





*Protecting, Maintaining and Improving the Health of All Minnesotans*

Electronically delivered  
November 24, 2020

CMS Certification Number (CCN): 245336

Administrator  
The Estates At Delano Llc  
433 County Road 30  
Delano, MN 55328

Dear Administrator:

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 November 8, 2020 the above facility is certified for:

46 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 46 skilled nursing facility beds.

We have recommended CMS approve the waivers that you requested for the following Life Safety Code Requirements: K521.

If you are not in compliance with the above requirements at the time of your next survey, you will be required to submit a Plan of Correction for this deficiency or renew your request for waiver in order to continue your participation in the Medicare and Medicaid Program.

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/or Medicaid provider agreement may be subject to non-renewal or termination.

Please contact me if you have any questions.

Sincerely,

A handwritten signature in black ink, appearing to read 'Douglas Larson'.

Douglas Larson, Enforcement Specialist  
Minnesota Department of Health  
Licensing and Certification Program  
Program Assurance Unit

*An equal opportunity employer.*

The Estates At Delano Llc

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Health Regulation Division

Telephone: 651-201-4118 Fax: 651-215-9697

Email: [doug.larson@state.mn.us](mailto:doug.larson@state.mn.us)

cc: Licensing and Certification File



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November 24, 2020

Administrator  
The Estates At Delano Llc  
433 County Road 30  
Delano, MN 55328

RE: CCN: 245336  
Cycle Start Date: September 3, 2020

Dear Administrator:

On September 23, 2020, we notified you a remedy was imposed. On October 27, 2020 the Minnesota Department(s) of Health and Public Safety completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of November 8, 2020.

As authorized by CMS the remedy of:

- Discretionary denial of payment for new Medicare and Medicaid admissions effective October 23, 2020 be discontinued as of November 8, 2020. (42 CFR 488.417 (b))

However, as we notified you in our letter of September 23, 2020, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from October 23, 2020. This does not apply to or affect any previously imposed NATCEP loss.

The CMS Region V Office may notify you of their determination regarding any imposed remedies.

Your request for a continuing waiver involving the deficiency(ies) cited under K521 at the time of the September 3, 2020 standard survey has been forwarded to CMS for their review and determination. Your facility's compliance is based on pending CMS approval of your request for waiver.

Feel free to contact me if you have questions.

Sincerely,

A handwritten signature in black ink, appearing to read 'Douglas Larson'.

Douglas Larson, Enforcement Specialist

The Estates At Delano Llc

November 24, 2020

Page 2

Minnesota Department of Health  
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MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: MTA3

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00933

Form sections 1-15: Includes provider information, facility address (THE ESTATES AT DELANO LLC), survey date (09/03/2020), accreditation status, and provider categories.

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

Signatures section 17-18: Lynn Moeller, HFE NE (L19) and Alison Helm, Enforcement Specialist (L20) dated 10/07/2020 and 11/04/2020.

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

Form sections 19-21: Eligibility determination (L21), Civil Rights Act compliance (L44), and financial solvency statement (L20).

Form sections 22-25: Participation date (L24), agreement dates (L25, L41, L45), sanctions (L44), and extension date (L27).

Form sections 26-32: Termination action (L30), remarks (L31), carrier number (0111), and approval date (L33).



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September 23, 2020

Administrator  
The Estates At Delano LLC  
433 County Road 30  
Delano, MN 55328

RE: CCN: 245336  
Cycle Start Date: September 3, 2020

Dear Administrator:

On September 3, 2020, a survey was completed at your facility by the Minnesota Department(s) 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 electronically delivered CMS-2567, whereby significant corrections are required.

## **REMEDIES**

As a result of the survey findings and in accordance with survey and certification memo 16-31-NH, this Department recommended the enforcement remedy(ies) listed below to the CMS Region V Office for imposition. The CMS Region V Office concurs and is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective October 23, 2020.
- Directed plan of correction (DPOC), Federal regulations at 42 CFR § 488.424. Please see electronically attached documents for the DPOC.

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective October 23, 2020. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective October 23, 2020.

You should notify all Medicare/Medicaid residents admitted on, or after, this date of the restriction. The remedy must remain in effect until your facility has been determined to be in substantial compliance or your provider agreement is terminated. Please note that the denial of payment for

The Estates At Delano LLC

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new admissions includes Medicare/Medicaid beneficiaries enrolled in managed care plans. It is your obligation to inform managed care plans contracting with your facility of this denial of payment for new admissions.

This Department is also recommending that CMS impose:

- Civil money penalty (42 CFR 488.430 through 488.444). You will receive a formal notice from the CMS RO only if CMS agrees with our recommendation.

### **NURSE AIDE TRAINING PROHIBITION**

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than \$11,160; has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

If you have not achieved substantial compliance by October 23, 2020, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, The Estates At Delano LLC will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from October 23, 2020. You will receive further information regarding this from the State agency. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions.

However, under Public Law 105-15, you may contact the State agency and request a waiver of this prohibition if certain criteria are met.

### **ELECTRONIC PLAN OF CORRECTION (ePOC)**

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved. The failure to submit an acceptable ePOC can lead to termination of your Medicare and Medicaid participation (42 CFR 488.456(b)).

To be acceptable, a provider's ePOC must include the following:

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.



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- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

## **DEPARTMENT CONTACT**

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

**Susie Haben, Unit Supervisor**  
**St. Cloud A Survey Team**  
**Licensing and Certification Program**  
**Health Regulation Division**  
**Minnesota Department of Health**  
**3333 West Division Street, Suite 212**  
**St. Cloud, Minnesota 56301**  
**Email: susie.haben@state.mn.us**  
**Phone: 320-223-7356**

## **PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE**

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. 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 - Health Regulation Division staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for their respective deficiencies (if any) is acceptable.

## **VERIFICATION OF SUBSTANTIAL COMPLIANCE**

Upon receipt of an acceptable ePoC, a Post Certification Revisit (PCR), of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

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.

## **FAILURE TO ACHIEVE SUBSTANTIAL COMPLIANCE BY THE SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY**

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by March 3, 2021 if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at § 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR § 488.412 and § 488.456.

**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.**

#### **APPEAL RIGHTS**

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40, et seq. You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at <https://dab.efile.hhs.gov> no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

**[Tamika.Brown@cms.hhs.gov](mailto:Tamika.Brown@cms.hhs.gov)**

Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted as of October 1, 2014, unless you do not have access to a computer or internet service. In those circumstances you may call the Civil Remedies Division to request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a written request for a waiver along with your written request for a hearing. A written request for a hearing must be filed no later than sixty (60) days after receiving this letter, by mailing to the following address:

**Department of Health & Human Services  
Departmental Appeals Board, MS 6132  
Director, Civil Remedies Division  
330 Independence Avenue, S.W.  
Cohen Building – Room G-644  
Washington, D.C. 20201  
(202) 565-9462**

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Tamika Brown, Principal Program Representative by phone at (312) 353-1502 or by e-mail at [Tamika.Brown@cms.hhs.gov](mailto:Tamika.Brown@cms.hhs.gov).

**INFORMAL DISPUTE RESOLUTION (IDR) / INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)**

The Estates At Delano LLC

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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: <https://mdhprovidercontent.web.health.state.mn.us/ltr/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: [https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04\\_8.html](https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html)

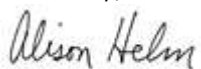
Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

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](mailto:tom.linhoff@state.mn.us)  
Telephone: (651) 430-3012  
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,



Alison Helm, Enforcement Specialist  
Licensing and Certification  
Minnesota Department of Health

The Estates At Delano LLC

September 23, 2020

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P.O. Box 64970

Saint Paul, Minnesota 55164-0970

Phone: 651-201-4206

Email: [alison.helm@state.mn.us](mailto:alison.helm@state.mn.us)

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

PRINTED: 10/08/2020  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>245336</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>09/03/2020</b>
NAME OF PROVIDER OR SUPPLIER  <b>THE ESTATES AT DELANO LLC</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>433 COUNTY ROAD 30</b> <b>DELANO, MN 55328</b>		
(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	
E 000	Initial Comments	E 000			
	A survey for compliance with CMS Appendix Z Emergency Preparedness Requirements, was conducted on 8/31/20-9/3/20, during a recertification survey. The facility is in compliance with the Appendix Z Emergency Preparedness Requirements.				
F 000	INITIAL COMMENTS	F 000			
	On 8/31/20, through 9/3/20, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was found not in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities.				
	The following complaints were found to be UNSUBSTANTIATED: H5336045C H5336046C H5336047C H5336048C H5336049C				
	The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance.				
	Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with				

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

TITLE

(X6) DATE

Electronically Signed

10/02/2020

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

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F 000	Continued From page 1	F 000			
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii)  §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii) Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to revise a care plan following discharge recommendations from Physical Therapy for 1 of 1 resident (R6) reviewed for care plan timing and revision.	F 657		10/9/20	
			F657: Care Plan Timing and Revision Immediate Corrective Action: R6 therapy recommendations were reviewed. R6 is currently being assessed by therapy to determine appropriateness		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>245336</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>09/03/2020</b>
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F 657	<p>Continued From page 2</p> <p>Findings include:</p> <p>R6's annual Minimum Data Set (MDS) dated 7/10/20, indicated R6 had diagnoses including right-side weakness, end-stage renal disease, depression, anxiety, and speech difficulty. The MDS further indicated R6 was severely cognitively impaired, needed extensive assist for toileting, was not steady and only able to stabilize with staff assistance when moving from seated to standing position and surface to surface transfers.</p> <p>A document titled Physical Therapy PT Discharge Summary, electronically signed by Staff-E and dated 8/14/20, indicated R6 should have AFO on at all times while out of bed and transferring. the document further indicated staff were trained in use of the AFO.</p> <p>R6's care plan, printed 9/2/20, was reviewed, and did not include ROM exercises or application of AFO.</p> <p>On 8/31/20, at 4:55 p.m., R6 was observed to be in their room, sitting in the wheelchair, with ankle-foot orthosis (AFO) splint not on R6's foot. The AFO was observed laying on the floor next to R6's nightstand.</p> <p>On 9/01/20, at 1:51 p.m., R6 was observed to be out of their room but R6's AFO was in the room laying on the floor next to the residents nightstand.</p> <p>-at 4:05 p.m. R6 was observed returning to the facility via transport van in a wheelchair with blue gripper socks on her feet. R6 was not wearing shoes nor the AFO.</p>	F 657	<p>of AFO. The recommendations will be added to the care plan and point of care task list.</p> <p>Action as it is applied to others: Restorative nursing services policy was reviewed and remains current Care Planning policy was reviewed and remains current Therapy recommendations for all residents were reviewed from the past 3 months to ensure that all recommendations were added to the care plan and point of care task list. Communication process between therapy and clinical was reviewed and revised. Reeducation has been initiated with therapy and clinical staff regarding communication, care planning, implementing and completing therapy recommendations. Date of completion: _10/9/2020 Recurrence will be prevented by: Audits of 3 therapy recommendations will be completed weekly x 4 then monthly x2 months to ensure that the therapy recommendations are care planned and are being followed. The results of these audits will be reviewed with the facility QAPI Committee for input on the need to increase, decrease or discontinue the audits.</p> <p>The correction will be monitored by: The DON and/or designee</p>		

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F 657	Continued From page 3  On 9/02/20, at 8:02 a.m., Nursing Assistant (NA) -B with NA-C were observed to perform incontinence cares and dressed R6 for the day. NA-B and NA-C did not offer to put on R6's AFO or shoes. NA-B placed blue gripper socks on R6. NA-B then transferred R6 to the wheelchair with a gait belt and pivot transfer. -at 8:26 a.m., NA-B was interviewed and stated R6 wears gripper socks all the time and therapy is responsible for placing the AFO to R6's right lower extremity. NA-B further stated she had not seen an order for putting on the AFO.  -at 9:10 a.m., NA-B was interviewed and stated the NA's will do range of motion (ROM) exercises on the right arm as R6 allows. NA-B further stated R6's lower extremities were "pretty good" and NA's do not do any ROM on them.  -at 9:53 a.m., RN-D was interviewed and stated there were no devices R6 needed to wear every day, and R6 wore gripper socks because it was easier for R6 to drag the right foot without a shoe in place. RN-D verified there was no order for ROM exercises and no order for application of an AFO in R6's chart.  On 9/03/20, at 10:23 a.m., Staff-E stated R6's AFO recommendations were in place to promote foot lift, and to maintain ROM.  On 9/2/20, at 12:47 p.m., RN-E was interviewed and verified there was no directive to apply an AFO to R6's Right lower extremity on the NA care sheet nor in R6's care plan.  On 9/2/20, at 8:40 a.m., Staff-D, Certified Occupational Therapy Assistant, was interviewed	F 657			



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F 657	<p>Continued From page 4</p> <p>and stated her expectation would be that R6 would be receiving ROM to both upper and lower extremities according to previous therapy recommendations.</p> <p>On 9/2/20, at 8:44 a.m., Staff-E, Physical Therapist, stated R6 is on a functional maintenance program and he would expect staff to follow therapy recommendations.</p> <p>On 9/2/20, at 12:47 p.m., RN-E was interviewed and stated therapy staff gives a copy of their recommendations to RN-E to add to the NA care sheet and point of care task list in the resident's medical chart. RN-E stated the therapy would also be in the resident's care plan. RN-E stated she did not receive any therapy recommendations for R6 during the month of August. RN-E verified there are no recommendations from therapy for R6 in the staff communication book for the month of August. RN-E further verified there was no directive to apply an AFO to R6's Right lower extremity on the NA care sheet nor in R6's care plan. RN-E stated it would be her expectation to receive a copy of any therapy recommendations. RN-E verified her signature appears at the bottom of the document titled PT/OT/ST Functional Maintenance Program dated 8/13/20, outlining therapy recommendations.</p> <p>The policy titled Restorative Nursing Services, revised July, 2017, indicated Residents will receive restorative nursing care as needed to help promote optimal safety and independence. The policy further indicated restorative goals and objectives are individualized and resident-centered, and are outlined in the resident's plan of care.</p>	F 657			

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F 657	Continued From page 5	F 657			
F 677 SS=D	<p>The Monarch Healthcare Management policy titled Care Planning, revised 6/2019, indicated the care plan is to be modified and updated as the condition and care needs of the resident changes.</p> <p>ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2)</p> <p>§483.24(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 assistance with grooming for 1 of 2 residents (R11), reviewed for activities of daily living (ADLs) and who were dependent on staff for care.</p> <p>Findings include:</p> <p>R11's Minimum Data Set (MDS) dated 7/24/20, indicated severe cognitive impairment, total dependent with transfers with 2 assist and Hoyer lift and always incontinent of bowel and bladder. Braden scale 14, which suggest moderate risk of skin breakdown.</p> <p>R11's bladder assessment dated 11/29/19, identified, R11 was not acceptable for bladder retraining.</p> <p>R11's Care Area Assessment dated 11/22/19, identified, R11 triggered for bladder incontinence during assessment period. Resident is able to make most needs known. Offer toileting every 2-3</p>	F 677	<p>F677: ADL Care Provided for Dependent Residents Immediate Corrective Action: A bowel and bladder assessment was completed for R11 and a toileting plan was implemented and care planned. R11 is being assisted with toileting per her plan.</p> <p>Action as it is applied to others: Urinary Continence and Incontinence-Assessment and Management Policy was reviewed and remains current. A bowel and bladder assessment were completed for residents to determine an appropriate toileting plan for each. These plans were implemented, and care planned. Education has been initiated with nursing staff regarding assessing bowel and bladder and initiating individualized toilet plans. Education was implemented for all</p>	10/9/20	

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F 677	<p>Continued From page 6 hours.</p> <p>R11's care plan dated 7/24/20, indicated pertinent diagnosis Type 1 Diabetes Mellitus, Alcohol abuse, ataxic (involuntary movement) gait, muscle weakness, Poly neuropathy (nerve pain), Other symptoms and signs involving cognitive functions and awareness, Disorientation unspecified, abnormalities of gait and mobility, History of transient ischemic attacks (TIA) (mini-stroke), and cerebral infarction (stroke) without residual deficits.</p> <p>During observation on 9/1/20, at 1:23 p.m. nursing assistant (NA)-A requested transfer assistance in R11's room. NA-A stated they are laying R11 down and checking/changing brief. NA-B came in to assist with transfer. Hoyer was hooked up to machine both aides assisted moving resident from wheelchair to bed. W R11 was laid down, brief and pants were identified as wet. NA-A removed R11's soiled clothing. Hoyer sheet, which was laying under R11 between she and her wheelchair cushion was soaked as well. NA-A cleaned R11's peri area and surrounding skin while NA-B wiped down wheelchair cushion. NA-A stated R11's skin was not red, but the coccyx appeared slightly pink after removing stool. R11's skin appeared to blanched when NA wiped area. NA's completed R11's cares and propped up her legs with a pillow before washing their hands and exiting the room.</p> <p>During interview on 9/1/20, at 1:30 p.m., NA-B stated staff usually check/change R11's brief about every 2.5-3 hour, and tries to write down on paper to remind herself of next changes. NA-B stated R11's brief usually had large amount of urine with each check and change.</p>	F 677	<p>nursing staff regarding following and providing toileting/incontinence cares. Date of completion: 10/9/2020</p> <p>Recurrence will be prevented by: Audits of 3 toileting plans will be completed weekly x 4 then monthly x2 months to ensure that residents are being assisted with toilet use/incontinent cares per their individualized plan. The results of these audits will be reviewed with the facility QAPI Committee for input on the need to increase, decrease or discontinue the audits.</p> <p>The correction will be monitored by: DON or/and designee</p>		

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F 677	Continued From page 7  During interview on 9/1/20, at 1:50 p.m. NA-A stated R11 usually lays down after every meal and always a check and change. NA-A stated R11 needed assist of two and a Hoyer lift for all transfers. NA-A indicated R11 cannot tell if she needs to urinate or have a bowel movement. NA-A further stated R11 had large amount of urine in brief when R11 laid down this afternoon and the last brief change and repositioned was this morning at 8:00 am, as they did not have time to get to her, but they usually check, change, and reposition her every 2-3 hours.  During interview on 9/1/20, at 2:53 p.m. registered nurse (RN)-C stated staff try to reposition R11 every hour or so and checked for incontinence. RN-C further stated R11 likes to be up in the wheelchair for meals and then likes to get back in bed after each meal. RN-C further stated if R11 did not get toileted from 8:00 a.m. to 1:30 p.m. it would not be acceptable, as R11 is at risk for skin break down.  During observation on 9/2/20, at 7:04 a.m. R11 laying on left side, room has strong smells of urine. Door was open can smell urine from hallway.  During observation on 9/2/20, at 7:25 a.m. NA-B and NA-C were in R11's room to assist with getting R11 in wheelchair for breakfast. NA-B stated R11 had a dry brief and offered a bedpan. R11 requested to get off bedpan and would try again later. NA-B assisted R11 off bedpan, cleaned peri area with wipe, no redness, or pink skin observed on coccyx, new brief applied. Hoyer sheet put under R11 and R11 rolled herself back and forth to allow clothing adjustment. R11	F 677			

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F 677	<p>Continued From page 8</p> <p>transferred to wheelchair via Hoyer lift by NA-B and NA-C.</p> <p>During observation on 9/2/20, at 9:46 a.m. R11 noted to be laying on right side in bed with lights off. R11's rooms smells of urine.</p> <p>During observation and interview on 9/2/20, at 1:33 p.m. R11 sitting in wheelchair, stated she wants to lay down. Urine odor noted when within 1 foot of R11. R11 stated she had not been back to bed since before lunch. Surveyor notified RN-D R11 wanted help. RN-D called for assistance with laying R11 back to bed. NA-C assisted RN-D with laying R11 in bed. RN-D stated resident had small wet brief with scant amount of blood, which she has a history of and will notify the nurse practitioner. Peri care performed, no redness observed.</p> <p>During interview on 9/2/20, at 2:38 p.m. NA-B stated R11 brief was usually "soaked" with each check and change. NA-B stated she changed R11 at 3:30 a.m. and then again, at 5:30 a.m. before getting her up for breakfast this morning.</p> <p>During observation on 9/3/20, at 8:30 a.m. R11 was sitting in her wheelchair in the the dining room having breakfast.</p> <p>During observation on 9/3/20, at 9:03 a.m. R11 was in her wheelchair sitting in her room, call light in reach. No observation of position change or brief change.</p> <p>During interview on 9/3/20, at 9:35 a.m., RN-B stated R11's assessments directed staff to check and change R11 about every 2-2.5 hours and it is</p>	F 677			

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

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F 677	Continued From page 9 not acceptable to go beyond that to prevent break down of her skin. RN-B stated R11 relies on staff for repositioning and bladder/bowel care as R11 unable to do this care for herself.  During observation on 9/3/20, at 10:28 a.m. R11 noted to be sitting up in wheelchair. No urine odor noted, call light in reach. R11 appeared to be watching television.  During interview on 9/3/20, at 10:46 a.m. NA-A stated R11 was repositioned last at 7:15 a.m. and this was the first time she could get back to her. NA-A stated no redness or skin breakdown of R11's coccyx. NA-A described R11's brief had large amount of urine. NA-A stated R11's care sheet indicates repositioning should occur about every 2-3 hours. R11 was transferred back into wheelchair for lunch.  During document review on 09/03/20, at 10:56 AM observed NA-A's care sheet which stated R11 brief changed and got up for breakfast at 7:15 a.m.  Policy Urinary Continence and Incontinence-Assessment and Management dated 9/2010 "As indicated, and if the individual remains incontinent despite treating transient causes of incontinence, the staff will initiate a toileting plan. As appropriate, based on assessing the category and causes of incontinence, the staff will provide scheduled toileting, prompted voiding, or other interventions to try to manage incontinence."	F 677			
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii)	F 686		10/9/20	

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F 686	<p>Continued From page 10</p> <p>§483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers.</p> <p>Based on the comprehensive assessment of a resident, the facility must ensure that-</p> <p>(i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and</p> <p>(ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, interview, and document review, the facility failed to implement care plan interventions to prevent pressure ulcers for 2 of 3 residents (R1, R11), who were dependent on staff for care.</p> <p>Findings include:</p> <p>R1's quarterly Minimum Data Set (MDS) dated 6/1/20, indicated R1 had severe cognitive impairment, required extensive assistance with cares, was dependent on staff to turn and reposition while in bed and in wheelchair.</p> <p>R1's care plan revised 4/7/20, identified R1 was at risk for pressure ulcers related to impaired mobility, failure to thrive, iron deficiency anemia, and poor nutritional intake.</p> <p>During observation on 9/2/20, at 8:33 a.m. R1 appeared to be sunk in to the center of the mattress laying on her left side but leaning backwards with her, with knees bent and pointing</p>	F 686	<p>F686 Treatment services to prevent pressure ulcers</p> <p>Immediate Corrective Action: R1 air mattress was assessed by the Maintenance Director and is functional. Orders to assess mattress function have been added. R1 was reviewed and assessed for risk of pressure ulcers and to determine repositioning schedule. Care plan has been updated to reflect pressure ulcer interventions including repositioning. Resident is being turned and repositioned per plan.</p> <p>Action as it is applied to others: Pressure Ulcer/Injury Risk Assessment Policy was reviewed and remains current Other residents with air mattresses were reviewed to ensure air mattress is functioning and orders were entered regarding monitoring the air mattress. Residents have been assessed for risk of pressure ulcers and to determine</p>		

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F 686	<p>Continued From page 11 upward towards ceiling.</p> <p>During observation at 9/2/20, at 8:46 a.m. nursing assistant (NA)-B transferred R1 out of bed, noted dip in the center of the bed. NA-B stated it was about one and a half feet across the bed, 10 inches high and 6 inches deep. NA-B further stated the air mattress had always done that, R1 sank in and was cocooned in the air mattress.</p> <p>During observation and interview on 9/2/20 at 10:26 a.m. NA-B and registered nurse (RN)-B identified R1's air mattress was set at the correct setting for her weight. RN-B stated maintenance would be contacted to check the air mattress as R1 should not sink into a pocket and be cocooned into the mattress, because that would increase R1's risk to develop a pressure sore.</p> <p>When interviewed on 9/2/20, at 1:12 p.m. maintenance director stated the air mattress was checked, had an air loss light on but the alarm did not sound as the alarm had been set to silent so no staff was aware that there was a problem with the inflation of the mattress.</p> <p>R11's Minimum Data Set (MDS) dated 7/24/20, indicated, R11 has moderate cognition impairment, total dependent with transfers. R11 has limited range of motion to bilateral lower legs.</p> <p>R11's Braden scaled dated 7/24/20, indicated, R11's Braden score of 14, which indicates a moderate risk for skin breakdown. R11 reposition</p>	F 686	<p>repositioning schedule when applicable. Residents care plans have been updated to reflect pressure ulcer prevention interventions including repositioning where applicable. Reeducation has been initiated with nursing staff regarding air mattresses and following and providing pressure ulcer prevention interventions, including repositioning. Date of completion: 10/9/2020</p> <p>Recurrence will be prevented by: Audits of 3 pressure ulcer interventions will be completed weekly x 4 then monthly x2 months to ensure that residents are being assisted with their interventions/repositioning per their individualized plan and that air mattresses are functional. The results of these audits will be reviewed with the facility QAPI Committee for input on the need to increase, decrease or discontinue the audits.</p> <p>The correction will be monitored by: DON and/or designee</p>		



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F 686	<p>Continued From page 12</p> <p>schedule indicates every 2.5-3 hours or as needed.</p> <p>R11's Care plan dated 7/24/20, diagnosis of right foot drop, abnormal gait, ataxic gait, muscle weakness, and alcohol encephalopathy with history of falls. Hoyer with two assists for all transfers.</p> <p>During observation on 9/1/20, at 1:23 p.m. R11 transferred to bed with the assistance of two nursing assistance and a Hoyer lift. During brief change nursing assistant (NA)-A indicated a slightly pink coccyx, but skin blanches when palpating after having a bowel movement. NA-A denies any observation of red skin or skin breakdown.</p> <p>During interview on 9/1/20, at 1:30 p.m. NA-B stated R11 care sheets indicated repositioning should occur every 2.5-3 hours. NA-B stated R11 care sheets indicate transfer with assist of two and Hoyer lift.</p> <p>During interview on 9/1/20, at 1:50 p.m. NA-A indicated R11 usually lays down after every meal with assist of two and the Hoyer lift. NA-A indicated they repositioned R11 last at 8:00 a.m. this morning and did not have time get back to her. NA-A stated R11's care sheets indication to reposition every 2-3 hours.</p> <p>During interview on 9/1/20, at 2:53 p.m. registered nurse (RN)-C stated staff try to reposition R11 about every hour or so due to R11's dependence on staff for repositioning, but was unsure what R11's care plan stated. RN-C stated it would be unacceptable if repositioning did not occur for R11 from 8:00 a.m. to 1:30 p.m.</p>	F 686			

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F 686	<p>Continued From page 13 as R11 is at risk of skin break down.</p> <p>During observation on 9/3/20, at 8:30 a.m. R11 was sitting in her wheelchair in the the dining room having breakfast.</p> <p>During observation on 9/3/20, at 9:03 a.m. R11 was in her wheelchair sitting in her room, call light in reach. No observation of position change.</p> <p>During interview on 9/3/20, at 9:35 a.m. RN-E indicated on admission all residents get a tissue tolerance, bowel, and bladder evaluation, which then identifies how often residents should be repositioned and toileted. Staff can identify resident's cares by their care sheets and care plans. RN-E stated R11 repositioning schedule indicated every 2-2.5 hours. RN-E indicated R11 could not move herself and was dependent on staff for repositioning. RN-E stated assessments for R11 indicated a risk of skin break down if not repositioned within her timeframe. RN-E confirmed the importance to reposition R11 to prevent pressure sores and other skin break down from forming.</p> <p>During observation on 9/3/20, at 10:28 a.m. R11 continues to be sitting in wheelchair. No urine odor noted, call light in reach. Resident appears to be watching television.</p> <p>During interview on 9/3/20, at 10:46 a.m. NA-A stated R11 was repositioned last at 7:15 a.m. and this was the first time she could get back to her. NA-A stated no redness or skin breakdown of R11's coccyx. NA-A stated R11's care sheet indicates repositioning should occur about every 2-3 hours.</p>	F 686			

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F 686	Continued From page 14 Observed NA-A's care sheet dated 9/3/20, at 10:56 a.m. indicated at 7:15 a.m. R11 transferred to wheelchair.  Policy Pressure Ulcer/Injury Risk Assessment dated 7/17, indicated "Develop the resident-centered care plan and interventions based on the risk factors identified in the assessments, the condition of the skin, the resident's overall clinical condition, and the resident's stated wishes and goals. a) The interventions must be based on current, recognized standards of care. b) The effects of the interventions must be evaluated. c) The Care plan must be modified as the resident's condition changes, or if current intervention are deemed inadequate."	F 686			
F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3)  §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and  §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion.  §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable.	F 688		10/9/20	

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NAME OF PROVIDER OR SUPPLIER  <b>THE ESTATES AT DELANO LLC</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>433 COUNTY ROAD 30</b> <b>DELANO, MN 55328</b>		
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F 688	<p>Continued From page 15</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure therapy services were provided to maintain range of motion (ROM) and prevent decline in mobility for 1 of 1 resident (R6) reviewed for ROM/Therapy services.</p> <p>Findings include:</p> <p>R6's annual Minimum Data Set (MDS) dated 7/10/20, indicated R6 had diagnoses including right-side weakness, end-stage renal disease, depression, anxiety, and speech difficulty. The MDS further indicated R6 was severely cognitively impaired, needed extensive assist for toileting, was not steady and only able to stabilize with staff assistance when moving from seated to standing position and surface to surface transfers.</p> <p>A document titled Physical Therapy PT Discharge Summary, electronically signed by Staff-E and dated 8/14/20, indicated R6 should have AFO on at all times while out of bed and transferring. the document further indicated staff were trained in use of the AFO.</p> <p>R6's care plan, printed 9/2/20, was reviewed, and did not include ROM exercises or application of AFO.</p> <p>On 8/31/20, at 4:55 p.m., R6 was observed to be in their room, sitting in the wheelchair, with ankle-foot orthosis (AFO) splint not on R6's foot. The AFO was observed laying on the floor next to R6's nightstand.</p>	F 688	<p>F 688 Increase/Prevent decrease in ROM/Mobility Immediate Corrective Action: R6 therapy recommendations are being assessed. R6 will have AFO applied per therapy recommendations. The recommendations were added to the care plan and point of care task list.</p> <p>Action as it is applied to others: Restorative nursing services policy was reviewed and remains current Care Planning policy was reviewed and remains current Therapy recommendations for all residents were reviewed from the past 3 months to ensure that all recommendations were added to the care plan and point of care task list. Communication process between therapy and clinical was reviewed and revised. Reeducation has been implemented with therapy and clinical staff regarding communication, care planning, implementing and providing therapy recommendations. Date of completion: 10/09/2020</p> <p>Recurrence will be prevented by: Audits of 3 therapy recommendations will be completed weekly x 4 then monthly x2 months to ensure that the therapy recommendations are care planned and are being followed. The results of these audits will be reviewed with the facility QAPI Committee for input on the need to increase, decrease or discontinue the</p>		

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F 688	<p>Continued From page 16</p> <p>On 9/01/20, at 1:51 p.m., R6 was observed to be out of their room but R6's AFO was in the room laying on the floor next to the residents nightstand.</p> <p>-at 4:05 p.m. R6 was observed returning to the facility via transport van in a wheelchair with blue gripper socks on her feet. R6 was not wearing shoes nor the AFO.</p> <p>On 9/02/20, at 8:02 a.m., Nursing Assistant (NA) -B with NA-C were observed to perform incontinence cares and dressed R6 for the day. NA-B and NA-C did not offer to put on R6's AFO or shoes. NA-B placed blue gripper socks on R6. NA-B then transferred R6 to the wheelchair with a gait belt and pivot transfer.</p> <p>-at 8:26 a.m., NA-B was interviewed and stated R6 wears gripper socks all the time and therapy is responsible for placing the AFO to R6's right lower extremity. NA-B further stated she had not seen an order for putting on the AFO.</p> <p>-at 9:10 a.m., NA-B was interviewed and stated the NA's will do range of motion (ROM) exercises on the right arm as R6 allows. NA-B further stated R6's lower extremities were "pretty good" and NA's do not do any ROM on them.</p> <p>-at 9:53 a.m., RN-D was interviewed and stated there were no devices R6 needed to wear every day, and R6 wore gripper socks because it was easier for R6 to drag the right foot without a shoe in place. RN-D verified there was no order for ROM exercises and no order for application of an AFO in R6's chart.</p> <p>On 9/03/20, at 10:23 a.m., Staff-E stated R6's AFO recommendations were in place to promote foot lift, and to maintain ROM.</p>	F 688	<p>audits.</p> <p>The correction will be monitored by: The DON or/and designee</p>		

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F 688	<p>Continued From page 17</p> <p>On 9/2/20, at 12:47 p.m., RN-E was interviewed and verified there was no directive to apply an AFO to R6's Right lower extremity on the NA care sheet nor in R6's care plan.</p> <p>On 9/2/20, at 8:40 a.m., Staff-D, Certified Occupational Therapy Assistant, was interviewed and stated her expectation would be that R6 would be receiving ROM to both upper and lower extremities according to previous therapy recommendations.</p> <p>On 9/2/20, at 8:44 a.m., Staff-E, Physical Therapist, stated R6 is on a functional maintenance program and he would expect staff to follow therapy recommendations.</p> <p>On 9/2/20, at 12:47 p.m., RN-E was interviewed and stated therapy staff gives a copy of their recommendations to RN-E to add to the NA care sheet and point of care task list in the resident's medical chart. RN-E stated the therapy would also be in the resident's care plan. RN-E stated she did not receive any therapy recommendations for R6 during the month of August. RN-E verified there are no recommendations from therapy for R6 in the staff communication book for the month of August. RN-E further verified there was no directive to apply an AFO to R6's Right lower extremity on the NA care sheet nor in R6's care plan. RN-E stated it would be her expectation to receive a copy of any therapy recommendations. RN-E verified her signature appears at the bottom of the document titled PT/OT/ST Functional Maintenance Program dated 8/13/20, outlining therapy recommendations.</p>	F 688			

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F 688	Continued From page 18 On 9/2/20, at 8:40 a.m., Staff-D, Certified Occupational Therapy Assistant, was interviewed and stated her expectation would be that R6 would be receiving ROM to both upper and lower extremities according to previous therapy recommendations.  On 9/2/20, at 8:44 a.m., Staff-E, Physical Therapist, stated R6 is on a functional maintenance program and he would expect staff to follow therapy recommendations.  The policy titled Restorative Nursing Services, revised July, 2017, indicated Residents will receive restorative nursing care as needed to help promote optimal safety and independence. The policy further indicated restorative goals and objectives are individualized and resident-centered, and are outlined in the resident's plan of care.	F 688			
F 761 SS=E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2)  §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.  §483.45(h) Storage of Drugs and Biologicals  §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.	F 761		10/9/20	

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F 761	<p>Continued From page 19</p> <p>§483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, interview, and document review, the facility failed to ensure stock filled medications (stored medications that can used for anybody in the facility) were not expired at medication administration. In addition, the facility failed to properly relabel resident medication for 1 of 7 residents (R23) reviewed for pharmacy services. This had the potential to affect all 26 residents residing in the facility at the time of the survey.</p> <p>During observation and medication storage review with RN-A on 8/31/20, at 3:00 p.m. of North medication cart, RN- verified the following bottles of stock medications were expired: Ocular vit (Vitamin), each expired 5/20 Calcium antacid 750 mg (milligrams) (acid reducer), each expired 7/20. Vitamin C (Vitamin C supplement), each expired 6/20 Prenatal (Vitamin supplement), each expired 9/2019. Fish oil (Vitamin supplement), each expired 6/20 Melatonin 1 mg (hormone supplement), each expired 7/20</p> <p>During interview on 8/31/20, at 3:00 p.m.</p>	F 761	<p>F761: Label/Store drugs &amp; biologicals</p> <p>Immediate Corrective Action: All expired medications were disposed of. R23 medication was relabeled with change of order sticker.</p> <p>Action as it is applied to others: Medication Ordering and Receiving from Pharmacy Policy was reviewed and remains current. Medication carts were reviewed, and change of order stickers were placed on all medication cards that had change of orders. Reeducation was implemented with licensed nursing staff regarding facility policy and procedure as it relates to storage of medication and utilization of "change or order" labels. Date of completion:10/9/2020</p> <p>Recurrence will be prevented by: Audits of all of the medications for 2 residents and of the stock medications will be completed weekly x 4 then monthly x2</p>		



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F 761	<p>Continued From page 20</p> <p>registered nurse (RN)-C stated night shift checked medication carts for expired or discontinued medications every 1-2 weeks for their tasks. RN-C further stated staff should not give residents expired medications, as they are not as therapeutic past expiration date. RN-C stated all residents could possibly use the stock medications, if they had an order for them.</p> <p>During observation and medication storage review with licensed practical nurse LPN-A on 8/31/20, at 3:35 p.m. of South medication cart, LPN-A verified the following bottles of stock medications were expired: 24 hour all day allergy 10 mg (antihistamine), each expired 3/2020. Vitamin C 500 mg (Vitamin C supplement), each expired 5/20. Aspirin 325 mg (nonsteroidal anti-inflammatory), each expired 5/2020. Oyster shell calcium 500 mg (calcium supplement), each expired 7/2020. 24 hour all day allergy 10 mg (antihistamine), each expired 6/20. Calcium antacid extra strength open (acid reducer), each expired 2/16/20. 24 hour all day allergy 10 mg (antihistamine), each expired 01/2020. Nicotine transdermal system patch 7mg each expired 6/20. Milk of magnesia (laxative and antacid), each expired 3/20.</p> <p>During interview on 8/31/20, at 3:35 p.m. LPN-A stated the night shift staff checks the medication carts for expired and discontinued medication. LPN-A further stated that expired medications are not as effective if given after expiration date.</p>	F 761	<p>months to ensure the medications are not expired and to ensure proper labeling. The results of these audits will be reviewed with the facility QAPI Committee for input on the need to increase, decrease or discontinue the audits.</p> <p>The correction will be monitored by: DON or/and designee</p>		

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F 761	<p>Continued From page 21</p> <p>During observation on 9/2/20, at 8:40 a.m. registered nurse (RN)-A gave R23 omeprazole 20 mg One Capsule (20) mg by mouth once a day per label on the medication bubble pack. Order in hard chart dated 9/1/20 states decrease omeprazole to 20 mg every other day for one week then discontinue.</p> <p>During interview on 9/2/20, at 10:16 a.m. RN-A stated the omeprazole order came in late yesterday and she forgot to change the label on R23's bubble pack. RN-A stated the process that she follows includes crossing off the incorrect information on the bubble pack and entering the correct order. Stated the nurse who writes the order is the one who makes sure the medication bubble card is correct. RN-A further stated correct medications labels help prevent medication errors from occurring.</p> <p>During interview on 9/3/20, at 9:35 a.m. RN-E stated best practice for labeling medication changes would include placing a sticker on the bubble pack that identifies the medication change.</p> <p>During observation on 9/2/20, at 10:17 a.m. RN-A crossed off the words once daily with a single line then wrote in pen "every other day."</p> <p>During phone interview on 9/3/20, at 11:10 a.m. Pharmacist-B stated most stock medications do not have a negative effect but they may not have their full therapeutic effect. Meaning they will not be as potent.</p> <p>During phone interview on 9/3/30, at 11:14 a.m. Pharmacist-C stated the consulting pharmacist has gone into the facility in the past and has</p>	F 761			

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F 761	<p>Continued From page 22</p> <p>found errors with expired medication being in the carts.</p> <p>During documentation review dated 9/3/20, Pharmacist-C identified, "Our last Delano med cart audit was on 3/9/20. There were some expired OTC medications identified at that time. If the physician's directions for use change or the label is inaccurate, the nurse may place a "change of order-- check chart" label on the container indicating there is a change in directions for use, taking care not to cover important label information."</p> <p>Policy Medication Ordering and Receiving from Pharmacy dated 4/2018, identified, "Medication labels are not altered, modified, or marked in any way by nursing personnel. Contents are not transferred from one container to another. Under no circumstances are unattached labels requested or accepted from the pharmacy. Only the pharmacy/registered pharmacist may place a label on the medication container. 1) If the physician's directions for use change or the label is inaccurate, the nurse may place a "change of order-- check chart" label on the container indicating there is a change in directions for use, taking care not to cover important label information".</p> <p>Policy Labeling of Medication Containers dated 4/2019, identified; only the dispensing pharmacy can label or alter the label on a medication container or package.</p> <p>Policy Medication Storage in the Facility dated 4/2018, "Outdated, contaminated, or deteriorated medications and those in containers that are cracked, soiled, or without secure closures are</p>	F 761			

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F 761	Continued From page 23 immediately removed from inventory, disposed of according to procedures for medication disposal (Section IE: Disposal of Medications and medication-related supplies), and reordered from the pharmacy. (See IC3: Ordering and receiving non-controlled medication from the dispensing pharmacy), if a current order exists.	F 761			
F 803 SS=D	Menus Meet Resident Nds/Prep in Adv/Followed CFR(s): 483.60(c)(1)-(7)  §483.60(c) Menus and nutritional adequacy. Menus must-  §483.60(c)(1) Meet the nutritional needs of residents in accordance with established national guidelines.;  §483.60(c)(2) Be prepared in advance;  §483.60(c)(3) Be followed;  §483.60(c)(4) Reflect, based on a facility's reasonable efforts, the religious, cultural and ethnic needs of the resident population, as well as input received from residents and resident groups;  §483.60(c)(5) Be updated periodically;  §483.60(c)(6) Be reviewed by the facility's dietitian or other clinically qualified nutrition professional for nutritional adequacy; and  §483.60(c)(7) Nothing in this paragraph should be construed to limit the resident's right to make personal dietary choices. This REQUIREMENT is not met as evidenced by:	F 803		10/9/20	

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F 803	<p>Continued From page 24</p> <p>Based on observation, interview, and document review, the facility failed to accommodate dietary preferences for 2 of 3 residents (R2, R20) reviewed for resident choices.</p> <p>Findings include:</p> <p>R2's quarterly Minimum Data Set (MDS) dated 6/3/20, indicated R2 was cognitively intact, received a regular diet and had a pressure sore.</p> <p>During an interview on 8/31/20, at 5:01 p.m. R2 stated he preferred to have bacon or sausage with breakfast but was not receiving regularly. R2 added that breakfast meats was his preferred protein over any other meat throughout the day and it was important that he ate enough protein because he has pressure ulcers. Lastly, R2 stated it would be also nice to have scrambled eggs every once in a while.</p> <p>When interviewed on 9/3/20, at 8:54 a.m. nursing assistant (NA)-A stated R2 had requested more bacon and sausage for breakfast.</p> <p>When interviewed on 9/03/20, at 9:35 a.m. registered nurse (RN)- verbalized R2 had mentioned several times he wanted meat with his breakfast. RN-F further stated that meat was served at breakfast 1-2 times per week.</p> <p>R20's MDS dated 7/31/20, indicated R20's had a moderate cognitive impairment and a diagnosis of anxiety and manic depression (bipolar disease). MDS did not indicate R20's food preferences.</p>	F 803	<p>F803: Food preferences R2 food preferences have been completed. R20 discharged from the facility on 9/26/2020. Food preferences completed on current residents.</p> <p>Re-education initiated to culinary staff on completing food preferences and follow resident food preferences to facilities capabilities.</p> <p>Audits of 3 residents food preferences, along with resident interviews will be completed weekly. Audits will be completed weekly x 4 then monthly x2 months to ensure residents food preferences are being met. The results of these audits will be reviewed with the facility QAPI Committee for input on the need to increase, decrease or discontinue the audits. Correction will be monitored by: Culinary services direct and/or designee</p>		

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F 803	<p>Continued From page 25</p> <p>R20's Care Area Assessment (CAA) dated 7/31/20, did not identify food preferences.</p> <p>R20's care plan dated 7/24/20, did not identify food preferences.</p> <p>R20's Food Preference Assessment was requested but not provided.</p> <p>R20's clinical nutrition evaluation dated 7/27/20, does not identify food preferences.</p> <p>On 9/1/20, at 8:18 a.m. R20 stated he would like to have pancakes, bacon and sunny side up eggs. R20 stated he had not been ask for his preference for breakfast proteins since admission to facility.</p> <p>On 9/2/30, at 2:35 p.m. the dietary manager (DM) -1 stated breakfast meal did not have an alternative with the menu and due to the COVID pandemic restrictions to menu items were put in place to make staffing accommodations. DM-1 stated she had chosen to keep staff hours and restructured the menu which included less meat for breakfast, add the menu now only included sausage three times a week and bacon was not on the menu. DM-1 stated when a resident had a preference an assessment was completed however, if a preference cannot be met, that resident is informed but no future attempts to meet the resident's preferences are made.</p> <p>The Estates at Delano SS [undefined] 2020 menu dated 8/30/20 identified sausage planned to be served 3 days out of the week.</p> <p>The Estates at Delano Alternative Menu, no date identified, had no breakfast alternative entree</p>	F 803			

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F 803	Continued From page 26 listed.	F 803			
F 880 SS=F	<p>The Estates at Delano Preference Assessment policy was requested but not provided.</p> <p>Infection Prevention &amp; Control CFR(s): 483.80(a)(1)(2)(4)(e)(f)</p> <p>§483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.</p> <p>§483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:</p> <p>§483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;</p> <p>§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of</p>	F 880		10/2/20	

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F 880	<p>Continued From page 27</p> <p>communicable disease or infections should be reported;</p> <p>(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;</p> <p>(iv)When and how isolation should be used for a resident; including but not limited to:</p> <p>(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and</p> <p>(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.</p> <p>(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and</p> <p>(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.</p> <p>§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.</p> <p>§483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.</p> <p>§483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Surveyor: Elyse Jones Based on observation, interview, and record review, the facility failed to ensure staff removed personal protective equipment (PPE) in a manner to prevent the potential spread of infection. This</p>	F 880	<p>F880 Infection Prevention &amp; Control Immediate Corrective Action: Identified nursing staff member was immediately educated regarding appropriate donning and doffing procedure.</p>		



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F 880	<p>Continued From page 28</p> <p>practice had the potential to affect all 27 residents residing at the facility. In addition, the facility failed to disinfect the Hoyer lift between residents use for 1 of 2 residents (R11) reviewed for infection control. This had the potential to affect all residents in the facility who required the use of the Hoyer lift.</p> <p>Findings include:</p> <p>On 8/31/20, at 4:22 p.m., certified occupational therapist assistant (COTA)-A was observed exiting a room designated for a resident with isolation precautions. COTA-A was noted to not be wearing a gown, gloves, or mask. When asked what the procedure for doffing person protective equipment (PPE), COTA-A stated that she removes her gown, then removes gloves and washes her hands, then removes her mask, and places items in receptacle in resident room as she is exiting. COTA-A stated she was instructed on doffing PPE in March or April and that a nurse manager did the training.</p> <p>On 8/31/20, at 4:51 p.m., activities director (AD) was noted to be walking out of a resident room that was designated for resident on isolation precautions. AD noted to not be wearing a gown, mask, or gloves. Writer asked AD what was required to be done when exiting a room with for a resident on isolation precautions, the AD stated that she removes her gloves, then removes her gown and throws items in the garbage. She then washes her hands. As she is leaving the room she removes her mask and places it in a garbage can by the door. AD stated that she was instructed when COVID-19 first developed on how to don and doff PPE.</p>	F 880	<p>Infections from the previous 2 months were re-reviewed including tracking and analyzing for trends and actions needed. All mechanical lifts were disinfected.</p> <p>Action as it is applied to others: Policy Cleaning and Disinfection of Resident-Care items and Equipment Policy was reviewed and remains current Coronavirus policy was reviewed and remains current. Reeducation was initiated for staff regarding cleaning and disinfection of resident-care items, specifically mechanical lifts. Reeducation was initiated with staff regarding donning and doffing PPE per CDC guidelines. Date of completion: 10/2/20</p> <p>Recurrence will be prevented by: Audits of PPE use and lift use will be completed weekly x 4 then monthly x2 months to ensure PPE is donned and doffed per CDC guidance and that the lifts are properly disinfected after each use. The results of these audits will be reviewed with the facility QAPI Committee for input on the need to increase, decrease or discontinue the audits.</p> <p>The correction will be monitored by: DON and/or designee</p>		

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

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F 880	<p>Continued From page 29</p> <p>On 9/02/20, at 10:24 a.m. Nursing Assistant (NA) -A was observed to don appropriate PPE before entering a resident room identified with droplet precaution. Upon exiting the room, NA-A was observed to have doffed the gown, gloves and facemask, and was only wearing a plastic face shield.</p> <p>-at 10:28 a.m., NA-A was interviewed and revealed staff have been trained on infection control procedures, stating the training included instructions to doff all PPE, including the facemask, before exiting an isolation room.</p> <p>On 9/2/2020, at 9:23 a.m., assistant director of nursing (ADON) was exiting a COVID-19 positive resident room that was designated as a room that required airborne isolation precautions. ADON noted to be wearing a face mask and a face shield as she exited the room. Writer asked ADON about doffing PPE procedure. ADON stated that before she leaves a room that has precautions she removes her gloves, places in garbage can, removes her gown, places them in garbage can, and washes her hands. When she is out of the room she removes her mask, puts it in garbage, then removes her face shield, cleans face shield with disinfectant and then washes her hands. ADON stated that she did PPE education with staff in April 2020. ADON stated all staff were instructed on the proper way to don and doff PPE. ADON stated it is her expectation staff will remove their mask after leaving a room that is designated an airborne isolation room. ADON also stated the directions are clearly defined for staff on the door to any of the airborne isolation rooms. ADON states they have been completing PPE audits routinely to ensure staff are donning and doffing PPE as instructed.</p>	F 880			

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F 880	<p>Continued From page 30</p> <p>Facilities In-Service training record dated 4/5/20, objectives for droplet and contact precautions for positive COVID identified that staff must remove PPE before leaving the room and use red top to wipe goggles/face shield. 10 staff members signed the in-service training record sheet. In service training sheet does not designate who the trainer was.</p> <p>Facility Coronavirus (COVID-19) Policy, undated, states appropriate PPE (gloves, gown, mask, eye protection) per isolation guidelines will be applied and removed when entering and before exiting the resident's room, per Centers for Disease Control (CDC) Donning and Doffing Guidance. Facility provided CDC donning and doffing guidance to writer. Per CDC doffing guidance staff are to remove gloves, remove gown, and may exit the room. Staff are then to perform hand hygiene, remove face shield or goggles, then remove and discard respirator (or facemask if use instead of respirator).</p> <p>During observation on 9/1/20, at 1:23 p.m. nursing assistant (NA)-B finished using Hoyer lift on R11 then pushed Hoyer lift into another resident room. No observation of disinfection of Hoyer.</p> <p>During interview on 9/1/20, at 1:30 p.m. NA-B stated she forgot to disinfect the Hoyer lift between residents use. NA-B further stated she should have cleaned the Hoyer lift after leaving R11's room to prevent the spread of disease and viruses, especially since COVID is already in the facility. NA-B stated she would disinfect the Hoyer lift immediately.</p>	F 880			

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F 880	Continued From page 31 During interview on 9/1/20, at 8:30 a.m. registered nurse (RN)-A stated all shared equipment must be disinfected after each residents use to prevent spreading germs.  Policy Cleaning and Disinfection of Resident-Care items and Equipment dated 10/2018, identified, "Reusable items are cleaned and disinfected or sterilized between resident (e.g., stethoscopes, durable medical equipment)." "Reusable resident care equipment will be decontaminated and/or sterilized between residents according to manufacturers' instructions."	F 880			

## **DIRECTED PLAN OF CORRECTION**

**A Directed Plan of Correction (DPOC) is imposed in accordance with 42 CFR § 488.424. Your facility must include the following in their POC for the deficient practice cited at F880:**

### **PERSONAL PROTECTIVE EQUIPMENT (PPE)**

- 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.

### **POLICIES/PROCEDURES/SYSTEM CHANGES:**

- The facility's Quality Assurance and Performance Improvement Committee must conduct a root cause analysis (RCA) to identify the problem(s) that resulted in this deficiency and develop intervention or corrective action plan to prevent recurrence.

The Infection Preventionist and Director of Nursing, shall complete the following:

- Review policies and procedures for donning/doffing PPE during COVID-19 with current guidelines to include crisis standard of care, contingency standard of care and standard care.
- Develop and implement a policy and procedure for source control masks.
- Review policies regarding standard and transmission based precautions and revise as needed.

### **TRAINING/EDUCATION:**

As a part of corrective action plan, the facility must provide training for the Infection Preventionist, the Director of Nursing, all staff providing direct care to residents, and all staff entering resident's rooms, whether it be for residents' dietary needs or cleaning and maintenance services. The training must cover standard infection control practices, including but not limited to, transmission-based precautions, appropriate PPE use, and donning and doffing of PPE.

- The training may be provided by the Director of Nursing, Infection Preventionist, or Medical Director with an attestation statement of completion.
  - The training must include competency testing of staff and this must be documented.
  - Residents and their representatives should receive education on the facility's Infection Prevention Control Program as it related to them and to the degree possible/consistent with resident's capacity.
- Online infection prevention training courses may be utilized. The CDC and MDH websites have several infection control training modules and materials.

### **CDC RESOURCES:**

Infection Control Guidance: <https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control.html>

CDC: Isolation Precautions Guideline:

<https://www.cdc.gov/infectioncontrol/guidelines/isolation/index.html>

CDC: Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings (2007): <https://www.cdc.gov/infectioncontrol/guidelines/isolation/index.html>

CDC: Personal Protective Equipment: <https://www.cdc.gov/niosh/ppe/>

Healthcare Infection Prevention and Control FAQs for COVID-19:

[https://www.cdc.gov/coronavirus/2019-ncov/hcp/faq.html?CDC\\_AA\\_refVal=https%3A%2F%2Fwww.cdc.gov%2Fcoronavirus%2F2019-ncov%2Fhcp%2Finfection-control-faq.html](https://www.cdc.gov/coronavirus/2019-ncov/hcp/faq.html?CDC_AA_refVal=https%3A%2F%2Fwww.cdc.gov%2Fcoronavirus%2F2019-ncov%2Fhcp%2Finfection-control-faq.html)

#### **MDH RESOURCES:**

Personal Protective Equipment (PPE) for Infection Control:

<https://www.health.state.mn.us/facilities/patientsafety/infectioncontrol/ppe/index.html>

MDH Contingency Standards of Care for COVID-19: Personal Protective Equipment for Congregate Care Settings (PDF): <https://www.health.state.mn.us/communities/ep/surge/crisis/ppegrid.pdf>

Interim Guidance on Facemasks as a Source Control Measure (PDF):

<https://www.health.state.mn.us/diseases/coronavirus/hcp/maskssource.pdf>

Interim Guidance on Alternative Facemasks (PDF):

<https://www.health.state.mn.us/diseases/coronavirus/hcp/masksalt.pdf>

Aerosol-Generating Procedures and Patients with Suspected or Confirmed COVID-19 (PDF):

<https://www.health.state.mn.us/diseases/coronavirus/hcp/aerosol.pdf>

Droplet Precautions:

<https://www.health.state.mn.us/facilities/patientsafety/infectioncontrol/pre/droplet.html>

Airborne Precautions:

<https://www.health.state.mn.us/facilities/patientsafety/infectioncontrol/pre/droplet.html>

#### **MONITORING/AUDITING:**

- The Director of Nursing, the Infection Preventionist, and other facility leadership will conduct audits of donning/doffing PPE with Transmission Based Precautions i.e. Droplet precautions.
- The Director of Nursing, Infection Preventionist, and other facility leadership will conduct routine audits on all shifts four times a week for one week, then twice weekly for one week once compliance is met. Audits should continue until 100% compliance is met on source control masking for staff, visitors and residents.
- The Director of Nursing, Infection Preventionist, and other facility leadership will conduct real time audits on all aerosolized generating procedures to ensure PPE is in use.
- The Director of Nursing, Infection Preventionist, or designee will review the results of audits and monitoring with the Quality Assurance Program Improvement (QAPI) program.

#### **EQUIPMENT/ENVIRONMENT**

- 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.

#### **POLICIES/PROCEDURES/SYSTEM CHANGES:**

- The facility's Quality Assurance and Performance Improvement Committee must conduct a root cause analysis (RCA) to identify the problem(s) that resulted in this deficiency and develop intervention or corrective action plan to prevent recurrence.
- The director of housekeeping, director of maintenance, and director of nursing must review policies and procedures regarding disinfecting multiuse/shared equipment/items and/or environmental disinfection to ensure they meet the CDC guidance for disinfection in health care facilities and follow disinfectant product manufacturer directions for use including contact time.

#### **TRAINING/EDUCATION:**

- The Director of Housekeeping/Maintenance, and/or Director of Nursing, or Infection Preventionist must train all staff responsible for resident care equipment and environment on the facility policies/practices for proper disinfection, including following manufacturer direction for use. Each staff person must demonstrate competency at the conclusion of the training.

Training and competency testing must be documented. The Minnesota Department of Health (MDH), Center for Disease Control (CDC), and Environmental Protection Agency have education materials that may be used for training.

- CDC: Infection Control Guidelines and Guidance Library.  
[https://www.cdc.gov/infectioncontrol/guidelines/index.html/eic\\_in\\_HCF\\_03.pdf](https://www.cdc.gov/infectioncontrol/guidelines/index.html/eic_in_HCF_03.pdf)
- MDH COVID-19 Toolkit.  
<https://www.health.state.mn.us/diseases/coronavirus/hcp/ltctoolkit.pdf>
- EPA: List N: Disinfectants for Use Against SARS-CoV-2 (COVID-19)  
<https://www.epa.gov/pesticide-registration/list-n-disinfectants-use-against-sars-cov-2-covid-19>

#### **CDC RESOURCES:**

Infection Control Guidance: <https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control.html>

CDC: Isolation Precautions Guideline:

<https://www.cdc.gov/infectioncontrol/guidelines/isolation/index.html>

CDC: Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings (2007): <https://www.cdc.gov/infectioncontrol/guidelines/isolation/index.html>

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Healthcare Infection Prevention and Control FAQs for COVID-19:

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#### **MDH RESOURCES:**

Personal Protective Equipment (PPE) for Infection Control:

<https://www.health.state.mn.us/facilities/patientsafety/infectioncontrol/ppe/index.html>

MDH Contingency Standards of Care for COVID-19: Personal Protective Equipment for Congregate Care Settings (PDF): <https://www.health.state.mn.us/communities/ep/surge/crisis/ppegrid.pdf>

Interim Guidance on Facemasks as a Source Control Measure (PDF):

<https://www.health.state.mn.us/diseases/coronavirus/hcp/masksource.pdf>

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<https://www.health.state.mn.us/diseases/coronavirus/hcp/aerosol.pdf>

Droplet Precautions:

<https://www.health.state.mn.us/facilities/patientsafety/infectioncontrol/pre/droplet.html>

Airborne Precautions:

<https://www.health.state.mn.us/facilities/patientsafety/infectioncontrol/pre/droplet.html>

**MONITORING/AUDITING:**

- The Director of Nursing, the Infection Preventionist, and/or other facility leadership will conduct audits for proper cleaning and disinfection of resident use equipment/environmental cleaning, on all shifts every day for one week, then may decrease frequency as determined by compliance.

**In accordance with 42 CFR § 488.402(f), this remedy is effective 15 calendar days from the date of the enforcement letter. The DPOC may be completed on or after that date. The effective date is not a deadline for completion of the DPOC. However, a revisit will not be approved prior to receipt of documentation confirming the DPOC was completed. To demonstrate that the facility successfully completed the DPOC, the facility must provide all of the following documentation. Documentation should be uploaded as attachments through ePOC.**

**Imposition of this DPOC does not replace the requirement that the facility must submit a complete POC for all cited deficiencies (including F880) within 10 days after receipt of the Form CMS 2567.**

Item	Checklist: Documents Required for Successful Completion of the Directed Plan
1	Documentation of the RCA and intervention or corrective action plan based on the results with signatures of the QAPI Committee members.
2	Documentation that the interventions or corrective action plan that resulted from the RCA was fully implemented
3	Content of the training provided to staff, including a syllabus, outline, or agenda, as well as any other materials used or provided to staff for the training
4	Names and positions of all staff that attended and took the trainings
5	Staff training sign-in sheets
6	Summary of staff training post-test results, to include facility actions in response to any failed post-tests
7	Documentation of efforts to monitor and track progress of the interventions or corrective action plan



**In order to speed up our review, identify all submitted documents with the number in the “Item” column.**

**Attach all items into ePOC.**

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K 000	<p>INITIAL COMMENTS</p> <p>THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE.</p> <p>UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION.</p> <p>A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey, The Estates at Delano was found 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) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care.</p> <p>IF OPTING TO USE AN EPOC, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED.</p> <p>PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES ( K-TAGS) TO:</p> <p>Health Care Fire Inspections State Fire Marshal Division</p>	K 000		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		10/02/2020

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

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

PRINTED: 10/23/2020  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>245336</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING <b>01 - MAIN BUILDING 01</b>  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>09/01/2020</b>
NAME OF PROVIDER OR SUPPLIER  <b>THE ESTATES AT DELANO LLC</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>433 COUNTY ROAD 30 DELANO, MN 55328</b>		
(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	<p>Continued From page 1 445 Minnesota St., Suite 145 St Paul, MN 55101-5145, or</p> <p>By email to: FM.HC.Inspections@state.mn.us</p> <p>THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION:</p> <ol style="list-style-type: none"> <li>1. A description of what has been, or will be, done to correct the deficiency.</li> <li>2. The actual, or proposed, completion date.</li> <li>3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. This facility will be surveyed as one building.</li> </ol> <p>The Estates at Delano is a 1-story building with no basement. The building was constructed at 3 different times. The original building was constructed in 1967 and was determined to be of Type II (000) construction. In 1988 a single story addition was constructed to the South Wing and determined to be of Type II (000) construction. An addition was constructed in 2008 and was determined to be Type II (000) to the East Wing.</p> <p>The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors that is monitored for automatic fire department notification.</p> <p>The facility has a capacity of 54 beds and had a census of 26 at the time of the survey.</p> <p>The requirement at 42 CFR, Subpart 483.70(a) is</p>	K 000			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>245336</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING <b>01 - MAIN BUILDING 01</b>  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>09/01/2020</b>
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K 000	Continued From page 2	K 000			
K 345 SS=F	<p>NOT MET as evidenced by:</p> <p>Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101</p> <p>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. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This REQUIREMENT is not met as evidenced by: Based on staff interview and a review of the available documentation, the facility has not maintained the fire alarm system testing and maintenance documentation in accordance with NFPA 72 National Fire Alarm Code 2010 edition. This deficient practice could affect 54 of 54 residents, as well as an undetermined number of staff, and visitors to the facility.</p> <p>Findings include:</p> <p>On facility tour between 8 AM -12 PM on September 1st, 2020, during a review of all available fire alarm maintenance and testing documentation for the last 12 months, and an interview with the Maintenance Director revealed that at the time of the inspection the facility's fire alarm test documentation did not contain a detailed list of all the devices that had been tested and the results of the testing completed on the devices.</p>	K 345	<p>K345: Facility received proper documentation to ensure compliance with NFPA72. Facility will ensure compliance on a quarterly basis of NFPA72. Re-education was initiated with maintenance staff specific to NFPA72 requirements. NFPA72 policy Audits of documentation specific to NFPA72 compliance will be complete quarterly X 1 year to ensure appropriate life safety documentation. The results of these audits will be reviewed with the facility QAPI Committee for input on the need to increase, decrease or discontinue the audits. Monitored by: Maintenance and/or designee</p>	10/9/20	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>245336</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING <b>01 - MAIN BUILDING 01</b>  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>09/01/2020</b>
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K 345	Continued From page 3	K 345			
K 521 SS=F	<p>This deficient practice was confirmed by the Maintenance Director.</p> <p>HVAC CFR(s): NFPA 101</p> <p>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</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations and an interview, it is revealed that the facility is using the corridors as part of the air distribution system to provide make-up air for the sleeping rooms' bathroom exhaust, throughout the building which is not in accordance with NFPA 90A. This deficient practice could allow the products of combustion to travel far from the fire origin and negatively affect all residents, staff and visitors by restricting their means of egress in a fire situation.</p> <p>Findings include: On the facility tour between 8:00 AM to 12:00 PM on 09/01/2020, observations revealed that the heating, ventilation, and air conditioning systems for the building is using the corridor system as part of the air distribution system for make-up air for the bathrooms exhaust.</p>	K 521	<p>Waiver request for September 2020 Life Safety Code Inspection. Waiver request submitted on September 9/3/2020 Currently, The Estates at Delano is using the corridors for both North and South wings as part of the heating, ventilation, and air conditioning air distribution system to provide make-up air for both resident rooms and bathrooms. This waiver is being requested for the following reasons:</p> <ol style="list-style-type: none"> <li>1. There will be no adverse effect on the health and safety of the facility's residents, family members, and staff because the building is equipped with an approved full smoke detector system, along with an automated full shutdown for the ventilation system and fans upon detection of smoke or activation of the building fire alarm or sprinkler system.</li> <li>2. The facility is protected by a 24-hour</li> </ol>	10/9/20	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>245336</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING <b>01 - MAIN BUILDING 01</b>  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>09/01/2020</b>
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K 521	Continued From page 4  This deficient condition was confirmed by the Maintenance Director.	K 521	<p>supervised automatic sprinkler system.</p> <p>3. The internal facility is smoke-free and signs are prominently posted at all major entrances/exits. There is a designated exterior smoking area on the far end of the patio in the back of the building, used only by a few residents. The area is equipped with approved metal self-closing containers for used cigarettes.</p> <p>4. Annual service and maintenance contracts exist to service all the facility's fire protection system including fire alarm, sprinkler system, and portable extinguishers.</p> <p>5. The building fire alarm system is monitored to provide automatic fire department notification.</p> <p>6. Fire safety training is provided for all employees on an annual basis and during orientation for all new hires.</p> <p>7. Fire drills are conducted quarterly on each shift.</p> <p>8. Compliance with this provision would impose an unreasonable hardship on the facility due to the disruption during 6 weeks of construction to the corridors leading to all the resident rooms. Additionally, the electrical system in the building would need to be upgraded to handle the power load requirements of the air handling system. The initial bid also proposed the installation of duct work that would negatively affect the structural integrity of the building.</p> <p>The Estates at Delano was not able to find a more cost effective solution for making the ventilation system upgrades to meet the current codes NFPA 90 A.</p>		

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

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K 918 K 918 SS=F	Continued From page 5 Electrical Systems - Essential Electric Syste CFR(s): NFPA 101  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, readily identifiable, and separate from normal power circuits. 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) This REQUIREMENT is not met as evidenced by:	K 918 K 918		10/9/20	

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K 918	<p>Continued From page 6</p> <p>Based on record review and staff interview the facility failed to provide test documentation in accordance with the 2012 edition of the Life Safety Code (NFPA 101) section 9.1.3.1 and the 2010 edition of NFPA 110 the Standard for Emergency and Standby Power Systems. This deficient practice could affect the safety of all of the 54 residents if the generator failed to operate during a power outage.</p> <p>Findings include:</p> <p>During the facility tour between 8:30 AM to 9:30 AM on 09/01/2020 during documentation review revealed the load bank testing as required for facilities that cannot meet the required 30% has not been conducted since 2/15/2019.</p> <p>This deficient condition was confirmed by the Maintenance Director.</p>	K 918	<p>K918 Load bank Generator load bank tested and completed 9/3/2020. Facility will ensure compliance on a annual basis to ensure load bank testing is completed per life safety code.</p> <p>Re-education was initiate with maintenance staff regarding life safety code for load bank testing. Audits of load bank will be completed annually X1 year.</p> <p>The results of these audits will be reviewed with the facility QAPI Committee for input on the need to increase, decrease or discontinue the audits. Correction will be monitored by maintenance or designee.</p>		




**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
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K400

K521	<p>Waiver request for September 2020 Life Safety Code Inspection. Waiver request submitted on September 9/3/2020 Currently, The Estates at Delano is using the corridors for both North and South wings as part of the heating, ventilation, and air conditioning air distribution system to provide make-up air for both resident rooms and bathrooms. This waiver is being requested for the following reasons:</p> <ol style="list-style-type: none"> <li>1. There will be no adverse effect on the health and safety of the facility's residents, family members, and staff because the building is equipped with an approved full smoke detector system, along with an automated full shutdown for the ventilation system and fans upon detection of smoke or activation of the building fire alarm or sprinkler system.</li> <li>2. The facility is protected by a 24-hour supervised automatic sprinkler system.</li> <li>3. The internal facility is smoke-free and signs are prominently posted at all major entrances/exits. There is a designated exterior smoking area on the far end of the patio in the back of the building, used only by a few residents. The area is equipped with approved metal self-closing containers for used cigarettes.</li> <li>4. Annual service and maintenance contracts exist to service all the facility's fire protection system including fire alarm, sprinkler system, and portable extinguishers.</li> <li>5. The building fire alarm system is monitored to provide automatic fire department notification.</li> <li>6. Fire safety training is provided for all employees on an annual basis and during orientation for all new hires.</li> <li>7. Fire drills are conducted quarterly on each shift.</li> <li>8. Compliance with this provision would impose an unreasonable hardship on the facility due to the disruption during 6 weeks of construction to the corridors leading to all the resident rooms. Additionally, the electrical system in the building would need to be upgraded to handle the power load requirements of the air handling system. The initial bid also proposed the installation of duct work that would negatively affect the structural integrity of the building.</li> </ol> <p>The Estates at Delano was not able to find a more cost effective solution for making the ventilation system upgrades to meet the current codes NFPA 90 A.</p>
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Surveyor (Signature)	Title	Office	Date
	12424 FIRE SAFETY SUPERVISOR	MN STATE FIRE MARSHAL	10-22-20

Sent to Tom Linnhoff 10/13/20

Ben Scherer Plumbing & Heating Inc.

4520 85th Street SE  
 Delano, MN 55328  
 63 972 8137  
 schererplumbing@gmail.com

# Estimate

Date	Estimate #
9/10/2020	2705

Name / Address
The Estates at Delano 433 County Road 30 SE Delano, MN 55328

Project

Description	Qty	Cost	Total
Price for changing the heating system so that it is not using the corridor system as part of the air distribution system and adding multiple-ducted make up air systems This system will include adding 3 new Renewaite CA2XRT Roof top heat and humidity air exchangers. This also includes running all of the existing roof top heating and cooling units to be piped in with sheet-metal instead of using the central return air system that they currently have. This price includes all sheet-metal work, new equipment, and controls		495,000.00	495,000.00
		<b>Total</b>	\$495,000.00

Customer Signature \_\_\_\_\_




**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
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K400

K521	<p>Waiver request for September 2020 Life Safety Code Inspection. Waiver request submitted on September 9/3/2020 Currently, The Estates at Delano is using the corridors for both North and South wings as part of the heating, ventilation, and air conditioning air distribution system to provide make-up air for both resident rooms and bathrooms. This waiver is being requested for the following reasons:</p> <ol style="list-style-type: none"> <li>1. There will be no adverse effect on the health and safety of the facility's residents, family members, and staff because the building is equipped with an approved full smoke detector system, along with an automated full shutdown for the ventilation system and fans upon detection of smoke or activation of the building fire alarm or sprinkler system.</li> <li>2. The facility is protected by a 24-hour supervised automatic sprinkler system.</li> <li>3. The internal facility is smoke-free and signs are prominently posted at all major entrances/exits. There is a designated exterior smoking area on the far end of the patio in the back of the building, used only by a few residents. The area is equipped with approved metal self-closing containers for used cigarettes.</li> <li>4. Annual service and maintenance contracts exist to service all the facility's fire protection system including fire alarm, sprinkler system, and portable extinguishers.</li> <li>5. The building fire alarm system is monitored to provide automatic fire department notification.</li> <li>6. Fire safety training is provided for all employees on an annual basis and during orientation for all new hires.</li> <li>7. Fire drills are conducted quarterly on each shift.</li> <li>8. Compliance with this provision would impose an unreasonable hardship on the facility due to the disruption during 6 weeks of construction to the corridors leading to all the resident rooms. Additionally, the electrical system in the building would need to be upgraded to handle the power load requirements of the air handling system. The initial bid also proposed the installation of duct work that would negatively affect the structural integrity of the building.</li> </ol> <p>The Estates at Delano was not able to find a more cost effective solution for making the ventilation system upgrades to meet the current codes NFPA 90 A.</p>
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Surveyor (Signature)	Title	Office	Date
	12424 FIRE SAFETY SUPERVISOR	MN STATE FIRE MARSHAL	10-22-20

*Sent to Tom Linnhoff 10/13/20*

Ben Scherer Plumbing & Heating Inc.

4520 85th Street SE  
 Delano, MN 55328  
 63 972 8137  
 schererplumbing@gmail.com

# Estimate

Date	Estimate #
9/10/2020	2705

Name / Address
The Estates at Delano 433 County Road 30 SE Delano, MN 55328

Project

Description	Qty	Cost	Total
Price for changing the heating system so that it is not using the corridor system as part of the air distribution system and adding multiple-ducted make up air systems This system will include adding 3 new Renewaite CA2XRT Roof top heat and humidity air exchangers. This also includes running all of the existing roof top heating and cooling units to be piped in with sheet-metal instead of using the central return air system that they currently have. This price includes all sheet-metal work, new equipment, and controls		495,000.00	495,000.00
		<b>Total</b>	\$495,000.00

Customer Signature \_\_\_\_\_

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER #  <b>245336</b>	MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	DATE SURVEY COMPLETE:  <b>9/3/2020</b>
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NAME OF PROVIDER OR SUPPLIER  <b>THE ESTATES AT DELANO LLC</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>433 COUNTY ROAD 30 DELANO, MN</b>
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ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
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<b>F 625</b>	<p>Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2)</p> <p>§483.15(d) Notice of bed-hold policy and return-</p> <p>§483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies-</p> <ul style="list-style-type: none"> <li>(i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility;</li> <li>(ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any;</li> <li>(iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e) (1) of this section, permitting a resident to return; and</li> <li>(iv) The information specified in paragraph (e)(1) of this section.</li> </ul> <p>§483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to provide the written bed hold policy at the time of hospital transfer for 1 of 1 residents (R8) who was reviewed for hospitalization.</p> <p>Findings include:</p> <p>R8's Significant Change Minimum Data Set (MDS) dated 7/17/20, identified R8 had intact cognition.</p> <p>R8's progress note(s) identified:</p> <ul style="list-style-type: none"> <li>- 7/3/20, at 6:47 p.m. R8 was admitted to the hospital for anemia and pleural effusion (fluid build up in lungs).</li> <li>- 8/4/20, at 2:09 a.m. R8 was transferred to the hospital for high blood pressure, headache and fever, R8 gave verbal consent for bed hold.</li> </ul> <p>R8's medical record lacked evidence a written bed hold agreement/policy was provided at the time of hospital transfer.</p> <p>During interview on 9/3/20, at 10:51 a.m. registered nurse (RN)-B indicated the nurse should try and get a verbal acceptance or denial to a bed hold when transferring to the hospital. The business office manager (BOM) followed up with the bed hold agreement/ policy with the resident or the responsible person.</p>
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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

The above isolated deficiencies pose no actual harm to the residents

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND Nfs	PROVIDER #  <b>245336</b>	MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	DATE SURVEY COMPLETE:  <b>9/3/2020</b>
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NAME OF PROVIDER OR SUPPLIER  <b>THE ESTATES AT DELANO LLC</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>433 COUNTY ROAD 30 DELANO, MN</b>
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ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
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<b>F 625</b>	<p>Continued From Page 1</p> <p>When interviewed on 9/3/20, at 12:42 p.m. BOM stated the nurses were supposed to ask verbally if the resident and/or the family wanted to hold the bed while hospitalized. If the resident/responsible party wanted to hold the bed she sent a written copy of the bed hold agreement/policy to the responsible party for signature. BOM identified there was no notes indicating a signed bed hold was obtained for R8's hospital admissions on 7/3/20 or 8/4/20. BOM stated a signed bed hold was obtained to identify that the resident/responsible party wanted to hold the bed for readmission and obtain consent to charge to hold the bed.</p> <p>The facility bed hold policy was requested, however none was received.</p>
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**SURVEY TEAM COMPOSITION AND WORKLOAD REPORT**

Public reporting burden for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing the burden, to Office of Financial Management, HCFA, P.O. Box 26684, Baltimore, MD 21207; or to the Office of Management and Budget, Paperwork Reduction Project(0838-0583), Washington, D.C. 20503.

Provider/Supplier Number 245336	Provider/Supplier Name THE ESTATES AT DELANO LLC
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Type of Survey (select all that apply):

I					
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- 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					
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- 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 40938	09-01-2020	09-03-2020	3.00	1.00	18.00	0.00	2.00	10.00
2. 42581	08-31-2020	09-09-2020	0.00	1.00	34.00	2.00	2.00	6.50
3. 42583	08-31-2020	09-03-2020	0.00	1.00	24.50	2.00	4.00	9.00
4. 43081	08-31-2020	09-03-2020	0.00	1.00	27.00	2.00	2.00	7.00
5. 43082	08-31-2020	09-03-2020	0.00	0.00	16.00	16.00	4.50	10.00
6.								
7.								
8.								
9.								
10.								

Total Supervisory Review Hours ..... 4.00  
 Total Clerical/Data Entry Hours..... 3.25  
 Was Statement of Deficiencies given to the provider on-site at completion of the survey? ..... U

**SURVEY TEAM COMPOSITION AND WORKLOAD REPORT**

Public reporting burden for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing the burden, to Office of Financial Management, HCFA, P.O. Box 26684, Baltimore, MD 21207; or to the Office of Management and Budget, Paperwork Reduction Project(0838-0583), Washington, D.C. 20503.

Provider/Supplier Number 245336	Provider/Supplier Name THE ESTATES AT DELANO LLC
------------------------------------	---

Type of Survey (select all that apply):

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

Extent of Survey (Select all that apply):

D					
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- 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**

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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. 43081	09-02-2020	09-02-2020	0.00	0.00	2.00	0.00	0.00	1.00
2.								
3.								
4.								
5.								
6.								
7.								
8.								
9.								
10.								

Total Supervisory Review Hours ..... 0.00

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

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



**SURVEY TEAM COMPOSITION AND WORKLOAD REPORT**

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Team Leader 1. 40938	08-31-2020	09-01-2020	0.00	0.00	3.00	0.00	0.00	0.00
2.								
3.								
4.								
5.								
6.								
7.								
8.								
9.								
10.								

Total Supervisory Review Hours ..... 0.25

Total Clerical/Data Entry Hours..... 2

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

**SURVEY TEAM COMPOSITION AND WORKLOAD REPORT**

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Team Leader 1. 40938	08-31-2020	09-01-2020	0.00	0.00	1.00	2.00	0.00	0.00
2.								
3.								
4.								
5.								
6.								
7.								
8.								
9.								
10.								

Total Supervisory Review Hours ..... 0.25

Total Clerical/Data Entry Hours..... 2

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

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Team Leader 1. 40938	08-31-2020	09-01-2020	0.00	0.00	2.50	0.00	0.00	0.00
2.								
3.								
4.								
5.								
6.								
7.								
8.								
9.								
10.								

Total Supervisory Review Hours ..... 0.25

Total Clerical/Data Entry Hours..... 2

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

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Team Leader 1. 40938	08-31-2020	09-01-2020	0.00	0.00	2.50	0.00	0.00	0.00
2.								
3.								
4.								
5.								
6.								
7.								
8.								
9.								
10.								

Total Supervisory Review Hours ..... 0.25  
 Total Clerical/Data Entry Hours..... 2  
 Was Statement of Deficiencies given to the provider on-site at completion of the survey? ..... U

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Extent of Survey (Select all that apply):

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- A Routine/Standard (all providers/suppliers)
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1. 43081			0.00	0.00	0.00	0.00	0.00	0.50
2.								
3.								
4.								
5.								
6.								
7.								
8.								
9.								
10.								

Total Supervisory Review Hours ..... 0.25

Total Clerical/Data Entry Hours..... 2

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

**SURVEY TEAM COMPOSITION AND WORKLOAD REPORT**

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Provider/Supplier Number 245336	Provider/Supplier Name THE ESTATES AT DELANO LLC
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Type of Survey (select all that apply):

H	I				
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- A Complaint Investigation
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Extent of Survey (Select all that apply):

A					
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- A Routine/Standard (all providers/suppliers)
- B Extended Survey (HHA or long term care facility)
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**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)
Team Leader 1. 34764	09-01-2020	09-02-2020	1.00	0.00	7.00	0.00	3.00	0.00
2.								
3.								
4.								
5.								
6.								
7.								
8.								
9.								
10.								

Total Supervisory Review Hours ..... 6.50

Total Clerical/Data Entry Hours.....

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



Minnesota Department of Health: Protecting, maintaining 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@state.mn.us](mailto:monica.larson@state.mn.us)

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

Standard Survey Date Format: mm/dd/yy From <b>F1: 08/31/20</b> To <b>F2: 09/03/20</b>		Extended Survey Date Format: mm/dd/yy From <b>F3:</b> To <b>F4:</b>	
Name of Facility: <b>THE ESTATES AT DELANO LLC</b>		Provider Number: <b>245336</b>	Fiscal Year ending:
Address: <b>433 COUNTY ROAD 30, DELANO, WRIGHT, MN 55328</b>			
Telephone Number: <b>F6</b> <b>7639722987</b>		State/County Code: <b>MN / WRIGHT</b>	State/Region Code: <b>MN / 05</b>
A. <b>F9 03 - SNF/NF - Medicare/Medicaid</b> B. Is this facility hospital based? <b>F10 No</b> If yes, indicate Hopsital Provider Number: <b>F11</b>			
Ownership: <b>F12 03 - For Profit - Corporation</b>			
Owned or leased by Multi-Facility Organization: <b>F13 Yes</b> Name of Multi-Facility Organization: <b>F14 Monarch Healthcare Management</b>			
Dedicated Special Care Units (show number of beds for all that apply)			
AIDS <b>F15 0</b> Dialysis <b>F17 0</b> Head Trama <b>F19 0</b>		Alzheimer's Disease <b>F16 0</b> Disabled Child Young Adult <b>F18 0</b> Hospice <b>F20 0</b>	

Huntington's Disease <b>F21 0</b>		Ventilator/Respiratory Care <b>F22 0</b>							
Other Spec Rehab. <b>F23 4</b>									
Does the facility currently have an organized resident group? <b>F24</b>		<b>Yes</b>							
Does the facility currently have an organized group of family members of residents? <b>F25</b>		<b>Yes</b>							
Does the facility conduct experimental research? <b>F26</b>		<b>No</b>							
Is the facility part of a continuing care retirement community (CCRC)? <b>F27</b>		<b>No</b>							
<p>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.</p> <table border="0"> <tr> <td>Waiver of seven day RN requirement.</td> <td>Date: mm/dd/yy <b>F28</b></td> <td>Hours waived per week: <b>F29</b></td> </tr> <tr> <td>Waiver of 24 hr licensed nursing requirement.</td> <td>Date: mm/dd/yy <b>F30</b></td> <td>Hours waived per week: <b>F31</b></td> </tr> </table>				Waiver of seven day RN requirement.	Date: mm/dd/yy <b>F28</b>	Hours waived per week: <b>F29</b>	Waiver of 24 hr licensed nursing requirement.	Date: mm/dd/yy <b>F30</b>	Hours waived per week: <b>F31</b>
Waiver of seven day RN requirement.	Date: mm/dd/yy <b>F28</b>	Hours waived per week: <b>F29</b>							
Waiver of 24 hr licensed nursing requirement.	Date: mm/dd/yy <b>F30</b>	Hours waived per week: <b>F31</b>							
Does the facility currently have an approved nurse aide training and competency program? <b>F32</b>		<b>No</b>							
<p><b>The following three questions are to be completed by the survey team.</b></p> <table border="0"> <tr> <td>1) Was this a staggered Survey?</td> <td><b>No - Not Staggered</b></td> </tr> <tr> <td>2) If staggered, day of the week starting?</td> <td><b>Surveyor to Complete</b></td> </tr> <tr> <td>3) If staggered, starting time?</td> <td><b>Surveyor to complete AM</b></td> </tr> </table>				1) Was this a staggered Survey?	<b>No - Not Staggered</b>	2) If staggered, day of the week starting?	<b>Surveyor to Complete</b>	3) If staggered, starting time?	<b>Surveyor to complete AM</b>
1) Was this a staggered Survey?	<b>No - Not Staggered</b>								
2) If staggered, day of the week starting?	<b>Surveyor to Complete</b>								
3) If staggered, starting time?	<b>Surveyor to complete AM</b>								

Name of Person Completing Form: <b>DEREK RIVARD</b>	Date: <b>09/16/20</b>
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## Spotlight

[Minnesota eLicensing](#)

## Questions?

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

See also > [Health Regulation](#)





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



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[monica.larson@health.state.mn.us](mailto:monica.larson@health.state.mn.us)

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

<p>THE ESTATES AT DELANO LLC</p>				
<p>Provider No. <b>245336</b></p>	<p>Medicare <b>F75</b> <b>10</b></p>	<p>Medicaid <b>F76</b> <b>15</b></p>	<p>Other <b>F77</b> <b>2</b></p>	<p>Total Residents <b>F78</b> <b>27</b></p>

ADL	Independent	Assist of One Two Staff	Dependent
Bathing	<b>F79 1</b>	<b>F80 26</b>	<b>F81 0</b>
Dressing	<b>F82 4</b>	<b>F83 23</b>	<b>F84 0</b>
Transferring	<b>F85 3</b>	<b>F86 19</b>	<b>F87 5</b>
Toilet Use	<b>F88 4</b>	<b>F89 22</b>	<b>F90 1</b>
Eating	<b>F91 23</b>	<b>F92 4</b>	<b>F93 0</b>

<p><b>A. Bowel/Bladder Status</b>  <b>F94 2</b> With indwelling or external catheter.   <b>F95</b> Of total number of residents with catheters, <b>2</b> were present on admission.</p>	<p><b>B. Mobility</b>  <b>F100 0</b> Bedfast all or most of time..  <b>F101 17</b> In chair all or most of time.   <b>F102 1</b> Independently ambulatory.</p>
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**F96 9** Occasionally or frequently incontinent of bladder.

**F97 8** Occasionally or frequently incontinent of bowel.

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

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

**F103 9** 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 4** With contractures.

**F107** Of total number of residents with contractures, **4** had contractures on admission.

### C. Mental Status

**F108 0** With mental retardation.

**F109 18** With documentation signs and symptoms of depression.

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

**F111 10** Dementia: multi-infarct, senile, Alzheimer's type, or other than Alzheimer's type.

**F112 5** With behavioral symptoms.

**F113 5** Of the total number of residents with behavioral symptoms, the total number receiving a behavior management program.

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

### D. Skin Integrity

**F115 1** With pressure sores (exclude stage I).

**F116 1** Of the total number of residents with pressure sores excluding stage I, how many residents had pressure sores on admission?

**F117 22** Receiving preventive skin care.

**F118 0** With rashes.

### E. Special Care

**F119 2** Receiving hospice care benefit.

**F120 0** Receiving radiation therapy.

**F121 0** Receiving chemotherapy.

**F127 0** Receiving suction.

**F128 6** Receiving injections (exclude vitamin B12 injections)

**F129 0** Receiving tube feedings.

<p><b>F122 4</b> Receiving dialysis.</p> <p><b>F123 0</b> Receiving intravenous therapy, parenteral nutrition, and/or blood transfusion.</p> <p><b>F124 0</b> Receiving respiratory treatment.</p> <p><b>F125 0</b> Receiving tracheostomy care.</p> <p><b>F126 2</b> Receiving ostomy care.</p>	<p><b>F130 3</b> Receiving mechanically altered diets including pureed and all chopped food (not only meat).</p> <p><b>F131 16</b> Receiving specialized rehabilitative services (Physical therapy, speech-language therapy, occupational therapy).</p> <p><b>F132 1</b> Assistive devices while eating.</p>
--	--

<p><b>F. Medication</b></p> <p><b>F133 17</b> Receiving any psychoactive medication.</p> <p><b>F134 5</b> Receiving antipsychotic medications.</p> <p><b>F135 6</b> Receiving antianxiety medications.</p> <p><b>F136 14</b> Receiving antidepressant medications.</p> <p><b>F137 0</b> Receiving hypnotic medication.</p> <p><b>F138 4</b> Receiving antibiotics.</p> <p><b>F139 19</b> On pain management program.</p>	<p><b>G. Other</b></p> <p><b>F140 3</b> With unplanned significant weight loss/gain.</p> <p><b>F141 0</b> Who do not communicate in the dominant language of the facility (includes those who use sign language).</p> <p><b>F142 1</b> Who use non-oral communication devices.</p> <p><b>F143 27</b> With advance directives.</p> <p><b>F144 20</b> Received influenza immunization.</p> <p><b>F145 24</b> Received pneumococcal vaccine.</p>
--	---

<b>I certify that this Information is accurate to the best of my knowledge.</b>		
Name of Person Completing	Title	Date
<b>Suzie Koosman</b>	<b>DON</b>	<b>09/16/2020</b>

<b>To be completed by MDH survey team.</b>
<b>F146</b> Was ombudsman office notified prior to survey? <b>Yes</b>
<b>F147</b> Was ombudsman present during any portion of the survey? <b>No</b>
<b>F148</b> Medication error rate <b>4%</b>

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S5336030

MINNESOTA DEPARTMENT OF HEALTH  
Health Regulation Division  
85 East Seventh Place, Suite 300, P.O. Box 64900  
St. Paul, Minnesota 55164-0900

Email for Administrator: lhogendorn@monarchmn.com  
Administrator: ~~JESSICA MISKA~~ Lynn Hogendorn  
National Provider Identifier (NPI) Number: 1720039001  
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: THE ESTATES AT DELANO LLC City: DELANO

Name of Legal Entity Operating Provider: THE ESTATES AT DELANO LLC

Name and Address of Governing Board President:

Name: JOSH LEGUM

Address: 638 SOUTHBEND AVENUE

City/State/Zip: MANKATO, MN 56001

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: Lynn Hogendorn

Title: LNHA

Date: 8/31/2020

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

PROVIDER NUMBER <b>K1 245336</b>	FACILITY NAME <b>THE ESTATES AT DELANO LLC</b>	SURVEY DATE <b>*K4 09/01/2020</b>
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K6 DATE OF PLAN APPROVAL	K3 : MULTIPLE CONSTRUCTION TOTAL NUMBER OF BUILDINGS <u>1</u> NUMBER OF THIS BUILDING <u>01</u>	<input checked="" type="checkbox"/> A BUILDING <input type="checkbox"/> B WING <input type="checkbox"/> C FLOOR <input type="checkbox"/> D APARTMENT UNIT
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<p>LSC FORM INDICATOR</p> <table border="1" style="width:100%; border-collapse: collapse; margin-bottom: 5px;"> <tr><th align="center" colspan="3">Health Care Form</th></tr> <tr><td style="width:5%;">12</td><td style="width:20%;">2786 R</td><td style="width:75%;">2012 EXISTING</td></tr> <tr><td>13</td><td>2786 R</td><td>2012 NEW</td></tr> </table> <table border="1" style="width:100%; border-collapse: collapse; margin-bottom: 5px;"> <tr><th align="center" colspan="3">ASC Form</th></tr> <tr><td style="width:5%;">14</td><td style="width:20%;">2786 U</td><td style="width:75%;">2012 EXISTING</td></tr> <tr><td>15</td><td>2786 U</td><td>2012 NEW</td></tr> </table> <table border="1" style="width:100%; border-collapse: collapse;"> <tr><th align="center" colspan="3">ICF/MR Form</th></tr> <tr><td style="width:5%;">16</td><td style="width:20%;">2786 V, W, X</td><td style="width:75%;">2012 EXISTING</td></tr> <tr><td>17</td><td>2786 V, W, X</td><td>2012 NEW</td></tr> </table> <p>*K7 <input type="checkbox"/> 12 SELECT NUMBER OF FORM USED FROM ABOVE</p> <p><i>(Check if K321 or K351 are marked as not applicable in the 2786 M, R, T, U, V, W, X, Y and Z.)</i></p> <p>K321: <input type="checkbox"/>      K351: <input type="checkbox"/></p>	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	<p>COMPLETE IF ICF/MR IS SURVEYED UNDER CHAPTER 21</p> <p>SMALL (16 BEDS OR LESS)</p> <p>K8: <input type="checkbox"/> 1 PROMPT 2 SLOW 3 IMPRACTICAL</p> <hr/> <p>LARGE</p> <p>K8: <input type="checkbox"/> 4 PROMPT 5 SLOW 6 IMPRACTICAL</p> <hr/> <p>APARTMENT HOUSE</p> <p>K8: <input type="checkbox"/> 7 PROMPT 8 SLOW 9 IMPRACTICAL</p> <hr/> <p>ENTER E-SCORE HERE</p> <p>K5: <input type="checkbox"/> e.g 2.5</p>
Health Care Form																												
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17	2786 V, W, X	2012 NEW																										

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

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

FACILITY DOES NOT MEET LSC: B. <input type="checkbox"/>	K180: A. <input checked="" type="checkbox"/> FULLY SPRINKLERED (All required areas are sprinklered)      B. <input type="checkbox"/> PARTIALLY SPRINKLERED (Not all required areas are sprinklered)      C. <input type="checkbox"/> NONE (No sprinkler system)
--	--

\*MANDATORY

<b>FIRE SAFETY SURVEY REPORT - 2012 LIFE SAFETY CODE HEALTHCARE</b>	1. (A) PROVIDER NUMBER <small>K1</small>	1. (B) MEDICAID I.D. NO. <small>K2</small>
---	---	---

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) A. BUILDING _____ B. WING _____ C. FLOOR _____ <small>K3</small>	2. (B) ADDRESS OF FACILITY (STREET, CITY, STATE, ZIP CODE)	A. <input type="checkbox"/> Fully Sprinklered (All required areas are sprinklered) B. <input type="checkbox"/> Partially Sprinklered (Not all required areas are sprinklered) C. <input type="checkbox"/> None (No sprinkler system) <small>K0180</small>
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3. SURVEY FOR <input type="checkbox"/> MEDICARE <input type="checkbox"/> MEDICAID	4. DATE OF SURVEY <small>K4</small>	DATE OF PLAN APPROVAL <small>K6</small>	SURVEY UNDER 5. <input type="checkbox"/> 2012 EXISTING      6. <input type="checkbox"/> 2012 NEW <small>K7</small>
--	--	--	--

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 _____
--------------------	--	---	--	--	--

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

SURVEYOR (S) <i>Kimberly Swenson</i>	TITLE	OFFICE	DATE
SURVEYOR ID <small>K10</small>			
FIRE AUTHORITY OFFICIAL (Signature) <i>T. Swenson 12/24</i>	TITLE	OFFICE	DATE

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

ID PREFIX		MET	NOT MET	N/A	REMARKS
	<b>PART I – NFPA 101 LSC REQUIREMENTS (Items in italics relate to the FSES)</b>				
	<b>SECTION 1 – GENERAL REQUIREMENTS</b>				
K100	<b>General Requirements – Other</b> 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	<b>Building Rehabilitation</b> <i>Repair, Renovation, Modification, or Reconstruction</i> Any building undergoing repair, renovation, modification, or reconstruction complies with both of the following: <ul style="list-style-type: none"> <li>• Requirements of Chapter 18 and 19.</li> <li>• 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</li> </ul> <b>Change of Use or Change of Occupancy</b> 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) <b>Additions</b> 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	<p><b>Sprinkler Requirements for Major Rehabilitation</b></p> <p>If a nonsprinklered smoke compartment has undergone major rehabilitation the automatic sprinkler requirements of 18.3.5 have been applied to the smoke compartment.</p> <p>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.</p> <p>Note: Major rehabilitation involves the modification of more than 50 percent, or more than 4500 ft<sup>2</sup> of the area of the smoke compartment.</p> <p>18.1.1.4.3.3, 19.1.1.4.3.3</p>				
K131	<p><b>Multiple Occupancies – Sections of Health Care Facilities</b></p> <p>Sections of health care facilities classified as other occupancies meet all of the following:</p> <ul style="list-style-type: none"> <li>• They are not intended to serve four or more inpatients for purposes of housing, treatment, or customary access.</li> <li>• They are separated from areas of health care occupancies by construction having a minimum two hour fire resistance rating in accordance with Chapter 8.</li> <li>• The entire building is protected throughout by an approved, supervised automatic sprinkler system in accordance with Section 9.7.</li> </ul> <p>Hospital outpatient surgical departments are required to be classified as an Ambulatory Health Care Occupancy regardless of the number of patients served.</p> <p>18.1.3.3, 19.1.3.3, 42 CFR 482.41, 42 CFR 485.623</p>				
K132	<p><b>Multiple Occupancies – Contiguous Non-Health Care Occupancies</b></p> <p>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.</p> <p>18.1.3.4.1, 19.1.3.4.1</p>				



ID PREFIX		MET	NOT MET	N/A	REMARKS																							
K133	<p><b>Multiple Occupancies – Construction Type</b></p> <p>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:</p> <ul style="list-style-type: none"> <li>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.</li> <li>The construction type of the areas of the building enclosing the other occupancies shall be based on the applicable occupancy chapters.</li> </ul> <p>18.1.3.5, 19.1.3.5, 8.2.1.3</p>																											
K161	<p><b>Building Construction Type and Height</b></p> <p>2012 EXISTING</p> <p>Building construction type and stories meets Table 19.1.6.1, unless otherwise permitted by 19.1.6.2 through 19.1.6.7</p> <p>19.1.6.4, 19.1.6.5</p> <table border="1" data-bbox="222 813 1100 1273"> <thead> <tr> <th></th> <th>Construction Type</th> <th></th> </tr> </thead> <tbody> <tr> <td>1</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>II (111)</td> <td>One story non-sprinklered Maximum 3 stories sprinklered</td> </tr> <tr> <td>3</td> <td>II (000)</td> <td rowspan="4">Not allowed non-sprinklered Maximum 2 stories sprinklered</td> </tr> <tr> <td>4</td> <td>III (211)</td> </tr> <tr> <td>5</td> <td>IV (2HH)</td> </tr> <tr> <td>6</td> <td>V (111)</td> </tr> <tr> <td>7</td> <td>III (200)</td> <td rowspan="2">Not allowed non-sprinklered Maximum 1 story sprinklered</td> </tr> <tr> <td>8</td> <td>V (000)</td> </tr> </tbody> </table> <p><i>Sprinklered stories must be sprinklered throughout by an approved, supervised automatic system in accordance with section 9.7. (See 19.3.5)</i></p> <p><i>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.</i></p>		Construction Type		1	I (442), I (332), II (222)	Any number of stories non-sprinklered or sprinklered	2	II (111)	One story non-sprinklered Maximum 3 stories sprinklered	3	II (000)	Not allowed non-sprinklered Maximum 2 stories sprinklered	4	III (211)	5	IV (2HH)	6	V (111)	7	III (200)	Not allowed non-sprinklered Maximum 1 story sprinklered	8	V (000)				
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K162	<p><b>Roofing Systems Involving Combustibles</b></p> <p>2012 EXISTING</p> <p>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:</p> <ol style="list-style-type: none"> <li>1. roof covering meets Class C requirements.</li> <li>2. roof is separated from occupied building portions with a noncombustible floor assembly using not less than 2½ inches concrete or gypsum fill.</li> <li>3. attic or other space is either unoccupied or protected throughout by an approved automatic sprinkler system.</li> </ol> <p>19.1.6.2*, ASTM E108, ANSI/UL 790</p>																											

ID PREFIX		MET	NOT MET	N/A	REMARKS
K162	<p>2012 NEW</p> <p>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:</p> <ol style="list-style-type: none"> <li>1. roof covering meets Class A requirements.</li> <li>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.</li> <li>3. the structural elements supporting the rated floor assembly meet the required fire resistance rating of the building.</li> </ol> <p>18.1.6.2, ASTM E108, ANSI/UL 790</p>				
K163	<p><b>Interior Nonbearing Wall Construction</b></p> <p>Interior nonbearing walls in Type I or II construction are constructed of noncombustible or limited-combustible materials.</p> <p>Interior nonbearing walls required to have a minimum 2 hour fire resistance rating are permitted to be fire-retardant-treated wood enclosed within noncombustible or limited-combustible materials, provided they are not used as shaft enclosures.</p> <p>18.1.6.4, 18.1.6.5, 19.1.6.4, 19.1.6.5</p>				
<b>SECTION 2 – MEANS OF EGRESS REQUIREMENTS</b>					
K200	<p><b>Means of Egress Requirements – Other</b></p> <p>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.</p> <p>18.2, 19.2</p>				
K211	<p><b>Means of Egress – General</b></p> <p>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.</p> <p>18.2.1, 19.2.1, 7.1.10.1</p>				

ID PREFIX		MET	NOT MET	N/A	REMARKS
K221	<p><b>Patient Sleeping Room Doors</b></p> <p>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.</p> <p>18.2.2.2, 19.2.2.2, TIA 12-4</p>				
K222	<p><b>Egress Doors</b></p> <p>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:</p> <p><input type="checkbox"/> CLINICAL NEEDS OR SECURITY THREAT LOCKING</p> <p>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.</p> <p>18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6</p> <p><input type="checkbox"/> SPECIAL NEEDS LOCKING ARRANGEMENTS</p> <p>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.</p> <p>18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4</p>				

ID PREFIX		MET	NOT MET	N/A	REMARKS
K222	<p><input type="checkbox"/> 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</p> <p><input type="checkbox"/> 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</p> <p><input type="checkbox"/> 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</p>				
K223	<p><b>Doors with Self-Closing Devices</b> 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:</p> <ul style="list-style-type: none"> <li>• Required manual fire alarm system; and</li> <li>• Local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system; and</li> <li>• Automatic sprinkler system, if installed; and</li> <li>• Loss of power.</li> </ul> <p>18.2.2.2.7, 18.2.2.2.8, 19.2.2.2.7, 19.2.2.2.8</p>				

ID PREFIX		MET	NOT MET	N/A	REMARKS
K224	<p><b>Horizontal-Sliding Doors</b></p> <p>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.</p> <p>Horizontal-sliding doors serving an occupant load fewer than 10 shall be permitted, providing all of the following criteria are met:</p> <ul style="list-style-type: none"> <li>• Area served by the door has no high hazard contents.</li> <li>• Door is operable from either side without special knowledge or effort.</li> <li>• Force required to operate the door in the direction of travel is <math>\leq 30</math> lbf to set the door in motion and <math>\leq 15</math> lbf to close or open to the required width.</li> <li>• 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.</li> <li>• Where required to latch, the door has a latch or other mechanism to ensure the door will not rebound.</li> </ul> <p>18.2.2.2.10, 19.2.2.2.10</p>				
K225	<p><b>Stairways and Smokeproof Enclosures</b></p> <p>Stairways and Smokeproof enclosures used as exits are in accordance with 7.2.</p> <p>18.2.2.3, 18.2.2.4, 19.2.2.3, 19.2.2.4, 7.2</p>				
K226	<p><b>Horizontal Exits</b></p> <p>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.</p> <p>18.2.2.5, 19.2.2.5</p>				
K227	<p><b>Ramps and Other Exits</b></p> <p>Ramps, exit passageways, fire and slide escapes, alternating tread devices, and areas of refuge are in accordance with the provisions 7.2.5 through 7.2.12.</p> <p>18.2.2.6 to 18.2.2.10 or 19.2.2.6 to 19.2.2.10</p>				
K231	<p><b>Means of Egress Capacity</b></p> <p>The capacity of required means of egress is in accordance with 7.3.</p> <p>18.2.3.1, 19.2.3.1</p>				

ID PREFIX		MET	NOT MET	N/A	REMARKS
K232	<p><b>Aisle, Corridor or Ramp Width</b> 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</p> <p>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</p>				
K233	<p><b>Clear Width of Exit and Exit Access Doors</b> 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</p> <p>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</p>				
K241	<p><b>Number of Exits – Story and Compartment</b> 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</p>				

ID PREFIX		MET	NOT MET	N/A	REMARKS
K251	<p><b>Dead-End Corridors and Common Path of Travel</b></p> <p>2012 EXISTING</p> <p>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.</p> <p>19.2.5.2</p>				
K251	<p>2012 NEW</p> <p>Dead-end corridors shall not exceed 30 feet. Common path of travel shall not exceed 100 feet.</p> <p>18.2.5.2, 18.2.5.3</p>				
K252	<p><b>Number of Exits – Corridors</b></p> <p>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.</p> <p>18.2.5.4, 19.2.5.4</p>				
K253	<p><b>Number of Exits – Patient Sleeping and Non-Sleeping Rooms</b></p> <p>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.</p> <p>18.2.5.5.1, 18.2.5.5.2, 19.2.5.5.1, 19.2.5.5.2</p>				
K254	<p><b>Corridor Access</b></p> <p>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.</p> <p>18.2.5.6.1 through 18.2.5.6.4, 19.2.5.6.1 through 19.2.5.6.4</p>				
K255	<p><b>Suite Separation, Hazardous Content, and Subdivision</b></p> <p>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.</p> <p>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</p>				



ID PREFIX		MET	NOT MET	N/A	REMARKS
K256	<p><b>Sleeping Suites</b></p> <p>Occupants shall have exit access to a corridor or direct access to a horizontal exit. Where <math>\geq 2</math> 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.</p> <p>Suites more than 1,000 ft<sup>2</sup> 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.</p> <p>Suites shall not exceed the following size limitations:</p> <ul style="list-style-type: none"> <li>• 5,000 square feet if the suite is not fully smoke detected or fully sprinklered.</li> <li>• 7,500 square feet if the suite is either fully smoke detected or fully sprinklered.</li> <li>• 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.</li> </ul> <p>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).</p> <p>18.2.5.7.2, 19.2.5.7.2</p>				
K257	<p><b>Non-Sleeping Suites</b></p> <p>Occupants shall have exit access to a corridor or direct access to a horizontal exit. Where <math>\geq 2</math> exits are required, one exit access door may be to a stairway, passageway or to the exterior.</p> <p>Suites more than 2,500 ft<sup>2</sup> 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.</p> <p>Suites shall not exceed 10,000 ft<sup>2</sup>.</p> <p>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).</p> <p>18.2.5.7.3, 19.2.5.7.3</p>				

ID PREFIX		MET	NOT MET	N/A	REMARKS
K261	<p><b>Travel Distance to Exits</b></p> <p>Travel distance (excluding suites) to exits are measured in accordance with 7.6.</p> <ul style="list-style-type: none"> <li>• 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).</li> <li>• Point in a room to room door less than or equal to 50 feet.</li> </ul> <p>18.2.6, 19.2.6</p>				
K271	<p><b>Discharge from Exits</b></p> <p>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.</p> <p>18.2.7, 19.2.7</p>				
K281	<p><b>Illumination of Means of Egress</b></p> <p>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.</p> <p>18.2.8, 19.2.8</p>				
K291	<p><b>Emergency Lighting</b></p> <p>Emergency lighting of at least 1-1/2 hour duration is provided automatically in accordance with 7.9.</p> <p>18.2.9.1, 19.2.9.1</p>				
K292	<p><b>Life Support Means of Egress</b></p> <p>2012 NEW (INDICATE N/A FOR EXISTING)</p> <p>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.</p> <p>(Indicate N/A if life support equipment is for emergency purposes only.)</p> <p>18.2.9.2, 18.2.10.5</p>				

ID PREFIX		MET	NOT MET	N/A	REMARKS
K293	<p><b>Exit Signage</b> 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.)</p>				
	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				
<b>SECTION 3 – PROTECTION</b>					
K300	<p><b>Protection – Other</b> 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.</p>				
K311	<p><b>Vertical Openings – Enclosure</b> 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 <i>If all vertical openings are properly enclosed with construction providing at least a 2 hour fire resistance rating, also check this box.</i> <input type="checkbox"/></p>				
	<p>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</p>				

ID PREFIX		MET	NOT MET	N/A	REMARKS																																
K321	<p><b>Hazardous Areas – Enclosure</b>                      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 or 19.3.5.9. 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.  <i>Describe the floor and zone locations of hazardous areas that are deficient in REMARKS.</i>                      19.3.2.1, 19.3.5.9</p> <table border="1" data-bbox="210 743 1045 1222"> <thead> <tr> <th data-bbox="210 743 613 800">Area</th> <th data-bbox="613 743 842 800">Automatic Sprinkler</th> <th data-bbox="842 743 972 800">Separation</th> <th data-bbox="972 743 1045 800">N/A</th> </tr> </thead> <tbody> <tr> <td data-bbox="210 800 613 857">a. Boiler and Fuel-Fired Heater Rooms</td> <td data-bbox="613 800 842 857"></td> <td data-bbox="842 800 972 857"></td> <td data-bbox="972 800 1045 857"></td> </tr> <tr> <td data-bbox="210 857 613 914">b. Laundries (larger than 100 sq. ft.)</td> <td data-bbox="613 857 842 914"></td> <td data-bbox="842 857 972 914"></td> <td data-bbox="972 857 1045 914"></td> </tr> <tr> <td data-bbox="210 914 613 971">c. Repair, Maintenance, and Paint Shops</td> <td data-bbox="613 914 842 971"></td> <td data-bbox="842 914 972 971"></td> <td data-bbox="972 914 1045 971"></td> </tr> <tr> <td data-bbox="210 971 613 1044">d. Soiled Linen Rooms (exceeding 64 gal.)</td> <td data-bbox="613 971 842 1044"></td> <td data-bbox="842 971 972 1044"></td> <td data-bbox="972 971 1045 1044"></td> </tr> <tr> <td data-bbox="210 1044 613 1109">e. Trash Collection Rooms (exceeding 64 gal.)</td> <td data-bbox="613 1044 842 1109"></td> <td data-bbox="842 1044 972 1109"></td> <td data-bbox="972 1044 1045 1109"></td> </tr> <tr> <td data-bbox="210 1109 613 1166">f. Combustible Storage Rooms/Spaces (over 50 sq. ft.)</td> <td data-bbox="613 1109 842 1166"></td> <td data-bbox="842 1109 972 1166"></td> <td data-bbox="972 1109 1045 1166"></td> </tr> <tr> <td data-bbox="210 1166 613 1222">g. Laboratories (if classified as Severe Hazard - see K322)</td> <td data-bbox="613 1166 842 1222"></td> <td data-bbox="842 1166 972 1222"></td> <td data-bbox="972 1166 1045 1222"></td> </tr> </tbody> </table>	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)							
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K321	<p>2012 NEW</p> <p>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.</p> <p><i>Describe the floor and zone locations of hazardous areas that are deficient in REMARKS.</i></p> <p>18.3.2.1, 7.2.1.8, 8.4, 8.7, 9.7</p> <table border="1" data-bbox="210 625 1043 1182"> <thead> <tr> <th data-bbox="210 625 613 682">Area</th> <th data-bbox="613 625 840 682">Automatic Sprinkler</th> <th data-bbox="840 625 970 682">Separation</th> <th data-bbox="970 625 1043 682">N/A</th> </tr> </thead> <tbody> <tr> <td data-bbox="210 682 613 738">a. Boiler and Fuel-Fired Heater Rooms</td> <td data-bbox="613 682 840 738"></td> <td data-bbox="840 682 970 738"></td> <td data-bbox="970 682 1043 738"></td> </tr> <tr> <td data-bbox="210 738 613 795">b. Laundries (larger than 100 sq. ft.)</td> <td data-bbox="613 738 840 795"></td> <td data-bbox="840 738 970 795"></td> <td data-bbox="970 738 1043 795"></td> </tr> <tr> <td data-bbox="210 795 613 852">c. Repair, Maintenance, and Paint Shops</td> <td data-bbox="613 795 840 852"></td> <td data-bbox="840 795 970 852"></td> <td data-bbox="970 795 1043 852"></td> </tr> <tr> <td data-bbox="210 852 613 933">d. Soiled Linen Rooms (exceeding 64 gal.)</td> <td data-bbox="613 852 840 933"></td> <td data-bbox="840 852 970 933"></td> <td data-bbox="970 852 1043 933"></td> </tr> <tr> <td data-bbox="210 933 613 998">e. Trash Collection Rooms (exceeding 64 gal.)</td> <td data-bbox="613 933 840 998"></td> <td data-bbox="840 933 970 998"></td> <td data-bbox="970 933 1043 998"></td> </tr> <tr> <td data-bbox="210 998 613 1063">f. Combustible Storage Rooms/Spaces (over 50 and less than 100 sq. ft.)</td> <td data-bbox="613 998 840 1063"></td> <td data-bbox="840 998 970 1063"></td> <td data-bbox="970 998 1043 1063"></td> </tr> <tr> <td data-bbox="210 1063 613 1128">g. Combustible Storage Rooms/Spaces (over 100 sq. ft.)</td> <td data-bbox="613 1063 840 1128"></td> <td data-bbox="840 1063 970 1128"></td> <td data-bbox="970 1063 1043 1128"></td> </tr> <tr> <td data-bbox="210 1128 613 1182">h. Laboratories (if classified as Severe Hazard - see K322)</td> <td data-bbox="613 1128 840 1182"></td> <td data-bbox="840 1128 970 1182"></td> <td data-bbox="970 1128 1043 1182"></td> </tr> </tbody> </table>	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)							
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ID PREFIX		MET	NOT MET	N/A	REMARKS
K322	<p><b>Laboratories</b></p> <p>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.</p> <p>Laboratories not considered a severe hazard are protected as hazardous areas (see K321).</p> <p>Laboratories using chemicals are in accordance with NFPA 45, <i>Standard on Fire Protection for Laboratories Using Chemicals</i>.</p> <p>Gas appliances are of appropriate design and installed in accordance with NFPA 54. Shutoff valves are marked to identify material they control.</p> <p>Devices requiring medical grade oxygen from the piped distribution system meet the requirements under 11.4.2.2 (NFPA 99).</p> <p>18.3.2.2, 19.3.2.2, 8.7, 8.7.4.1 (LSC)</p> <p>9.3.1.2, 11.4.3.2, 15.4 (NFPA 99)</p>				

ID PREFIX		MET	NOT MET	N/A	REMARKS
K323	<p><b>Anesthetizing Locations</b></p> <p>Areas designated for administration of general anesthesia (i.e., inhalation anesthetics) are in accordance with 8.7 and NFPA 99.</p> <p>Zone valves are: located immediately outside each life-support, critical care, and anesthetizing location of moderate sedation, deep sedation, or general anesthesia for medical gas or vacuum; readily accessible in an emergency; and arranged so shutting off any one anesthetizing location will not affect others.</p> <p>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.</p> <p>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.</p> <p>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&amp;C 13-58.</p> <p>18.3.2.3, 19.3.2.3 (LSC)</p> <p>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)</p>				

ID PREFIX		MET	NOT MET	N/A	REMARKS
K324	<p><b>Cooking Facilities</b></p> <p>Cooking equipment is protected in accordance with NFPA 96, <i>Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations</i>, unless:</p> <ul style="list-style-type: none"> <li>• 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.</li> <li>• 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</li> <li>• cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4.</li> </ul> <p>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.</p> <p>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</p>				
K325	<p><b>Alcohol Based Hand Rub Dispenser (ABHR)</b></p> <p>ABHRs are protected in accordance with 8.7.3.1, unless all conditions are met:</p> <ul style="list-style-type: none"> <li>• Corridor is at least 6 feet wide.</li> <li>• Maximum individual dispenser capacity is 0.32 gallons (0.53 gallons in suites) of fluid and 18 ounces of Level 1 aerosols.</li> <li>• Dispensers shall have a minimum of four foot horizontal spacing.</li> <li>• 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.</li> <li>• Storage in a single smoke compartment greater than 5 gallons complies with NFPA 30.</li> <li>• Dispensers are not installed within 1 inch of an ignition source.</li> <li>• Dispensers over carpeted floors are in sprinklered smoke compartments.</li> <li>• ABHR does not exceed 95 percent alcohol.</li> <li>• Operation of the dispenser shall comply with Section 18.3.2.6(11) or 19.3.2.6(11).</li> <li>• ABHR is protected against inappropriate access.</li> </ul> <p>18.3.2.6, 19.3.2.6, 42 CFR Parts 403, 418, 460, 482, 483, and 485</p>				



ID PREFIX		MET	NOT MET	N/A	REMARKS
K331	<p><b>Interior Wall and Ceiling Finish</b> 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 <i>Indicate flame spread rating(s).</i> _____</p> <p>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 <i>Indicate flame spread rating(s).</i> _____</p>				
K332	<p><b>Interior Floor Finish</b> 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</p>				
K341	<p><b>Fire Alarm System – Installation</b> A fire alarm system is installed with systems and components approved for the purpose in accordance with NFPA 70, <i>National Electric Code</i>, and NFPA 72, <i>National Fire Alarm Code</i> 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</p>				

ID PREFIX		MET	NOT MET	N/A	REMARKS
K342	<p><b>Fire Alarm System – Initiation</b></p> <p>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.</p> <p>18.3.4.2.1, 18.3.4.2.2, 19.3.4.2.1, 19.3.4.2.2, 9.6.2.5</p>				
K343	<p><b>Fire Alarm – Notification</b></p> <p>2012 EXISTING</p> <p>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.</p> <p>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.</p> <p>19.3.4.3, 19.3.4.3.1, 19.3.4.3.2, 9.6.4, 9.7.1.1(1)</p>				
	<p>2012 NEW</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>18.3.4.3 through 18.3.4.3.3, 9.6.4</p>				
K344	<p><b>Fire Alarm – Control Functions</b></p> <p>The fire alarm automatically activates required control functions and is provided with an alternative power supply in accordance with NFPA 72.</p> <p>18.3.4.4, 19.3.4.4, 9.6.1, 9.6.5, NFPA 72</p>				

ID PREFIX		MET	NOT MET	N/A	REMARKS
K345	<p><b>Fire Alarm System – Testing and Maintenance</b></p> <p>A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, <i>National Electric Code</i>, and NFPA 72, <i>National Fire Alarm and Signaling Code</i>. Records of system acceptance, maintenance and testing are readily available.</p> <p>9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72</p>				
K346	<p><b>Fire Alarm – Out of Service</b></p> <p>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.</p> <p>9.6.1.6</p>				
K347	<p><b>Smoke Detection</b></p> <p>2012 EXISTING</p> <p>Smoke detection systems are provided in spaces open to corridors as required by 19.3.6.1.</p> <p>19.3.4.5.2</p>				
	<p>2012 NEW</p> <p>Smoke detection systems are provided in spaces open to corridors as required by 18.3.6.1</p> <p>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:</p> <ul style="list-style-type: none"> <li>• smoke detection, or</li> <li>• automatic door closing devices with integral smoke detectors on the room side that provide occupant notification.</li> </ul> <p>Such detectors are electrically interconnected to the fire alarm system.</p> <p>18.3.4.5.2, 18.3.4.5.3</p>				

ID PREFIX		MET	NOT MET	N/A	REMARKS
K351	<p><b>Sprinkler System – Installation</b> 2012 EXISTING</p> <p>Nursing homes, and hospitals where required by construction type, are protected throughout by an approved automatic sprinkler system in accordance with NFPA 13, <i>Standard for the Installation of Sprinkler Systems</i>.</p> <p>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.</p> <p>In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area of the closet does not exceed 6 ft<sup>2</sup> and sprinkler coverage covers the closet footprint as required by NFPA 13, <i>Standard for Installation of Sprinkler Systems</i>.</p> <p>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)</p>				
	<p>2012 NEW</p> <p>Buildings are to be protected throughout by an approved automatic sprinkler system in accordance with NFPA 13, <i>Standard for the Installation of Sprinkler Systems</i>.</p> <p>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.</p> <p>Listed quick-response or listed residential sprinklers are used throughout smoke compartments with patient sleeping rooms.</p> <p>In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area of the closet does not exceed 6 ft<sup>2</sup> and sprinkler coverage covers the closet footprint as required by NFPA 13, <i>Standard for Installation of Sprinkler Systems</i>.</p> <p>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</p>				
K352	<p><b>Sprinkler System – Supervisory Signals</b></p> <p>Automatic sprinkler system supervisory attachments are installed and monitored for integrity in accordance with NFPA 72, <i>National Fire Alarm and Signaling Code</i>, and provide a signal that sounds and is displayed at a continuously attended location or approved remote facility when sprinkler operation is impaired.</p> <p>9.7.2.1, NFPA 72</p>				

ID PREFIX		MET	NOT MET	N/A	REMARKS
K353	<p><b>Sprinkler System – Maintenance and Testing</b></p> <p>Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, <i>Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems</i>. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available.</p> <p>a) Date sprinkler system last checked. _____</p> <p>b) Who provided system test. _____</p> <p>c) Water system supply source. _____</p> <p><i>Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system.</i></p> <p>9.7.5, 9.7.7, 9.7.8, and NFPA 25</p>				
K354	<p><b>Sprinkler System – Out of Service</b></p> <p>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.</p> <p>18.3.5.1, 19.3.5.1, 9.7.5, 15.5.2 (NFPA 25)</p>				
K355	<p><b>Portable Fire Extinguishers</b></p> <p>Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, <i>Standard for Portable Fire Extinguishers</i>.</p> <p>18.3.5.12, 19.3.5.12, NFPA 10</p>				
K361	<p><b>Corridors – Areas Open to Corridor</b></p> <p>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.</p> <p>18.3.6.1, 19.3.6.1</p>				

ID PREFIX		MET	NOT MET	N/A	REMARKS
K362	<p><b>Corridors – Construction of Walls</b></p> <p>2012 EXISTING</p> <p>Corridors are separated from use areas by walls constructed with at least ½ hour fire resistance rating. In fully sprinklered smoke compartments, partitions are only required to resist the 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.</p> <p>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.</p> <p><i>If the walls have a fire resistance rating, give the rating _____ if the walls terminate at the underside of the ceiling, give brief description in REMARKS, describing the ceiling throughout the floor area.</i></p> <p>19.3.6.2, 19.3.6.2.7</p>				
	<p>2012 NEW</p> <p>Corridor walls shall form a barrier to limit the transfer of smoke. Such walls shall be permitted to terminate at the ceiling where the ceiling is constructed to limit the transfer of smoke. No fire resistance rating is required for the corridor walls.</p> <p>18.3.6.2</p>				

ID PREFIX		MET	NOT MET	N/A	REMARKS
K363	<p><b>Corridor – Doors</b> 2012 EXISTING</p> <p>Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1¾ inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material.</p> <p>Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5lbf is applied, whether or not power is applied.</p> <p>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. 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.</p> <p>19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485</p> <p>Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc.</p>				
	<p>2012 NEW</p> <p>Doors protecting corridor openings shall be constructed to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have self-latching and positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material.</p> <p>Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5lbf is applied, whether or not power is applied.</p> <p>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. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 18.3.6.3.6 are permitted.</p> <p>18.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485</p> <p>Show in REMARKS details of doors such as fire protection ratings, automatic closing devices, etc.</p>				

ID PREFIX		MET	NOT MET	N/A	REMARKS
K364	<p><b>Corridor – Openings</b></p> <p>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.</p> <p>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 in<sup>2</sup> and are at or below half the distance from floor to ceiling. In sprinklered rooms, the openings per room do not exceed 80 in<sup>2</sup>.</p> <p>Vision panels in corridor walls or doors shall be fixed window assemblies in approved frames. (In fully sprinklered smoke compartments, there are no restrictions in the area and fire resistance of glass and frames.)</p> <p>18.3.6.5.1, 19.3.6.5.2, 8.3</p>				
K371	<p><b>Subdivision of Building Spaces – Smoke Compartments</b></p> <p>2012 EXISTING</p> <p>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.</p> <p>19.3.7.1, 19.3.7.2</p> <p><i>Detail in REMARKS zone dimensions including length of zones and dead-end corridors.</i></p>				
	<p>2012 NEW</p> <p>Smoke barriers shall be provided to form at least two smoke compartments on every floor used by inpatients for sleeping or treatment, and on every floor with an occupant load of 50 or more persons, regardless of use.</p> <p>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.</p> <p>Smoke subdivision requirements do not apply to any of the stories or areas described in 18.3.7.2.</p> <p>18.3.7.1, 18.3.7.2</p> <p><i>Detail in REMARKS zone dimensions including length of zones and dead-end corridors.</i></p>				



ID PREFIX		MET	NOT MET	N/A	REMARKS
K372	<p><b>Subdivision of Building Spaces – Smoke Barrier Construction</b> 2012 EXISTING</p> <p>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.</p> <p>19.3.7.3, 8.6.7.1(1)</p> <p><i>Describe any mechanical smoke control system in REMARKS.</i></p>				
	<p>2012 NEW</p> <p>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.</p> <p>18.3.7.3, 18.3.7.4, 18.3.7.5, 8.3</p> <p><i>Describe any mechanical smoke control system in REMARKS.</i></p>				
K373	<p><b>Subdivision of Building Spaces – Accumulation Space</b></p> <p>Space shall be provided on each side of smoke barriers to adequately accommodate the total number of occupants in adjoining compartments.</p> <p>18.3.7.5.1, 18.3.7.5.2, 19.3.7.5.1, 19.3.7.5.2</p>				
K374	<p><b>Subdivision of Building Spaces – Smoke Barrier Doors</b> 2012 EXISTING</p> <p>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.</p> <p>19.3.7.6, 19.3.7.8, 19.3.7.9</p>				

ID PREFIX		MET	NOT MET	N/A	REMARKS
K374	<p>2012 NEW</p> <p>Doors in smoke barriers have at least a 20-minute fire protection rating or are at least 1¾-inch thick solid bonded core wood.</p> <p>Required clear widths are provided per 18.3.7.6(4) and (5).</p> <p>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.</p> <p>Doors shall be self-closing and rabbets, bevels, or astragals are required at the meeting edges. Positive latching is not required.</p> <p>18.3.7.6, 18.3.7.7, 18.3.7.8</p>				
K379	<p><b>Smoke Barrier Door Glazing</b></p> <p>2012 EXISTING</p> <p>Openings in smoke barrier doors shall be fire-rated glazing or wired glass panels in steel frames.</p> <p>19.3.7.6, 19.3.7.6.2, 8.5</p>				
	<p>2012 NEW</p> <p>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.</p> <p>18.3.7.9</p>				
K381	<p><b>Sleeping Room Outside Windows and Doors</b></p> <p>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.</p> <p>42 CFR 403, 418, 460, 482, 483, and 485</p>				
<b>SECTION 4 – SPECIAL PROVISIONS</b>					
K400	<p><b>Special Provisions – Other</b></p> <p>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.</p>				

ID PREFIX		MET	NOT MET	N/A	REMARKS
K421	<b>High-Rise Buildings</b> 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				
<b>SECTION 5 – BUILDING SERVICES</b>					
K500	<b>Building Services – Other</b> 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	<b>Utilities – Gas and Electric</b> Equipment using gas or related gas piping complies with NFPA 54, <i>National Fuel Gas Code</i> , electrical wiring and equipment complies with NFPA 70, <i>National Electric Code</i> . 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	<b>HVAC</b> 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	<b>HVAC – Any Heating Device</b> 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: <ul style="list-style-type: none"> <li>• is chimney or vent connected.</li> <li>• takes air for combustion from outside.</li> <li>• provides for a combustion system separate from occupied area atmosphere.</li> </ul> 18.5.2.2, 19.5.2.2				

ID PREFIX		MET	NOT MET	N/A	REMARKS
K523	<p><b>HVAC – Suspended Unit Heaters</b></p> <p>Suspended unit heaters are permitted provided the following are met:</p> <ul style="list-style-type: none"> <li>• Not located in means of egress or in patient rooms.</li> <li>• Located high enough to be out of reach of people in the area.</li> <li>• Has a safety feature to stop fuel and shut down equipment if there is excessive temperature or ignition failure.</li> </ul> <p>18.5.2.3(1), 19.5.2.3(1)</p>				
K524	<p><b>HVAC – Direct-Vent Gas Fireplaces</b></p> <p>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).</p> <p>18.5.2.3(2), 19.5.2.3(2), NFPA 54</p>				
K525	<p><b>HVAC – Solid Fuel-Burning Fireplaces</b></p> <p>Solid fuel-burning fireplaces are permitted in other than patient sleeping areas provided:</p> <ul style="list-style-type: none"> <li>• Areas are separated by 1-hour fire resistance construction.</li> <li>• Fireplace complies with 9.2.2.</li> <li>• Fireplace enclosure resists breakage up to 650°F and has heat-tempered glass.</li> <li>• Room has supervised CO detection per 9.8.</li> </ul> <p>18.5.2.3(3) and 19.5.2.3(3)</p>				
K531	<p><b>Elevators</b></p> <p>2012 EXISTING</p> <p>Elevators comply with the provision of 9.4. Elevators are inspected and tested as specified in ASME A17.1, <i>Safety Code for Elevators and Escalators</i>. Firefighter’s Service is operated monthly with a written record. Existing elevators conform to ASME/ANSI A17.3, <i>Safety Code for Existing Elevators and Escalators</i>. 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.)</p> <p>19.5.3, 9.4.2, 9.4.3</p>				

ID PREFIX		MET	NOT MET	N/A	REMARKS
K531	<p>2012 NEW</p> <p>Elevators comply with the provision of 9.4. Elevators are inspected and tested as specified in ASME A17.1, <i>Safety Code for Elevators and Escalators</i>. Firefighter's Service is operated monthly with a written record. New elevators conform to ASME/ANSI A17.1, <i>Safety Code for Elevators and Escalators</i>, 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.)</p> <p>18.5.3, 9.4.2, 9.4.3</p>				
K532	<p><b>Escalators, Dumbwaiters, and Moving Walks</b></p> <p>2012 EXISTING</p> <p>Escalators, dumbwaiters, and moving walks comply with the provisions of 9.4.</p> <p>All existing escalators, dumbwaiters, and moving walks conform to the requirements of ASME/ANSI A17.3, <i>Safety Code for Existing Elevators and Escalators</i>.</p> <p>(Includes escalator emergency stop buttons and automatic skirt obstruction stop. For power dumbwaiters, includes hoistway door locking to keep doors closed except for floor where car is being loaded or unloaded.)</p> <p>19.5.3, 9.4.2.2</p>				
	<p>2012 NEW</p> <p>Escalators, dumbwaiters, and moving walks comply with the provisions of 9.4.</p> <p>18.5.3, 9.4.2.2</p>				

ID PREFIX		MET	NOT MET	N/A	REMARKS
K541	<p><b>Rubbish Chutes, Incinerators, and Laundry Chutes</b> 2012 EXISTING</p> <p>(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.</p> <p>(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.</p> <p>(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.)</p> <p>(4) Existing fuel-fed incinerators shall be sealed by fire resistive construction to prevent further use.</p> <p>19.5.4, 9.5, 8.4, NFPA 82</p>				
	<p>2012 NEW</p> <p>Rubbish chutes, incinerators, and laundry chutes shall comply with the provisions of Section 9.5, unless otherwise specified in 18.5.4.2.</p> <ul style="list-style-type: none"> <li>• The fire resistance rating of chute charging room shall not be required to exceed 1-hour.</li> <li>• Any rubbish chute or linen chute shall be provided with automatic extinguishing protection in accordance with Section 9.7.</li> <li>• Chutes shall discharge into a trash collection room used for no other purpose and shall be protected in accordance with 8.7.</li> </ul> <p>18.5.4.2, 8.7, 9.5, 9.7, NFPA 82</p>				
<b>SECTION 6 – RESERVED</b>					
<b>SECTION 7 – OPERATING FEATURES</b>					
K700	<p><b>Operating Features – Other</b></p> <p>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.</p>				

ID PREFIX		MET	NOT MET	N/A	REMARKS
K711	<p><b>Evacuation and Relocation Plan</b></p> <p>There is a written plan for the protection of all patients and for their evacuation in the event of an emergency.</p> <p>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.</p> <p>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</p>				
K712	<p><b>Fire Drills</b></p> <p>Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and 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. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms.</p> <p>18.7.1.4 through 18.7.1.7, 19.7.1.4 through 19.7.1.7</p>				

ID PREFIX		MET	NOT MET	N/A	REMARKS
K741	<p><b>Smoking Regulations</b></p> <p>Smoking regulations shall be adopted and shall include not less than the following provisions:</p> <ol style="list-style-type: none"> <li>(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.</li> <li>(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.</li> <li>(3) Smoking by patients classified as not responsible shall be prohibited.</li> <li>(4) The requirement of 18.7.4(3) shall not apply where the patient is under direct supervision.</li> <li>(5) Ashtrays of noncombustible material and safe design shall be provided in all areas where smoking is permitted.</li> <li>(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.</li> </ol> <p>18.7.4, 19.7.4</p>				
K751	<p><b>Draperies, Curtains, and Loosely Hanging Fabrics</b></p> <p>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.</p> <p>18.7.5.1, 18.3.5.11, 19.7.5.1, 19.3.5.11, 10.3.1</p>				



ID PREFIX		MET	NOT MET	N/A	REMARKS
K752	<p><b>Upholstered Furniture and Mattresses</b></p> <p>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.</p> <p>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.</p> <p>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.</p> <p>Newly introduced upholstered furniture and mattresses means purchased on or after the LSC final rule effective date.</p> <p>18.7.5.2, 18.7.5.4, 19.7.5.2, 19.7.5.4</p>				
K753	<p><b>Combustible Decorations</b></p> <p>Combustible decorations shall be prohibited unless one of the following is met:</p> <ul style="list-style-type: none"> <li>• Flame retardant or treated with approved fire-retardant coating that is listed and labeled for product.</li> <li>• Decorations meet NFPA 701.</li> <li>• Decorations exhibit heat release less than 100 kilowatts in accordance with NFPA 289.</li> <li>• 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(4) or 19.7.5.6(4).</li> <li>• The decorations in existing occupancies are in such limited quantities that a hazard of fire development or spread is not present.</li> </ul> <p>18.7.5.6, 19.7.5.6</p>				
K761	<p><b>Maintenance, Inspection &amp; Testing - Doors</b></p> <p>Fire doors assemblies are inspected and tested annually in accordance with NFPA 80 <i>Standard for Fire Doors and Other Opening Protectives</i>.</p> <p>Fire doors that are not located in required fire barriers, including corridor doors to patient rooms and smoke barrier doors, are routinely inspected as part of the facility maintenance program.</p> <p>Individuals performing the door inspection and testing have an understanding of the operating components of the doors. Written records of inspection and testing are maintained and are available for review.</p> <p>18.7.6, 19.7.6, 8.3.3.1 (LSC), 5.2, 5.2.3 (NFPA 80)</p>				

ID PREFIX		MET	NOT MET	N/A	REMARKS
K754	<p><b>Soiled Linen and Trash Containers</b></p> <p>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.</p> <p>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.</p> <p>18.7.5.7, 19.7.5.7</p>				
K771	<p><b>Engineer Smoke Control Systems</b></p> <p>2012 EXISTING</p> <p>When installed, engineered smoke control systems are tested in accordance with established engineering principles. Test documentation is maintained on the premises.</p> <p>19.7.7</p>				
	<p>2012 NEW</p> <p>When installed, engineered smoke control systems are tested in accordance with NFPA 92, <i>Standard for Smoke Control Systems</i>. Test documentation is maintained on the premises.</p> <p>18.7.7</p>				
K781	<p><b>Portable Space Heaters</b></p> <p>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).</p> <p>18.7.8, 19.7.8</p>				
K791	<p><b>Construction, Repair, and Improvement Operations</b></p> <p>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.</p> <p>18.7.9, 19.7.9, 4.6.10, 7.1.10.1</p>				

ID PREFIX		MET	NOT MET	N/A	REMARKS
<b>PART II – HEALTH CARE FACILITIES CODE REQUIREMENTS</b>					
K900	<b>Health Care Facilities Code - Other</b> 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	<b>Fundamentals – Building System Categories</b> 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	<b>Gas and Vacuum Piped Systems – Other</b> 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	<b>Gas and Vacuum Piped Systems – Categories</b> Medical gas, medical air, surgical vacuum, WAGD, and air supply systems are designated: <input type="checkbox"/> Category 1. Systems in which failure is likely to cause major injury or death. <input type="checkbox"/> Category 2. Systems in which failure is likely to cause minor injury. <input type="checkbox"/> Category 3. Systems in which failure is not likely to cause injury, but can cause discomfort. Deep sedation and general anesthesia are not to be administered 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	<b>Gas and Vacuum Piped Systems – Warning Systems</b> 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	<p><b>Gas and Vacuum Piped Systems – Central Supply System Identification and Labeling</b></p> <p>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."</p> <p>5.1.3.1, 5.2.3.1, 5.3.10 (NFPA 99)</p>				
K906	<p><b>Gas and Vacuum Piped Systems – Central Supply System Operations</b></p> <p>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.</p> <p>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)</p>				
K907	<p><b>Gas and Vacuum Piped Systems – Maintenance Program</b></p> <p>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.</p> <p>5.1.14.2.1, 5.1.14.2.2, 5.1.15, 5.2.14, 5.3.13.4.2 (NFPA 99)</p>				

ID PREFIX		MET	NOT MET	N/A	REMARKS
K908	<p><b>Gas and Vacuum Piped Systems – Inspection and Testing Operations</b></p> <p>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.</p> <p>5.1.14.2.3, B.5.2, 5.2.13, 5.3.13, 5.3.13.4 (NFPA 99)</p>				
K909	<p><b>Gas and Vacuum Piped Systems – Information and Warning Signs</b></p> <p>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.</p> <p>5.1.14.3, 5.1.11.1, 5.1.11.2, 5.2.11, 5.3.13.3, 5.3.11 (NFPA 99)</p>				
K910	<p><b>Gas and Vacuum Piped Systems – Modifications</b></p> <p>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.</p> <p>5.1.14.4.1, 5.1.14.4.6, 5.2.13, 5.3.13.4.3 (NFPA 99)</p>				
K911	<p><b>Electrical Systems – Other</b></p> <p>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.</p> <p>Chapter 6 (NFPA 99)</p>				
K912	<p><b>Electrical Systems – Receptacles</b></p> <p>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.</p> <p>If used in patient care room, ground-fault circuit interrupters (GFCI) are listed.</p> <p>6.3.2.2.6.2 (F), 6.3.2.2.4.2 (NFPA 99)</p>				

ID PREFIX		MET	NOT MET	N/A	REMARKS
K913	<p><b>Electrical Systems – Wet Procedure Locations</b></p> <p>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.</p> <p>6.3.2.2.8.4, 6.3.2.2.8.7, 6.4.4.2</p>				
K914	<p><b>Electrical Systems – Maintenance and Testing</b></p> <p>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.</p> <p>6.3.4 (NFPA 99)</p>				
K915	<p><b>Electrical Systems – Essential Electric System Categories</b></p> <p><input type="checkbox"/> 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.</p> <p><input type="checkbox"/> 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.</p> <p><input type="checkbox"/> 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.</p> <p>3.3.138, 6.3.2.2.10, 6.6.2.2.2, 6.6.3.1.1 (NFPA 99), TIA 12-3</p>				

ID PREFIX		MET	NOT MET	N/A	REMARKS
K916	<p><b>Electrical Systems – Essential Electric System Alarm Annunciator</b></p> <p>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.</p> <p>6.4.1.1.17, 6.4.1.1.17.5 (NFPA 99)</p>				
K917	<p><b>Electrical Systems – Essential Electric System Receptacles</b></p> <p>Electrical receptacles or cover plates supplied from the life safety and critical branches have a distinctive color or marking.</p> <p>6.4.2.2.6, 6.5.2.2.4.2, 6.6.2.2.3.2 (NFPA 99)</p>				
K918	<p><b>Electrical Systems – Essential Electric System Maintenance and Testing</b></p> <p>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.</p> <p>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, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations.</p> <p>6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70)</p>				

ID PREFIX		MET	NOT MET	N/A	REMARKS
K919	<p><b>Electrical Equipment – Other</b></p> <p>List in the REMARKS section any NFPA 99 Chapter 10, <i>Electrical Equipment</i>, 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)</p>				
K920	<p><b>Electrical Equipment – Power Cords and Extension Cords</b></p> <p>Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assemblies 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.</p> <p>10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5</p>				



ID PREFIX		MET	NOT MET	N/A	REMARKS
K921	<p><b>Electrical Equipment – Testing and Maintenance Requirements</b></p> <p>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.</p> <p>10.3, 10.5.2.1, 10.5.2.1.2, 10.5.2.5, 10.5.3, 10.5.6, 10.5.8</p>				
K922	<p><b>Gas Equipment – Other</b></p> <p>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.</p> <p>Chapter 11 (NFPA 99)</p>				

ID PREFIX		MET	NOT MET	N/A	REMARKS
K923	<p><b>Gas Equipment – Cylinder and Container Storage</b></p> <p><b>≥ 3,000 cubic feet</b> Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3.</p> <p><b>&gt; 300 but &lt;3,000 cubic feet</b> 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.</p> <p><b>≤ 300 cubic feet</b> 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.</p> <p>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".</p> <p>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.</p> <p>11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99)</p>				
K924	<p><b>Gas Equipment – Testing and Maintenance Requirements</b></p> <p>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.</p> <p>11.4.1.3, 11.5.1.3, 11.6.2.5, 11.6.2.6 (NFPA 99)</p>				

ID PREFIX		MET	NOT MET	N/A	REMARKS
K925	<p><b>Gas Equipment – Respiratory Therapy Sources of Ignition</b></p> <p>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.</p> <p>11.5.1.1, TIA 12-6 (NFPA 99)</p>				
K926	<p><b>Gas Equipment – Qualifications and Training of Personnel</b></p> <p>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.</p> <p>11.5.2.1 (NFPA 99)</p>				
K927	<p><b>Gas Equipment – Transfilling Cylinders</b></p> <p>Transfilling of oxygen from one cylinder to another is in accordance with CGA P-2.5, <i>Transfilling of High Pressure Gaseous Oxygen Used for Respiration</i>. 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).</p> <p>11.5.2.2 (NFPA 99)</p>				

ID PREFIX		MET	NOT MET	N/A	REMARKS
K928	<p><b>Gas Equipment – Labeling Equipment and Cylinders</b></p> <p>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.</p> <p>11.5.3.1 (NFPA 99)</p>				
K929	<p><b>Gas Equipment – Precautions for Handling Oxygen Cylinders and Manifolds</b></p> <p>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).</p> <p>11.6.2 (NFPA 99)</p>				
K930	<p><b>Gas Equipment – Liquid Oxygen Equipment</b></p> <p>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).</p> <p>11.7 (NFPA 99)</p>				
K931	<p><b>Hyperbaric Facilities</b></p> <p>All occupancies containing hyperbaric facilities comply with construction, equipment, administration, and maintenance requirements of NFPA 99. Chapter 14 (NFPA 99)</p>				
K932	<p><b>Features of Fire Protection – Other</b></p> <p>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.</p> <p>Chapter 15 (NFPA 99)</p>				

ID PREFIX		MET	NOT MET	N/A	REMARKS
K933	<p><b>Features of Fire Protection – Fire Loss Prevention in Operating Rooms</b></p> <p>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:</p> <ul style="list-style-type: none"> <li>• packaging is non-flammable.</li> <li>• applicators are in unit doses.</li> <li>• Preoperative "time-out" is conducted prior the initiation of any surgical procedure to verify:                             <ul style="list-style-type: none"> <li>○ application site is dry prior to draping and use of surgical equipment.</li> <li>○ pooling of solution has not occurred or has been corrected.</li> <li>○ solution-soaked materials have been removed from the OR prior to draping and use of surgical devices.</li> <li>○ policies and procedures are established outlining safety precautions related to the use of flammable germicide or antiseptic use.</li> </ul> </li> </ul> <p>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.</p> <p>15.13 (NFPA 99)</p>				

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

<b>FIRE SAFETY SURVEY REPORT - 2012 LIFE SAFETY CODE HEALTHCARE</b>	1. (A) PROVIDER NUMBER <small>K1</small>	1. (B) MEDICAID I.D. NO. <small>K2</small>
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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) A. BUILDING _____ B. WING _____ C. FLOOR _____ <small>K3</small>	2. (B) ADDRESS OF FACILITY (STREET, CITY, STATE, ZIP CODE)	A. <input type="checkbox"/> Fully Sprinklered (All required areas are sprinklered) B. <input type="checkbox"/> Partially Sprinklered (Not all required areas are sprinklered) C. <input type="checkbox"/> None (No sprinkler system) <small>K0180</small>
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3. SURVEY FOR <input type="checkbox"/> MEDICARE <input type="checkbox"/> MEDICAID	4. DATE OF SURVEY <small>K4</small>	DATE OF PLAN APPROVAL <small>K6</small>	SURVEY UNDER 5. <input type="checkbox"/> 2012 EXISTING      6. <input type="checkbox"/> 2012 NEW <small>K7</small>
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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 _____
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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

SURVEYOR (S) <i>Kimberly Swenson</i>	TITLE	OFFICE	DATE
SURVEYOR ID <small>K10</small>			
FIRE AUTHORITY OFFICIAL (Signature)	TITLE	OFFICE	DATE

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

ID PREFIX		MET	NOT MET	N/A	REMARKS
	<b>PART I – NFPA 101 LSC REQUIREMENTS</b> <i>(Items in italics relate to the FSES)</i>				
	<b>SECTION 1 – GENERAL REQUIREMENTS</b>				
K100	<b>General Requirements – Other</b> 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	<b>Building Rehabilitation</b> <i>Repair, Renovation, Modification, or Reconstruction</i> Any building undergoing repair, renovation, modification, or reconstruction complies with both of the following: <ul style="list-style-type: none"> <li>• Requirements of Chapter 18 and 19.</li> <li>• 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</li> </ul> <b>Change of Use or Change of Occupancy</b> 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) <b>Additions</b> 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	<p><b>Sprinkler Requirements for Major Rehabilitation</b></p> <p>If a nonsprinklered smoke compartment has undergone major rehabilitation the automatic sprinkler requirements of 18.3.5 have been applied to the smoke compartment.</p> <p>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.</p> <p>Note: Major rehabilitation involves the modification of more than 50 percent, or more than 4500 ft<sup>2</sup> of the area of the smoke compartment.</p> <p>18.1.1.4.3.3, 19.1.1.4.3.3</p>				
K131	<p><b>Multiple Occupancies – Sections of Health Care Facilities</b></p> <p>Sections of health care facilities classified as other occupancies meet all of the following:</p> <ul style="list-style-type: none"> <li>• They are not intended to serve four or more inpatients for purposes of housing, treatment, or customary access.</li> <li>• They are separated from areas of health care occupancies by construction having a minimum two hour fire resistance rating in accordance with Chapter 8.</li> <li>• The entire building is protected throughout by an approved, supervised automatic sprinkler system in accordance with Section 9.7.</li> </ul> <p>Hospital outpatient surgical departments are required to be classified as an Ambulatory Health Care Occupancy regardless of the number of patients served.</p> <p>18.1.3.3, 19.1.3.3, 42 CFR 482.41, 42 CFR 485.623</p>				
K132	<p><b>Multiple Occupancies – Contiguous Non-Health Care Occupancies</b></p> <p>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.</p> <p>18.1.3.4.1, 19.1.3.4.1</p>				

ID PREFIX		MET	NOT MET	N/A	REMARKS																							
K133	<p><b>Multiple Occupancies – Construction Type</b></p> <p>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:</p> <ul style="list-style-type: none"> <li>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.</li> <li>The construction type of the areas of the building enclosing the other occupancies shall be based on the applicable occupancy chapters.</li> </ul> <p>18.1.3.5, 19.1.3.5, 8.2.1.3</p>																											
K161	<p><b>Building Construction Type and Height</b></p> <p>2012 EXISTING</p> <p>Building construction type and stories meets Table 19.1.6.1, unless otherwise permitted by 19.1.6.2 through 19.1.6.7</p> <p>19.1.6.4, 19.1.6.5</p> <table border="1" data-bbox="222 813 1100 1273"> <thead> <tr> <th></th> <th>Construction Type</th> <th></th> </tr> </thead> <tbody> <tr> <td>1</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>II (111)</td> <td>One story non-sprinklered Maximum 3 stories sprinklered</td> </tr> <tr> <td>3</td> <td>II (000)</td> <td rowspan="4">Not allowed non-sprinklered Maximum 2 stories sprinklered</td> </tr> <tr> <td>4</td> <td>III (211)</td> </tr> <tr> <td>5</td> <td>IV (2HH)</td> </tr> <tr> <td>6</td> <td>V (111)</td> </tr> <tr> <td>7</td> <td>III (200)</td> <td rowspan="2">Not allowed non-sprinklered Maximum 1 story sprinklered</td> </tr> <tr> <td>8</td> <td>V (000)</td> </tr> </tbody> </table> <p><i>Sprinklered stories must be sprinklered throughout by an approved, supervised automatic system in accordance with section 9.7. (See 19.3.5)</i></p> <p><i>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.</i></p>		Construction Type		1	I (442), I (332), II (222)	Any number of stories non-sprinklered or sprinklered	2	II (111)	One story non-sprinklered Maximum 3 stories sprinklered	3	II (000)	Not allowed non-sprinklered Maximum 2 stories sprinklered	4	III (211)	5	IV (2HH)	6	V (111)	7	III (200)	Not allowed non-sprinklered Maximum 1 story sprinklered	8	V (000)				
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K162	<p><b>Roofing Systems Involving Combustibles</b></p> <p>2012 EXISTING</p> <p>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:</p> <ol style="list-style-type: none"> <li>1. roof covering meets Class C requirements.</li> <li>2. roof is separated from occupied building portions with a noncombustible floor assembly using not less than 2½ inches concrete or gypsum fill.</li> <li>3. attic or other space is either unoccupied or protected throughout by an approved automatic sprinkler system.</li> </ol> <p>19.1.6.2*, ASTM E108, ANSI/UL 790</p>																											

ID PREFIX		MET	NOT MET	N/A	REMARKS
K162	<p>2012 NEW</p> <p>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:</p> <ol style="list-style-type: none"> <li>1. roof covering meets Class A requirements.</li> <li>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.</li> <li>3. the structural elements supporting the rated floor assembly meet the required fire resistance rating of the building.</li> </ol> <p>18.1.6.2, ASTM E108, ANSI/UL 790</p>				
K163	<p><b>Interior Nonbearing Wall Construction</b></p> <p>Interior nonbearing walls in Type I or II construction are constructed of noncombustible or limited-combustible materials.</p> <p>Interior nonbearing walls required to have a minimum 2 hour fire resistance rating are permitted to be fire-retardant-treated wood enclosed within noncombustible or limited-combustible materials, provided they are not used as shaft enclosures.</p> <p>18.1.6.4, 18.1.6.5, 19.1.6.4, 19.1.6.5</p>				
<b>SECTION 2 – MEANS OF EGRESS REQUIREMENTS</b>					
K200	<p><b>Means of Egress Requirements – Other</b></p> <p>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.</p> <p>18.2, 19.2</p>				
K211	<p><b>Means of Egress – General</b></p> <p>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.</p> <p>18.2.1, 19.2.1, 7.1.10.1</p>				

ID PREFIX		MET	NOT MET	N/A	REMARKS
K221	<p><b>Patient Sleeping Room Doors</b></p> <p>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.</p> <p>18.2.2.2, 19.2.2.2, TIA 12-4</p>				
K222	<p><b>Egress Doors</b></p> <p>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:</p> <p><input type="checkbox"/> CLINICAL NEEDS OR SECURITY THREAT LOCKING</p> <p>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.</p> <p>18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6</p> <p><input type="checkbox"/> SPECIAL NEEDS LOCKING ARRANGEMENTS</p> <p>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.</p> <p>18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4</p>				

ID PREFIX		MET	NOT MET	N/A	REMARKS
K222	<p><input type="checkbox"/> 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</p> <p><input type="checkbox"/> 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</p> <p><input type="checkbox"/> 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</p>				
K223	<p><b>Doors with Self-Closing Devices</b> 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:</p> <ul style="list-style-type: none"> <li>• Required manual fire alarm system; and</li> <li>• Local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system; and</li> <li>• Automatic sprinkler system, if installed; and</li> <li>• Loss of power.</li> </ul> <p>18.2.2.2.7, 18.2.2.2.8, 19.2.2.2.7, 19.2.2.2.8</p>				

ID PREFIX		MET	NOT MET	N/A	REMARKS
K224	<p><b>Horizontal-Sliding Doors</b></p> <p>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.</p> <p>Horizontal-sliding doors serving an occupant load fewer than 10 shall be permitted, providing all of the following criteria are met:</p> <ul style="list-style-type: none"> <li>• Area served by the door has no high hazard contents.</li> <li>• Door is operable from either side without special knowledge or effort.</li> <li>• Force required to operate the door in the direction of travel is <math>\leq 30</math> lbf to set the door in motion and <math>\leq 15</math> lbf to close or open to the required width.</li> <li>• 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.</li> <li>• Where required to latch, the door has a latch or other mechanism to ensure the door will not rebound.</li> </ul> <p>18.2.2.2.10, 19.2.2.2.10</p>				
K225	<p><b>Stairways and Smokeproof Enclosures</b></p> <p>Stairways and Smokeproof enclosures used as exits are in accordance with 7.2.</p> <p>18.2.2.3, 18.2.2.4, 19.2.2.3, 19.2.2.4, 7.2</p>				
K226	<p><b>Horizontal Exits</b></p> <p>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.</p> <p>18.2.2.5, 19.2.2.5</p>				
K227	<p><b>Ramps and Other Exits</b></p> <p>Ramps, exit passageways, fire and slide escapes, alternating tread devices, and areas of refuge are in accordance with the provisions 7.2.5 through 7.2.12.</p> <p>18.2.2.6 to 18.2.2.10 or 19.2.2.6 to 19.2.2.10</p>				
K231	<p><b>Means of Egress Capacity</b></p> <p>The capacity of required means of egress is in accordance with 7.3.</p> <p>18.2.3.1, 19.2.3.1</p>				

ID PREFIX		MET	NOT MET	N/A	REMARKS
K232	<p><b>Aisle, Corridor or Ramp Width</b> 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</p> <p>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</p>				
K233	<p><b>Clear Width of Exit and Exit Access Doors</b> 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</p> <p>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</p>				
K241	<p><b>Number of Exits – Story and Compartment</b> 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</p>				



ID PREFIX		MET	NOT MET	N/A	REMARKS
K251	<p><b>Dead-End Corridors and Common Path of Travel</b></p> <p>2012 EXISTING</p> <p>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.</p> <p>19.2.5.2</p>				
K251	<p>2012 NEW</p> <p>Dead-end corridors shall not exceed 30 feet. Common path of travel shall not exceed 100 feet.</p> <p>18.2.5.2, 18.2.5.3</p>				
K252	<p><b>Number of Exits – Corridors</b></p> <p>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.</p> <p>18.2.5.4, 19.2.5.4</p>				
K253	<p><b>Number of Exits – Patient Sleeping and Non-Sleeping Rooms</b></p> <p>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.</p> <p>18.2.5.5.1, 18.2.5.5.2, 19.2.5.5.1, 19.2.5.5.2</p>				
K254	<p><b>Corridor Access</b></p> <p>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.</p> <p>18.2.5.6.1 through 18.2.5.6.4, 19.2.5.6.1 through 19.2.5.6.4</p>				
K255	<p><b>Suite Separation, Hazardous Content, and Subdivision</b></p> <p>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.</p> <p>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</p>				

ID PREFIX		MET	NOT MET	N/A	REMARKS
K256	<p><b>Sleeping Suites</b></p> <p>Occupants shall have exit access to a corridor or direct access to a horizontal exit. Where <math>\geq 2</math> 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.</p> <p>Suites more than 1,000 ft<sup>2</sup> 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.</p> <p>Suites shall not exceed the following size limitations:</p> <ul style="list-style-type: none"> <li>• 5,000 square feet if the suite is not fully smoke detected or fully sprinklered.</li> <li>• 7,500 square feet if the suite is either fully smoke detected or fully sprinklered.</li> <li>• 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.</li> </ul> <p>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).</p> <p>18.2.5.7.2, 19.2.5.7.2</p>				
K257	<p><b>Non-Sleeping Suites</b></p> <p>Occupants shall have exit access to a corridor or direct access to a horizontal exit. Where <math>\geq 2</math> exits are required, one exit access door may be to a stairway, passageway or to the exterior.</p> <p>Suites more than 2,500 ft<sup>2</sup> 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.</p> <p>Suites shall not exceed 10,000 ft<sup>2</sup>.</p> <p>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).</p> <p>18.2.5.7.3, 19.2.5.7.3</p>				

ID PREFIX		MET	NOT MET	N/A	REMARKS
K261	<p><b>Travel Distance to Exits</b></p> <p>Travel distance (excluding suites) to exits are measured in accordance with 7.6.</p> <ul style="list-style-type: none"> <li>• 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).</li> <li>• Point in a room to room door less than or equal to 50 feet.</li> </ul> <p>18.2.6, 19.2.6</p>				
K271	<p><b>Discharge from Exits</b></p> <p>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.</p> <p>18.2.7, 19.2.7</p>				
K281	<p><b>Illumination of Means of Egress</b></p> <p>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.</p> <p>18.2.8, 19.2.8</p>				
K291	<p><b>Emergency Lighting</b></p> <p>Emergency lighting of at least 1-1/2 hour duration is provided automatically in accordance with 7.9.</p> <p>18.2.9.1, 19.2.9.1</p>				
K292	<p><b>Life Support Means of Egress</b></p> <p>2012 NEW (INDICATE N/A FOR EXISTING)</p> <p>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.</p> <p>(Indicate N/A if life support equipment is for emergency purposes only.)</p> <p>18.2.9.2, 18.2.10.5</p>				

ID PREFIX		MET	NOT MET	N/A	REMARKS
K293	<p><b>Exit Signage</b> 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.)</p>				
	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				
	<b>SECTION 3 – PROTECTION</b>				
K300	<p><b>Protection – Other</b> 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.</p>				
K311	<p><b>Vertical Openings – Enclosure</b> 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 <i>If all vertical openings are properly enclosed with construction providing at least a 2 hour fire resistance rating, also check this box.</i> <input type="checkbox"/></p>				
	<p>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</p>				

ID PREFIX		MET	NOT MET	N/A	REMARKS																																
K321	<p><b>Hazardous Areas – Enclosure</b>                      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 or 19.3.5.9. 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.  <i>Describe the floor and zone locations of hazardous areas that are deficient in REMARKS.</i>                      19.3.2.1, 19.3.5.9</p> <table border="1" data-bbox="210 743 1045 1222"> <thead> <tr> <th data-bbox="210 743 613 800">Area</th> <th data-bbox="613 743 842 800">Automatic Sprinkler</th> <th data-bbox="842 743 972 800">Separation</th> <th data-bbox="972 743 1045 800">N/A</th> </tr> </thead> <tbody> <tr> <td data-bbox="210 800 613 857">a. Boiler and Fuel-Fired Heater Rooms</td> <td data-bbox="613 800 842 857"></td> <td data-bbox="842 800 972 857"></td> <td data-bbox="972 800 1045 857"></td> </tr> <tr> <td data-bbox="210 857 613 914">b. Laundries (larger than 100 sq. ft.)</td> <td data-bbox="613 857 842 914"></td> <td data-bbox="842 857 972 914"></td> <td data-bbox="972 857 1045 914"></td> </tr> <tr> <td data-bbox="210 914 613 971">c. Repair, Maintenance, and Paint Shops</td> <td data-bbox="613 914 842 971"></td> <td data-bbox="842 914 972 971"></td> <td data-bbox="972 914 1045 971"></td> </tr> <tr> <td data-bbox="210 971 613 1044">d. Soiled Linen Rooms (exceeding 64 gal.)</td> <td data-bbox="613 971 842 1044"></td> <td data-bbox="842 971 972 1044"></td> <td data-bbox="972 971 1045 1044"></td> </tr> <tr> <td data-bbox="210 1044 613 1109">e. Trash Collection Rooms (exceeding 64 gal.)</td> <td data-bbox="613 1044 842 1109"></td> <td data-bbox="842 1044 972 1109"></td> <td data-bbox="972 1044 1045 1109"></td> </tr> <tr> <td data-bbox="210 1109 613 1166">f. Combustible Storage Rooms/Spaces (over 50 sq. ft.)</td> <td data-bbox="613 1109 842 1166"></td> <td data-bbox="842 1109 972 1166"></td> <td data-bbox="972 1109 1045 1166"></td> </tr> <tr> <td data-bbox="210 1166 613 1222">g. Laboratories (if classified as Severe Hazard - see K322)</td> <td data-bbox="613 1166 842 1222"></td> <td data-bbox="842 1166 972 1222"></td> <td data-bbox="972 1166 1045 1222"></td> </tr> </tbody> </table>	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)							
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K321	<p>2012 NEW</p> <p>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.</p> <p><i>Describe the floor and zone locations of hazardous areas that are deficient in REMARKS.</i></p> <p>18.3.2.1, 7.2.1.8, 8.4, 8.7, 9.7</p> <table border="1" data-bbox="210 625 1043 1183"> <thead> <tr> <th data-bbox="210 625 613 682">Area</th> <th data-bbox="613 625 840 682">Automatic Sprinkler</th> <th data-bbox="840 625 970 682">Separation</th> <th data-bbox="970 625 1043 682">N/A</th> </tr> </thead> <tbody> <tr> <td data-bbox="210 682 613 738">a. Boiler and Fuel-Fired Heater Rooms</td> <td data-bbox="613 682 840 738"></td> <td data-bbox="840 682 970 738"></td> <td data-bbox="970 682 1043 738"></td> </tr> <tr> <td data-bbox="210 738 613 795">b. Laundries (larger than 100 sq. ft.)</td> <td data-bbox="613 738 840 795"></td> <td data-bbox="840 738 970 795"></td> <td data-bbox="970 738 1043 795"></td> </tr> <tr> <td data-bbox="210 795 613 852">c. Repair, Maintenance, and Paint Shops</td> <td data-bbox="613 795 840 852"></td> <td data-bbox="840 795 970 852"></td> <td data-bbox="970 795 1043 852"></td> </tr> <tr> <td data-bbox="210 852 613 933">d. Soiled Linen Rooms (exceeding 64 gal.)</td> <td data-bbox="613 852 840 933"></td> <td data-bbox="840 852 970 933"></td> <td data-bbox="970 852 1043 933"></td> </tr> <tr> <td data-bbox="210 933 613 998">e. Trash Collection Rooms (exceeding 64 gal.)</td> <td data-bbox="613 933 840 998"></td> <td data-bbox="840 933 970 998"></td> <td data-bbox="970 933 1043 998"></td> </tr> <tr> <td data-bbox="210 998 613 1063">f. Combustible Storage Rooms/Spaces (over 50 and less than 100 sq. ft.)</td> <td data-bbox="613 998 840 1063"></td> <td data-bbox="840 998 970 1063"></td> <td data-bbox="970 998 1043 1063"></td> </tr> <tr> <td data-bbox="210 1063 613 1128">g. Combustible Storage Rooms/Spaces (over 100 sq. ft.)</td> <td data-bbox="613 1063 840 1128"></td> <td data-bbox="840 1063 970 1128"></td> <td data-bbox="970 1063 1043 1128"></td> </tr> <tr> <td data-bbox="210 1128 613 1183">h. Laboratories (if classified as Severe Hazard - see K322)</td> <td data-bbox="613 1128 840 1183"></td> <td data-bbox="840 1128 970 1183"></td> <td data-bbox="970 1128 1043 1183"></td> </tr> </tbody> </table>	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)							
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K322	<p><b>Laboratories</b></p> <p>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.</p> <p>Laboratories not considered a severe hazard are protected as hazardous areas (see K321).</p> <p>Laboratories using chemicals are in accordance with NFPA 45, <i>Standard on Fire Protection for Laboratories Using Chemicals</i>.</p> <p>Gas appliances are of appropriate design and installed in accordance with NFPA 54. Shutoff valves are marked to identify material they control.</p> <p>Devices requiring medical grade oxygen from the piped distribution system meet the requirements under 11.4.2.2 (NFPA 99).</p> <p>18.3.2.2, 19.3.2.2, 8.7, 8.7.4.1 (LSC)</p> <p>9.3.1.2, 11.4.3.2, 15.4 (NFPA 99)</p>				

ID PREFIX		MET	NOT MET	N/A	REMARKS
K323	<p><b>Anesthetizing Locations</b></p> <p>Areas designated for administration of general anesthesia (i.e., inhalation anesthetics) are in accordance with 8.7 and NFPA 99.</p> <p>Zone valves are: located immediately outside each life-support, critical care, and anesthetizing location of moderate sedation, deep sedation, or general anesthesia for medical gas or vacuum; readily accessible in an emergency; and arranged so shutting off any one anesthetizing location will not affect others.</p> <p>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.</p> <p>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.</p> <p>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&amp;C 13-58.</p> <p>18.3.2.3, 19.3.2.3 (LSC)</p> <p>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)</p>				



ID PREFIX		MET	NOT MET	N/A	REMARKS
K324	<p><b>Cooking Facilities</b></p> <p>Cooking equipment is protected in accordance with NFPA 96, <i>Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations</i>, unless:</p> <ul style="list-style-type: none"> <li>• 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.</li> <li>• 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</li> <li>• cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4.</li> </ul> <p>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.</p> <p>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</p>				
K325	<p><b>Alcohol Based Hand Rub Dispenser (ABHR)</b></p> <p>ABHRs are protected in accordance with 8.7.3.1, unless all conditions are met:</p> <ul style="list-style-type: none"> <li>• Corridor is at least 6 feet wide.</li> <li>• Maximum individual dispenser capacity is 0.32 gallons (0.53 gallons in suites) of fluid and 18 ounces of Level 1 aerosols.</li> <li>• Dispensers shall have a minimum of four foot horizontal spacing.</li> <li>• 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.</li> <li>• Storage in a single smoke compartment greater than 5 gallons complies with NFPA 30.</li> <li>• Dispensers are not installed within 1 inch of an ignition source.</li> <li>• Dispensers over carpeted floors are in sprinklered smoke compartments.</li> <li>• ABHR does not exceed 95 percent alcohol.</li> <li>• Operation of the dispenser shall comply with Section 18.3.2.6(11) or 19.3.2.6(11).</li> <li>• ABHR is protected against inappropriate access.</li> </ul> <p>18.3.2.6, 19.3.2.6, 42 CFR Parts 403, 418, 460, 482, 483, and 485</p>				

ID PREFIX		MET	NOT MET	N/A	REMARKS
K331	<p><b>Interior Wall and Ceiling Finish</b> 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 <i>Indicate flame spread rating(s).</i> _____</p> <p>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 <i>Indicate flame spread rating(s).</i> _____</p>				
K332	<p><b>Interior Floor Finish</b> 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</p>				
K341	<p><b>Fire Alarm System – Installation</b> A fire alarm system is installed with systems and components approved for the purpose in accordance with NFPA 70, <i>National Electric Code</i>, and NFPA 72, <i>National Fire Alarm Code</i> 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</p>				

ID PREFIX		MET	NOT MET	N/A	REMARKS
K342	<p><b>Fire Alarm System – Initiation</b></p> <p>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.</p> <p>18.3.4.2.1, 18.3.4.2.2, 19.3.4.2.1, 19.3.4.2.2, 9.6.2.5</p>				
K343	<p><b>Fire Alarm – Notification</b></p> <p>2012 EXISTING</p> <p>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.</p> <p>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.</p> <p>19.3.4.3, 19.3.4.3.1, 19.3.4.3.2, 9.6.4, 9.7.1.1(1)</p>				
	<p>2012 NEW</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>18.3.4.3 through 18.3.4.3.3, 9.6.4</p>				
K344	<p><b>Fire Alarm – Control Functions</b></p> <p>The fire alarm automatically activates required control functions and is provided with an alternative power supply in accordance with NFPA 72.</p> <p>18.3.4.4, 19.3.4.4, 9.6.1, 9.6.5, NFPA 72</p>				

ID PREFIX		MET	NOT MET	N/A	REMARKS
K345	<p><b>Fire Alarm System – Testing and Maintenance</b></p> <p>A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, <i>National Electric Code</i>, and NFPA 72, <i>National Fire Alarm and Signaling Code</i>. Records of system acceptance, maintenance and testing are readily available.</p> <p>9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72</p>				
K346	<p><b>Fire Alarm – Out of Service</b></p> <p>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.</p> <p>9.6.1.6</p>				
K347	<p><b>Smoke Detection</b></p> <p>2012 EXISTING</p> <p>Smoke detection systems are provided in spaces open to corridors as required by 19.3.6.1.</p> <p>19.3.4.5.2</p>				
	<p>2012 NEW</p> <p>Smoke detection systems are provided in spaces open to corridors as required by 18.3.6.1</p> <p>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:</p> <ul style="list-style-type: none"> <li>• smoke detection, or</li> <li>• automatic door closing devices with integral smoke detectors on the room side that provide occupant notification.</li> </ul> <p>Such detectors are electrically interconnected to the fire alarm system.</p> <p>18.3.4.5.2, 18.3.4.5.3</p>				

ID PREFIX		MET	NOT MET	N/A	REMARKS
K351	<p><b>Sprinkler System – Installation</b> 2012 EXISTING</p> <p>Nursing homes, and hospitals where required by construction type, are protected throughout by an approved automatic sprinkler system in accordance with NFPA 13, <i>Standard for the Installation of Sprinkler Systems</i>.</p> <p>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.</p> <p>In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area of the closet does not exceed 6 ft<sup>2</sup> and sprinkler coverage covers the closet footprint as required by NFPA 13, <i>Standard for Installation of Sprinkler Systems</i>.</p> <p>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)</p>				
	<p>2012 NEW</p> <p>Buildings are to be protected throughout by an approved automatic sprinkler system in accordance with NFPA 13, <i>Standard for the Installation of Sprinkler Systems</i>.</p> <p>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.</p> <p>Listed quick-response or listed residential sprinklers are used throughout smoke compartments with patient sleeping rooms.</p> <p>In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area of the closet does not exceed 6 ft<sup>2</sup> and sprinkler coverage covers the closet footprint as required by NFPA 13, <i>Standard for Installation of Sprinkler Systems</i>.</p> <p>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</p>				
K352	<p><b>Sprinkler System – Supervisory Signals</b></p> <p>Automatic sprinkler system supervisory attachments are installed and monitored for integrity in accordance with NFPA 72, <i>National Fire Alarm and Signaling Code</i>, and provide a signal that sounds and is displayed at a continuously attended location or approved remote facility when sprinkler operation is impaired.</p> <p>9.7.2.1, NFPA 72</p>				

ID PREFIX		MET	NOT MET	N/A	REMARKS
K353	<p><b>Sprinkler System – Maintenance and Testing</b></p> <p>Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, <i>Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems</i>. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available.</p> <p>a) Date sprinkler system last checked. _____</p> <p>b) Who provided system test. _____</p> <p>c) Water system supply source. _____</p> <p><i>Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system.</i></p> <p>9.7.5, 9.7.7, 9.7.8, and NFPA 25</p>				
K354	<p><b>Sprinkler System – Out of Service</b></p> <p>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.</p> <p>18.3.5.1, 19.3.5.1, 9.7.5, 15.5.2 (NFPA 25)</p>				
K355	<p><b>Portable Fire Extinguishers</b></p> <p>Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, <i>Standard for Portable Fire Extinguishers</i>.</p> <p>18.3.5.12, 19.3.5.12, NFPA 10</p>				
K361	<p><b>Corridors – Areas Open to Corridor</b></p> <p>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.</p> <p>18.3.6.1, 19.3.6.1</p>				

ID PREFIX		MET	NOT MET	N/A	REMARKS
K362	<p><b>Corridors – Construction of Walls</b></p> <p>2012 EXISTING</p> <p>Corridors are separated from use areas by walls constructed with at least ½ hour fire resistance rating. In fully sprinklered smoke compartments, partitions are only required to resist the 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.</p> <p>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.</p> <p><i>If the walls have a fire resistance rating, give the rating _____ if the walls terminate at the underside of the ceiling, give brief description in REMARKS, describing the ceiling throughout the floor area.</i></p> <p>19.3.6.2, 19.3.6.2.7</p>				
	<p>2012 NEW</p> <p>Corridor walls shall form a barrier to limit the transfer of smoke. Such walls shall be permitted to terminate at the ceiling where the ceiling is constructed to limit the transfer of smoke. No fire resistance rating is required for the corridor walls.</p> <p>18.3.6.2</p>				

ID PREFIX		MET	NOT MET	N/A	REMARKS
K363	<p><b>Corridor – Doors</b> 2012 EXISTING</p> <p>Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1¾ inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material.</p> <p>Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5lbf is applied, whether or not power is applied.</p> <p>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. 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.</p> <p>19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485</p> <p>Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc.</p>				
	<p>2012 NEW</p> <p>Doors protecting corridor openings shall be constructed to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have self-latching and positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material.</p> <p>Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5lbf is applied, whether or not power is applied.</p> <p>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. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 18.3.6.3.6 are permitted.</p> <p>18.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485</p> <p>Show in REMARKS details of doors such as fire protection ratings, automatic closing devices, etc.</p>				



ID PREFIX		MET	NOT MET	N/A	REMARKS
K364	<p><b>Corridor – Openings</b></p> <p>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.</p> <p>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 in<sup>2</sup> and are at or below half the distance from floor to ceiling. In sprinklered rooms, the openings per room do not exceed 80 in<sup>2</sup>.</p> <p>Vision panels in corridor walls or doors shall be fixed window assemblies in approved frames. (In fully sprinklered smoke compartments, there are no restrictions in the area and fire resistance of glass and frames.)</p> <p>18.3.6.5.1, 19.3.6.5.2, 8.3</p>				
K371	<p><b>Subdivision of Building Spaces – Smoke Compartments</b></p> <p>2012 EXISTING</p> <p>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.</p> <p>19.3.7.1, 19.3.7.2</p> <p><i>Detail in REMARKS zone dimensions including length of zones and dead-end corridors.</i></p> <p>2012 NEW</p> <p>Smoke barriers shall be provided to form at least two smoke compartments on every floor used by inpatients for sleeping or treatment, and on every floor with an occupant load of 50 or more persons, regardless of use.</p> <p>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.</p> <p>Smoke subdivision requirements do not apply to any of the stories or areas described in 18.3.7.2.</p> <p>18.3.7.1, 18.3.7.2</p> <p><i>Detail in REMARKS zone dimensions including length of zones and dead-end corridors.</i></p>				

ID PREFIX		MET	NOT MET	N/A	REMARKS
K372	<p><b>Subdivision of Building Spaces – Smoke Barrier Construction</b> 2012 EXISTING</p> <p>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.</p> <p>19.3.7.3, 8.6.7.1(1)</p> <p><i>Describe any mechanical smoke control system in REMARKS.</i></p>				
	<p>2012 NEW</p> <p>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.</p> <p>18.3.7.3, 18.3.7.4, 18.3.7.5, 8.3</p> <p><i>Describe any mechanical smoke control system in REMARKS.</i></p>				
K373	<p><b>Subdivision of Building Spaces – Accumulation Space</b></p> <p>Space shall be provided on each side of smoke barriers to adequately accommodate the total number of occupants in adjoining compartments.</p> <p>18.3.7.5.1, 18.3.7.5.2, 19.3.7.5.1, 19.3.7.5.2</p>				
K374	<p><b>Subdivision of Building Spaces – Smoke Barrier Doors</b> 2012 EXISTING</p> <p>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.</p> <p>19.3.7.6, 19.3.7.8, 19.3.7.9</p>				

ID PREFIX		MET	NOT MET	N/A	REMARKS
K374	<p>2012 NEW</p> <p>Doors in smoke barriers have at least a 20-minute fire protection rating or are at least 1¾-inch thick solid bonded core wood.</p> <p>Required clear widths are provided per 18.3.7.6(4) and (5).</p> <p>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.</p> <p>Doors shall be self-closing and rabbets, bevels, or astragals are required at the meeting edges. Positive latching is not required.</p> <p>18.3.7.6, 18.3.7.7, 18.3.7.8</p>				
K379	<p><b>Smoke Barrier Door Glazing</b></p> <p>2012 EXISTING</p> <p>Openings in smoke barrier doors shall be fire-rated glazing or wired glass panels in steel frames.</p> <p>19.3.7.6, 19.3.7.6.2, 8.5</p>				
	<p>2012 NEW</p> <p>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.</p> <p>18.3.7.9</p>				
K381	<p><b>Sleeping Room Outside Windows and Doors</b></p> <p>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.</p> <p>42 CFR 403, 418, 460, 482, 483, and 485</p>				
<b>SECTION 4 – SPECIAL PROVISIONS</b>					
K400	<p><b>Special Provisions – Other</b></p> <p>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.</p>				

ID PREFIX		MET	NOT MET	N/A	REMARKS
K421	<p><b>High-Rise Buildings</b> 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</p>				
	<p>2012 NEW High-rise buildings comply with section 11.8. 18.4.2</p>				
<b>SECTION 5 – BUILDING SERVICES</b>					
K500	<p><b>Building Services – Other</b> 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.</p>				
K511	<p><b>Utilities – Gas and Electric</b> Equipment using gas or related gas piping complies with NFPA 54, <i>National Fuel Gas Code</i>, electrical wiring and equipment complies with NFPA 70, <i>National Electric Code</i>. 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</p>				
K521	<p><b>HVAC</b> 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</p>				
K522	<p><b>HVAC – Any Heating Device</b> 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:</p> <ul style="list-style-type: none"> <li>• is chimney or vent connected.</li> <li>• takes air for combustion from outside.</li> <li>• provides for a combustion system separate from occupied area atmosphere.</li> </ul> <p>18.5.2.2, 19.5.2.2</p>				

ID PREFIX		MET	NOT MET	N/A	REMARKS
K523	<p><b>HVAC – Suspended Unit Heaters</b></p> <p>Suspended unit heaters are permitted provided the following are met:</p> <ul style="list-style-type: none"> <li>• Not located in means of egress or in patient rooms.</li> <li>• Located high enough to be out of reach of people in the area.</li> <li>• Has a safety feature to stop fuel and shut down equipment if there is excessive temperature or ignition failure.</li> </ul> <p>18.5.2.3(1), 19.5.2.3(1)</p>				
K524	<p><b>HVAC – Direct-Vent Gas Fireplaces</b></p> <p>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).</p> <p>18.5.2.3(2), 19.5.2.3(2), NFPA 54</p>				
K525	<p><b>HVAC – Solid Fuel-Burning Fireplaces</b></p> <p>Solid fuel-burning fireplaces are permitted in other than patient sleeping areas provided:</p> <ul style="list-style-type: none"> <li>• Areas are separated by 1-hour fire resistance construction.</li> <li>• Fireplace complies with 9.2.2.</li> <li>• Fireplace enclosure resists breakage up to 650°F and has heat-tempered glass.</li> <li>• Room has supervised CO detection per 9.8.</li> </ul> <p>18.5.2.3(3) and 19.5.2.3(3)</p>				
K531	<p><b>Elevators</b></p> <p>2012 EXISTING</p> <p>Elevators comply with the provision of 9.4. Elevators are inspected and tested as specified in ASME A17.1, <i>Safety Code for Elevators and Escalators</i>. Firefighter’s Service is operated monthly with a written record. Existing elevators conform to ASME/ANSI A17.3, <i>Safety Code for Existing Elevators and Escalators</i>. 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.)</p> <p>19.5.3, 9.4.2, 9.4.3</p>				

ID PREFIX		MET	NOT MET	N/A	REMARKS
K531	<p>2012 NEW</p> <p>Elevators comply with the provision of 9.4. Elevators are inspected and tested as specified in ASME A17.1, <i>Safety Code for Elevators and Escalators</i>. Firefighter's Service is operated monthly with a written record. New elevators conform to ASME/ANSI A17.1, <i>Safety Code for Elevators and Escalators</i>, 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.)</p> <p>18.5.3, 9.4.2, 9.4.3</p>				
K532	<p><b>Escalators, Dumbwaiters, and Moving Walks</b></p> <p>2012 EXISTING</p> <p>Escalators, dumbwaiters, and moving walks comply with the provisions of 9.4.</p> <p>All existing escalators, dumbwaiters, and moving walks conform to the requirements of ASME/ANSI A17.3, <i>Safety Code for Existing Elevators and Escalators</i>.</p> <p>(Includes escalator emergency stop buttons and automatic skirt obstruction stop. For power dumbwaiters, includes hoistway door locking to keep doors closed except for floor where car is being loaded or unloaded.)</p> <p>19.5.3, 9.4.2.2</p>				
	<p>2012 NEW</p> <p>Escalators, dumbwaiters, and moving walks comply with the provisions of 9.4.</p> <p>18.5.3, 9.4.2.2</p>				

ID PREFIX		MET	NOT MET	N/A	REMARKS
K541	<p><b>Rubbish Chutes, Incinerators, and Laundry Chutes</b> 2012 EXISTING</p> <p>(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.</p> <p>(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.</p> <p>(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.)</p> <p>(4) Existing fuel-fed incinerators shall be sealed by fire resistive construction to prevent further use.</p> <p>19.5.4, 9.5, 8.4, NFPA 82</p>				
	<p>2012 NEW</p> <p>Rubbish chutes, incinerators, and laundry chutes shall comply with the provisions of Section 9.5, unless otherwise specified in 18.5.4.2.</p> <ul style="list-style-type: none"> <li>• The fire resistance rating of chute charging room shall not be required to exceed 1-hour.</li> <li>• Any rubbish chute or linen chute shall be provided with automatic extinguishing protection in accordance with Section 9.7.</li> <li>• Chutes shall discharge into a trash collection room used for no other purpose and shall be protected in accordance with 8.7.</li> </ul> <p>18.5.4.2, 8.7, 9.5, 9.7, NFPA 82</p>				
<b>SECTION 6 – RESERVED</b>					
<b>SECTION 7 – OPERATING FEATURES</b>					
K700	<p><b>Operating Features – Other</b></p> <p>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.</p>				

ID PREFIX		MET	NOT MET	N/A	REMARKS
K711	<p><b>Evacuation and Relocation Plan</b></p> <p>There is a written plan for the protection of all patients and for their evacuation in the event of an emergency.</p> <p>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.</p> <p>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</p>				
K712	<p><b>Fire Drills</b></p> <p>Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and 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. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms.</p> <p>18.7.1.4 through 18.7.1.7, 19.7.1.4 through 19.7.1.7</p>				



ID PREFIX		MET	NOT MET	N/A	REMARKS
K741	<p><b>Smoking Regulations</b></p> <p>Smoking regulations shall be adopted and shall include not less than the following provisions:</p> <ol style="list-style-type: none"> <li>(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.</li> <li>(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.</li> <li>(3) Smoking by patients classified as not responsible shall be prohibited.</li> <li>(4) The requirement of 18.7.4(3) shall not apply where the patient is under direct supervision.</li> <li>(5) Ashtrays of noncombustible material and safe design shall be provided in all areas where smoking is permitted.</li> <li>(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.</li> </ol> <p>18.7.4, 19.7.4</p>				
K751	<p><b>Draperies, Curtains, and Loosely Hanging Fabrics</b></p> <p>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.</p> <p>18.7.5.1, 18.3.5.11, 19.7.5.1, 19.3.5.11, 10.3.1</p>				

ID PREFIX		MET	NOT MET	N/A	REMARKS
K752	<p><b>Upholstered Furniture and Mattresses</b></p> <p>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.</p> <p>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.</p> <p>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.</p> <p>Newly introduced upholstered furniture and mattresses means purchased on or after the LSC final rule effective date.</p> <p>18.7.5.2, 18.7.5.4, 19.7.5.2, 19.7.5.4</p>				
K753	<p><b>Combustible Decorations</b></p> <p>Combustible decorations shall be prohibited unless one of the following is met:</p> <ul style="list-style-type: none"> <li>• Flame retardant or treated with approved fire-retardant coating that is listed and labeled for product.</li> <li>• Decorations meet NFPA 701.</li> <li>• Decorations exhibit heat release less than 100 kilowatts in accordance with NFPA 289.</li> <li>• 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(4) or 19.7.5.6(4).</li> <li>• The decorations in existing occupancies are in such limited quantities that a hazard of fire development or spread is not present.</li> </ul> <p>18.7.5.6, 19.7.5.6</p>				
K761	<p><b>Maintenance, Inspection &amp; Testing - Doors</b></p> <p>Fire doors assemblies are inspected and tested annually in accordance with NFPA 80 <i>Standard for Fire Doors and Other Opening Protectives</i>.</p> <p>Fire doors that are not located in required fire barriers, including corridor doors to patient rooms and smoke barrier doors, are routinely inspected as part of the facility maintenance program.</p> <p>Individuals performing the door inspection and testing have an understanding of the operating components of the doors. Written records of inspection and testing are maintained and are available for review.</p> <p>18.7.6, 19.7.6, 8.3.3.1 (LSC), 5.2, 5.2.3 (NFPA 80)</p>				

ID PREFIX		MET	NOT MET	N/A	REMARKS
K754	<p><b>Soiled Linen and Trash Containers</b></p> <p>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.</p> <p>Containers used solely for recycling are permitted to be excluded from the above requirements where each container is <math>\leq</math> 96 gal. unless attended, and containers for combustibles are labeled and listed as meeting FM Approval Standard 6921 or equivalent.</p> <p>18.7.5.7, 19.7.5.7</p>				
K771	<p><b>Engineer Smoke Control Systems</b></p> <p>2012 EXISTING</p> <p>When installed, engineered smoke control systems are tested in accordance with established engineering principles. Test documentation is maintained on the premises.</p> <p>19.7.7</p>				
	<p>2012 NEW</p> <p>When installed, engineered smoke control systems are tested in accordance with NFPA 92, <i>Standard for Smoke Control Systems</i>. Test documentation is maintained on the premises.</p> <p>18.7.7</p>				
K781	<p><b>Portable Space Heaters</b></p> <p>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).</p> <p>18.7.8, 19.7.8</p>				
K791	<p><b>Construction, Repair, and Improvement Operations</b></p> <p>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.</p> <p>18.7.9, 19.7.9, 4.6.10, 7.1.10.1</p>				

ID PREFIX		MET	NOT MET	N/A	REMARKS
<b>PART II – HEALTH CARE FACILITIES CODE REQUIREMENTS</b>					
K900	<b>Health Care Facilities Code - Other</b> 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	<b>Fundamentals – Building System Categories</b> 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	<b>Gas and Vacuum Piped Systems – Other</b> 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	<b>Gas and Vacuum Piped Systems – Categories</b> Medical gas, medical air, surgical vacuum, WAGD, and air supply systems are designated: <input type="checkbox"/> Category 1. Systems in which failure is likely to cause major injury or death. <input type="checkbox"/> Category 2. Systems in which failure is likely to cause minor injury. <input type="checkbox"/> Category 3. Systems in which failure is not likely to cause injury, but can cause discomfort. Deep sedation and general anesthesia are not to be administered 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	<b>Gas and Vacuum Piped Systems – Warning Systems</b> 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	<p><b>Gas and Vacuum Piped Systems – Central Supply System Identification and Labeling</b></p> <p>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."</p> <p>5.1.3.1, 5.2.3.1, 5.3.10 (NFPA 99)</p>				
K906	<p><b>Gas and Vacuum Piped Systems – Central Supply System Operations</b></p> <p>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.</p> <p>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)</p>				
K907	<p><b>Gas and Vacuum Piped Systems – Maintenance Program</b></p> <p>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.</p> <p>5.1.14.2.1, 5.1.14.2.2, 5.1.15, 5.2.14, 5.3.13.4.2 (NFPA 99)</p>				

ID PREFIX		MET	NOT MET	N/A	REMARKS
K908	<p><b>Gas and Vacuum Piped Systems – Inspection and Testing Operations</b></p> <p>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.</p> <p>5.1.14.2.3, B.5.2, 5.2.13, 5.3.13, 5.3.13.4 (NFPA 99)</p>				
K909	<p><b>Gas and Vacuum Piped Systems – Information and Warning Signs</b></p> <p>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.</p> <p>5.1.14.3, 5.1.11.1, 5.1.11.2, 5.2.11, 5.3.13.3, 5.3.11 (NFPA 99)</p>				
K910	<p><b>Gas and Vacuum Piped Systems – Modifications</b></p> <p>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.</p> <p>5.1.14.4.1, 5.1.14.4.6, 5.2.13, 5.3.13.4.3 (NFPA 99)</p>				
K911	<p><b>Electrical Systems – Other</b></p> <p>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.</p> <p>Chapter 6 (NFPA 99)</p>				
K912	<p><b>Electrical Systems – Receptacles</b></p> <p>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.</p> <p>If used in patient care room, ground-fault circuit interrupters (GFCI) are listed.</p> <p>6.3.2.2.6.2 (F), 6.3.2.2.4.2 (NFPA 99)</p>				

ID PREFIX		MET	NOT MET	N/A	REMARKS
K913	<p><b>Electrical Systems – Wet Procedure Locations</b></p> <p>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.</p> <p>6.3.2.2.8.4, 6.3.2.2.8.7, 6.4.4.2</p>				
K914	<p><b>Electrical Systems – Maintenance and Testing</b></p> <p>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.</p> <p>6.3.4 (NFPA 99)</p>				
K915	<p><b>Electrical Systems – Essential Electric System Categories</b></p> <p><input type="checkbox"/> 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.</p> <p><input type="checkbox"/> 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.</p> <p><input type="checkbox"/> 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.</p> <p>3.3.138, 6.3.2.2.10, 6.6.2.2.2, 6.6.3.1.1 (NFPA 99), TIA 12-3</p>				

ID PREFIX		MET	NOT MET	N/A	REMARKS
K916	<p><b>Electrical Systems – Essential Electric System Alarm Annunciator</b></p> <p>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.</p> <p>6.4.1.1.17, 6.4.1.1.17.5 (NFPA 99)</p>				
K917	<p><b>Electrical Systems – Essential Electric System Receptacles</b></p> <p>Electrical receptacles or cover plates supplied from the life safety and critical branches have a distinctive color or marking.</p> <p>6.4.2.2.6, 6.5.2.2.4.2, 6.6.2.2.3.2 (NFPA 99)</p>				
K918	<p><b>Electrical Systems – Essential Electric System Maintenance and Testing</b></p> <p>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.</p> <p>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, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations.</p> <p>6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70)</p>				



ID PREFIX		MET	NOT MET	N/A	REMARKS
K919	<p><b>Electrical Equipment – Other</b></p> <p>List in the REMARKS section any NFPA 99 Chapter 10, <i>Electrical Equipment</i>, 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)</p>				
K920	<p><b>Electrical Equipment – Power Cords and Extension Cords</b></p> <p>Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assemblies 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.</p> <p>10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5</p>				

ID PREFIX		MET	NOT MET	N/A	REMARKS
K921	<p><b>Electrical Equipment – Testing and Maintenance Requirements</b></p> <p>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.</p> <p>10.3, 10.5.2.1, 10.5.2.1.2, 10.5.2.5, 10.5.3, 10.5.6, 10.5.8</p>				
K922	<p><b>Gas Equipment – Other</b></p> <p>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.</p> <p>Chapter 11 (NFPA 99)</p>				

ID PREFIX		MET	NOT MET	N/A	REMARKS
K923	<p><b>Gas Equipment – Cylinder and Container Storage</b></p> <p><b>≥ 3,000 cubic feet</b> Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3.</p> <p><b>&gt; 300 but &lt;3,000 cubic feet</b> 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.</p> <p><b>≤ 300 cubic feet</b> 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.</p> <p>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".</p> <p>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.</p> <p>11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99)</p>				
K924	<p><b>Gas Equipment – Testing and Maintenance Requirements</b></p> <p>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.</p> <p>11.4.1.3, 11.5.1.3, 11.6.2.5, 11.6.2.6 (NFPA 99)</p>				

ID PREFIX		MET	NOT MET	N/A	REMARKS
K925	<p><b>Gas Equipment – Respiratory Therapy Sources of Ignition</b></p> <p>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.</p> <p>11.5.1.1, TIA 12-6 (NFPA 99)</p>				
K926	<p><b>Gas Equipment – Qualifications and Training of Personnel</b></p> <p>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.</p> <p>11.5.2.1 (NFPA 99)</p>				
K927	<p><b>Gas Equipment – Transfilling Cylinders</b></p> <p>Transfilling of oxygen from one cylinder to another is in accordance with CGA P-2.5, <i>Transfilling of High Pressure Gaseous Oxygen Used for Respiration</i>. 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).</p> <p>11.5.2.2 (NFPA 99)</p>				

ID PREFIX		MET	NOT MET	N/A	REMARKS
K928	<p><b>Gas Equipment – Labeling Equipment and Cylinders</b></p> <p>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.</p> <p>11.5.3.1 (NFPA 99)</p>				
K929	<p><b>Gas Equipment – Precautions for Handling Oxygen Cylinders and Manifolds</b></p> <p>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).</p> <p>11.6.2 (NFPA 99)</p>				
K930	<p><b>Gas Equipment – Liquid Oxygen Equipment</b></p> <p>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).</p> <p>11.7 (NFPA 99)</p>				
K931	<p><b>Hyperbaric Facilities</b></p> <p>All occupancies containing hyperbaric facilities comply with construction, equipment, administration, and maintenance requirements of NFPA 99. Chapter 14 (NFPA 99)</p>				
K932	<p><b>Features of Fire Protection – Other</b></p> <p>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.</p> <p>Chapter 15 (NFPA 99)</p>				

ID PREFIX		MET	NOT MET	N/A	REMARKS
K933	<p><b>Features of Fire Protection – Fire Loss Prevention in Operating Rooms</b></p> <p>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:</p> <ul style="list-style-type: none"> <li>• packaging is non-flammable.</li> <li>• applicators are in unit doses.</li> <li>• Preoperative "time-out" is conducted prior the initiation of any surgical procedure to verify:                             <ul style="list-style-type: none"> <li>○ application site is dry prior to draping and use of surgical equipment.</li> <li>○ pooling of solution has not occurred or has been corrected.</li> <li>○ solution-soaked materials have been removed from the OR prior to draping and use of surgical devices.</li> <li>○ policies and procedures are established outlining safety precautions related to the use of flammable germicide or antiseptic use.</li> </ul> </li> </ul> <p>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.</p> <p>15.13 (NFPA 99)</p>				

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

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

Provider Number  K1	Facility Name	Survey Date  *K4
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K6 DATE OF PLAN APPROVAL	K3 MULTIPLE CONSTRUCTION TOTAL NUMBER OF BUILDINGS _____ NUMBER OF THIS BUILDING _____	<input type="checkbox"/> A. BUILDING <input type="checkbox"/> B. WING <input type="checkbox"/> C. FLOOR <input type="checkbox"/> D. APARTMENT UNIT
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<p>LSC FORM INDICATOR</p> <table border="1" style="width:100%; border-collapse: collapse; margin-bottom: 10px;"> <tr><th align="center" colspan="3">HEALTH CARE FORM</th></tr> <tr><td style="width:10%;">12</td><td style="width:15%;">2786R</td><td style="width:75%;">2012 EXISTING</td></tr> <tr><td>13</td><td>2786R</td><td>2012 NEW</td></tr> </table> <table border="1" style="width:100%; border-collapse: collapse; margin-bottom: 10px;"> <tr><th align="center" colspan="3">AHCO FORM</th></tr> <tr><td>14</td><td>2786U</td><td>2012 EXISTING</td></tr> <tr><td>15</td><td>2786U</td><td>2012 NEW</td></tr> </table> <table border="1" style="width:100%; border-collapse: collapse; margin-bottom: 10px;"> <tr><th align="center" colspan="3">ICF/IID FORM</th></tr> <tr><td>16</td><td>2786V, W, X</td><td>2012 EXISTING</td></tr> <tr><td>17</td><td>2786V, W, X</td><td>2012 NEW</td></tr> </table> <p>*K7 <input type="checkbox"/> SELECT NUMBER OF FORM USED FROM ABOVE</p>	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	<p>COMPLETE IF ICF/IID IS SURVEYED UNDER CHAPTER 33, EXISTING</p> <p>SMALL (16 BEDS OR LESS)</p> <p>K8 <input type="checkbox"/> 1. PROMPT 2. SLOW 3. IMPRACTICAL</p> <hr/> <p>LARGE</p> <p>K8 <input type="checkbox"/> 4. PROMPT 5. SLOW 6. IMPRACTICAL</p> <hr/> <p>APARTMENT HOUSE</p> <p>K8 <input type="checkbox"/> 7. PROMPT 8. SLOW 9. IMPRACTICAL</p>
HEALTH CARE FORM																												
12	2786R	2012 EXISTING																										
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ICF/IID FORM																												
16	2786V, W, X	2012 EXISTING																										
17	2786V, W, X	2012 NEW																										

<p><i>(Check if K321 or K351 are marked as not applicable in the 2786 M, R, T, U, V, W, X, and Y.)</i></p> <p>K321: <input type="checkbox"/>      K351: <input type="checkbox"/></p>	<p>COMPLETE IF ICF/IID IS SURVEYED UNDER CHAPTER 33, EXISTING</p> <p>ENTER E – SCORE</p> <p>K5: <input type="checkbox"/> e.g. 2.5</p>
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\*K9 FACILITY MEETS LSC BASED ON *(Check all that Apply)*

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

<p>FACILITY DOES NOT MEET LSC</p> <p style="text-align: center;">B. <input type="checkbox"/></p>	<p>K0180</p> <table style="width:100%;"> <tr> <td style="text-align: center;">A. <input type="checkbox"/></td> <td style="text-align: center;">B. <input type="checkbox"/></td> <td style="text-align: center;">C. <input type="checkbox"/></td> </tr> <tr> <td style="text-align: center;">FULLY SPRINKLERED <small>(All required areas are sprinklered)</small></td> <td style="text-align: center;">PARTIALLY SPRINKLERED <small>(Not all required areas are sprinklered)</small></td> <td style="text-align: center;">NONE <small>(No sprinkler system)</small></td> </tr> </table>	A. <input type="checkbox"/>	B. <input type="checkbox"/>	C. <input type="checkbox"/>	FULLY SPRINKLERED <small>(All required areas are sprinklered)</small>	PARTIALLY SPRINKLERED <small>(Not all required areas are sprinklered)</small>	NONE <small>(No sprinkler system)</small>
A. <input type="checkbox"/>	B. <input type="checkbox"/>	C. <input type="checkbox"/>					
FULLY SPRINKLERED <small>(All required areas are sprinklered)</small>	PARTIALLY SPRINKLERED <small>(Not all required areas are sprinklered)</small>	NONE <small>(No sprinkler system)</small>					

\*MANDATORY




GOLDEN LIVINGCENTER - DELANO

433 COUNTY ROAD 30

DELANO, MN 55328

Smoke Barrier 

Fire Separation 

Required EXIT 

Fully Sprinkled



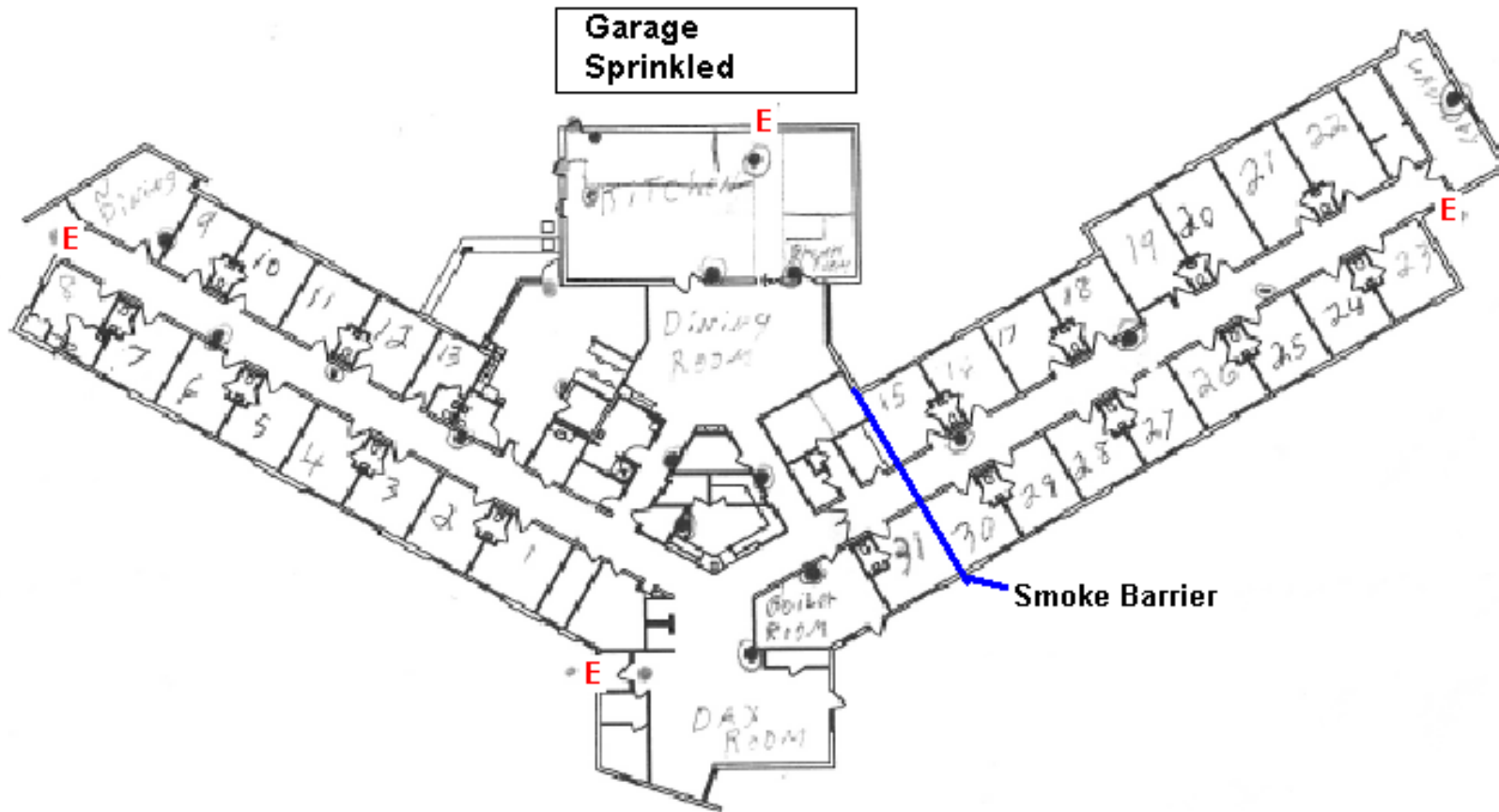
1st Floor

# ORIGINAL

For Fire Marshal Division File

GLS 07/19/12

JAA 03/25/2014









PROJECT NUMBER:	PROVIDER NAME	SURVEY DATE
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Administrator:	Phone Number:
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Email address:
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State Fire Inspector:
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These are preliminary findings only. A complete and final Statement of Deficiencies 2567 report will be provided by US Mail.

<input type="checkbox"/> At the time of this inspection, this facility was found to comply with the requirements of the 2012 Life Safety Code applicable to: <input type="checkbox"/> SNF/NF <input type="checkbox"/> Hospital <input type="checkbox"/> ICFMR <input type="checkbox"/> ASC Facilities participating in the Medicare/Medicaid programs.
<input type="checkbox"/> The following fire/life safety deficiencies were found during this inspection:

K TAG S & S	<input type="checkbox"/> Draft Summary of Deficiency(ies)	<input type="checkbox"/> Revisit	<input type="checkbox"/> Clearance
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