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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: LE6X

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00576

1. MEDICARE/MEDICAID PROVIDER NO.(L1) **245548**

2. STATE VENDOR OR MEDICAID NO. (L2) **230743000**

3. NAME AND ADDRESS OF FACILITY
(L3) **TUFF MEMORIAL HOME**
(L4) **505 EAST 4TH STREET**
(L5) **HILLS, MN** (L6) **56138**

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)

6. DATE OF SURVEY **08/23/2017** (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

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

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

* Code: **A** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	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 : 09/11/2017
Kathryn Serie, Unit Supervisor (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 09/11/2017 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION **03/01/1991** (L24)

23. LTC AGREEMENT BEGINNING DATE (L41)

24. LTC AGREEMENT ENDING DATE (L25)

25. LTC EXTENSION DATE: (L27)

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

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

28. TERMINATION DATE: (L28)

29. INTERMEDIARY/CARRIER NO. **03001** (L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE (L33)

DETERMINATION APPROVAL

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

CMS Certification Number (CCN): 245548

September 11, 2017

Mr. Alex Dysthe, Administrator
Tuff Memorial Home
505 East 4th Street
Hills, MN 56138

Dear Mr. Dysthe:

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 August 22, 2017 the above facility is certified for:

50 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 50 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
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: kamala.fiske-downing@state.mn.us

cc: Licensing and Certification File

Electronically delivered

September 11, 2017

Mr. Alex Dysthe, Administrator
Tuff Memorial Home
505 East 4th Street
Hills, MN 56138

RE: Project Number S5548026

Dear Mr. Dysthe:

On July 26, 2017, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on July 13, 2017. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required.

On August 23, 2017, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on August 25, 2017 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on July 13, 2017. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of August 22, 2017. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on July 13, 2017, effective August 22, 2017 and therefore remedies outlined in our letter to you dated July 26, 2017, will not be imposed.

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

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

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

cc: Licensing and Certification File

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: LE6X

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00576

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245548**

2.STATE VENDOR OR MEDICAID NO.
(L2) **230743000**

3. NAME AND ADDRESS OF FACILITY
(L3) **TUFF MEMORIAL HOME**
(L4) **505 EAST 4TH STREET**
(L5) **HILLS, MN** (L6) **56138**

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)

6. DATE OF SURVEY **07/13/2017** (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

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	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 :
Kathryn Serie, Unit Supervisor 08/14/2017 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 08/28/2017 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
03/01/1991
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
July 26, 2017

Mr. Alex Dysthe, Administrator
Tuff Memorial Home
505 East 4th Street
Hills, MN 56138

RE: Project Number S5548026

Dear Mr. Dysthe:

On July 13, 2017, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

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

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

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

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

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

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

DEPARTMENT CONTACT

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

Kathryn Serie, Unit Supervisor
Mankato Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
1400 East Lyon Street, Suite 201
Marshall, Minnesota 56258-2504
Email: kathryn.serie@state.mn.us
Phone: (507) 476-4233
Fax: (507) 344-2723

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 August 22, 2017, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by August 22, 2017 the following remedy will be imposed:

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

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

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

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

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

Public Safety, State Fire Marshal Division staff, if your ePoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by October 13, 2017 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and

Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by January 13, 2018 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

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

Mr. Tom Linhoff, Fire Safety Supervisor
Health Care Fire Inspections
Minnesota Department of Public Safety
State Fire Marshal Division

445 Minnesota Street, Suite 145
St. Paul, Minnesota 55101-5145
Email: tom.linhoff@state.mn.us
Telephone: (651) 430-3012
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

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

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245548	A. BUILDING _____ B. WING _____	07/13/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TUFF MEMORIAL HOME	**505 EAST 4TH STREET HILLS, MN 56138**

(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 On 7/10/17, 7/11/17, 7/12/17 and 7/13/17, a recertification standard survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with requirements of 42 CFR Part 483, Subpart B, and Requirements for Long Term Care Facilities. 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 (electronic plan of correction), 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 157 SS=D	483.10(g)(14) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) (g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical,	F 157		7/17/17

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

Electronically Signed | 08/07/2017

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245548	A. BUILDING _____ B. WING _____	07/13/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TUFF MEMORIAL HOME	**505 EAST 4TH STREET HILLS, MN 56138**

(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 157	Continued From page 1 mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to notify the physician of falls with injury for 2 of 3 residents (R25, R3) reviewed for	F 157	The Tuff Memorial Home sent a letter to all Physicians to inform them we will be notifying them with all incident reports as	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245548	A. BUILDING _____ B. WING _____	07/13/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TUFF MEMORIAL HOME	505 EAST 4TH STREET HILLS, MN 56138

(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 157	Continued From page 2 accidents and failed to follow-up with the physician related to effectiveness of medication changes for 1 of 5 residents (R48) reviewed for unnecessary medications. Findings include: R25's diagnosis listing dated 7/13/17, identified diagnoses of osteoarthritis, anxiety disorder and Dementia. R25's quarterly Minimum Data Set (MDS) dated 6/6/17, indicated a Brief Interview for Mental Status (BIMS) score of 3 indicating severe cognitive impairment. The MDS also indicated R25 required supervision with walking, transfers and locomotion and had no recent falls. R25's Care Area Assessment (CAA) for falls dated 12/19/16, indicated R25 had a risk for falls demonstrated by a history of wandering, unsteady balance and the use of antidepressant medications. The CAA indicated R25 had a fall on 11/23/16, and identified risk factors related to falls including fractures, injuries and pain. R25's care plan last revised 6/13/17, indicated R25 was a fall risk and had unsteady balance. The care plan indicated R25 should receive stand by assist as needed when knees are weak, walker always within reach and remind to take to all destinations and received restorative nursing two times weekly. R25's incident report dated 7/4/17, identified R25 was in her room and was observed falling to her right knee. R25 was noted to have a 2 cm by 2 cm circular pink abrasion to right anterior knee and a 1 cm by 1 cm oval shaped purple bruise to	F 157	required by regulations. The Tuff Memorial Home will be sending written notification of all incident reports to the Physicians as well as calling the resident's legal representative/interested family members to notify them. The Tuff Memorial Home will be in compliance by July 17th, 2017. The Director of Nursing and Administrator will monitor compliance with this correction.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245548	A. BUILDING _____ B. WING _____	07/13/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TUFF MEMORIAL HOME	**505 EAST 4TH STREET HILLS, MN 56138**

(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 157	Continued From page 3	F 157		

right index finger. The incident report did not indicate the physician was notified of the fall.

R25's fall risk score dated 6/6/17, indicated R25 had a score of 40 indicating high risk for falls.

R25's nurses notes provided dated 7/4/17 to 7/6/17, did not identify the abrasion nor bruise that resulted from R25's fall and did not identify physician notification of the fall and/or injuries.

During interview on 7/13/17, at 12:19 p.m. registered nurse (RN)-B stated staff don't notify the physician unless there are abnormal findings; that is our current policy but indicating it will be changed.

R48's quarterly MDS assessment dated 4/18/17, included a BIMS score of 4 indicating severe cognitive impairment, and a PHQ9 (a questionnaire for depression scoring) score of 12 indicating moderate depression. The MDS further indicated diagnoses including: dementia, anxiety disorder, and depression.

R48's care plan last edited 7/11/17, directed staff to monitor R48 when near other residents for potential of becoming agitated and potential for physical contact with another resident. Staff and volunteers were to redirect R48 as much as possible when propelling past residents throughout the facility if the resident attempted to strike out or use verbal negative statements to others. The care plan also indicated R48 was to have no knives on room trays or at her place at the table due to concerns of self harm.

The Consultant Pharmacist Communication to Physician dated 5/12/17, directed the physician to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245548	A. BUILDING _____ B. WING _____	07/13/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TUFF MEMORIAL HOME	**505 EAST 4TH STREET HILLS, MN 56138**

(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 157	Continued From page 4	F 157		

review R48's medical record and notes for increase in dementia-related behaviors and medications which may require adjustment or alternative medications. The communication form identified recommendations to consider related to laboratory studies to rule out medical causes for increased symptoms of dementia and alternative medications to attempt to stabilize behaviors.

The fax to physician dated 5/15/17 indicated: Please review pharmacy report on your desk. Med list updated. Behaviors of resident include hitting staff, has hit other residents, exiting facility, refusing cares, wandering in wheelchair throughout facility. Please advise for changes.

The fax from physician (P)-A dated 5/16/17, included the following medication orders: Start on Depakote (a seizure medication also used for mood stabilization) 250 milligrams (mg) tid (three times a day). DC (discontinue) Celexa (an antidepressant). Start on Zoloft (an antidepressant) 25 mg daily for 1 week then increase to 50 mg daily. Aricept (a medication used to treat dementia) 5 mg daily.

The physician progress note from the medical director dated 6/1/17, indicated R48 had been put on 3 new medications by P-A and had been going downhill since then. 'In the last 2 weeks since making these medication changes [R48] has had extreme agitation. [R48] has been hitting and kicking at staff, getting into arguments with other residents, and has had tremendous diarrhea. [R48] has troubles with stools just coming out without any sort of control; has had a difficult time sleeping and struggles with sleeplessness; very difficult to redirect. [R48] has lost about 6 pounds

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245548	A. BUILDING _____ B. WING _____	07/13/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TUFF MEMORIAL HOME	**505 EAST 4TH STREET HILLS, MN 56138**

(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 157	Continued From page 5	F 157		

in the last couple of weeks. Staff have noticed significant worsening in [R48] mood rather than improvement. The patient also does have some dementia which likely is contributing to this.' The plan indicated the medical director would continue R48 on the Zoloft 50 mg daily but would stop the Depakote and Aricept. '"we will just keep her on the Zoloft first for the next couple of weeks and have nursing staff call me back and give me an update on how she is doing. If that is going really well and she is kind of back to baseline then we can leave that as it is for now. If we are having further issues we can talk about adjusting meds as needed from there."

The nursing progress note dated 6/16/17, indicated: 1 month psychotropic evaluation of Zoloft 25 mg PO (by mouth) x (times) 7 days then 50 mg PO daily. Resident continues with verbal and aggressive behaviors. Resident has had 53 documented behaviors of wandering/attempting to exit the facility since starting on Zoloft; 36 documented behaviors of yelling/hitting staff members since start of medication; 61 document behaviors of repetitive verbalizations of "What should I do now, now what, etc."; 4 documented behaviors regarding resident refusing to give back silverware or taking others silverware and 3 documented behaviors between other residents in the past month since Zoloft was initiated.

When interviewed on 7/13/17, at 12:30 p.m. RN-B reviewed R48's medical record and confirmed that although R48 was seen by P-A on 7/6/17 (35 days after evaluation by the medical director), the medical director had not been updated on R48's behaviors following discontinuation of Depakote and Aricept on 6/1/17.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245548	A. BUILDING _____ B. WING _____	07/13/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TUFF MEMORIAL HOME	**505 EAST 4TH STREET HILLS, MN 56138**

(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 157	Continued From page 6	F 157		

It was observed on 7/12/17, at 8:00 a.m. that R3 had bruising noted around the eyes and forehead area which had a small scabbed area.

The diagnosis listing identified R3 had diagnoses including dementia, psychosis, osteoporosis and postural kyphosis. The quarterly MDS assessment dated 7/4/17 identified R3 as having a BIMS of 3/15 indicating severe cognitive impairment. The MDS identified that R3 was independent with ambulation, transfers, bed mobility, toileting and received assistance from one person with morning and evening personal cares.

Review of incident reports that resulted in injury were as noted:

(1) On 5/2/17, at 7:15 a.m.: R3 discovered seated on the floor in her room leaning against the recliner rubbing her head. When questioned about circumstances, R3 indicated she hit her head on a table, resulting in an observed bump on the back of the head according to documentation. Documentation was lacking to indicate physician notification had occurred.

(2) On 7/9/17, at 4:00 p.m.-following a "bang" two nursing assistants found R3 lying on the floor between the end of the bed and bathroom. A laceration to the right lateral forehead and mid-spine was documented on the incident report. No notification to the physician was evident.

When interviewed on 7/13/17, at 9:05 a.m. RN-B was questioned about physician notification in the event of an accident. RN-B stated the reason

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245548	A. BUILDING _____ B. WING _____	07/13/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TUFF MEMORIAL HOME	505 EAST 4TH STREET HILLS, MN 56138

(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 157	Continued From page 7 physicians are not notified of incidents or accidents is they don't want to be notified unless it is an emergency and request the medical provider receive updates at the quarterly quality assurance meetings. During an interview on 7/13/17, at 10:12 a.m. director of nursing (DON) indicated it was her expectation that staff notify the physician immediately of an incident or accident and was unaware of this process not being implemented. During a subsequent interview on 7/13/17, at 10:36 a.m. DON, RN-B and RN-A it was confirmed that unless a severe injury occurred, routine notification of incidents and/or accidents was not the routine. When questioned regarding the definition of a severe injury they explained it was defined as a suspected fracture, an injury requiring suturing, changes in neurological status, uncontrollable bleeding and/or seizures. The DON further indicated the facility policy did not specify the physician should be notified unless further treatment was needed. RN-A and RN-B confirmed this had "always" been the policy. Review of the facility policy Incident/Fall Policy of the Tuff Memorial Home with the most recent policy review date of 3/29/16 listed: Notify the physician if further treatment is needed; Do neuro checks immediately and every four hours for 24 hours if any suspected or actual head injury occurred, and document on appropriate form. Notify the physician immediately of any abnormal findings.	F 157		
F 244 SS=E	483.10(f)(5)(iv)(A)(B) LISTEN/ACT ON GROUP GRIEVANCE/RECOMMENDATION	F 244		8/7/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245548	A. BUILDING _____ B. WING _____	07/13/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TUFF MEMORIAL HOME	505 EAST 4TH STREET HILLS, MN 56138

(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 244	Continued From page 8 (f)(5) The resident has a right to organize and participate in resident groups in the facility. (iv) The facility must consider the views of a resident or family group and act promptly upon the grievances and recommendations of such groups concerning issues of resident care and life in the facility. (A) The facility must be able to demonstrate their response and rationale for such response. (B) This should not be construed to mean that the facility must implement as recommended every request of the resident or family group. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to act upon concerns related to uncomfortable/cold temperatures in various areas of the building voiced during resident council meetings in an attempt to accommodate the recommendation. This has the potential to affect any of the 45 residents who reside in the facility. Findings include: Review of the resident council meeting minutes dated June 2017, indicated 15 residents were in attendance and several residents complained of cold temperatures throughout various areas of the building. The activities director facilitated the meeting with assistance by the social services designee. The resident council meeting minutes dated July 2017, indicated 13 residents were in attendance. The activities director and the interim director of	F 244	The Tuff Memorial Home has implemented a tracking system to track all grievances produced by the residents during Resident Council. The Administrator will sign off on all resident council minutes as well as all of the grievance tracking reports. In response to the grievance regarding the temperature of the Tuff Memorial Home, we have hired an outside company to check all thermostats to determine whether they are functioning properly. This company will also be adding thermostats in areas that have not been regulated correctly in regards to temperature. The temperature in the facility has been raised slightly to be within the range of 71-81 degrees Fahrenheit while we wait for the company to put in the new thermostats.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245548	A. BUILDING _____ B. WING _____	07/13/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TUFF MEMORIAL HOME	**505 EAST 4TH STREET HILLS, MN 56138**

(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 244	Continued From page 9 nursing also attended. Follow up documentation from the June 2017, was noted in the meeting minutes related to the cold temperatures in the facility under the section labeled "Maintenance". Documentation indicated some residents expressed they felt the facility was cold in some of the hallways and discussion included that residents should "use a sweater and a blanket when needed." There was no indication that air conditioning units and/or thermostats were checked for accuracy and/or functioning properly. No further action related to this issue was documented. During interviews on 7/10/17 and 7/11/17, R24, R26, R40 and family member (F)-A of R44 indicated they all had concerns related to uncomfortable temperatures throughout the building. The comments voiced were as noted: (1) On 7/10/17, at 4:41 p.m. R24 felt it was always cold everywhere, especially in the dining room; (2) R26 stated on 7/10/17, at 5:03 p.m. the dining room was especially cold but was cold throughout the facility; (3) R40 stated on 7/10/17, at 3:52 p.m. that she wore a jacket and/or was covered with a blanket most of the time and when voiced concern to staff their response was -the temperature was "regulated by the State"; nothing could be done; and (4) On 7/11/17, at 11:00 a.m. F-A of R44 indicated they often retrieve blankets and/or sweaters because resident's complained it was too cold; stating they themselves felt cold in the facility, especially in the dining area and the therapy department. During a walk thru of the facility and interview on	F 244	Residents will be informed of the response and plan of correction to their grievance regarding the temperature of the Tuff Memorial Home at the Resident Council meeting. The Tuff Memorial Home will be in compliance August 7th, 2017. The Activity Director and Administrator will monitor compliance with this correction.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245548	A. BUILDING _____ B. WING _____	07/13/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TUFF MEMORIAL HOME	505 EAST 4TH STREET HILLS, MN 56138

(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 244	Continued From page 10	F 244		

7/12/17, at 1:30 p.m. the maintenance supervisor (MS) indicated the thermostats were set to 75 degrees Fahrenheit (F). He was unsure what thermostats exactly regulated what areas in the building as there was a mixture of older and newer thermostats. MS explained that some thermostats had lock boxes which staff could not access and some thermostats could be accessed by staff to control the room temperature. MS indicated being aware of resident complaints related to cold temperatures and he attempted to offset the cold temperatures by turning on the boiler system. MS stated their cooling system cooled the hallways and the main areas of the facility but did not cool resident rooms. MS further explained that residents were able to control the heat in their rooms and discovered the boiler shut-off defaults to 70 degrees F. and consequently, this had not been the "fix" for resident complaints of the cold temperature. He stated he made the recommendation that resident's use extra clothing etc if they were cold as he was unsure what else to do. MS confirmed he was not familiar with the heating and cooling systems and had not consulted with any professionals to determine whether their equipment functioned properly and/or if resident complaints could be resolved with further equipment adjustment.

The identified thermostats were observed and the temperatures were as noted during the 7/12/17, 1:30 p.m. tour:
(1) The thermostat (#3) was set at 80 degrees; however, the temperature reading was only 68 degrees F.
(2) The area located outside the chapel including the hallway and alcove area indicated the thermostat was set at 84 degrees F.; the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245548	A. BUILDING _____ B. WING _____	07/13/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TUFF MEMORIAL HOME	**505 EAST 4TH STREET HILLS, MN 56138**

(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 244	Continued From page 11	F 244		

temperature read only 68 degrees F.
(3) Inside the chapel area the thermostat was set at 73 degrees F. in the front by the alter; however, the temperature registered 68 degree F. in the area the resident's sat for church service and/or activity programs. Temperature readings and thermostat settings were not consistent throughout the facility.

When interviewed on 7/12/17, at 2:00 p.m. the administrator indicated he had been aware of the temperature related complaints expressed by residents from time to time but was unaware of the resident council complaints. He indicated there was a process in place for individual grievances but not for resident council concerns. The administrator stated he expected grievances to be followed up and acted upon; stating the follow-up given was "unacceptable." He further indicated he was going to have a heating and cooling company review their system to ensure it was functioning properly.

During interview on 7/13/17, at 9:01 a.m. with the activity director (AD)-F regarding the resident council complaints, she indicated the first half hour of the meeting was time designated for resident's to share compliments, complaints and other issues. For the remainder of the time, resident council would invite department heads to the meeting which gave resident's the opportunity to share complaints or concerns but if they felt uncomfortable voicing complaints at that time, she would address on their behalf. AD-F stated any ongoing concerns would be communicated to the quality assurance committee; however resident council concerns were not regularly discussed unless there were ongoing issues.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245548	A. BUILDING _____ B. WING _____	07/13/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TUFF MEMORIAL HOME	505 EAST 4TH STREET HILLS, MN 56138

(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 244	Continued From page 12 Review of the facility's undated Grievance policy indicated: all grievances identified through resident council meeting were to be submitted immediately to the grievance official for investigation and resolution,. Reporting of resolution outcome will be given to the resident council per protocol. The facility was to strive for a prompt resolution outcome for all grievances or complaints rendered, and a reasonable timeframe was to have been agreed upon by all parties involved. The grievance official would complete written response to the resident or representative that included the date, summary, investigation, findings, and the resolution. The facility was to then track, trend and analyze that information and incorporate that data into their Quality Assurance and Performance Improvement program.	F 244		
F 257 SS=E	483.10(i)(6) COMFORTABLE & SAFE TEMPERATURE LEVELS (i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81 degrees F. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to maintain comfortable temperatures in a range of 71 to 81 degrees Fahrenheit (F) in various hallways throughout the building. This has the potential to affect all 45 residents who reside in the facility. Findings include: During interviews on 7/10/17 and 7/11/17, R24,	F 257	The Tuff Memorial Home has elected to contract with an outside company to put new thermostats with remote sensors to help regulate the temperature. We will also be removing any thermostats that serve no purpose. The Maintenance Supervisor will do bi-weekly audits of the temperature throughout the home to be sure we	8/22/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245548	A. BUILDING _____ B. WING _____	07/13/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TUFF MEMORIAL HOME	505 EAST 4TH STREET HILLS, MN 56138

(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 257	Continued From page 13 R26, R40 and family member (F)-A of R44 indicated they all had concerns related to uncomfortable temperatures throughout the building. The comments voiced were as noted: (1) On 7/10/17, at 4:41 p.m. R24 felt it was always cold everywhere, especially in the dining room; (2) R26 stated on 7/10/17, at 5:03 p.m. the dining room was especially cold but was cold throughout the facility; (3) R40 stated on 7/10/17, at 3:52 p.m. she wore a jacket and/or was covered with a blanket most of the time and when voiced concern to staff their response was -the temperature was "regulated by the State"; nothing could be done; and (4) On 7/11/17, at 11:00 a.m. F-A of R44 indicated they often retrieve blankets and/or sweaters because resident's complained it was too cold; stating they themselves felt cold in the facility, especially in the dining area and the therapy department. It was noted during the afternoon and evening on 7/10/17, areas/pockets of the building including the west hallway, dining area and chapel felt cold and uncomfortable. Review of the resident council meeting minutes dated June 2017, indicated 15 residents were in attendance and several residents complained of cold temperatures throughout various areas of the building. The July 2017 meeting minutes also identified that residents felt cold in some hallways of the building. During a walk thru of the facility and interview on 7/12/17, at 1:30 p.m. the maintenance supervisor (MS) indicated the thermostats were set to 75 degrees Fahrenheit (F). He was unsure what	F 257	continue to be in compliance. Residents will be asked their comfort level regarding temperature at each Resident Council, and will be encouraged to bring any issues with the temperature to the Administrator. The Tuff Memorial Home will be in compliance by August 22nd, 2017. The Maintenance Supervisor and Administrator will monitor compliance with this correction and assure the temperature in the Tuff Memorial Home is between 71 and 81 degrees Fahrenheit.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245548	A. BUILDING _____ B. WING _____	07/13/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TUFF MEMORIAL HOME	505 EAST 4TH STREET HILLS, MN 56138

(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 257	Continued From page 14	F 257		

thermostats exactly regulated what areas in the building as there was a mixture of older and newer thermostats. MS explained that some thermostats had lock boxes which staff could not access and some thermostats could be accessed by staff to control the temperature. MS indicated being aware of resident complaints related to cold temperatures and he attempted to offset the cold temperatures by turning on the boiler system. MS stated their cooling system cooled the hallways and the main areas of the facility but did not cool resident rooms. MS further explained that residents were able to control the heat in their rooms and that he discovered the boiler shut off defaults to 70 degrees F. and consequently, this had not been the "fix" for resident complaints of the cold temperature. He stated he made the recommendation that resident's use extra clothing etc if they were cold as he was unsure what else to do. MS confirmed he was not familiar with heating and cooling systems and had not consulted with any professionals to determine whether their equipment functioned properly and/or if resident complaints could be resolved with equipment adjustment.

The identified thermostats were observed and the temperatures were as noted during the 7/12/17, 1:30 p.m. tour:
(1) The thermostat (#3) was set at 80 degrees; however, the temperature reading was only 68 degrees F.
(2) The area located outside the chapel including the hallway and alcove area indicated the thermostat was set at 84 degrees; however, the temperature read only 68 degrees F.
(3) Inside the chapel area the thermostat was set at 73 degrees F. in the front by the alter, however, the temperature registered 68 degree F in the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245548	A. BUILDING _____ B. WING _____	07/13/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TUFF MEMORIAL HOME	505 EAST 4TH STREET HILLS, MN 56138

(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 257	Continued From page 15 area the resident's sat for church service and/or activity programs. Temperature readings and thermostat settings were not consistent throughout the building. When interviewed on 7/12/17, at 2:00 p.m. the administrator indicated he had been aware of the temperature related complaints expressed by residents from time to time but was unaware of the resident council complaints. He further indicated he was going to have a heating and cooling company review their system to ensure it was functioning properly. There was no policy submitted for maintenance of the heating and cooling systems.	F 257		
F 309 SS=D	483.24, 483.25(k)(l) PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING 483.24 Quality of life Quality of life is a fundamental principle that applies to all care and services provided to facility residents. 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, consistent with the resident's comprehensive assessment and plan of care. 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices, including	F 309		8/11/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245548	A. BUILDING _____ B. WING _____	07/13/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TUFF MEMORIAL HOME	505 EAST 4TH STREET HILLS, MN 56138

(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 309	Continued From page 16 but not limited to the following: (k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. (l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to assess and monitor injuries that occurred from a fall for 1 of 3 resident (R25) reviewed for accidents. Findings include: R25's diagnosis listing dated 7/13/17, identified diagnoses of osteoarthritis, anxiety disorder and Dementia. R25's quarterly Minimum Data Set (MDS) assessment dated 6/6/17, indicated a Brief Interview for Mental Status (BIMS) score of 3 indicating severe cognitive impairment. The MDS also indicated R25 required supervision with walking, transfers and locomotion and had no recent falls. R25's Care Area Assessment (CAA) related to falls dated 12/19/16, indicated R25 had a risk for falls demonstrated by a history of wandering,	F 309	The Tuff Memorial Home has implemented the Braden Assessment which will be done once a week for the first three weeks of admission and quarterly thereafter. It will be done more frequently for those with higher risk of skin breakdown. The Braden Assessment is a skin assessment that monitors for risk factors for skin breakdown. Education was completed with Nurses regarding the importance of documentation for incident reports. The Director of Nursing monitors documentation daily. The Tuff Memorial Home will notify the physician and family members whenever there is a fall or incident that happens on all residents. Gait belt training is being done by our	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245548	A. BUILDING _____ B. WING _____	07/13/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TUFF MEMORIAL HOME	505 EAST 4TH STREET HILLS, MN 56138

(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 309	Continued From page 17 unsteady balance and the use of antidepressant medications. The CAA indicated R25 had a fall on 11/23/16, and identified risk factors related to falls including fractures, injuries and pain. R25's care plan last revised 6/13/17, indicated R25 was a fall risk and had unsteady balance. The care plan indicated R25 should receive stand by assist as needed when knees are weak, walker always within reach and remind to take to all destinations and received restorative nursing two times weekly. During an observation on 7/10/17, at 4:29 p.m. it was noted that R25 had a large dark purple bruise on right index finger past knuckle, at base and part way up third finger. R25 unable to explain what happened. . Observation on 7/13/17, at 12:31 p.m. identified R25's bruising was still present but fading. R25's incident report dated 7/4/17, identified R25 was in her room and was observed falling to her right knee. R25 was noted to have a 2 cm by 2 cm circular pink abrasion to right anterior knee and a 1 cm by 1 cm oval shaped purple bruise to right index finger. R25's nurses notes provided and dated 7/4/17 through 7/6/17, did not identify the abrasion nor the bruise that resulted from R25's fall on 7/4/17. When interviewed on 7/13/17, at 12:31 registered nurse (RN) B stated injuries resulting from a fall are to be monitored in the nurses notes. During interview on 7/13/17, at 12:59 p.m. the director of nursing (DON) stated we do not do	F 309	consulting physical therapist for all employees by August 18th for all staff. The Tuff Memorial Home Nurses will follow-up on bruises and abrasions that result from resident falls. These bruises and abrasions will be monitored daily until they have resolved/healed. Falls interventions will be discussed at the monthly QAPI meeting to see the success of those interventions. The Director of Nursing will monitor compliance with this correction. The Tuff Memorial Home will be in compliance by August 11th, 2017.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245548	A. BUILDING _____ B. WING _____	07/13/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TUFF MEMORIAL HOME	505 EAST 4TH STREET HILLS, MN 56138

(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 309	Continued From page 18 follow-up on bruises nor abrasions that result from falls. The DON stated they do not conduct weekly skin assessments nor ongoing monitoring; however, stated there should be monitoring and follow-up on any injuries resulting from a fall. The Skin Care Policy updated 4/28/16, identified skin conditions of open area, bruises, skin tears etc. are to be reported to the charge nurse by direct care staff. The policy also identified A daily treatment for the injury is set up in the computer so the injury can be checked daily.	F 309		
F 312 SS=D	483.24(a)(2) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS (a)(2) 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 nail care for 1 of 3 resident (R25) reviewed who was dependent upon staff for grooming needs. Findings include: R25's Diagnosis Listing dated 7/13/17, identified a diagnosis of Alzheimer's disease. R25's quarterly Minimum Data Set (MDS) assessment dated 6/6/17, indicated a Brief Interview for Mental Status (BIMS) score of 3 indicative of severe cognitive impairment. The MDS also identified R25 required extensive assistance of one staff for grooming activities. R25's Care Area Assessment (CAA) related to	F 312	The Tuff Memorial Home has implemented a Nail Care Policy based on the Minnesota Certified Nursing Assistant curriculum. Director of Nursing will discuss the importance of Nail Care with all staff and training will be done to teach correct process. All those required to assist with nail care will sign a sheet noting the importance of nail care. R25's nails have been cleaned and trimmed. Bath Aides have received training regarding the importance of nail care. If a resident declines to have nail care completed, the Bath Aide are required to document refusal.	8/11/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245548	A. BUILDING _____ B. WING _____	07/13/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TUFF MEMORIAL HOME	505 EAST 4TH STREET HILLS, MN 56138

(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 312	Continued From page 19 activities of daily living (ADLs) dated 12/19/16, indicated R25 had potential for an ADL functional/rehabilitation problem due to cues needed for daily cares and assist with peri care. The care plan dated 6/12/17, indicated R25 needed staff assist with combing hair, dressing, peri care and washing face and hands. R25's current nursing assistant assignment sheet undated, indicated R25 required set-up for washing hands/face, assist with dressing and pericares and received a bath on Monday's. On 7/10/17, at 4:29 p.m. R25 was observed to have very long fingernails which had black debris under the nails. During observation on 7/12/17, at 2:10 p.m. and 7/13/17, at 9:39 a.m. R25's nails continued to be long with black debris under the nails. R25 stated, "I could use them cut". During interview on 7/12/17, at 2:06 p.m. nursing assistant (NA)-A stated R25 receives a bath on Monday's. She stated the bath aides were responsible for nail care after a bath. During interview on 7/13/17, at 10:40 a.m. NA-B stated she had given R25 a bath [7/10/17] and did not trim nor clean her nails. NA-B stated she thought R25 would not allow and confirmed she did not re-approach R25 nor document a refusal. When interviewed on 7/13/17, at 9:45 a.m. licensed practical nurse (LPN)-A verified that R25's nails were long and dirty. She confirmed they need to be trimmed and cleaned, stating it should have been provided with her bath on Monday (7/10). LPN-A stated sometimes resident's refuse but when re-approached they usually allow nail trimming.	F 312	The Director of Nursing will conduct bi-weekly audits of nail care to determine whether the Nail Care Policy is being followed. The Director of Nursing will monitor compliance with this correction bi-weekly. The Tuff Memorial Home will be in compliance by August 11th, 2017.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245548	A. BUILDING _____ B. WING _____	07/13/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TUFF MEMORIAL HOME	505 EAST 4TH STREET HILLS, MN 56138

(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 312	Continued From page 20 During interview on 7/13/17, at 12:04 p.m. the director of nursing (DON) verified that nail care should be performed weekly with the resident's bath and as needed. A policy on nail care was requested but none was provided.	F 312		
F 329 SS=D	483.45(d)(e)(1)-(2) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS 483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used-- (1) In excessive dose (including duplicate drug therapy); or (2) For excessive duration; or (3) Without adequate monitoring; or (4) Without adequate indications for its use; or (5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or (6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. 483.45(e) Psychotropic Drugs. Based on a comprehensive assessment of a resident, the facility must ensure that-- (1) Residents who have not used psychotropic	F 329		8/18/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245548	A. BUILDING _____ B. WING _____	07/13/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TUFF MEMORIAL HOME	505 EAST 4TH STREET HILLS, MN 56138

(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 329	Continued From page 21 drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; (2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to monitor behaviors related to the use of the antipsychotic medication (Seroquel) to evaluate it's effectiveness and to monitor laboratory levels related to the lipid lowering medication (Zocor) for 2 of 5 residents (R44, R11) reviewed for unnecessary medications. Findings include: R44's Diagnosis Listing dated 7/13/17, identified diagnosis of unspecified psychosis not due to a substance or known physiological condition. The quarterly Minimum Data Set (MDS) assessment dated 7/11/17, identified a Brief Interview for Mental Status (BIMS) of 3 indicating severe cognitive impairment. The MDS also identified wandering 1-3 days. No other behaviors were identified. The physician orders dated 7/2017, identified an order for Seroquel (an antipsychotic medication used to treat psychotic disorders) 25 milligrams (mg) three times daily.	F 329	The Tuff Memorial Home will teach the Nurses how and when to complete the AIMs (Abnormal Involuntary Movement Scale). The Director of Nursing will provide education about the AIMs. This will be done by August 18th. Nurses have been re-educated on the importance of charting any abnormal behaviors to better monitor residents medication effects. R44's care plan has been updated to indicate the behavior associated with the use of Seroquel as well any 'hallucinations' to assist with the monitoring of medication effectiveness. R11 will have a lipid panel yearly to monitor the effectiveness of Zocor. The consulting pharmacist will set reminders on calendar for all residents who need yearly testing to prevent the same instance happening with another resident. Any residents who report any 'hallucinations' will have that documented in their chart and the consulting	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245548	A. BUILDING _____ B. WING _____	07/13/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TUFF MEMORIAL HOME	505 EAST 4TH STREET HILLS, MN 56138

(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 329	Continued From page 22 R44's medication administration record (MAR) dated 7/13/17, identified R44 was still receiving Seroquel three times daily. R44's care plan dated 7/7/17, identified the use of antipsychotic medication. The care plan also identified R44 was usually cooperative-easily redirected when wandering within the facility, asking for family. The Mood Evaluations Report for R44 from 10/7/16 through 712/17, identified wandering occurred 19 times and one (1) incident of hallucinations as documented on 2/10/17. During observation on 7/11/17, at 3:24 p.m. R44 attempted to walk in the hall without his walker. During observation on 7/12/17 at 3:00 p.m. R44 was noted in the dining room attending an activity. At no time during the survey was R44 observed to have any identified behaviors (wandering). When interviewed on 7/12/17, at 11:49 a.m. family member (F)- A stated R44 does experience hallucinations at times. F-A stated a week or so ago R44 saw 30 deer outside but when she looked out the window and there were no deer outside. She stated he has less hallucinations than when at home, but still hallucinates. During interview on 7/13/17, at 11:16 a.m. F-A stated recently R44 told F-A that a lady from the assisted living had a baby and brought the baby to the facility, laid it on the floor, it appeared all bloody and the lady wanted R44 to care for the baby; R44 said no. F-A also stated that R44 had a history of hallucinations while at home. F-A	F 329	pharmacist will be notified. The consulting pharmacist will be sure the medication has an appropriate diagnosis, review behavioral charting on, at minimum, a quarterly basis, and monitor for excessive dosing and side effect events. The Director of Nursing and Consulting Pharmacist will monitor compliance with this correction with monthly charting audits. The Tuff Memorial Home will be in compliance by August 9th, 2017.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245548	A. BUILDING _____ B. WING _____	07/13/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TUFF MEMORIAL HOME	505 EAST 4TH STREET HILLS, MN 56138

(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 329	Continued From page 23	F 329		

explained R44 thought he saw a baby in the living room chair, wouldn't sleep as he sat in the living room all night watching the baby. F-A stated for awhile R44 did not know the family, thinking she was a neighbor trying to get together with him which caused distress for R44, exhibiting hand wringing and worried about disloyalty to his family.

During interview on 7/12/17, at 12:16 p.m. registered nurse (RN)-B stated she was not aware R44 experienced hallucinations but stated R44 was usually looking for his wife, daughter and/or son-in-law. RN-B stated R44 experienced one fall in which he informed staff he was stepping over a red brick.

During interview on 7/13/17, at 1:20 p.m. the director of nursing (DON) verified behaviors [hallucinations] related to the use of Seroquel were not being monitored. She agreed the care plan should indicate this behavior and subsequent behavior charting should identify 'hallucinations' to monitor medication effectiveness.

The facility policy entitled Behavior Monitoring, reviewed 3/23/16, indicated behaviors were to be monitored regularly. The behaviors are to be addressed and charted accordingly in order to ultimately reduce behaviors.

R11's signed physician orders dated 7/6/17, identified diagnoses including: hyperlipidemia (high cholesterol), and type 2 diabetes. The physician orders also included a current order for Zocor 20 milligrams (mg) by mouth at bedtime for hyperlipidemia.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245548	A. BUILDING _____ B. WING _____	07/13/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TUFF MEMORIAL HOME	505 EAST 4TH STREET HILLS, MN 56138

(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 329	Continued From page 24 Review of R11's medical record did not include evidence a recent lipid panel had been completed to monitor the effectiveness of Zocor. The most recent lipid panel located in the record was dated 10/27/15; R11's triglyceride (a type of fat found in the blood) level was noted to be high at 311 (reference range: 0-149). When interviewed on 7/13/17, at 12:16 p.m. RN-B confirmed R11's last lipid panel was completed on 10/27/15. RN-B stated resident's on cholesterol lowering medications typically have a lipid panel drawn yearly. Documentation was lacking to indicate the physician had addressed the necessity of lab testing related to cholesterol lowering medications. When interviewed on 7/13/17, at 12:37 p.m. the consulting pharmacist confirmed she had not made a recommendation for laboratory testing to monitor the efficacy of R11's Zocor. The pharmacist indicated being unaware R11's last lipid panel drawn 10/27/15, included a high triglyceride level of 311. The pharmacist confirmed her expectation for any resident utilizing Zocor was to have lipid panel and liver function tests completed yearly.	F 329		
F 371 SS=F	483.60(i)(1)-(3) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY (i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations.	F 371		8/7/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245548	A. BUILDING _____ B. WING _____	07/13/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TUFF MEMORIAL HOME	505 EAST 4TH STREET HILLS, MN 56138

(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 371	Continued From page 25 (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. (i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. (i)(3) Have a policy regarding use and storage of foods brought to residents by family and other visitors to ensure safe and sanitary storage, handling, and consumption. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure the proper chemical sanitization was implemented for oversized pots and pans that did not fit in the dishwasher and failed to ensure the dishwasher reached 180 degrees Fahrenheit with the final rinse cycle for proper heat sanitization. This practice had the potential to affect all 45 residents who received meals from the dietary kitchen. Findings include: During observation, interview, and document review on 7/12/17, at 12:40 p.m. while touring the dishwashing room, dietary aide (DA)-B indicated the dishwashing machine was a hot temperature (temp) machine and thus no chemical sanitizer was utilized in the cleaning and sanitization process. DA-B indicated staff were to monitor and log/document temperatures for each meal to ensure temperatures were maintained for proper	F 371	The Tuff Memorial Home has implemented a new log to better track the sanitation of dishes through the dishwasher. Staff were trained on the importance of religiously filling out the log. If temperature does not reach 180 degrees during the rinse cycle, dishes will be rerun until it reaches that temperature. If it does not reach temperature, Maintenance will be informed to determine why the temperature is not reaching 180 degrees Fahrenheit. Dietary Supervisor checks the log weekly and Administrator checks the log monthly. When soaking large pots and pans, the Tuff Memorial Home will be using Sanibet multi-range disinfectant and sanitizer to ensure the proper sanitation of those pots and pans. Test strips will be used daily to determine whether the correct	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245548	A. BUILDING _____ B. WING _____	07/13/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TUFF MEMORIAL HOME	505 EAST 4TH STREET HILLS, MN 56138

(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 371	Continued From page 26 sanitization. DA-B agreed this practice had not been completed daily as she worked the day shift and at times, got too busy. When the logs were reviewed with DA-B, it was noted that some of the temps documented were below the 180 degrees Fahrenheit (F) final rinse and 150-165 degrees F wash temperature requirements. DA-B also confirmed she was unsure who to notify if the dish machine failed to reach the appropriate temperature. DA-B then verified she was currently soaking an oversize pan in water with the addition of Dawn dishwashing soap. It was observed there was no 3-compartment sink available in the dietary kitchen to sanitize oversize pots which did not fit thru the dishwasher. DA-B confirmed the Quaternary product available for dispensation located on the wall above the handwashing sink was used only to disinfect tables. It was also noted that test strips were unavailable to check whether the correct concentration of Quaternary was effective if utilized for chemical sanitization of large pots and pans. During a subsequent interview on 7/12/17, at 12:50 p.m. in the dishwashing room, dietary manager (DM)-A confirmed she had not monitored/audited staff responsible for washing dishes to ensure the proper dishwashing temperatures had been reached during the dishwashing process. DM-A indicated she was aware staff soaked and washed large oversize pots in Dawn dish soap but was unaware these large pots required chemical and/or heat for appropriate sanitization. DA-B, who was present during this time, indicated she was aware they were suppose to utilize the Quaternary chemical used for washing the dining tables when soaking large pots/pans but explained they changed to	F 371	concentration of Quaternary product was effective. The Dietary Supervisor has trained all staff, who are responsible for the soaking of large pots and pans, on the proper use of the Sanibet as well as the length the pots and pans must be in contact with the Sanibet. The Dietary Supervisor and Administrator will monitor compliance with this correction weekly to ensure the process is being followed correctly. A log will be kept to ensure the monitoring is being followed. The Tuff Memorial Home will be in compliance by August 7th, 2017.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245548	A. BUILDING _____ B. WING _____	07/13/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TUFF MEMORIAL HOME	505 EAST 4TH STREET HILLS, MN 56138

(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 371	Continued From page 27	F 371		

using only Dawn dish soap, a long time ago. It was indicated by DM-A that staff were to use test strips; however, DA-B indicated she had never seen the strips and was unaware of the need to use them. DM-A agreed staff needed additional training in this area.

During further interview on 7/12/17, at 1:15 p.m. DM-A explained she was new to the dietary manager role and currently enrolled in the certified dietary managers course which included Serve Safe training. DM-A confirmed competencies upon hire and/or thereafter had not been implemented to ensure staff were washing dishes, monitoring temperatures and ensuring the appropriate chemical was used for large pots and pans. During review of the facility's dietary staffing roster at this time indicated there were 5 staff assigned responsibility for washing dishes.

On 7/12/17, during review of the monthly Dishwasher Temperature logs it was noted that dishwashing and rinse temperatures were to be documented with each meal according to facility policy. The monthly logs over the past 6 months (January-June) were reviewed and final rinse temperatures were recorded as low as noted: January-160 degrees F., February- 164 degrees F., March-157 degrees F., April-166 degrees F., and May-140 degrees F. During this same time frame it was noted that an average of 93 meals were served monthly and 61-79 of those meals lacked any dishwashing temperature documentation, ensuring the hot water reached 180 degrees Fahrenheit ensuring proper heat sanitization with the final rinse.

Infection control logs were reviewed and no food borne illness was documented.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245548	A. BUILDING _____ B. WING _____	07/13/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TUFF MEMORIAL HOME	505 EAST 4TH STREET HILLS, MN 56138

(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 371	Continued From page 28 Review of the facility's undated Sanitation and Infection Control policy indicated high temp dishwashers should be used. It also indicated the temperature should be at a minimum 120 degrees F, not the recommended guideline for heat sanitization for the temperatures to reach 150-165 degrees F. during the wash cycle and 180 degrees F. for final rinse. No policy was available for review related to sanitation of dishware in the absence of a 3-compartment sink and when dishware did not fit thru the dishwashing machine to ensure heat sanitization.	F 371		
F 428 SS=D	483.45(c)(1)(3)-(5) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON c) Drug Regimen Review (1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. (3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic. (4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon.	F 428		8/11/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245548	A. BUILDING _____ B. WING _____	07/13/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TUFF MEMORIAL HOME	505 EAST 4TH STREET HILLS, MN 56138

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 428	Continued From page 29 (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. (5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to ensure the consulting pharmacist reported the recommendation related to lab monitoring for a lipid lowering medication (Zocor) for 1 of 5 residents (R11) reviewed for unnecessary medications. Findings include:	F 428	Consulting Pharmacist went through all resident charts and determined all residents who need labs done. All residents needing labs have been sent in. Consulting Pharmacist will make sure lab work is followed appropriately for risk medications. Pharmacist will program a reminder into the computer system to update her when she needs to send lab	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245548	A. BUILDING _____ B. WING _____	07/13/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TUFF MEMORIAL HOME	505 EAST 4TH STREET HILLS, MN 56138

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 428	Continued From page 30 R11's signed physician orders dated 7/6/17, identified diagnoses including: hyperlipidemia (high cholesterol), and type 2 diabetes. The physician orders also included a current order for Zocor 20 milligrams (mg) by mouth at bedtime for hyperlipidemia. Review of R11's medical record did not include evidence a recent lipid panel had been completed to monitor the effectiveness of Zocor. The most recent lipid panel located in the record was dated 10/27/15; R11's triglyceride (a type of fat found in the blood) level was noted to be high at 311 (reference range: 0-149). Review of the Consultant Pharmacist Communication to Physician forms dated 6/2016 through 7/2016, did not include a recommendation for laboratory monitoring related to the use of Zocor. When interviewed on 7/13/17, at 12:16 p.m. registered nurse (RN)-B confirmed R11's last lipid panel was completed on 10/27/15. RN-B stated residents on cholesterol lowering medications usually have a lipid panel drawn yearly but could find no further documentation from the pharmacist. When interviewed on 7/13/17, at 12:37 p.m. the consulting pharmacist confirmed she had not made a recommendation related to laboratory testing to monitor the efficacy of R11's Zocor. The pharmacist indicated she was unaware R11's last lipid panel drawn was dated 10/27/15, and included a high triglyceride level of 311. The pharmacist confirmed her expectation for any resident utilizing Zocor was to have lipid panel and liver function tests completed yearly.	F 428	work recommendations to the physician. This will eliminate the risk that any other residents who need labs drawn for lipids would be missed. R11 and all residents needing a lipid panel received a lipid panel. The Director of Nursing and Consulting Pharmacist will monitor compliance with this correction with monthly audits. The Tuff Memorial Home will be in compliance by August 11th, 2017.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245548	A. BUILDING _____ B. WING _____	07/13/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TUFF MEMORIAL HOME	**505 EAST 4TH STREET HILLS, MN 56138**

(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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245548	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**07/11/2017**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TUFF MEMORIAL HOME	**505 EAST 4TH STREET** **HILLS, MN 56138**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey, Tuff Memorial Home was found to be not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101 Life Safety Code (LSC), Chapter 19 Existing Health Care Occupancies. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: Health Care Fire Inspections State Fire Marshal Division 445 Minnesota Street, Suite 145 St. Paul, MN 55101-5145, or By email to:	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		08/07/2017

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245548	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**07/11/2017**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TUFF MEMORIAL HOME	**505 EAST 4TH STREET** **HILLS, MN 56138**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	Continued From page 1 Marian.Whitney@state.mn.us <mailto:Marian.Whitney@state.mn.us> and Angela.Kappenman@state.mn.us <mailto: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. Tuff Memorial Home was constructed as follows: The original building was constructed in 1959, is one-story, has a partial basement, is fully fire sprinkler protected and is of Type II(111) construction; The 1st Addition was constructed in 1962, is one-story, has no basement, is fully fire sprinkler protected and is of Type II(111) construction; The 2nd Addition was constructed in 1975, is one-story, has no basement, is fully fire sprinkler protected and is of Type II(111) construction; The 3rd Addition was constructed in 1988, is one-story, has a full basement, is fully fire sprinkler protected and is of Type V(111) construction; The 4th Addition was constructed in 1998, is one-story, has no basement, is fully fire sprinkler protected and is of Type V(000) construction. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the	K 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245548	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**07/11/2017**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TUFF MEMORIAL HOME	**505 EAST 4TH STREET** **HILLS, MN 56138**

(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 corridors which is monitored for automatic fire department notification. There are two-hour fire walls equipped with labeled 90-minute fire door assemblies, separating the buildings of Type II(111) construction from the additions of Type V(000) construction. The facility has a capacity of 50 beds and had a census of 49 at time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 345 SS=E	NFPA 101 Fire Alarm System - Testing and Maintenance Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This STANDARD is not met as evidenced by: Based on documentation review and interview, the Facility failed to test and maintain the Fire Alarm System in accordance with NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. This deficient practice could effect 49 of 49 residents. Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in	K 345	The Tuff Memorial Home will, after all fire drills, contact Criticom, the alarm monitoring call system, to verify they received the transmission that a fire alarm had been pulled at the Tuff Memorial Home. Documentation will be written on the fire drill report form to verify the response.	8/1/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245548	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**07/11/2017**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TUFF MEMORIAL HOME	**505 EAST 4TH STREET** **HILLS, MN 56138**

(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 345	Continued From page 3 accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.7.5, 9.7.7, 9.7.8, and NFPA 25. FINDINGS INCLUDE: On facility tour between 8:00 AM and 12:00 PM on 7/11/2017, during documentation review, it was revealed that the DACT System Testing was not being documented. This deficient practice was verified by the Facility Maintenance Director.	K 345	The Tuff Memorial Home will be in compliance by August 1st, 2017. The Administrator and Maintenance Supervisor will monitor compliance with this correction.	
K 920 SS=E	NFPA 101 Electrical Equipment - Power Cords and Extens Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a	K 920		7/22/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245548	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**07/11/2017**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TUFF MEMORIAL HOME	**505 EAST 4TH STREET** **HILLS, MN 56138**

(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 920	Continued From page 4 substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 This STANDARD is not met as evidenced by: Based on observation and interview, the Facility failed to comply with 10.2.4 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5.This deficient practice could affect 49 of the 49 residents. Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5	K 920	The Tuff Memorial Home will have an electrician put in a permanent outlet to connect IT equipment without the use of an extension cord. Extensions cords are forbidden to be used in the Tuff Memorial Home. Electrician was contacted and service was completed to replace kitchen ice machine outlet as well as fix frayed wires. The Tuff Memorial Home is in compliance beginning July 22nd, 2017. The Maintenance Supervisor will monitor compliance with this correction.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245548	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**07/11/2017**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TUFF MEMORIAL HOME	**505 EAST 4TH STREET** **HILLS, MN 56138**

(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 920	Continued From page 5 FINDINGS INCLUDE: On facility tour between 8:00 AM and 12:00 PM on 07/11/2017, an extension cord was observed being used as a source of fixed wiring in the West Lower Storage IT Room and wires were observed around the plug on the kitchen ice machine. This deficient practice was verified by the Facility Maintenance Director.	K 920		
K 926 SS=E	NFPA 101 Gas Equipment - Qualifications and Training Gas Equipment - Qualifications and Training of Personnel Personnel concerned with the application, maintenance and handling of medical gases and cylinders are trained on the risk. Facilities provide continuing education, including safety guidelines and usage requirements. Equipment is serviced only by personnel trained in the maintenance and operation of equipment. 11.5.2.1 (NFPA 99) This STANDARD is not met as evidenced by: Gas Equipment - Qualifications and Training of Personnel Personnel concerned with the application, maintenance and handling of medical gases and cylinders are trained on the risk. Facilities provide continuing education, including safety guidelines and usage requirements. Equipment is serviced only by personnel trained in the maintenance and operation of equipment. This deficient practice could effect 49 out of 49 residents. 11.5.2.1 (NFPA 99) FINDINGS INCLUDE:	K 926	On July 31st, an in-service was held for all employees who handle medical gas, presented by the company who supplies our medical gas. In-service was recorded so new staff could receive training. Documentation on attendance will be held in the Maintenance Supervisor's Log Book. The Tuff Memorial Home will be in compliance by August 11th, 2017. The Director of Nursing and Maintenance Supervisor will monitor compliance with	8/11/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245548	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**07/11/2017**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TUFF MEMORIAL HOME	**505 EAST 4TH STREET** **HILLS, MN 56138**

(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 926	Continued From page 6 On facility tour between 8:00 AM and 12:00 PM on 07/11/2017, documentation could not be located to show that staff that handle medical gas have been properly trained. This deficient practice was verified by the Facility Maintenance Director.	K 926	this correction.	

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

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

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

Standard Survey Date Format: mm/dd/yy From F1: **07/10/17** To F2: **07/13/17**	Extended Survey Date Format: mm/dd/yy From F3: To F4:	
Name of Facility: **TUFF MEMORIAL HOME**	Provider Number: **245548**	Fiscal Year ending:
Address: **505 EAST 4TH STREET, HILLS, ROCK, MN 56138**		
Telephone Number: F6 **507-962-3275**	State/County Code: **MN / ROCK**	State/Region Code: **MN / 05**
A. F9 **03 SNF/NF Medicare/Medicaid** B. Is this facility hospital based? F10 **No** If yes, indicate Hopsital Provider Number: F11		
Ownership: F12 **04 - Non Profit - Church Related**		
Owned or leased by Multi-Facility Organization: F13 **No** Name of Multi-Facility Organization: F14		
Dedicated Special Care Units (show number of beds for all that apply)		
AIDS F15 **0** Dialysis F17 **0** Head Trama F19 **0**	Alzheimer's Disease F16 **0** Disabled Child Young Adult F18 **0** Hospice F20 **0**	

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

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

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

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

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

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

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

FACILITY STAFFING

		A	B	C	D
	Tag #	Services Provided 1 2 3	Full-Time Staff (hours)	Part-Time Staff (hours)	Contract (hours)
Administration	F33		**134**	**0**	**0**
Physician Services	F34	**Yes No No**			
Medical Director	F35		**0**	**0**	**0**
Other Physician	F36		**0**	**0**	**3**
Physician Extender	F37	**No No No**	**0**	**0**	**0**

Nursing Services	F38	Yes No No			
RN Director of Nursing	F39		0	0	80
Nurses with Admin Duties	F40		0	0	0
Registered Nurses	F41		249	0	0
Licensed Practical/ Vocational Nurses	F42		163	106	0
Certified Nurse Aides	F43		859	638	0
Nurse Aides in Training	F44		0	32	0
Medication	F45		91	105	0
Pharmacists	F46	Yes No No	0	0	8
Dietary Services	F47	Yes No No			
Dietitian	F48		0	0	8
Food Service Workers	F49		231	413	0
Therapeutic Services	F50				
Occupational Therapist	F51	Yes Yes No	0	0	3
Occupational Therapy Assistant	F52		0	0	2
Occupational Therapy Aides	F53		0	0	0
Physical Therapist	F54	Yes Yes No	0	0	14
Physical Therapy Assist	F55		0	0	5
Physical Therapy Aides	F56		0	0	0
Speech/Language	F57	Yes Yes No	0	0	0
Therapeutic Recreation Spec.	F58	No No No	0	0	0
Qualified Activities Prof.	F59	No No No	0	0	0
Other Activities Staff	F60	Yes No No	117	86	0
Qualified Social Workers	F61	No No No	0	0	0

Other Social Services Staff	F62	Yes No No	70	0	0
Dentists	F63	No No No	0	0	0
Podiatrists	F64	Yes No No	0	0	0
Mental Health Services	F65	No No No	0	0	0
Vocational Services	F66	No No No			
Clinical Laboratory Services	F67	No No No			
Diagnostic X-ray Services	F68	No No No			
Administration Storage of Blood	F69	No No No			
Housekeeping Services	F70	Yes No No	330	7	0
Other	F71		0	0	0
Name of Person Completing Form: **Alex Dysthe**					Date: **07/14/17**

- Share This

Spotlight

Minnesota eLicensing

Questions?

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

See also > Health Regulation

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

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

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

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

TUFF MEMORIAL HOME				
Provider No. **245548**	Medicare F75 **0**	Medicaid F76 **21**	Other F77 **24**	Total Residents F78 **45**

ADL	Independent	Assist of One Two Staff	Dependent
Bathing	F79 **0**	F80 **38**	F81 **7**
Dressing	F82 **0**	F83 **45**	F84 **0**
Transferring	F85 **1**	F86 **38**	F87 **6**
Toilet Use	F88 **3**	F89 **38**	F90 **4**
Eating	F91 **32**	F92 **13**	F93 **0**

A. Bowel/Bladder Status	**B. Mobility**
F94 **3** With indwelling or external catheter.	F100 **0** Bedfast all or most of time..
F95 Of total number of residents with catheters, **1** were present on admission.	F101 **43** In chair all or most of time.
	F102 **0** Independently ambulatory.

F96 **39** Occasionally or frequently incontinent of bladder.

F97 **20** Occasionally or frequently incontinent of bowel.

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

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

F103 **2** Ambulation with assistance or assistive device.

F104 **0** Physically restrained.

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

F106 **22** With contractures.

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

C. Mental Status

F108 **0** With mental retardation.

F109 **17** With documentation signs and symptoms of depression.

F110 **13** With documentation psychiatric diagnosis (excluding dementias and depression).

F111 **21** Dementia: multi-infarct, senile, Alzheimer's type, or other than Alzheimer's type.

F112 **7** With behavioral symptoms.

F113 **7** Of the total number of residents with behavioral symptoms, the total number receiving a behavior management prpgram.

F114 **0** Receiving health rehabilitative services for MI/MR.

D. Skin Integrity

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

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

F117 **44** Receiving preventive skin care.

F118 **0** With rashes.

E. Special Care

F119 **0** Receiving hospice care benefit.

F120 **0** Receiving radiation therapy.

F121 **1** Receiving chemotherapy.

F127 **0** Receiving suction.

F128 **3** Receiving injections (exclude vitamin B12 injections)

F129 **0** Receiving tube feedings.

F122 **0** Receiving dialysis.	F130 **9** Receiving mechanically altered diets including pureed and all chopped food (not only meat).
F123 **0** Receiving intravenous therapy, parenteral nutrition, and/or blood transfusion.	F131 **3** Receiving specialized rehabilitative services (Physical therapy, speech-language therapy, occupational therapy).
F124 **3** Receiving respiratory treatment.	F132 **0** Assistive devices while eating.
F125 **0** Receiving tracheostomy care.	
F126 **0** Receiving ostomy care.	

F. Medication	**G. Other**
F133 **29** Receiving any psychoactive medication.	F140 **1** With unplanned significant weight loss/gain.
F134 **6** Receiving antipsychotic medications.	F141 **0** Who do not communicate in the dominant language of the facility (includes those who use sign language).
F135 **8** Receiving antianxiety medications.	F142 **0** Who use non-oral communicationdevices.
F136 **25** Receiving antidepressant medications.	F143 **45** With advance directives.
F137 **2** Receiving hypnotic medication.	F144 **32** Received influenza immunization.
F138 **5** Receiving antibiotics.	F145 **45** Received pneumococcal vaccine.
F139 **41** On pain management program.	

I certify that this Information is accurate to the best of my knowledge.		
Name of Person Completing	Title	Date
Alex Dysthe	**Administrator**	**07/14/2017**

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

- Share This

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINSTRATION

FORM APPROVED
OMB No. 0938-0391

SURVEY TEAM COMPOSITION AND WORKLOAD REPORT

Provider/Supplier Number	Provider/Supplier Name
245548	TUFF MEMORIAL HOME

Type of Survey (select all that apply):

I					

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

Extent of Survey (Select all that apply):

A					

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

SURVEY TEAM AND WORKLOAD DATA

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

Surveyor Id Number (A)	First Date Arrived (B)	Last Date Departed (C)	Pre-Survey Preparation Hours (D)	On-Site Hours 12am-8am (E)	On-Site Hours 8am-6pm (F)	On-Site Hours 6pm-12am (G)	Travel Hours (H)	Off-Site Report Preparation Hours (I)
1. 28651	07-10-2017	07-13-2017	0.00	1.00	24.75	2.00	6.00	5.00
2. 31767	07-10-2017	07-13-2017	0.00	1.00	24.75	2.00	6.00	8.00
3. 34083	07-10-2017	07-13-2017	0.75	2.00	24.50	2.00	3.00	4.50
4. Team Leader 38687	07-10-2017	07-13-2017	0.75	1.50	26.00	0.00	4.50	8.00
5.								
6.								
7.								
8.								
9.								
10.								

Total Supervisory Review Hours 8.75

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

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

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINSTRATION

FORM APPROVED
OMB No. 0938-0391

SURVEY TEAM COMPOSITION AND WORKLOAD REPORT

Provider/Supplier Number	Provider/Supplier Name
245548	TUFF MEMORIAL HOME

Type of Survey (select all that apply):

H	I				

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

Extent of Survey (Select all that apply):

A					

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

SURVEY TEAM AND WORKLOAD DATA

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

Surveyor Id Number (A)	First Date Arrived (B)	Last Date Departed (C)	Pre-Survey Preparation Hours (D)	On-Site Hours 12am-8am (E)	On-Site Hours 8am-6pm (F)	On-Site Hours 6pm-12am (G)	Travel Hours (H)	Off-Site Report Preparation Hours (I)
1. Team Leader 35482	07-11-2017	07-11-2017	2.00	0.00	4.00	0.00	5.00	2.00
2.								
3.								
4.								
5.								
6.								
7.								
8.								
9.								
10.								

Total Supervisory Review Hours 0.25

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

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

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

PROVIDER NUMBER	FACILITY NAME	SURVEY DATE
K1 245548	**TUFF MEMORIAL HOME**	*K4 **07/11/2017**

K6 DATE OF PLAN APPROVAL

K3 : MULTIPLE CONSTRUCTION

TOTAL NUMBER OF BUILDINGS 1

NUMBER OF THIS BUILDING 01

[A] A BUILDING
B WING
C FLOOR
D APARTMENT UNIT

LSC FORM INDICATOR

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

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

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

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

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

K321: [3] K351: [3]

COMPLETE IF ICF/MR IS SURVEYED UNDER CHAPTER 21

SMALL (16 BEDS OR LESS)

K8: [ ] 1 PROMPT 2 SLOW 3 IMPRACTICAL

LARGE

K8: [ ] 4 PROMPT 5 SLOW 6 IMPRACTICAL

APARTMENT HOUSE

K8: [ ] 7 PROMPT 8 SLOW 9 IMPRACTICAL

ENTER E-SCORE HERE

K5: [ ] e.g 2.5

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

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

FACILITY DOES NOT MEET LSC:

B. [ ]

K180:

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

*MANDATORY

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

1. (A) PROVIDER NUMBER	1. (B) MEDICAID I.D. NO.
245548 K1	K2

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

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

2. NAME OF FACILITY	2. (A) MULTIPLE CONSTRUCTION (BLDGS)	2. (B) ADDRESS OF FACILITY (STREET, CITY, STATE, ZIP CODE)	
Tuff Memorial Home	A. BUILDING X B. WING C. FLOOR K3	505 EAST 4TH STREET HILLS, MN 56138	A. (●) Fully Sprinklered (All required areas are sprinklered) B. ( ) Partially Sprinklered (Not all required areas are sprinklered) C. ( ) None (No sprinkler system) K0180

3. SURVEY FOR	4. DATE OF SURVEY	DATE OF PLAN APPROVAL	SURVEY UNDER
☑ MEDICARE ☑ MEDICAID	07-11-2017 K4	K6	5. (●) 2012 EXISTING 6. ( ) 2012 NEW K7

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

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

3. ☐ IF DISTINCT PART OF HOSPITAL, IS HOSPITAL ACCREDITED?
a. ☐ YES b. ☐ NO

6. BED COMPOSITION a. TOTAL NO. OF BEDS IN THE FACILITY	b. NUMBER OF HOSPITAL BEDS CERTIFIED FOR MEDICARE	c. NUMBER OF SKILLED BEDS CERTIFIED FOR MEDICARE	d. NUMBER OF SKILLED BEDS CERTIFIED FOR MEDICAID	e. NUMBER OF NF or ICF/IID BEDS CERTIFIED FOR MEDICAID
50	N/A	50	50	N/A

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

SURVEYOR (Signature)	TITLE	OFFICE	DATE
Larry Gannon	Deputy State Fire Marshal	State Fire Marshal Division	07-11-2017
SURVEYOR ID K10 35482			
F Thomas R. Linhoff 12424	TITLE Fire Safety Supervisor	OFFICE State Fire Marshal Division	DATE 07-18-2017

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

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

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

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

<table>
<tr><th>ID PREFIX</th><th></th><th>MET</th><th>NOT MET</th><th>N/A</th><th>REMARKS</th></tr>
<tr><td>K133</td><td>Multiple Occupancies – Construction Type
Where separated occupancies are in accordance with 18/19.1.3.2 or 18/19.1.3.4, the most stringent construction type is provided throughout the building, unless a two hour separation is provided in accordance with 8.2.1.3, in which case the construction type is determined as follows:
• The construction type and supporting construction of the health care occupancy is based on the story in which it is located in the building in accordance with 18/19.1.6 and Tables 18/19.1.6.1.
• The construction type of the areas of the building enclosing the other occupancies shall be based on the applicable occupancy chapters.
18.1.3.5, 19.1.3.5, 8.2.1.3</td><td>○</td><td>○</td><td>◉</td><td></td></tr>
<tr><td>K161</td><td>Building Construction Type and Height
2012 EXISTING
Building construction type and stories meets Table 19.1.6.1, unless otherwise permitted by 19.1.6.2 through 19.1.6.7
19.1.6.4, 19.1.6.5
<table>
<tr><th></th><th></th><th>Construction Type</th><th></th></tr>
<tr><td>1</td><td>○</td><td>I (442), I (332), II (222)</td><td>Any number of stories non-sprinklered or sprinklered</td></tr>
<tr><td>2</td><td>○</td><td>II (111)</td><td>One story non-sprinklered
Maximum 3 stories sprinklered</td></tr>
<tr><td>3</td><td>○</td><td>II (000)</td><td rowspan="4">Not allowed non-sprinklered
Maximum 2 stories sprinklered</td></tr>
<tr><td>4</td><td>○</td><td>III (211)</td></tr>
<tr><td>5</td><td>○</td><td>IV (2HH)</td></tr>
<tr><td>6</td><td>○</td><td>V (111)</td></tr>
<tr><td>7</td><td>○</td><td>III (200)</td><td rowspan="2">Not allowed non-sprinklered
Maximum 1 story sprinklered</td></tr>
<tr><td>8</td><td>○</td><td>V (000)</td></tr>
</table>
Sprinklered stories must be sprinklered throughout by an approved, supervised automatic system in accordance with section 9.7. (See 19.3.5)
Give a brief description, in REMARKS, of the construction, the number of stories, including basements, floors on which patients are located, location of smoke or fire barriers and dates of approval. Complete sketch or attach small floor plan of the building as appropriate.</td><td>○</td><td>○</td><td>○</td><td>Tuff Memorial Home was constructed as follows:
The original building was constructed in 1959, is one-story, has a partial basement, is fully fire sprinkler protected and is of Type II(111) construction;
The 1st Addition was constructed in 1962, is one-story, has no basement, is fully fire sprinkler protected and is of Type II(111) construction;
The 2nd Addition was constructed in 1975, is one-story, has no basement, is fully fire sprinkler protected and is of Type II(111) construction;
The 3rd Addition was constructed in 1988, is one-story, has a full basement, is fully fire sprinkler protected and is of Type V(111) construction;
The 4th Addition was constructed in 1998, is one-story, has no basement, is fully fire sprinkler protected and is of Type V(000) construction.</td></tr>
</table>

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

ID PREFIX		MET	NOT MET	N/A	REMARKS
K353	**Sprinkler System – Maintenance and Testing** Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, *Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems.* Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked. 06/07/2016 b) Who provided system test. BSI c) Water system supply source. City *Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system.* 9.7.5, 9.7.7, 9.7.8, and NFPA 25	◉	○	○	
K354	**Sprinkler System – Out of Service** Where the sprinkler system is impaired, the extent and duration of the impairment has been determined, areas or buildings involved are inspected and risks are determined, recommendations are submitted to management or designated representative, and the fire department and other authorities having jurisdiction have been notified. Where the sprinkler system is out of service for more than 10 hours in a 24 hour period, the building or portion of the building affected are evacuated or an approved fire watch is provided until the sprinkler system has been returned to service. 18.3.5.1, 19.3.5.1, 9.7.5, 15.5.2 (NFPA 25)	◉	○	○	
K355	**Portable Fire Extinguishers** Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, *Standard for Portable Fire Extinguishers.* 18.3.5.12, 19.3.5.12, NFPA 10	◉	○	○	
K361	**Corridors – Areas Open to Corridor** Spaces (other than patient sleeping rooms, treatment rooms and hazardous areas), waiting areas, nurse's stations, gift shops, and cooking facilities, open to the corridor are in accordance with the criteria under 18.3.6.1 and 19.3.6.1. 18.3.6.1, 19.3.6.1	◉	○	○	

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

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

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

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

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

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

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

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

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

ID PREFIX		MET	NOT MET	N/A	REMARKS
K711	**Evacuation and Relocation Plan** There is a written plan for the protection of all patients and for their evacuation in the event of an emergency. Employees are periodically instructed and kept informed with their duties under the plan, and a copy of the plan is readily available with telephone operator or with security. The plan addresses the basic response required of staff per 18/19.7.2.1.2 and provides for all of the fire safety plan components per 18/19.7.2.2. 18.7.1.1 through 18.7.1.3, 18.7.2.1.2, 18.7.2.2, 18.7.2.3, 19.7.1.1 through 19.7.1.3, 19.7.2.1.2, 19.7.2.2, 19.7.2.3	◉	○	○	
K712	**Fire Drills** Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 18.7.1.4 through 18.7.1.7, 19.7.1.4 through 19.7.1.7	◉	○	○	

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

PROVISION NUMBER(S)	JUSTIFICATION
K400	

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

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

Provider Number	Facility Name	Survey Date
K1		*K4

K6 DATE OF PLAN APPROVAL

K3 MULTIPLE CONSTRUCTION ☐

TOTAL NUMBER OF BUILDINGS _____

NUMBER OF THIS BUILDING _____

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

LSC FORM INDICATOR

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

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

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

*K7 ☐ SELECT NUMBER OF FORM USED FROM ABOVE

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

SMALL (16 BEDS OR LESS)

K8 ☐
1. PROMPT
2. SLOW
3. IMPRACTICAL

LARGE

K8 ☐
4. PROMPT
5. SLOW
6. IMPRACTICAL

APARTMENT HOUSE

K8 ☐
7. PROMPT
8. SLOW
9. IMPRACTICAL

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

K321: ☐ K351: ☐

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

ENTER E – SCORE

K5: ☐ e.g. 2.5

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

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

FACILITY DOES NOT MEET LSC

B. ☐

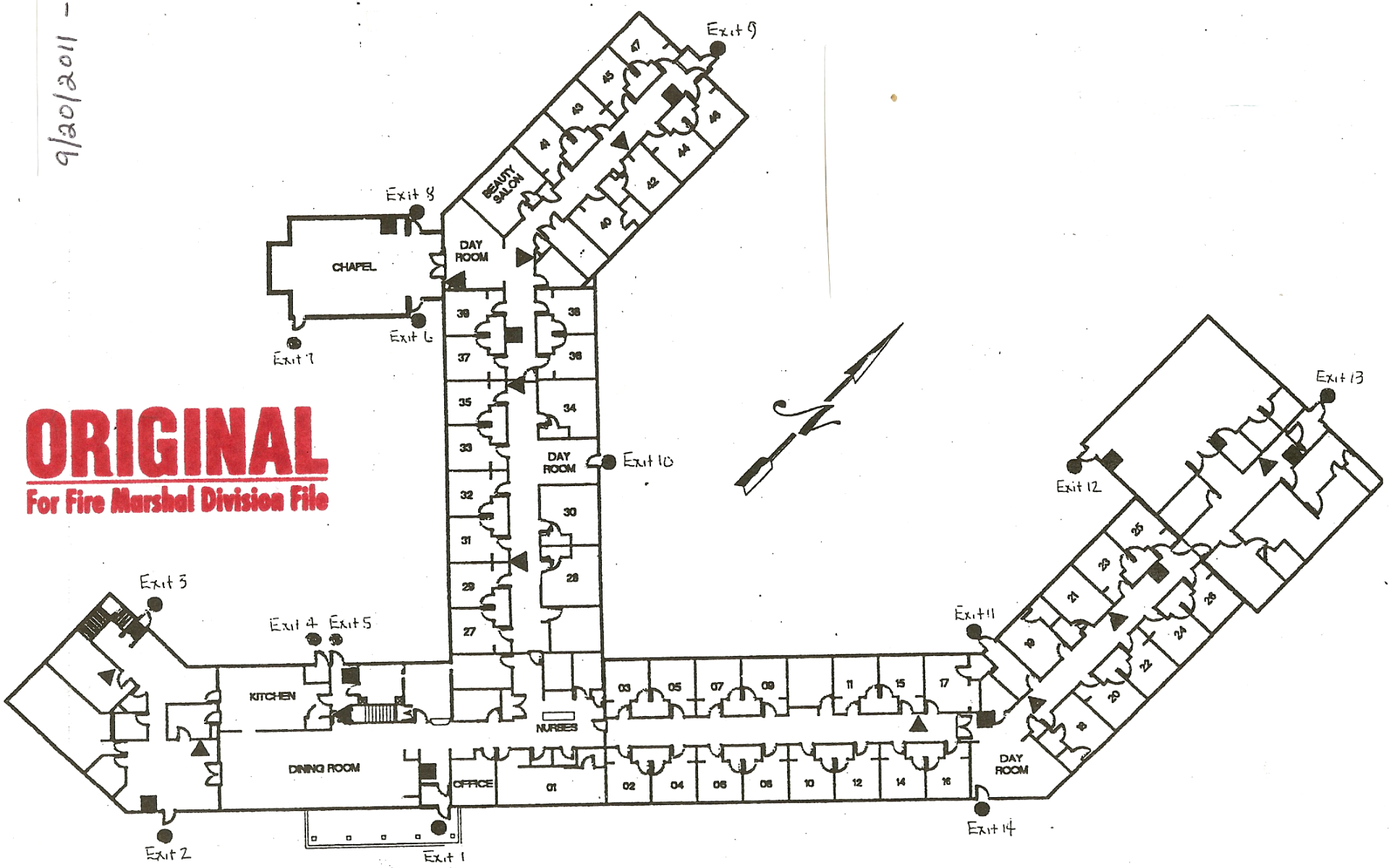
K0180

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

*MANDATORY

TUFF MEMORIAL HOME
HILLS, MN.

9/20/2011 - MS



ORIGINAL
For Fire Marshal Division File

PROJECT NUMBER:	PROVIDER NAME	SURVEY DATE
F5548026	Tuff Memorial Home	07/11/2017

Administrator: Alex Dysthe | Phone Number: 507-962-3275

Email address: adysthe@tuffmemorialhome.com

State Fire Inspector: Larry Gannon, DSFM, 651-769-7779

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

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

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

K TAG S& S	◉ **Draft Summary of Deficiency(ies)** ○ **Revisit** ○ **Clearance**
K345 S/S=E	During documentation review, it was revealed that the DACT System Testing was not being documented.
K920 S/S=E	During the inspection, an extension cord was observed being used as a source of fixed wiring in the West Lower Storage IT Room and wires were observed around the plug on the kitchen ice machine.
K926 S/S=E	Documentation could not be located to show that staff that handle medical gas have been properly trained.

S5548026

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

Email for Administrator: adysthe@tuffmemorialhome.com

National Provider Identifier (NPI) Number: 1790785194
One facility may have multiple NPI Numbers. Please verify the NPI number associated with the provider type for this survey, i.e. for a nursing home survey, the NPI Number will be associated with the Nursing Home.

OWNERSHIP INFORMATION AT THE TIME OF SURVEY

Name of Facility: TUFF MEMORIAL HOME City: HILLS

Name of Legal Entity Operating Provider: TUFF MEMORIAL HOME

Name and Address of Governing Board President:

Name: GREG SPATH
Address: 602 BRITZ DRIVE

City/State/Zip: LUVERNE, MN 56156

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

Name of Facility: _____ City: _____

Name of Legal Entity Operating Provider: _____

Name and Address of Governing Board President:

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

SIGNATURE

Completed by: Alex Dysthe
Title: Administrator
Date: 7/10/17