plan and stated "she would expect staff to follow the care plan." During interview on 9/17/15 at 8:49 a.m. NA-F verified R32 was to have her heels floated while in bed and stated " care sheets say off load heels while in bed." At 12:00 p.m. NA-F verified that lifting the head of the bed up slightly is not repositioning and stated "you need to off load their bottom or side to side or back." During interview on 9/17/15 at 11:44 a.m. director of nursing (DON) confirmed R32 was at risk for the development of pressure ulcers, confirmed R32's current care plan and indicated she would expect staff to follow the care plan by off loading and repositioning every two hours, off loading her heels and to be checking resident to see if she was incontinent and to check/change her and stated "staff should be following the care plan." DON also indicated she did not consider elevating the head of the bed up as repositioning and stated "repositioning, you have to off load and lifting the head of the bed is not off loading to patient." During interview on 9/17/15 at 12:07 p.m. TMA-A confirmed R32 was routinely incontinent of bowel and bladder and needed to be repositioned every two hours and checked/changed. TMA-A verified that R32 was not repositioned by her today and indicated that lifting the head of the bed up is not	F 314		

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F 314	Continued From page 43 repositioning and stated "I personally do not consider that repositioning." Review of facility policy, titled Skin Ulcer Protocol revised on 2/1/5 indicated any resident identified at moderate to high risk by the Braden scale will have a comprehensive pressure ulcer risk assessment completed to determine appropriate, individualized interventions for prevention and treatment of pressure/skin ulcers. (pressure relief mattress, pressure relief cushion in chair, turning and repositioning schedule and heel lifts).	F 314		
F 319 SS=D	483.25(f)(1) TX/SVC FOR MENTAL/PSYCHOSOCIAL DIFFICULTIES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who displays mental or psychosocial adjustment difficulty receives appropriate treatment and services to correct the assessed problem. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide necessary care and services for 1 of 1 recently admitted resident (R68) who displayed an adjustment disorder in the facility.. Findings include: R68's admission Minimum Data Set (MDS), dated 6/20/15, identified R68 had diagnoses which included diabetes and stroke, had severe cognitive impairment and required extensive assistance with all activities of daily living (ADLs). The MDS also identified R68 had mild depression	F 319	R 68¿s care plan was reviewed and updated by DON/designee for mood altering medication. All residents admitted to the facility who display mental or physical adjustment difficulty will be identified and will receive appropriate treatment and services to correct the assessed problem. In addition any resident on a psychoactive medication who displays a lack of response to a psychoactive medication will be identified and the physician will be notified of such a change.	10/16/15

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F 319	Continued From page 44 and took antidepressant medication. R68's symptoms of depression included; little interest or pleasure in doing things, feeling down or depressed, hopeless, feeling tired and having little energy for half of more of the days. R68's care area assessment (CAA), dated 6/23/15 identified R68 had mild depression, and received 20 milligrams (mg) Celexa (anti-depressant medication). The CAA revealed the family reported R68's wife died a few months before admission and he took care of her before she died. The family reported after she died he just gave up, and his health declined, he didn't want to get out of bed all day, or even want to get dressed. R68's quarterly MDS, dated 9/1/15 identified R68 had diagnosis which included diabetes, stroke and dementia, had severe cognitive impairment and required extensive assistance with all activities of daily living. The MDS also identified R68 had worsening, moderate depression and took antidepressant medication. R68's symptoms of depression included; little interest or pleasure in doing things, trouble falling or staying asleep, or sleeping too much, feeling tired and had little energy, and trouble concentrating nearly everyday. R68's nursing assessment, dated 9/1/15 identified R68 had moderate depression, and received 20 mg Celexa. The CAA revealed prior to admission R68's life centered almost entirely on family activities, and his weaknesses were his adjustment to placement, limited group	F 319	The following approach was added to R 68¿s care plan, ` to notify PA, NP or MD if any change in resident mood or response to medication is noted¿. All other residents in the facility on psychoactive medications were identified and their care plans reviewed and updated for physician notification of any changes in mood or response to medication. In addition the PHQ-9 portion of the Mayo Report sheet was updated to include the results of the previous PHQ-9. This was added to allow for comparison and to facilitate notification of any changes at the time of NP/MD regulatory rounds. With the addition of a Social Worker to facility staff the PHQ-9 is now being completed by the social worker vs the activity director. Random audits of residents on psychoactive medications for monitoring of lack of response to medication or changes in mood, with report to NP/MD prn, will be conducted by the DON/designee 2XweekX2, and on a weekly basis thereafter. Audit results will be brought to the QAPI Committee for review and further recommendations. The DON and Administrator are responsible for sustained compliance of the Plan of Correction.	

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F 319	Continued From page 45	F 319		

interaction, prefers solitude.

R68's current care plan , dated 9/10/15 identified he had limited socialization, preferred to stay in his room, did not pursue independent activities, had the potential for inability to verbally communicate his needs, and was vulnerable because of his physical and cognitive condition. The care plan failed to identify R68 had depression, was taking anti-depressant medication, did not include any interventions for mood, and failed to include any monitoring of signs and symptoms of worsening depression for R68.

R68's Resident Activity Assessment, dated 9/1/15 identified R68 enjoyed arts and crafts, music, radio, hunting/fishing, watching TV, movies, outdoors, talking/conversing and volunteer, family, friend and staff visits. The assessment identified R68 was awake all or most evenings and preferred evening activities in his own room.

R68's monthly activity attendance record identified the following:

-In June R68 had 3 visitors and 3 visits by staff or volunteers. No further participation or refusal of other activities of interest recorded.

-In July R68 had 2 visitors, attended 3 music activities, and refused 1 outdoor activity. No further participation or refusal of other activities of interest recorded.

-In August R68 had 1 visitor, 1 visit by a staff person or volunteer, and attended 1 music activity. No further participation or refusal of other activities of interest recorded.

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F 319	Continued From page 46 -In September R68 had 2 visitors, 1 visit by a staff or volunteer, and no further participation or refusal of other activities of interest recorded. On 9/15/15, at 9:14 a.m. R68 was observed asleep in bed, on his back in a blue hospital gown. R68's room was dark, the TV was off, room was quiet, no music playing or radio observed in room. On 9/16/15, at 9:27 a.m. R68 was observed asleep in bed, on his back, covered up with blue fleece blanket. R68's room was dark, the TV was off, room was quiet, no music playing or radio observed in room. On 9/16/15, at 12:52 p.m. R68 was observed asleep in bed, lying on his back covered up with blue fleece blanket. R68's room was dark, the TV was off, room was quiet, no music playing or radio observed in room. On 9/17/15, at 2:20 p.m. R68 was observed asleep in bed, on his back, covered up with blue fleece blanket. R68's room was dark, the TV was off, room was quiet, no music playing or radio observed in room. On 09/15/15, at 2:21 p.m. family member (FM-A) was very tearful, and choked up while talking during interview. FM-A stated R68 was depressed because of multiple, recent, significant losses in his life. She stated over the last year R68's wife passed away, he had a stroke, lost his ability to care for himself, moved into a different nursing home after he was discharged from the hospital after his stroke and due to neglect of care at the previous nursing home he developed significant	F 319		

POC NOT FINAL

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245376	A. BUILDING ______ B. WING ______	09/17/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ZUMBROTA CARE CENTER	433 MILL STREET ZUMBROTA, MN 55992

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 319	Continued From page 47	F 319		

health implications, and finally transferred to this nursing home, and had lost his independence. She stated R68 continued to sleep a lot due to his depression, and it has been difficult for R68 to adjust moving into the nursing home to live with a bunch of other people, when he is used to being independent, living in his own home, and taking care of his wife.

On 09/17/15, at 8:34 a.m. the activities director (AD) stated she also shared the social services duties with the clinical coordinator (CC). She stated over the last year R68 had lost his wife, had a stroke, and moved to the nursing home. She stated whenever they asked him how he was doing, he would just say everything is ok, he had a "whatever," type demeanor, no facial expression, and would never want to talk. She stated they feel that's just the way he is. She stated he liked to go to bed early, sleep in, and nap throughout the day. She confirmed R68's activities assessment, identifying R68 enjoyed arts and crafts, music, radio, watching TV and movies, hunting, fishing, outdoors and visiting. She confirmed R68's CP identified R68 did not like groups, would refuse activities, wanted to stay in his room and would not pursue independent activities. She stated she would know if his depression got worse if his participation in activities decreased, and stated all refusals to activity invitations would be documented on his activity record. She stated it was her goal to have R68 exercise everyday, although R68 did not identify exercise as a preferred activity on his assessment. She stated R68 received an antidepressant medication as the only intervention for R68's depression. She stated it was the responsibility of either CC or herself to develop R68's social services care

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F 319	Continued From page 48 plan, and it had not been done. On 09/17/15, at 9:23 a.m. the CC stated she shared the social services duties with the AD. She stated R68 had recently lost his wife, had a stroke and was admitted to the nursing home. She stated, "He'll never ask for help, he'd love to lay in bed all the time if he could." She confirmed 20 mg of Celexa (antidepressant medication) was the facilities only intervention for R68's depression. She stated the dose had not changed since admission, so she felt it was effective. She confirmed R68's CP including the absence of a social services care plan, interventions and monitoring for R68's depression and anti-depressant medication. She stated it was the responsibility of either the AD, clinical manager (CM-A) or herself to develop R68's care plan, and it had not been done. She stated R68 spends most of his day in bed. She said he naps after breakfast until lunch, takes another nap after lunch, and is in bed from 7:00 p.m. to 8:30 a.m. She stated she would know if R68's depression got worse if he showed a lack of interest, or if he became weepy. She stated staff would let her know if they saw these behaviors. She stated she was unaware of any concerns related to R68's depression. On 09/17/15, at 11:37 a.m. the CM-A stated it was facility standard of practice if a resident received a psychoactive drug and had a change in mood they would inform the physician and the family. She confirmed R68's 9/1/15 MDS which identified R68's depression was worse. She stated she was not aware of his mood, and the physician and family had not been notified. She stated she expected R68's CP to include social services interventions and monitoring of R68's	F 319		

POC NOT FINAL

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245376	A. BUILDING ______ B. WING ______	09/17/2015

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F 319	Continued From page 49	F 319		

depression and medication. She stated staff should encourage R68 to come out of his room more, encourage him to self-propel in his wheelchair, and help dress himself to help manage his depression. She stated she felt he was doing better, and that his sleepiness was partly related to his stroke. She confirmed staff would not know how to monitor or what to do for R68's depression because it is not on his CP.

On 09/17/15, at 1:54 p.m. nursing assistant (NA-A) and NA-B both stated R68 spends most of his time in bed sleeping, and felt he doesn't want to get up to do anything. They stated they felt R68 was depressed because his wife died. They confirmed the nurse aide care guide, utilized by the facility, and stated R68's nurse aide guide and care plan did not direct them to do anything for R68's depression, and they were not aware of anything special they could do for R68's depression or what symptoms to watch for.

On 9/29/15, at 5:15 p.m. director of nurses (DON), confirmed the facility did not have a social services policy, and provided a copy of the social services designees (SSD) job description. The job description dated 6/14/12, revealed the SSD would provide individual services to improve social functioning and reduce psychological problems of residents, contribute to an environment designed to enhance the positive self-images of residents and preserve their human dignity, and assist residents as necessary to find appropriate mental health resources.

Review of the facilities Activity Department Policy, dated 2/28/07, revealed the activities program would promote the emotional health, enhance the mental status, and promote each residents sense

POC NOT FINAL

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	245376	A. BUILDING ______ B. WING ______	**09/17/2015**

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F 319	Continued From page 50 of self respect.	F 319		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245376	A. BUILDING **01 - MAIN BUILDING 01** B. WING ______	**09/18/2015**

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K 000	INITIAL COMMENTS	K 000		

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 WILL BE USED AS VERIFICATION OF COMPLIANCE.

UPON RECEIPT OF AN ACCEPTABLE POC, AN ON-SITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION.

A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety - State Fire Marshal Division. At the time of this survey, Zumbrota Care Center 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
(K-TAGS) TO:

Health Care 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	(X6) DATE
Electronically Signed		10/15/2015

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245376	A. BUILDING 01 - MAIN BUILDING 01 B. WING	09/18/2015

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K 000	Continued From page 1 By email to: Marian.Whitney@state.mn.us and Angela.Kappenman@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. This facility will be surveyed as two separate buildings. Zumbrota Care Center is a 1-story building. The building was constructed at 2 different times. The original building was constructed in 1964 and was determined to be of Type II(000) construction, with a partial basement. In 1968, an addition was constructed that was determined to be of Type II(000) construction, with no basement. Because the original building and the 1 addition are of the same type of construction and meet the construction type allowed for existing buildings, the facility was surveyed as one building. The building is fully sprinklered. The facility has a fire alarm system with partial smoke detection in corridor and spaces open to the corridors that is monitored for automatic fire department notification.	K 000		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245376	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING	(X3) DATE SURVEY COMPLETED 09/18/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ZUMBROTA CARE CENTER	433 MILL STREET ZUMBROTA, MN 55992

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	Continued From page 2 The facility has a capacity of 50 beds and had a census of 48 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 025 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain corridor wall in accordance with the following requirements of 2000 NFPA 101, Section 19.3.7.3, 8.3.2 and 8.3.6. The deficient practice could affect 10 out of 48 residents. Findings include: On facility tour between 9:45 AM and 11:45 AM on 09/18/2015, observation revealed that the 2nd floor- smoke barrier wall by nursing station has open penetrations above lay in ceiling.	K 025	Smoke barriers were repaired and penetrations were sealed with fire caulk. Large openings were sheetrocked and closed on both sides. To insure future compliance, Environmental Services Director will inspect all contracted work projects immediately upon completion to insure all wall penetrations meet fire safety codes. Random audits will be done to insure ongoing compliance.	10/16/15

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	245376	A. BUILDING 01 - MAIN BUILDING 01 B. WING	09/18/2015

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K 025	Continued From page 3 NOTE: All smoke barriers need to be checked from exterior wall to exterior wall. This deficient practice was confirmed by the Director of Maintenance (RG) at the time of discovery.	K 025		
K 072 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Means of egress are continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. No furnishings, decorations, or other objects obstruct exits, access to, egress from, or visibility of exits. 7.1.10 This STANDARD is not met as evidenced by: Based on observations and staff interview, the facility has corridor obstructions. These obstructions could interfere with the convenient and effective removal of patients, staff and visitors in an emergency situation. The deficient practice could affect all 48 residents. Findings include: On facility tour between 9:45 AM and 11:45 AM on 09/18/2015, observation revealed, that the installation of the interior finishes in the North, South and West corridors has diminished the width of an existing corridor. The corridors width was reduced from 84-3/4 inches to 75-3/4 inches the entire length of each corridor.	K 072	In order to gain compliance with K 072 a FSES survey will be conducted at the Zumbrota Care Center. Zumbrota Care Center will achieve a passing FSES score by Nov 15, 2015	10/16/15

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	245376	A. BUILDING **01 - MAIN BUILDING 01** B. WING	**09/18/2015**

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K 072	Continued From page 4 This deficient practice was confirmed by the Director of Maintenance (RG) at the time of discovery. NOTE: This deficiency need not be corrected if an FSES can establish that the facility has a level of fire safety equivalent to the required by the Life Safety Code, NFPA 101, 2000 Edition.	K 072		
K 144 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1. This STANDARD is not met as evidenced by: Based on documentation review and staff interview, the facility failed to inspect the emergency generator in accordance with the requirements of 2000 NFPA 101 - 9.1.3 and 1999 NFPA 110 Chapter 6.4.2. The deficient practice could affect all 48 residents. Findings include: On facility tour between 9:45 AM and 11:45 AM on 09/18/2015, documentation review of the monthly generator logs revealed the following:	K 144	Generator was inspected by manufacturer and 2 hour load test was performed. Report was received confirming generator passed fire safety codes for 2 hour load test. Environmental Service Director or designee will perform monthly load testing and a yearly 2 hour load test as required by the fire safety codes as well as maintaining a generator log for both.	10/16/15

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K 144	Continued From page 5 1. The review of the monthly run test indicated that the generator did not meet one of the following: a. loading that maintains the minimum exhaust gas temperatures as recommended by the manufacturer or b. under load of 30 percent or more of the nameplate rating of generator or c. 2 hour load bank test (first 30 minutes - 25%, next 30 minutes - 50%, and last 1 hour - 75%) This deficient practice was confirmed by the Director of Maintenance (RG) at the time of discovery. *TEAM COMPOSITION* Gary Schroeder, Life Safety Code Spc.	K 144		

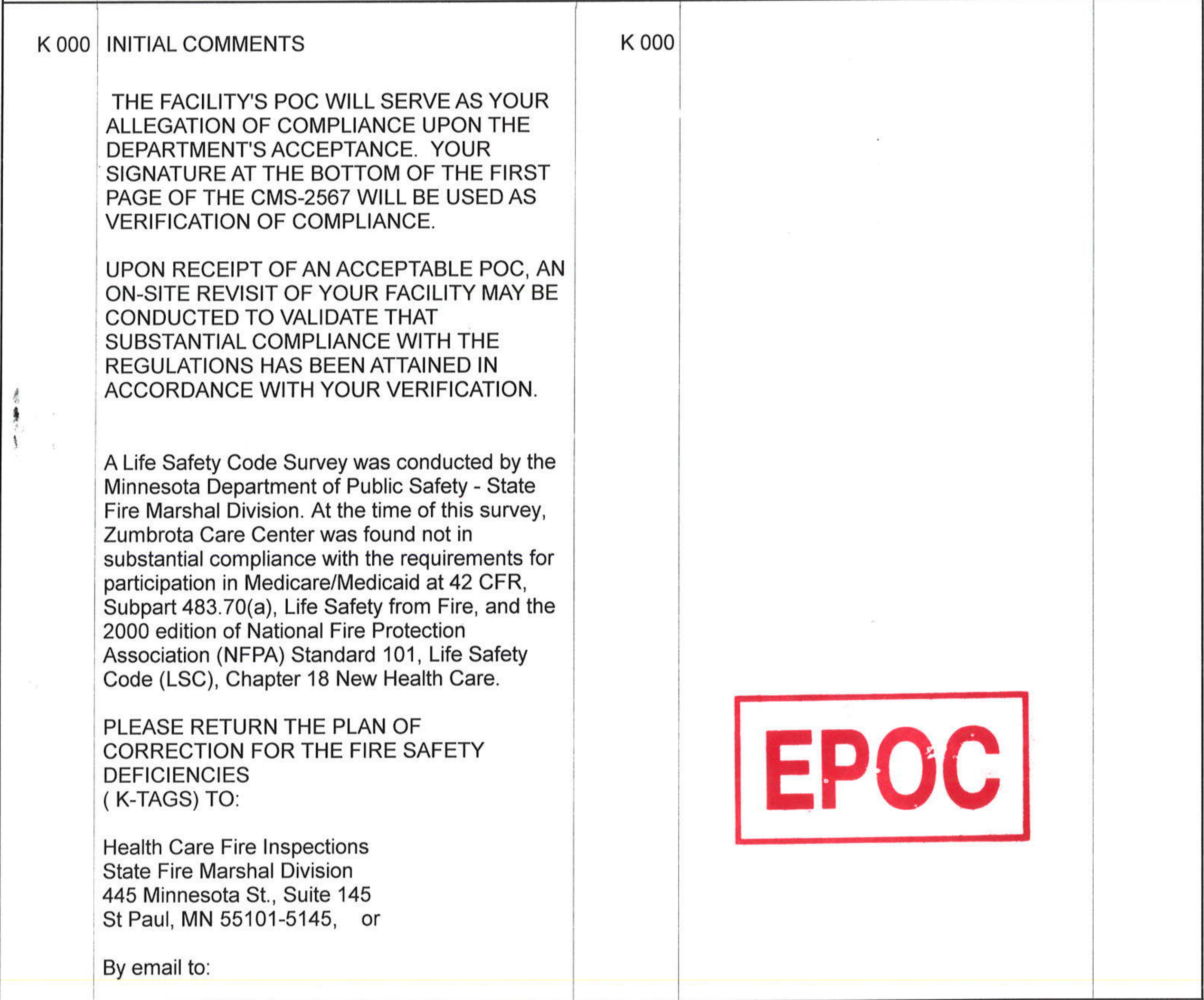
DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

F5376023

PRINTED: 10/23/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245376	A. BUILDING **02 - 2014 ADDTION** B. WING ______	**09/18/2015**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ZUMBROTA CARE CENTER	**433 MILL STREET** **ZUMBROTA, MN 55992**



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K 000	INITIAL COMMENTS	K 000		

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 WILL BE USED AS VERIFICATION OF COMPLIANCE.

UPON RECEIPT OF AN ACCEPTABLE POC, AN ON-SITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION.

A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety - State Fire Marshal Division. At the time of this survey, Zumbrota Care Center 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 18 New Health Care.

PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO:

Health Care Fire Inspections
State Fire Marshal Division
445 Minnesota St., Suite 145
St Paul, MN 55101-5145, or

By email to:

EPOC

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 10/15/2015

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

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K 000	Continued From page 1 Marian.Whitney@state.mn.us and Angela.Kappenman@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. This facility will be surveyed as two separate buildings. In 2014 a 2-story addition was constructed that was determined to be of Type II(000) construction with no basement. The building is fully sprinklered. The facility has a fire alarm system with full corridor smoke detection and spaces open to the corridor that is monitored for automatic fire department notification. The facility has a capacity of 50 beds and had a census of 48 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 062 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 18.7.6, 4.6.12, NFPA 13, NFPA 25,	K 062		10/16/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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ZUMBROTA CARE CENTER	**433 MILL STREET** **ZUMBROTA, MN 55992**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 062	Continued From page 2 9.7.5 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain the fire sprinkler system in accordance with the requirements of 2000 NFPA 101, Sections 18.3.5 and 9.7, and 1998 NFPA 25, section 2-4.1.1 (c). This deficient practice could affect all 5 out of 48 residents. Findings include: On facility tour between 9:45 AM and 11:45 AM on 09/18/2015, observation revealed that the dry fire sprinkler heads in the walk-in cooler and the freezer have clear fluid in them. This deficient practice was confirmed by the Director of Maintenance (RG) at the time of discovery.	K 062	Facility contacted Olson Fire Protection to replace sprinkler heads. Upon inspection, it was determined that the sprinkler was not defective and the clear color within the head does not determine if a sprinkler is defective, but instead tells the temperature by which the sprinkler is set at. The sprinkler was set at 175 degrees which is in range for the area in questions. The owner of the company emailed the following: ¿The issue was raised as to the compliance of the dry pendant sprinklers in your cooler/freezer. Gary Schroder from the State Fire Marshal¿s office noted that the liquid was out of the glass bulb. This condition would render the sprinkler defective and it would need to be replaced. When we came down there we noticed that the liquid was if fact still in the glass bulb but was a light yellow. This would indicate that the sprinkler has a 175 deg. Glass bulb. The temperatures allowed in cooler/freezers are 155deg., 165 deg., 200 deg., or 286 deg. All your sprinklers are within that range.¿ Environmental Services Director will audit sprinklers in all areas on a monthly basis to insure that they are all in working condition.	
K 144 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised	K 144		10/16/15

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245376	A. BUILDING **02 - 2014 ADDTION** B. WING ______	**09/18/2015**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 144	Continued From page 3 under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1. This STANDARD is not met as evidenced by: Based on documentation review and staff interview, the facility failed to inspect the emergency generator in accordance with the requirements of 2000 NFPA 101 - 9.1.3 and 1999 NFPA 110 Chapter 6.4.2. The deficient practice could affect all 48 residents. Findings include: On facility tour between 9:45 AM and 11:45 AM on 09/18/2015, documentation review of the monthly generator logs revealed the following: 1. The review of the monthly run test indicated that the generator did not meet one of the following: a. loading that maintains the minimum exhaust gas temperatures as recommended by the manufacturer or b. under load of 30 percent or more of the nameplate rating of generator or c. 2 hour load bank test (first 30 minutes - 25%, next 30 minutes - 50%, and last 1 hour - 75%) This deficient practice was confirmed by the Director of Maintenance (RG) at the time of discovery.	K 144	Generator was inspected by manufacturer and 2 hour load test was performed. Report was received confirming generator passed fire safety codes for 2 hour load test. Environmental Service Director or designee will perform monthly load testing and a yearly 2 hour load test as required by the fire safety codes as well as maintaining a generator log for both.	

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K 144	Continued From page 4 *TEAM COMPOSITION* Gary Schroeder, Life Safety Code Spc.	K 144		