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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: OT1D
Facility ID: 00557

1. MEDICARE/MEDICAID PROVIDER NO.(L1) **245554**

2. STATE VENDOR OR MEDICAID NO. (L2) **792697900**

3. NAME AND ADDRESS OF FACILITY
(L3) **RENVILLA HEALTH CENTER**
(L4) **205 SOUTHEAST ELM AVENUE**
(L5) **RENVILLE, MN** (L6) **56284**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9) **07/01/2005**

6. DATE OF SURVEY **9/26/2016** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35) **09/30**

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

12.Total Facility Beds **56** (L18)

13.Total Certified Beds **56** (L17)

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

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

B.IIINotIinIComplianceIwithIProgram Requirements and/or Applied Waivers: * Code: **A** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	56			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Kathryn Serie, Unit Supervisor 10/20/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 10/20/2016 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION **04/01/1991** (L24)

23. LTC AGREEMENT BEGINNING DATE (L41)

24. LTC AGREEMENT ENDING DATE (L25)

25. LTC EXTENSION DATE: (L27)

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

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

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

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE: (L28)

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

30. REMARKS

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE (L33)

DETERMINATION APPROVAL

CMS Certification Number (CCN): 245554

October 20, 2016

Mr. Tennes Eeg, Administrator
Renvilla Health Center
205 Southeast Elm Avenue
Renville, MN 56284

Dear Mr. Eeg:

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 September 16, 2016 the above facility is certified for:

56 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 56 skilled nursing facility beds.

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

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

Please contact me if you have any questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
October 20, 2016

Mr. Tennes Eeg, Administrator
Renvilla Health Center
205 Southeast Elm Avenue
Renville, MN 56284

RE: Project Number S5554027

Dear Mr. Eeg:

On August 25, 2016, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on August 10, 2016. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required.

On September 26, 2016, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on October 4, 2016 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on August 10, 2016. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of September 16, 2016. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on August 10, 2016, effective September 16, 2016 and therefore remedies outlined in our letter to you dated August 25, 2016, will not be imposed.

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

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER 245554 Y1	MULTIPLE CONSTRUCTION A. Building B. Wing Y2	DATE OF REVISIT 9/26/2016 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
RENVILLA HEALTH CENTER	205 SOUTHEAST ELM AVENUE RENVILLE, MN 56284

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0176 Reg. # 483.10(n) LSC	Correction Completed 09/16/2016	ID Prefix F0279 Reg. # 483.20(d), 483.20(k)(1) LSC	Correction Completed 09/16/2016	ID Prefix F0309 Reg. # 483.25 LSC	Correction Completed 09/16/2016
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS) KS/kfd	DATE 10/20/2016	SIGNATURE OF SURVEYOR 03048	DATE 9/26/2016
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON 8/10/2016	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
245554	A. Building 01 - MAIN BUILDING 01 B. Wing	10/4/2016

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
RENVILLA HEALTH CENTER	205 SOUTHEAST ELM AVENUE RENVILLE, MN 56284

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix Reg. # NFPA 101 LSC K0018	Correction Completed 09/16/2016	ID Prefix Reg. # NFPA 101 LSC K0072	Correction Completed 09/16/2016	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
	TL/kfd	10/20/2016	37008	10/4/2016
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON
8/11/2016

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

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: OT1D
Facility ID: 00557

1. MEDICARE/MEDICAID PROVIDER NO.(L1) **245554**

2. STATE VENDOR OR MEDICAID NO. (L2) **792697900**

3. NAME AND ADDRESS OF FACILITY
(L3) **RENVILLA HEALTH CENTER**
(L4) **205 SOUTHEAST ELM AVENUE**
(L5) **RENVILLE, MN** (L6) **56284**

4. TYPE OF ACTION: **2** (L8)

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9) **07/01/2005**

6. DATE OF SURVEY **08/10/2016** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35) **09/30**

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

12.Total Facility Beds **56** (L18)

13.Total Certified Beds **56** (L17)

10.THE FACILITY IS CERTIFIED AS:
A. In Compliance With Program Requirements Compliance Based On:
___1. Acceptable POC

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

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

* Code: **B** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	56			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Wendy Willson, HFE NE II 09/15/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 09/20/2016 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

26. TERMINATION ACTION: (L30)

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

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

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE: (L28)

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

30. REMARKS

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE (L33)

DETERMINATION APPROVAL

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

CCN 24 5554

At the time of the Standard survey, the facility was not in substantial compliance with Federal Certification Regulations. This survey found the most serious deficiencies in the facility to widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F). Post Certification Revisit to follow. Please refer to the CMS 2567 along with the facility's plan of correction.

In addition to the Health and LSC surveys that were conducted, there was a Fire Safety Evaluation System (FSES) conducted on 9/13/2016. This facility, Renvilla Health Center, has achieved a passing score.

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
August 25, 2016

Mr. Tennes Eeg, Administrator
Renvilla Health Center
205 Southeast Elm Avenue
Renville, MN 56284

RE: Project Number S5554027

Dear Mr. Eeg:

On August 10, 2016, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

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

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

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

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

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

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

DEPARTMENT CONTACT

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

Kathryn Serie, Unit Supervisor
Health Regulation Division
Minnesota Department of Health
1400 E. Lyon Street
Marshall, Minnesota 56258
Email: Kathryn.serie@state.mn.us
Office: (507) 476-4233 Fax: (507) 537-7194

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by September 19, 2016, the Department of Health will impose the following remedy:

• State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by September 19, 2016 the following remedy will be imposed:

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

been affected by the deficient practice;

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

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

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

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

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

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by November 10, 2016 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the

identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by February 10, 2017 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

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

Mr. Tom Linhoff, Fire Safety Supervisor
Health Care Fire Inspections
Minnesota Department of Public Safety
State Fire Marshal Division
445 Minnesota Street, Suite 145
St. Paul, Minnesota 55101-5145

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

Feel free to contact me if you have questions.

Sincerely,

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245554	A. BUILDING ______ B. WING ______	08/10/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RENVILLA HEALTH CENTER	**205 SOUTHEAST ELM AVENUE RENVILLE, MN 56284**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 176 SS=D	483.10(n) RESIDENT SELF-ADMINISTER DRUGS IF DEEMED SAFE An individual resident may self-administer drugs if the interdisciplinary team, as defined by §483.20(d)(2)(ii), has determined that this practice is safe. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure 1 of 8 residents (R1) observed during medication administration was assessed for safe self-administration of medications. Findings include: R1's annual Minimum Data Set (MDS) assessment dated 6/7/16, indicated a Brief Interview for Mental Status (BIMS) score of 9 (moderate cognitive impairment).	F 176	R1 SAM reviewed and eMar updated on 8/15/16 with results of R1 needing to be observed taking her medications. All residents who wish to self-administer medications are potentially affected by this and SAM risk assessments will be reviewed to ensure completion. Results of SAM assessment will be noted on each resident s eMar so all staff administering medications are aware of SAM results. All staff responsible for administering	9/16/16

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		09/02/2016

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245554	A. BUILDING ______ B. WING ______	08/10/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RENVILLA HEALTH CENTER	**205 SOUTHEAST ELM AVENUE RENVILLE, MN 56284**

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F 176	Continued From page 1 R1's face sheet, dated 8/10/16, indicated a diagnosis of dementia without behavioral disturbances. R1's physician's orders, dated 7/26/16 did not indicate R1 could self-administer medications. R1's medication self-administration assessment dated 6/6/16, indicated R1 was physically and cognitively incapable of self-administration of medications, and her family had chosen to have nursing staff administer all medications. R1's 8/16 electronic medication administration record (MAR) dated 8/10/16, indicated she was to receive Norvasc (a blood pressure medication), aspirin, calcium with vitamin D, a multivitamin, Cozaar (a blood pressure medication), Miralax (a powdered laxative which is mixed with fluids) and lutein (for eyesight) daily at 8:00 a.m. During medication pass on 8/10/16, at 8:59 a.m. R1 was observed to receive a cup of medications containing her 8:00 a.m. medications as well as a glass of water containing the Miralax powder from trained medication aide (TMA)-A. TMA-A set the medications in front of R1, stated they would "check back in a while" and exited the room. When asked if R1 needed to be assessed for self-administration prior to being left alone with medications, TMA-A was not sure if a physician's order was required and stated R1 was usually "pretty good," about taking her medication. TMA-A left the room and continued with medication pass on another hallway off of R1's unit. Continuous observation revealed that R1 subsequently dropped her calcium on the floor while attempting to take her medications, calling out to a maintenance staff member (unidentified)	F 176	medications will be educated on topics that include SAM assessments, results of SAM assessments, and updating eMar with results of assessment. Audits will be done to ensure SAM assessments are completed for any resident who wishes to self-administer medications. eMar s will be audited to ensure SAM results are listed on eMar. A sample of resident charts will be reviewed weekly x 4weeks then a sample of resident charts will be audited per month x2months. A sample of medication passes will be audited weekly x4weeks to ensure SAM assessment is being followed. Results of Audit will be reviewed at Monthly QA meetings for any further recommendations. Staff will be educated as needed based on audit results. DON or Designee will be responsible for ensuring compliance. Completion Date: 9/16/2016	

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F 176	Continued From page 2 for help. Maintenance staff indicated they could not assist with medications, but would find someone to help her. During interview on 8/10/16, at 9:03 a.m. registered nurse (RN)-A stated she was not sure if R1 required orders or an assessment to be left alone with her medications, and stated R1 was usually good about taking them and they [TMA staff] "probably do" leave her alone with them. During interview on 8/10/16, at 12:53 p.m. the director of nursing (DON) indicated it would be her expectation that residents are not left alone with their medications, unless their assessment indicated it was safe. The policy, entitled Self Administration of Medication by Residents, revised 7/8/15 indicated the interdisciplinary team will define what self-administration will be for the resident, including the ability to administer oral medications after nurse set-up.	F 176		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are	F 279		9/16/16

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F 279	Continued From page 3 to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to develop a comprehensive care plan related to the use of an antidepressant medication (Zoloft) for 1 of 5 residents (R5) reviewed for unnecessary medications. Findings include: R5's diagnosis included major depression per Disease Diagnosis & Allergies form. R5's quarterly Minimum Data Set (MDS) dated 7/5/16, reflected R5 had received antidepressant medication and diagnosis of depression. The MDS further indicated R5 had mild depression with a Patient Health Questionnaire (PHQ-9) score of 9. Review of the signed physician orders dated 7/26/16, included an order for Zoloft 25 milligrams (mg) by mouth one time a day for major depression, with an original start date on physician orders dated 8/11/2015. R5's care plan last dated 7/28/16, lacked an individualized comprehensive care plan for	F 279	R5 s care plan was updated 08/10/16 to address current use of Zoloft, goals, and interventions for use of an antidepressant. All residents who are currently receiving an antidepressant will have their care plans reviewed to ensure their plan of care includes the use of an antidepressant. All licensed staff will be educated on ensuring that resident care plans are identifying resident s needs, problems, and concerns. Care plans of residents receiving antidepressants will be audited to ensure accuracy of residents plan of care. A sample of resident charts will be audited per week x4 weeks then a sample of charts will be audited per month x2 months, then as required thereafter. Results of Audit will be reviewed at monthly QA meetings for any further recommendations. Staff will be educated as needed based on audit results.	

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F 279	Continued From page 4 managing depression. During interview on 8/10/16, at 10:11 a.m. social worker (SW) and registered nurse (RN)-B, verified R5's diagnosis of depression and use of Zoloft was not addressed on the care plan and should have been. During interview on 8/10/16, at 10:40 a.m. director of nursing (DON) stated her expectation is that a care plan would include use of antidepressant medication. The facility's policy for Care Plans revised 7/27/16, indicated the plan of care includes identified resident needs, problems or concerns.	F 279	DON, MDS Coordinator, or designee will be responsible for ensuring compliance.	
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to monitor positioning and ensure proper leg support was provided and re-assess 1 of 1 resident (R19) reviewed who utilized a wheelchair for mobility. Findings include:	F 309	OT orders were received on 08/24/16 for R19 for OT to evaluate and treat for w/c positioning. All residents who are able to propel themselves in w/c may be potentially affected by this. All residents who self propel themselves in w/c will be assessed	9/16/16

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F 309	Continued From page 5 R19's quarterly Minimum Data Set (MDS) assessment dated 7/7/16, identified R19 had moderate cognitive impairment, and required extensive assistance of one with mobility to reach destinations. R19's face sheet indicated diagnoses of cerebral vascular disease (right sided weakness with uncontrolled movements) and osteoarthritis. The OT (occupational therapy)-Therapist Progress and Discharge Summary, dated 9/28/15 indicated R19 was able to self propel her wheelchair short distances with the strong left arm and leg. The Tissue Tolerance-Repositioning Observation form, dated 5/17/16 indicated R19 had a new ROHO cushion. R19's care plan dated 8/10/16, indicated R19 needed assistance with wheelchair mobility. The care plan identified interventions including: (1) staff assist if R19 feeling too tired or having difficulty, (2) ensure proper footwear worn, (3) ensure right foot pedal in use and (4) monitor for positioning in the wheelchair. When observed on 8/9/16, at 2:36 p.m. R19 was seated in her wheelchair, wearing slippers on both feet. The wheelchair had a thick air cushion (ROHO) in place. R19's left foot was not supported in the wheelchair, causing it to dangle towards the floor being suspended approximately 2-3 inches from the floor. The right leg was supported on a footrest with a calf pad. When observed again on 8/10/16, at 1:04 p.m. R19 was seated in the wheelchair with the left foot unsupported causing it to dangle. R19 was	F 309	to ensure proper w/c positioning. All licensed staff will be educated on proper positioning in w/c and if any change is done to a resident s w/c, the resident will be assessed for proper positioning. OT will also be involved to ensure proper positioning as well. W/C positioning audits will be completed on residents that propel themselves in wheelchair. A sample of residents will be audited per week x 4 weeks then a sample of residents will be audited per month x2 months then as required thereafter. Results of Audit will be reviewed at Monthly QA meetings for any further recommendations. Staff will be educated as needed based on audit results. DON or designee will be responsible for ensuring compliance.	

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F 309	Continued From page 6	F 309		

observed minutes later to have her right foot unsupported and dangling. Registered nurse (RN)-A assisted R19 to put leg back onto foot rest. RN-A asked R19 if her leg (left) gets tired from dangling, R19 responded, "yes it does". R19 then proceeded to try and touch the floor with her left foot and stated, "I can't even touch the floor". On 8/10/16 at 2:20 p.m. R19 was observed in her room seated in the wheelchair with her left leg dangling. R19's foot was not touching the floor.

When interviewed on 8/10/16, at 10:49 a.m. RN-A indicated R19 had received a new ROHO cushion, but was unsure of the date. RN-A further indicated R19 does not propel herself in the wheelchair anymore, but previously had been able. RN-A stated R19 was unable to move her right leg due to the stroke and had involuntary movements of the right arm and leg as a result.

When interviewed on 8/10/16, at 11:35 a.m. the certified occupational therapy assistant (COTA) reported she replaced the ROHO cushion and adjusted the right foot pedal to the right height. The COTA verified the left foot should not be dangling and should touch the floor or be supported on a foot rest. She further stated, "She [R19] would propel herself with her good leg". The COTA could not verify whether R19 had utilized a different wheelchair and further stated a seating evaluation was needed.

When interviewed on 8/10/16, at 1:00 p.m. the director of nursing (DON) reported R19 had a blister on the outside of the heel and a root cause analysis was done 8/2/16. A new footrest with a calf pad was applied to the wheelchair at that time which adequately supported the weak and

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F 309	Continued From page 7 spastic right leg. The DON verified the left leg was unsupported and dangling while the right leg was supported, and indicated a seating evaluation would be requested. A policy related to wheelchair positioning was requested, none was provided.	F 309		

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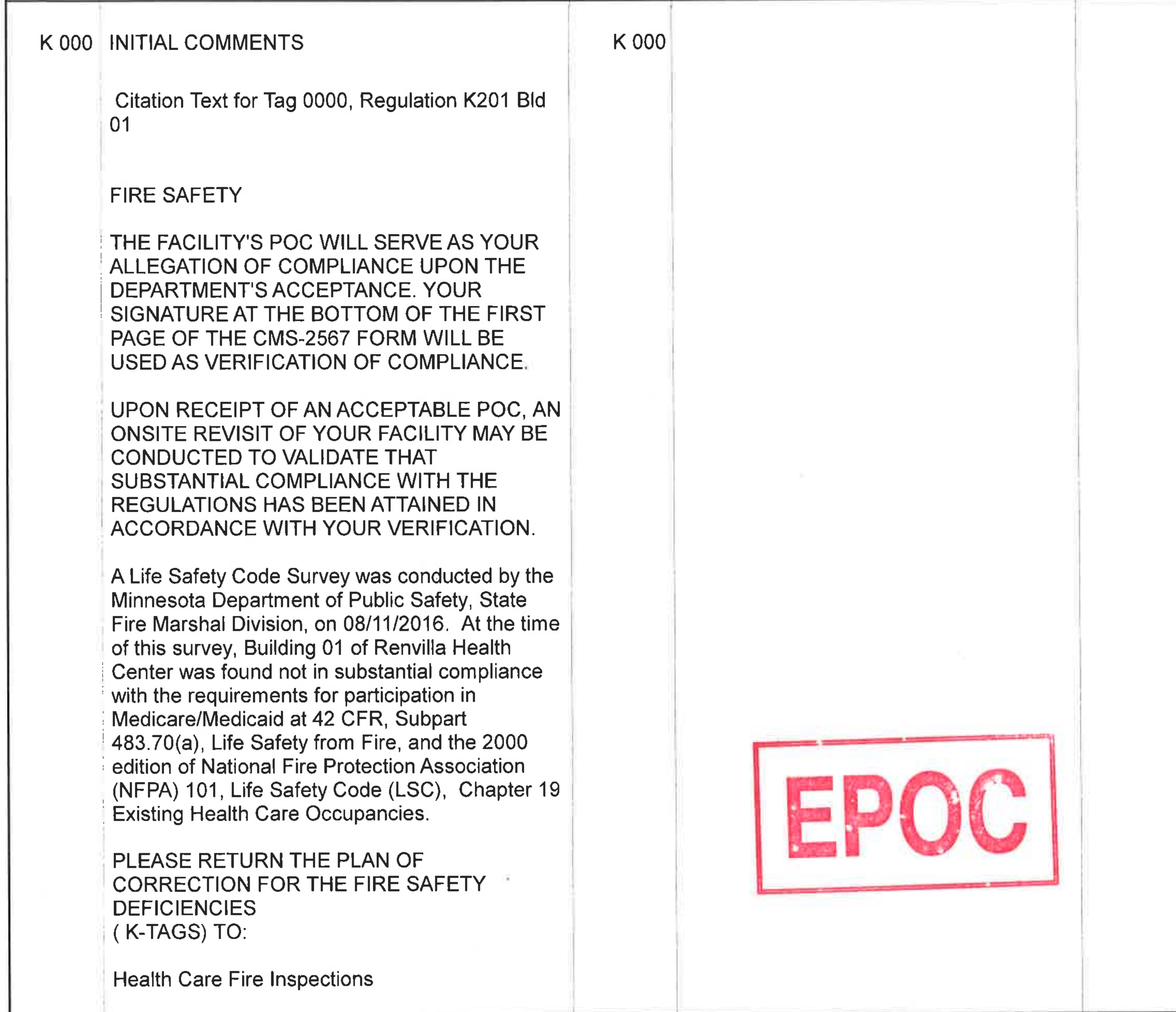

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K 000	INITIAL COMMENTS Citation Text for Tag 0000, Regulation K201 Bld 01 FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division, on 08/11/2016. At the time of this survey, Building 01 of Renvilla Health Center was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care Occupancies. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: Health Care Fire Inspections	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE
(X6) DATE: 09/02/2016

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K 000	Continued From page 1 State Fire Marshal Division 445 Minnesota St., Suite 145 St Paul, MN 55101-5145, or By email to: Marian.Whitney@state.mn.us <mailto:Marian.Whitney@state.mn.us> and Angela.Kappenman@state.mn.us <mailto:Angela.Kappenman@state.mn.us> THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency Building 01 of Renvilla Health Center was built in 1963, with building additions constructed in 1970 and 1993. This one-story with partial basement facility is fully fire sprinkler protected. The original building and both additions were determined to be of Type II(111) construction. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors which is monitored for automatic fire department notification. The facility has a licensed capacity of 56 beds and had a census of 56 at time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		

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K 018 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas shall be substantial doors, such as those constructed of 13/4 inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Clearance between bottom of door and floor covering is not exceeding 1 inch. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Doors shall be provided with a means suitable for keeping the door closed. 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 8.2.3.2.1. Roller latches are prohibited by CMS regulations in all health care facilities. 19.3.6.3 This STANDARD is not met as evidenced by: Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas shall be substantial doors, such as those constructed of 13/4 inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Clearance between bottom of door and floor covering is not exceeding 1 inch. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Doors shall be provided with a means suitable for keeping the door closed. 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 8.2.3.2.1. Roller latches are prohibited by CMS regulations in all health care facilities. 19.3.6.3	K 018	The Farmland Avenue doors are not part of the facility smoke compartment barrier separation and are convenience doors only. These Dutch-style doors will be removed due to the integrity of the door being compromised. The magnetic locks and all other hardware associated with the door will be removed and taken out of service. The Activities office door will be placed on a magnetic holder and set up to close upon fire detection. When the Farmland Avenue doors are removed, all residents will no longer be affected by the failing doors. Upon installation of the magnetic door	9/16/16

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K 018	Continued From page 3 On facility tour between 09:30 AM and 12:30 PM on August 11, 2016, based on observation and interview revealed that Findings include: 1.Fire rated doors in the Farmland ave wing did not close and latch when tested. Findings was observed by Ben Ryan Direct of Environment Services. 2. Door for office in the 1992 addition is part of the fire wall assembly and is not on a magnet holder. Door does have a door closer on it and did close when tested. This deficient practice could affect the safety of the residents within the smoke compartment. This deficient practice was confirmed by the Facility Maintenance Director (BR) at the time of discovery.	K 018	holder on the Activities office, all residents will be safe from the threat of smoke resulting from the door that did not have a magnetic door holder on it. A sample of corridor doors will be routinely inspected and the findings documented twice annually at minimum. Environmental Services will report audit findings at monthly QA meetings for a period of three months and as required thereafter. The Environmental Services Supervisor will be responsible for ensuring compliance.	
K 072 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Means of egress shall be continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. No furnishings, decorations, or other objects shall obstruct exits, access thereto, egress there from, or visibility thereof shall be in accordance with 7.1.10. 18.2.1, 19.2.1 This STANDARD is not met as evidenced by: Based on observation and a staff interview, the facility has corridor obstructions. In an emergency evacuation situation, these obstructions could interfere with the convenient and effective removal of residents, staff and visitors from the affected smoke compartment. FINDINGS INCLUDE:	K 072	Corrected pending FSES certification on 9/13/16.	9/16/16

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	245554	A. BUILDING **01 - MAIN BUILDING 01** B. WING	**08/11/2016**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RENVILLA HEALTH CENTER	**205 SOUTHEAST ELM AVENUE** **RENVILLE, MN 56284**

(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 072	Continued From page 4	K 072		

On 08/11/2016 between 09:30 AM and 12:30 PM, it was observed that:
A). Interior finish materials mounted on corridor walls in the 100 Wing and 200 Wing have diminished the width of these existing corridors. The original corridor width of 82 1/4-inches has been reduced at various points along the entire length of the corridors by as little as one-inch [between the aluminum siding on one side to the lap siding on the opposite side) to as much as 5 1/4-inches [between the faux tree trunk on one side to the frame of the faux window on the other side].;
B). Grab rails mounted on corridor walls of the 100 Wing and 200 Wing project between 5-inches and 5 1/2-inches into the corridors, as measured from the original gypsum wall board to the outside edges of the wooden rails.

NOTE This K-Tag will not need to be corrected if an FSES can establish that the facility has an overall level of fire safety equivalent to that required by the Life Safety Code, 2000 edition.

This deficient practice was confirmed by the Facility Maintenance Director (BR) at the time of discovery.

REPORT OF CONSULTANT FSES FINDINGS

RenVilla Health Center

205 Southeast Elm Avenue

Renville, MN 56284

Provider No. 245554

Date of Survey: September 13, 2016

Prepared by:
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September 14, 2016

Mr. Ben Ryan
Director of Environmental Services
RenVilla Health Center
205 Southeast Elm Avenue
Renville, Minnesota 56284

RE: FSES at RenVilla Health Center

Dear Mr. Ryan:

Enclosed please find the survey information relating to the fire safety evaluation of RenVilla Health Center, 205 Southeast Elm Avenue in Renville, MN conducted on 09/13/2016. This evaluation was conducted in accordance with the Fire Safety Evaluation System (FSES) specified in Chapter 4 of NFPA 101A(01), *Guide to Alternative Approaches to Life Safety*.

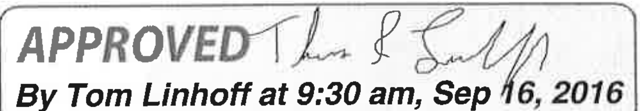
As you're aware, the FSES is a rating system designed to evaluate the level of fire/life safety in health care facilities and serves as a method to demonstrate alternative compliance with the 2000 edition of the *Life Safety Code*® (NFPA 101). An FSES was made necessary in this case because of a corridor obstruction (K072) deficiency cited during a state fire/life safety recertification survey conducted on 08/11/2016.

A review of the Statement of Deficiencies from the 08/11/2016 recertification survey revealed that RenVilla Health Center was surveyed as two buildings: Building 01 – Main Building (consisting of the 1963 original building and 1970 and 1993 additions) and Building 02 – 2008 resident wing addition. Buildings 01 and 02 are separated by construction having a fire resistance rating of at least 2 hours. Because the deficiency that triggered the FSES was cited in Building 01 (Main Building), this FSES covers that building only.

The following factors served as the basis for this evaluation:

- Because the original building and additions were constructed prior to 03/11/2003, RenVilla Health Center was considered an existing building.
- RenVilla Health Center is one story in height and has a partial basement. For purposes of this FSES, the two occupied building levels were divided into three (3) separate smoke zones.
- For purposes of this FSES, it was assumed that the basement level does not involve resident housing, treatment or customary access.

Based on the conditions found during an on-site visit made to the facility on 09/13/2016, all four parameters in Table 7 of the FSES worksheets, ZONE FIRE SAFETY EQUIVALENCY EVALUATION, in all three (3) zones evaluated were found to have a score of zero or greater. *Fire Safety Resources* finds, therefore, that RenVilla Health Center has achieved a passing FSES score.



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

Wishing you a safe day!

Robert L. Imholte
President/Chief Manager
Fire Safety Resources, LLC

Enclosures

RLI/rli

FIRE SAFETY EVALUATION

Name of Facility: RenVilla Health Center
Address: 205 Southeast Elm Avenue, Renville, MN 56284
Phone: 320-329-4373
Licensed capacity: 56
Census at time of survey: 52

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

What follows is a report on the findings of a fire safety evaluation of the above-named facility that was conducted during an on-site visit to the facility between 0845 hours and 1600 hours on 09/13/2016. This evaluation was conducted in accordance with the Fire Safety Evaluation System (FSES) specified in Chapter 4 of NFPA 101A(01), *Guide to Alternative Approaches to Life Safety*. Based on this evaluation, RenVilla Health Center has achieved a passing score on the FSES.

In addition to observations made and documentation review conducted during the 09/13/2016 on-site visit, the findings outlined herein are based on:

- Information provided by Mr. Ben Ryan, Director of Environmental Services; and
- A review of the Statement of Deficiencies (Form CMS-2567) from a fire/life safety recertification survey conducted on 08/11/2016.

Initial Comments:
A review of the Statement of Deficiencies from the 08/11/2016 fire/life safety recertification survey revealed that RenVilla Health Center was surveyed as two buildings: Building 01 – Main Building, consisting of the 1963 original building and 1970 and 1993 additions, and Building 02, the 2008 resident wing addition. Buildings 01 and 02 are separated by construction having a fire resistance rating of at least 2 hours. Because the deficiency that triggered the FSES was cited in Building 01 (Main Building), this FSES covers that building only.

At the east end of the building's 400 Wing, the nursing home is connected to a senior assisted living facility called East Ridge Court. At the south end of the basement level of the 1993 addition there is a connection to an adjacent senior living building called Meadows on Main. Because neither East Ridge Court nor Meadows on Main is used for purposes of housing, treatment or customary access by the facility's residents and because both are separated from the nursing home by 2-hour-rated fire barriers, those buildings were not included in this evaluation.

Building 01 (Main Building) was originally constructed in 1963 as a single story building with no basement. In 1970 a one-story addition with no basement was added to the south of the original building. In 1993 another single story addition with basement was added to the south of the 1970 addition.

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

It was determined that the original building and 1970 addition were constructed of masonry exterior walls and a precast concrete plank roof deck. Due to the presence of protected steel structural members supporting the roof deck, the original building and 1970 addition were assigned a Type II(111) construction type in accordance with NFPA 220(99), Sec. 3-2 and Table 3-1.

In past FSES evaluations, the 1993 addition was also assigned a Type II(111) construction type. A check of the attic during this evaluation, however, revealed that the building has a roof of wood truss construction. Based on this discovery, the construction type for this addition was downgraded to Type V(111) for purposes of this evaluation. In past evaluations, the south and east walls of the South Dining Room/Chapel area were assumed to be of masonry construction. Based on the discovery of the wood roof and because the actual construction of these walls could not be confirmed at the time of the on-site visit, these walls were assumed to be constructed of protected wood frame construction for purposes of this evaluation to ensure that the FSES addresses the "worst-case scenario".

The 1993 addition appears to be separated from the 1970 addition by a 2-hour-rated fire barrier wall; however, this could not be confirmed at the time of the on-site visit. Four (4) door openings were found in this wall. Two of the openings were found to be protected by 90-minute fire-rated door assemblies. The other two openings were found to be protected by 60-minute fire-rated door assemblies. Because 60-minute fire-rated door assemblies do not meet the requirements of NFPA 101(00), Sec. 8.2.3.2.3.1 for opening protectives in 2-hour fire barriers, this wall could not be treated as a 2-hour separation between the 1993 addition and the remainder of the building. As a result, in accordance with the provisions of NFPA 101(00), Sec. 8.2.1, the construction type of the entire building – i.e. Building 01 (Main Building) – was downgraded to a Type V(111) construction type for purposes of this evaluation.

The facility has a fire alarm system with automatic smoke detection in the corridors and spaces open to corridors, which is monitored for automatic fire department notification. Based on documentation review, the fire alarm system is being inspected, tested and maintained in accordance with NFPA 72.

The facility is protected throughout by a supervised, wet-pipe automatic fire sprinkler system, with the exception of the administrative area located in the 1970 addition, which is protected by a dry-pipe automatic fire sprinkler system. Based on documentation review, the fire sprinkler system is being inspected, tested and maintained in accordance with NFPA 25.

For purposes of this FSES, the various building levels in Building 01 (Main Building) were divided into three (3) separate smoke zones as follows:

Zone 1 – Basement
Zone 2 – Main Level 100/200/300 Wings
Zone 3 – Main Level 400/500/Administrative Wings

This report is intended to serve as an explanation of the scores entered on Tables 1, 4 and 8 of the FSES worksheets (i.e. Forms CMS-2786T) for the facility as it was found on 09/13/2016. The score assigned to each item is noted in brackets ([ ]). It must be noted that numbers were rounded to the nearest tenth of a point and that measurements of over one-half inch were rounded to the nearest inch. To ensure that the FSES addresses the "worst-case scenario", the product of the multiplication in Table 3B (i.e. value of "R") was rounded up to the nearest whole number. Code references are provided where appropriate. Codes referenced include the 2001 edition of NFPA 101A and the 2000 edition of the *Life Safety Code*® (NFPA 101).

With the exception of Table 8, which applies to all zones, this narrative will address each of the three (3) zones separately.

All Zones – TABLE 8. FACILITY FIRE SAFETY REQUIREMENTS WORKSHEET

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

- Building utilities and heating and air conditioning systems appeared to be in conformance with applicable requirements.
- No incinerator or space heaters were found.
- The facility's evacuation plan and fire drill records were reviewed and appeared to be in order.
- The facility's smoking regulations were reviewed and appeared to be in order. RenVilla Health Center is a smoke-free facility.
- Documentation review showed all draperies, cubicle curtains, upholstered furniture, mattresses and decorations to be in accordance with NFPA 101(00), Sec. 19.7.5. Documentation was provided certifying that the plantscapes (e.g faux trees) installed in the facility's public spaces are flame resistant when tested in accordance with NFPA 701.
- Portable fire extinguishers, EXIT signage and emergency lighting appeared to be provided in accordance with applicable requirements.

Zone 1 – Basement Level:

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

TABLE 4. SAFETY PARAMETERS and SAFETY PARAMETER VALUES

1. Construction [Score: -2]:
   The building was assigned a Type V(111) construction type.
2. Interior Finish (Corridors and Exits) [Score: +3]:
   Walls in corridors and exits were found to be of masonry and plaster. Documentation was provided certifying that the vinyl wall coverings and acoustical ceiling tile carry a Class A (25 or less) flame spread rating.
3. Interior Finish (Rooms) [Score: +3]:
   Walls in rooms were found to be of masonry and plaster. Documentation was provided certifying that the acoustical ceiling tile carries a Class A (25 or less) flame spread rating.
4. Corridor Partitions/Walls [Score: +2]:
   Corridor walls were determined to be constructed of masonry and plaster and extend to the floor deck above.
5. Doors to Corridor [Score: +1]:
   Corridor doors in this zone were found to be a mixture of 60-minute and 90-minute fire-rated doors in steel frames.

6. Zone Dimensions [Score: +1]:
   This zone measures approximately 90 feet in length and has no dead ends.
7. Vertical Openings [Score: +2]:
   Vertical openings were found to be enclosed with construction providing a minimum 1-hour fire resistance.
8. Hazardous Areas [Score: 0]:
   No hazardous area deficiencies were found in this zone.
9. Smoke Control [Score: 0]:
   This score was assigned per Footnote *c* to this Table and the fact that residents are not allowed on this level.
10. Emergency Movement Routes [Score: 0]:
    There are two remote exits from this zone.
11. Manual Fire Alarm [Score: +2]:
    Manual fire alarm pull stations are provided in accordance with NFPA 101(00), Sec. 19.3.4.2. The fire alarm system is monitored by Rapid Response.
12. Smoke Detection and Alarm [Score: +2]:
    System-connected automatic smoke detectors were found in the egress corridor
13. Automatic Sprinklers [Score: +10]:
    The building is protected throughout by a supervised automatic fire sprinkler system.

Zone 2 – Main Level 100/200/300 Wings:

TABLE 1. OCCUPANY RISK PARAMETER FACTORS

1. Resident Mobility (*M*) [Value assigned = 3.2]: It was reported that some residents in the zone may need assistance with evacuation.
2. Patient Density (*D*) [Value assigned = 1.5]: There is bed capacity for up to 17 residents in this zone. The zone also contains an OT/PT/Speech Therapy space. It was reported that there are a maximum of three (3) residents in this space at any one time.
3. Zone Location (*L*) [Value assigned = 1.1]: This zone is less than one-half floor height above grade.
4. Ratio of Patients to Attendants (*T*) [Value assigned = 1.2]: It was reported that there are two (2) staff persons on duty in this zone on the night shift.
5. Patient Average Age (*A*) [Value assigned = 1.2]: Residents housed in this zone average over 65 years of age.

TABLE 4. SAFETY PARAMETERS and SAFETY PARAMETER VALUES

1. Construction [Score: 0]:
   The building was assigned a Type V(111) construction type.
2. Interior Finish (Corridors and Exits) [Score: +3]:
   Walls in corridors and exits were found to be of masonry and plaster. Documentation was provided certifying that wall and ceiling finishes [i.e. aesthetics ("home front facades") installed in the corridors of the 100 and 200 wings and acoustical ceiling tile] carry a Class A (25 or less) flame spread rating.
3. Interior Finish (Rooms) [Score: +3]:
   While most walls and ceilings in rooms were found to be plaster, acoustical ceiling tile was found in some rooms. Documentation was provided certifying that the acoustical ceiling tile carries a Class A (25 or less) flame spread rating.

4. Corridor Partitions/Walls [Score: 0]:
   Three 23" x 52" glass vision panels in metal frames were found in the corridor wall at the main lobby. As a result, the corridor walls were graded as "<½ hour".
5. Doors to Corridor [Score: +1]:
   Corridor doors in this zone were found to be of 1¾-inch-thick solid wood construction in steel frames.
6. Zone Dimensions [Score: -2]:
   This zone measures approximately 220 feet in length and has no dead ends.
7. Vertical Openings [Score: 0]:
   This score was assigned per Footnote *e* to this Table – Parameter 1 is based on a first floor zone. Although there is no basement beneath this portion of the building, it is separated from the adjacent zone with construction providing less than 1-hour fire resistance. Vertical openings in the adjacent zone were found to be enclosed with construction providing a minimum 1-hour fire resistance.
8. Hazardous Areas [Score: 0]:
   No hazardous area deficiencies were found in this zone.
9. Smoke Control [Score: 0]:
   A smoke barrier serves this zone.
10. Emergency Movement Routes [Score: -2]:
    A review of the Statement of Deficiencies from the 08/11/2016 fire/life safety recertification survey revealed that RenVilla Health Center was cited for the presence of interior finish materials mounted on the corridor walls in the 100 and 200 Wings that diminished the width of the existing corridors by up to 5¼ inches (see data tag K072). In addition, grab rails mounted on the corridor walls of the 100 and 200 Wings were cited for projecting 5 inches to 5½ inches into the corridors as measured from the original corridor wall to the outside edges of the wooden rails. While the resulting clear width of the corridors still exceeds the 4 ft clear width required by NFPA 101(00), Sec. 19.2.3.3, the reduction of the original 82¼-inch corridor width does not meet the requirements of NFPA 101(00), Sec. 4.6.7.
11. Manual Fire Alarm [Score: +2]:
    Manual fire alarm pull stations are provided in accordance with NFPA 101(00), Sec. 19.3.4.2. The fire alarm system is monitored by Rapid Response.
12. Smoke Detection and Alarm [Score: +2]:
    System-connected automatic smoke detectors were found in the egress corridor and spaces open to the corridor.
13. Automatic Sprinklers [Score: +10]:
    The building is protected throughout by a supervised automatic fire sprinkler system.

Zone 3 – Main Level 400/500/Administrative Wings:

TABLE 1. OCCUPANY RISK PARAMETER FACTORS

1. Resident Mobility (*M*) [Value assigned = 3.2]: It was reported that some residents in the zone may need assistance with evacuation.
2. Patient Density (*D*) [Value assigned = 2.0]: This score was assigned to ensure that the FSES addresses the "worst-case scenario". There is bed capacity for up to eight (8) nursing home residents and one (1) assisted living resident in the 400 Wing and up to eight (8) nursing home residents in the 500 Wing. There are no sleeping rooms in the Administrative Wing, but it contains the facility's South Dining Room, chapel, Spiritual Care space, beauty shop and administrative offices, which are available for use by all residents. The zone also includes the dayroom space between the 400 and 500 Wings. It was reported that the Administrative Wing is not used by residents after 8:00PM.

3. Zone Location (*L*) [Value assigned = 1.1]: This zone is less than one-half floor height above grade.
4. Ratio of Patients to Attendants (*T*) [Value assigned = 1.5]: It was reported that there is one (1) staff person on duty in this zone on the night shift.
5. Patient Average Age (*A*) [Value assigned = 1.2]: Residents using this zone average over 65 years of age.

TABLE 4. SAFETY PARAMETERS and SAFETY PARAMETER VALUES

1. Construction [Score: 0]:
   The building was assigned a Type V(111) construction type.
2. Interior Finish (Corridors and Exits) [Score: +3]:
   Documentation was provided certifying that:
   - Wall and ceiling finishes (i.e. vinyl wall coverings and acoustical ceiling tile) in corridors and exits carry a Class A (25 or less) flame spread rating, and
   - The wood wainscot on the corridor walls at the 500 Wing was treated with Flame Control Fire Retardant Clear Satin Varnish to achieve a Class A (25 or less) flame spread rating.
3. Interior Finish (Rooms) [Score: +3]:
   Walls in rooms were found to be of gypsum wallboard and/or plaster. Acoustical ceiling tile was found throughout the Administrative Wing and in some spaces in the 400 and 500 Wings. Documentation was provided certifying that the acoustical ceiling tile carries a Class A (25 or less) flame spread rating.
4. Corridor Partitions/Walls [Score: 0]:
   Walls in corridors and exits were found to be constructed of glazed block, gypsum wallboard and/or plaster. Three 23" x 42" glass vision panels in metal frames were found in the corridor wall at the South Dining Room. In addition, a 22" x 42" glass vision panel and 19" x 79" glass sidelight were found in the corridor wall at the Business Office. As a result, the corridor walls were graded as "<½ hour".
5. Doors to Corridor [Score: +1]:
   Corridor doors in this zone were found to be a mixture of 1¾-inch-thick solid wood construction and 20-minute-rated door assemblies in steel frames.

   Surveyor Note: *A review of the Statement of Deficiencies from the 08/11/2016 fire/life safety recertification survey revealed that:*
   1. *The facility was cited because the fire-rated cross-corridor doors in the Farmland Avenue (500) Wing did not close and latch when tested (see data tag K018, Item 1). Based on observation and interview of the Director of Environmental Services, it was confirmed that these doors are not part of a required fire or smoke barrier and have been removed.*
   2. *The facility was cited because the 60-minute fire-rated door into the Activities Office is part of a fire barrier and is equipped with an automatic closer, but was not on a magnetic holder (see data tag K018, Item 2). Based on observation and interview of the Director of Environmental Services, it was confirmed that this door is now equipped with a magnetic holder.*

6. Zone Dimensions [Score: -2]:
   This zone measures approximately 200 feet in length and has no dead ends.
7. Vertical Openings [Score: 0]:
   This score was assigned per Footnote *e* to this Table – Parameter 1 is based on a first floor zone. Vertical openings were found to be enclosed with construction providing a minimum 1-hour fire resistance.
8. Hazardous Areas [Score: 0]:
   No hazardous area deficiencies were found in this zone.

9. Smoke Control [Score: 0]:
   A smoke barrier serves this zone.
10. Emergency Movement Routes [Score: 0]:
    There are multiple emergency movement routes from this zone.
11. Manual Fire Alarm [Score: +2]:
    Manual fire alarm pull stations are provided in accordance with NFPA 101(00), Sec. 19.3.4.2. The fire alarm system is monitored by Rapid Response.
12. Smoke Detection and Alarm [Score: +2]:
    System-connected Automatic smoke detectors were found in the egress corridor and spaces open to the corridor.
13. Automatic Sprinklers [Score: +10]:
    The building is protected throughout by a supervised automatic fire sprinkler system.

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

It must be noted that the scores and values assigned to the parameters in the tables on the FSES worksheets are based on conditions found between 0845 hours and 1600 hours on 09/13/2016. Any changes in those conditions after this date could affect those scores and values, either positively or negatively. Again, based on this evaluation, RenVilla Health Center **has** achieved a passing score on the FSES. No other assessment of the level of safety in this facility is either intended or implied by *Fire Safety Resources, LLC.*

APPROVED [signature]
By Tom Linhoff at 9:26 am, Sep 16, 2016

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

Form Approved
OMB Exempt

ZONE 1 OF 3 ZONES

FIRE/SMOKE ZONE* EVALUATION WORKSHEET FOR HEALTH CARE FACILITIES

2000 LIFE SAFETY CODE

FACILITY RenVilla Health Center	BUILDING 01-Main Building
ZONE(S) EVALUATED Basement	
PROVIDER/VENDOR NO. 245554	DATE OF SURVEY 09/13/2016

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

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

TABLE 1. OCCUPANCY RISK PARAMETER FACTORS

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

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

TABLE 2. OCCUPANCY RISK FACTOR CALCULATION

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

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

TABLE 3A. (NEW BUILDINGS)

	F		R
1.0 X		=	

TABLE 3B. (EXISTING BUILDINGS)

	F		R
0.6 X	1.6	=	1.0

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

SURVEYOR SIGNATURE [signature], Fire Safety Resources, LLC	TITLE President	DATE 09/14/2016
FIRE AUTHORITY SIGNATURE	TITLE	DATE

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

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

TABLE 4.

Safety Parameters	Safety Parameters Values						
1. Construction	Combustible Types III, IV, and V				NonCombustible Types I and II		
Floor or Zone	000	111	200	211 + 2HH	000	111	222, 332, 433
First	-2	0	-2	0	0	2	2
Second	-7	-2	-4	-2	-2	2	4
Third	-9	-7	-9	-7	-7	2	4
4th and Above	-13	-7	-13	-7	-9	-7	4
2. Interior Finish (Corridors and Exits)	Class C	Class B	Class A				
	-5(0)[f]	0(3)[f]	3				
3. Interior Finish (Rooms)	Class C	Class B	Class A				
	-3(1)[f]	1(3)[f]	3				
4. Corridor Partitions/Walls	None or Incomplete	<½ hour	≥½ to <1 hour	≥1 hour			
	-10(0)[a]	0	1(0)[a]	2(0)[a]			
5. Doors to Corridor	No Door	<20 min FPR	≥20 min FPR	≥20 min FPR and Auto Clos.			
	-10	0	1(0)[d]	2(0)[d]			
6. Zone Dimensions	Dead End			No Dead Ends >30 ft and Zone Length Is			
	>100 ft*	>50 ft to 100 ft	30 ft to 50 ft	>150 ft	100 ft to 150 ft	<100 ft	
	-6(0)[b]	-4(0)[b]	-2(0)[b]	-2(0)[c]	0	1	
7. Vertical Openings	Open 4 or More Floors	Open 2 or 3 Floors	Enclosed with Indicated Fire Resist.				
			<1 hr	≥1 hr to <2 hr	≥2 hr		
	-14	-10	0	2(0)[e]	3(0)[e]		
8. Hazardous Areas	Double Deficiency		Single Deficiency		No Deficiencies		
	In Zone	Outside Zone	In Zone	In Adjacent Zone			
	-11	-5	-6	-2	0		
9. Smoke Control	No Control	Smoke Barrier Serves Zone	Mech. Assisted Systems by Zone				
	-5(0)[c]	0	3				
10. Emergency Movement Routes	<2 Routes	Multiple Routes					
		Deficient	W/O Horizontal Exit(s)	Horizontal Exit(s)	Direct Exit(s)		
	-8	-2	0	1	5		
11. Manual Fire Alarm	No Manual Fire Alarm		Manual Fire Alarm				
			W/O F.D. Conn.	W/F.D. Conn			
	-4		1	2			
12. Smoke Detection and Alarm	None	Corridor Only	Rooms Only	Corridor and Habit. Spaces	Total Spaces In Zone		
	0(3)[g]	2(3)[g]	3(3)[g]	4	5		
13. Automatic Sprinklers	None	Corridor and Habit. Space	Entire Building				
	0	8	10				

NOTE:

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

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

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

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

For SI units: 1 ft = 0.3048 m

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

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

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

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

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

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

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

TABLE 5. INDIVIDUAL SAFETY EVALUATIONS

Safety Parameters	Containment Safety (S_1)	Extinguishment Safety (S_2)	People Movement Safety (S_3)	General Safety (S_4)
1. Construction	-2	-2		-2
2. Interior Finish (Corr. and Exit)	3		3	3
3. Interior Finish (Rooms)	3			3
4. Corridor Partitions/Walls	2			2
5. Doors to Corridor	1		1	1
6. Zone Dimensions			1	1
7. Vertical Openings	2		2	2
8. Hazardous Areas	0	0		0
9. Smoke Control			0	0
10. Emergency Movement Routes			0	0
11. Manual Fire Alarm		2		2
12. Smoke Detection and Alarm		2	2	2
13. Automatic Sprinklers	10	10	10 ÷ 2 = 5	10
Total Value	S_1= 19	S_2= 12	S_3= 14	S_4= 24

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

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

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

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

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

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

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

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

TABLE 7. ZONE FIRE SAFETY EQUIVALENCY EVALUATION					Yes	No
Containment Safety (S_1)	minus	Mandatory Containment (S_a)	≥ 0	S_1 19 − S_a 9 = C 10	√	
Extinguishment Safety (S_2)	minus	Mandatory Extinguishment (S_b)	≥ 0	S_2 12 − S_b 6 = E 6	√	
People Movement Safety (S_3)	minus	Mandatory People Movement (S_c)	≥ 0	S_3 14 − S_c 3 = P 11	√	
General Safety (S_4)	minus	Occupancy Risk (R)	≥ 0	S_4 24 − R 1 = G 23	√	

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

CONCLUSIONS

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

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

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

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

APPROVED By Tom Linhoff at 9:26 am, Sep 16, 2016

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

Form Approved
OMB Exempt

ZONE 2 OF 3 ZONES

FIRE/SMOKE ZONE* EVALUATION WORKSHEET FOR HEALTH CARE FACILITIES

2000 LIFE SAFETY CODE

FACILITY RenVilla Health Center	BUILDING 01 - Main Building
ZONE(S) EVALUATED Main Level 100/200/300 Wings	
PROVIDER/VENDOR NO. 245554	DATE OF SURVEY 09/13/2016

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

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

TABLE 1. OCCUPANCY RISK PARAMETER FACTORS

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

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

TABLE 2. OCCUPANCY RISK FACTOR CALCULATION

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

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

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

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

SURVEYOR SIGNATURE [signature] Fire Safety Resources, LLC	TITLE President	DATE 09/14/2016
FIRE AUTHORITY SIGNATURE	TITLE	DATE

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

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

TABLE 4.

Safety Parameters	Safety Parameters Values						
1. Construction	Combustible Types III, IV, and V				NonCombustible Types I and II		
Floor or Zone	000	111	200	211 + 2HH	000	111	222, 332, 433
First	-2	0	-2	0	0	2	2
Second	-7	-2	-4	-2	-2	2	4
Third	-9	-7	-9	-7	-7	2	4
4th and Above	-13	-7	-13	-7	-9	-7	4
2. Interior Finish (Corridors and Exits)	Class C	Class B	Class A				
	-5(0)[f]	0(3)[f]	3				
3. Interior Finish (Rooms)	Class C	Class B	Class A				
	-3(1)[f]	1(3)[f]	3				
4. Corridor Partitions/Walls	None or Incomplete	<1/2 hour	≥1/2 to <1 hour	≥1 hour			
	-10(0)[a]	0	1(0)[a]	2(0)[a]			
5. Doors to Corridor	No Door	<20 min FPR	≥20 min FPR	≥20 min FPR and Auto Clos.			
	-10	0	1(0)[d]	2(0)[d]			
6. Zone Dimensions	Dead End			No Dead Ends >30 ft and Zone Length Is			
	>100 ft	>50 ft to 100 ft	30 ft to 50 ft	>150 ft	100 ft to 150 ft	<100 ft	
	-6(0)[b]	-4(0)[b]	-2(0)[b]	-2(0)[c]	0	1	
7. Vertical Openings	Open 4 or More Floors	Open 2 or 3 Floors	Enclosed with Indicated Fire Resist.				
			<1 hr	≥1 hr to <2 hr	≥2 hr		
	-14	-10	0	2(0)[e]	3(0)[e]		
8. Hazardous Areas	Double Deficiency		Single Deficiency		No Deficiencies		
	In Zone	Outside Zone	In Zone	In Adjacent Zone			
	-11	-5	-6	-2	0		
9. Smoke Control	No Control	Smoke Barrier Serves Zone	Mech. Assisted Systems by Zone				
	-5(0)[c]	0	3				
10. Emergency Movement Routes	<2 Routes	Multiple Routes					
		Deficient	W/O Horizontal Exit(s)	Horizontal Exit(s)	Direct Exit(s)		
	-8	-2	0	1	5		
11. Manual Fire Alarm	No Manual Fire Alarm		Manual Fire Alarm				
			W/O F.D. Conn.	W/F.D. Conn			
	-4		1	2			
12. Smoke Detection and Alarm	None	Corridor Only	Rooms Only	Corridor and Habit. Spaces	Total Spaces In Zone		
	0(3)[g]	2(3)[g]	3(3)[g]	4	5		
13. Automatic Sprinklers	None	Corridor and Habit. Space	Entire Building				
	0	8	10				

NOTE:
[a] Use (0) where parameter 5 is -10.
[b] Use (0) where parameter 10 is -8.
[c] Use (0) on floor with fewer than 31 patients (existing buildings only)
[d] Use (0) where parameter 4 is -10.
[e] Use (0) where Parameter 1 is based on first floor zone or on an unprotected type of construction (columns marked "000" or "200")
[f] Use ( ) if the area of Class B or C interior finish in the corridor and exit or room is protected by automatic sprinklers and Parameter 13 is 0; use ( ) if the room with existing Class C interior finish is protected by automatic sprinklers, Parameter 4 is greater than or equal to 1, and Parameter 13 is 0.
[g] Use this value in addition to Parameter 13 if the entire zone is protected with quick-response automatic sprinklers.

For SI units: 1 ft = 0.3048 m

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

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

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

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

TABLE 5. INDIVIDUAL SAFETY EVALUATIONS

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

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

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

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

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

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

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

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

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

TABLE 7. ZONE FIRE SAFETY EQUIVALENCY EVALUATION						Yes	No
Containment Safety (S_1)	minus	Mandatory Containment (S_a)	≥ 0	S_1 17 − S_a 5 = C 12		√	
Extinguishment Safety (S_2)	minus	Mandatory Extinguishment (S_b)	≥ 0	S_2 14 − S_b 4 = E 10		√	
People Movement Safety (S_3)	minus	Mandatory People Movement (S_c)	≥ 0	S_3 7 − S_c 1 = P 6		√	
General Safety (S_4)	minus	Occupancy Risk (R)	≥ 0	S_4 17 − R 5 = G 12		√	

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

CONCLUSIONS

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

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

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

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

APPROVED By Tom Linhoff at 9:27 am, Sep 16, 2016

Form Approved
OMB Exempt

ZONE 3 OF 3 ZONES

FIRE/SMOKE ZONE* EVALUATION WORKSHEET FOR HEALTH CARE FACILITIES

2000 LIFE SAFETY CODE

FACILITY: RenVilla Health Center	BUILDING: 01-Main Building
ZONE(S) EVALUATED: Main Level 400/500/Administrative Wings	
PROVIDER/VENDOR NO.: 245554	DATE OF SURVEY: 09/13/2016

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

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

TABLE 1. OCCUPANCY RISK PARAMETER FACTORS

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

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

TABLE 2. OCCUPANCY RISK FACTOR CALCULATION

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

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

TABLE 3A. (NEW BUILDINGS)

	F		R
1.0 X		=	

TABLE 3B. (EXISTING BUILDINGS)

	F		R
0.6 X	12.7	=	7.6 = 8

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

SURVEYOR SIGNATURE: [signature] Fire Safety Resources, LLC	TITLE: President	DATE: 09/14/2016
FIRE AUTHORITY SIGNATURE	TITLE	DATE

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

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

TABLE 4.

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

Safety Parameters	Safety Parameters Values					
2. Interior Finish (Corridors and Exits)	Class C	Class B	Class A			
	-5(0)[f]	0(3)[f]	3			
3. Interior Finish (Rooms)	Class C	Class B	Class A			
	-3(1)[f]	1(3)[f]	3			
4. Corridor Partitions/Walls	None or Incomplete	<½ hour	≥½ to <1 hour	≥1 hour		
	-10(0)[a]	0	1(0)[a]	2(0)[a]		
5. Doors to Corridor	No Door	<20 min FPR	≥20 min FPR	≥20 min FPR and Auto Clos.		
	-10	0	1(0)[d]	2(0)[d]		
6. Zone Dimensions	Dead End			No Dead Ends >30 ft and Zone Length Is		
	>100 ft	>50 ft to 100 ft	30 ft to 50 ft	>150 ft	100 ft to 150 ft	<100 ft
	-6(0)[b]	-4(0)[b]	-2(0)[b]	-2(0)[c]	0	1
7. Vertical Openings	Open 4 or More Floors	Open 2 or 3 Floors	Enclosed with Indicated Fire Resist.			
			<1 hr	≥1 hr to <2 hr	≥2 hr	
	-14	-10	0	2(0)[e]	3(0)[e]	
8. Hazardous Areas	Double Deficiency		Single Deficiency		No Deficiencies	
	In Zone	Outside Zone	In Zone	In Adjacent Zone		
	-11	-5	-6	-2	0	
9. Smoke Control	No Control	Smoke Barrier Serves Zone	Mech. Assisted Systems by Zone			
	-5(0)[c]	0	3			
10. Emergency Movement Routes	<2 Routes	Multiple Routes				
		Deficient	W/O Horizontal Exit(s)	Horizontal Exit(s)	Direct Exit(s)	
	-8	-2	0	1	5	
11. Manual Fire Alarm	No Manual Fire Alarm		Manual Fire Alarm			
			W/O F.D. Conn.	W/F.D. Conn		
	-4		1	2		
12. Smoke Detection and Alarm	None	Corridor Only	Rooms Only	Corridor and Habit. Spaces	Total Spaces In Zone	
	0(3)[g]	2(3)[g]	3(3)[g]	4	5	
13. Automatic Sprinklers	None	Corridor and Habit. Space	Entire Building			
	0	8	10			

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

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

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

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

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

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

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

For SI units: 1 ft = 0.3048 m

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

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

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

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

TABLE 5. INDIVIDUAL SAFETY EVALUATIONS

Safety Parameters	Containment Safety (S_1)	Extinguishment Safety (S_2)	People Movement Safety (S_3)	General Safety (S_4)
1. Construction	0	0		0
2. Interior Finish (Corr. and Exit)	3		3	3
3. Interior Finish (Rooms)	3			3
4. Corridor Partitions/Walls	0			0
5. Doors to Corridor	1		1	1
6. Zone Dimensions			-2	-2
7. Vertical Openings	0		0	0
8. Hazardous Areas	0	0		0
9. Smoke Control			0	0
10. Emergency Movement Routes			0	0
11. Manual Fire Alarm		2		2
12. Smoke Detection and Alarm		2	2	2
13. Automatic Sprinklers	10	10	10 ÷ 2 = 5	10
Total Value	S_1= 17	S_2= 14	S_3= 9	S_4= 19

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

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

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

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

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

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

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

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

TABLE 7. ZONE FIRE SAFETY EQUIVALENCY EVALUATION					Yes	No
Containment Safety (S_1)	minus	Mandatory Containment (S_a)	≥ 0	S_1 17 - S_a 5 = C 12	√	
Extinguishment Safety (S_2)	minus	Mandatory Extinguishment (S_b)	≥ 0	S_2 14 - S_b 4 = E 10	√	
People Movement Safety (S_3)	minus	Mandatory People Movement (S_c)	≥ 0	S_3 9 - S_c 1 = P 8	√	
General Safety (S_4)	minus	Occupancy Risk (R)	≥ 0	S_4 19 - R 8 = G 11	√	

TABLE 8. FACILITY FIRE SAFETY REQUIREMENTS WORKSHEET

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

CONCLUSIONS

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

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

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

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

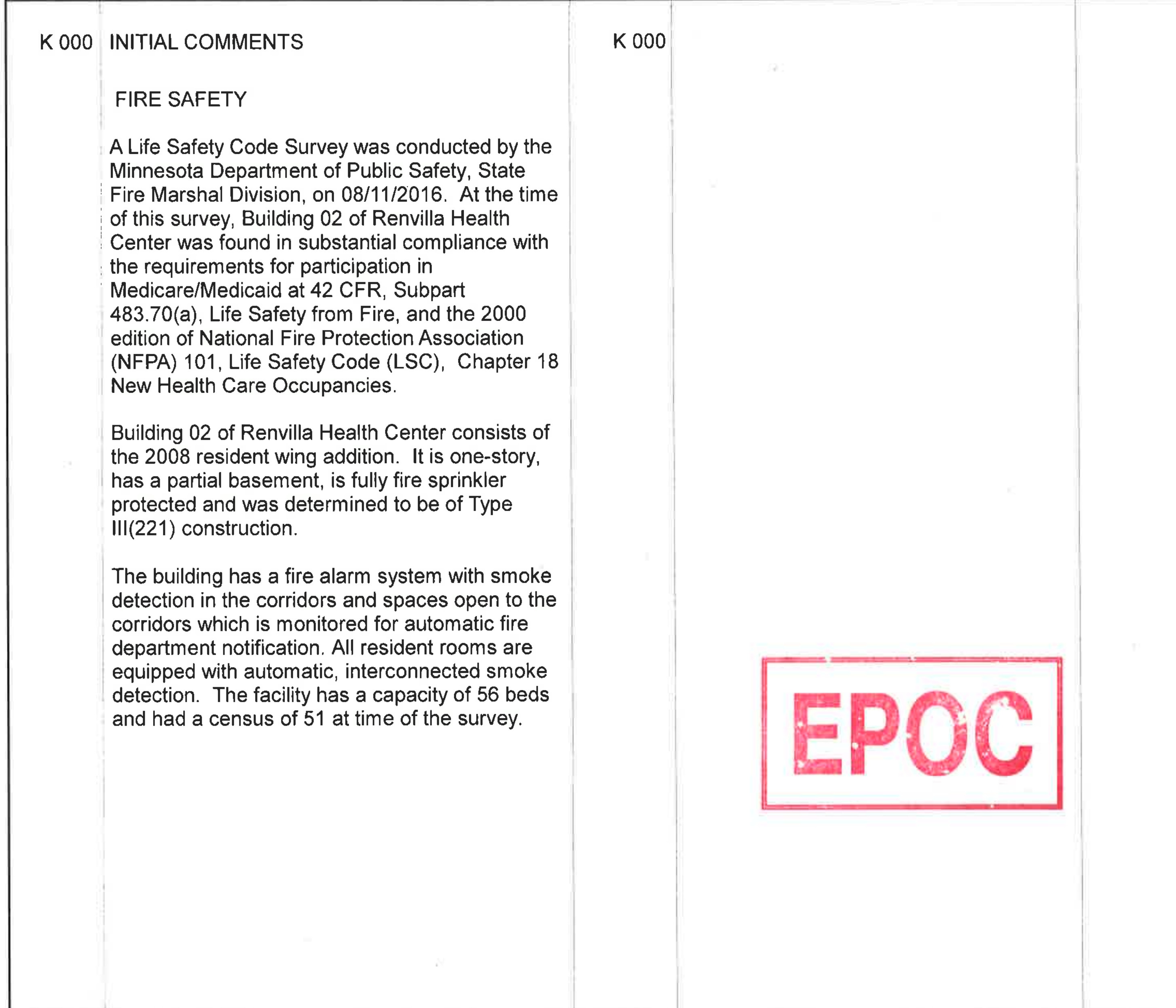
DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

F5554024

PRINTED: 09/15/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245554	A. BUILDING **02 - 2008 RESIDENT WING ADDITION** B. WING ______	**08/11/2016**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RENVILLA HEALTH CENTER	**205 SOUTHEAST ELM AVENUE** **RENVILLE, MN 56284**



(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS FIRE SAFETY A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division, on 08/11/2016. At the time of this survey, Building 02 of Renvilla Health Center was found in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 18 New Health Care Occupancies. Building 02 of Renvilla Health Center consists of the 2008 resident wing addition. It is one-story, has a partial basement, is fully fire sprinkler protected and was determined to be of Type III(221) construction. The building has a fire alarm system with smoke detection in the corridors and spaces open to the corridors which is monitored for automatic fire department notification. All resident rooms are equipped with automatic, interconnected smoke detection. The facility has a capacity of 56 beds and had a census of 51 at time of the survey.	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 09/02/2016

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

Protecting, maintaining and improving the health of all Minnesotans

Electronically submitted

August 25, 2016

Mr. Tennes Eeg, Administrator
Renvilla Health Center
205 Southeast Elm Avenue
Renville, MN 56284

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5554027

Dear Mr. Eeg:

The above facility was surveyed on August 8, 2016 through August 10, 2016 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health, Health Regulation Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

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

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

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed

in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute after the statement, "This Rule is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.

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

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should contact Kathryn Serie, Unit Supervisor at (507) 476-4233.

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

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

Please feel free to call me with any questions.

Sincerely,

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245554	A. BUILDING ______ B. WING ______	08/10/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RENVILLA HEALTH CENTER	**205 SOUTHEAST ELM AVENUE RENVILLE, MN 56284**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 176 SS=D	483.10(n) RESIDENT SELF-ADMINISTER DRUGS IF DEEMED SAFE An individual resident may self-administer drugs if the interdisciplinary team, as defined by §483.20(d)(2)(ii), has determined that this practice is safe. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure 1 of 8 residents (R1) observed during medication administration was assessed for safe self-administration of medications. Findings include: R1's annual Minimum Data Set (MDS) assessment dated 6/7/16, indicated a Brief Interview for Mental Status (BIMS) score of 9 (moderate cognitive impairment).	F 176	R1 SAM reviewed and eMar updated on 8/15/16 with results of R1 needing to be observed taking her medications. All residents who wish to self-administer medications are potentially affected by this and SAM risk assessments will be reviewed to ensure completion. Results of SAM assessment will be noted on each resident s eMar so all staff administering medications are aware of SAM results. All staff responsible for administering	9/16/16

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		09/02/2016

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

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F 176	Continued From page 1 R1's face sheet, dated 8/10/16, indicated a diagnosis of dementia without behavioral disturbances. R1's physician's orders, dated 7/26/16 did not indicate R1 could self-administer medications. R1's medication self-administration assessment dated 6/6/16, indicated R1 was physically and cognitively incapable of self-administration of medications, and her family had chosen to have nursing staff administer all medications. R1's 8/16 electronic medication administration record (MAR) dated 8/10/16, indicated she was to receive Norvasc (a blood pressure medication), aspirin, calcium with vitamin D, a multivitamin, Cozaar (a blood pressure medication), Miralax (a powdered laxative which is mixed with fluids) and lutein (for eyesight) daily at 8:00 a.m. During medication pass on 8/10/16, at 8:59 a.m. R1 was observed to receive a cup of medications containing her 8:00 a.m. medications as well as a glass of water containing the Miralax powder from trained medication aide (TMA)-A. TMA-A set the medications in front of R1, stated they would "check back in a while" and exited the room. When asked if R1 needed to be assessed for self-administration prior to being left alone with medications, TMA-A was not sure if a physician's order was required and stated R1 was usually "pretty good," about taking her medication. TMA-A left the room and continued with medication pass on another hallway off of R1's unit. Continuous observation revealed that R1 subsequently dropped her calcium on the floor while attempting to take her medications, calling out to a maintenance staff member (unidentified)	F 176	medications will be educated on topics that include SAM assessments, results of SAM assessments, and updating eMar with results of assessment. Audits will be done to ensure SAM assessments are completed for any resident who wishes to self-administer medications. eMar s will be audited to ensure SAM results are listed on eMar. A sample of resident charts will be reviewed weekly x 4weeks then a sample of resident charts will be audited per month x2months. A sample of medication passes will be audited weekly x4weeks to ensure SAM assessment is being followed. Results of Audit will be reviewed at Monthly QA meetings for any further recommendations. Staff will be educated as needed based on audit results. DON or Designee will be responsible for ensuring compliance. Completion Date: 9/16/2016	

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F 176	Continued From page 2 for help. Maintenance staff indicated they could not assist with medications, but would find someone to help her. During interview on 8/10/16, at 9:03 a.m. registered nurse (RN)-A stated she was not sure if R1 required orders or an assessment to be left alone with her medications, and stated R1 was usually good about taking them and they [TMA staff] "probably do" leave her alone with them. During interview on 8/10/16, at 12:53 p.m. the director of nursing (DON) indicated it would be her expectation that residents are not left alone with their medications, unless their assessment indicated it was safe. The policy, entitled Self Administration of Medication by Residents, revised 7/8/15 indicated the interdisciplinary team will define what self-administration will be for the resident, including the ability to administer oral medications after nurse set-up.	F 176		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are	F 279		9/16/16

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F 279	Continued From page 3 to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to develop a comprehensive care plan related to the use of an antidepressant medication (Zoloft) for 1 of 5 residents (R5) reviewed for unnecessary medications. Findings include: R5's diagnosis included major depression per Disease Diagnosis & Allergies form. R5's quarterly Minimum Data Set (MDS) dated 7/5/16, reflected R5 had received antidepressant medication and diagnosis of depression. The MDS further indicated R5 had mild depression with a Patient Health Questionnaire (PHQ-9) score of 9. Review of the signed physician orders dated 7/26/16, included an order for Zoloft 25 milligrams (mg) by mouth one time a day for major depression, with an original start date on physician orders dated 8/11/2015. R5's care plan last dated 7/28/16, lacked an individualized comprehensive care plan for	F 279	R5 s care plan was updated 08/10/16 to address current use of Zoloft, goals, and interventions for use of an antidepressant. All residents who are currently receiving an antidepressant will have their care plans reviewed to ensure their plan of care includes the use of an antidepressant. All licensed staff will be educated on ensuring that resident care plans are identifying resident s needs, problems, and concerns. Care plans of residents receiving antidepressants will be audited to ensure accuracy of residents plan of care. A sample of resident charts will be audited per week x4 weeks then a sample of charts will be audited per month x2 months, then as required thereafter. Results of Audit will be reviewed at monthly QA meetings for any further recommendations. Staff will be educated as needed based on audit results.	

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F 279	Continued From page 4 managing depression. During interview on 8/10/16, at 10:11 a.m. social worker (SW) and registered nurse (RN)-B, verified R5's diagnosis of depression and use of Zoloft was not addressed on the care plan and should have been. During interview on 8/10/16, at 10:40 a.m. director of nursing (DON) stated her expectation is that a care plan would include use of antidepressant medication. The facility's policy for Care Plans revised 7/27/16, indicated the plan of care includes identified resident needs, problems or concerns.	F 279	DON, MDS Coordinator, or designee will be responsible for ensuring compliance.	
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to monitor positioning and ensure proper leg support was provided and re-assess 1 of 1 resident (R19) reviewed who utilized a wheelchair for mobility. Findings include:	F 309	OT orders were received on 08/24/16 for R19 for OT to evaluate and treat for w/c positioning. All residents who are able to propel themselves in w/c may be potentially affected by this. All residents who self propel themselves in w/c will be assessed	9/16/16

F 309 Continued From page 5

R19's quarterly Minimum Data Set (MDS) assessment dated 7/7/16, identified R19 had moderate cognitive impairment, and required extensive assistance of one with mobility to reach destinations. R19's face sheet indicated diagnoses of cerebral vascular disease (right sided weakness with uncontrolled movements) and osteoarthritis.

The OT (occupational therapy)-Therapist Progress and Discharge Summary, dated 9/28/15 indicated R19 was able to self propel her wheelchair short distances with the strong left arm and leg.

The Tissue Tolerance-Repositioning Observation form, dated 5/17/16 indicated R19 had a new ROHO cushion.

R19's care plan dated 8/10/16, indicated R19 needed assistance with wheelchair mobility. The care plan identified interventions including: (1) staff assist if R19 feeling too tired or having difficulty, (2) ensure proper footwear worn, (3) ensure right foot pedal in use and (4) monitor for positioning in the wheelchair.

When observed on 8/9/16, at 2:36 p.m. R19 was seated in her wheelchair, wearing slippers on both feet. The wheelchair had a thick air cushion (ROHO) in place. R19's left foot was not supported in the wheelchair, causing it to dangle towards the floor being suspended approximately 2-3 inches from the floor. The right leg was supported on a footrest with a calf pad.

When observed again on 8/10/16, at 1:04 p.m. R19 was seated in the wheelchair with the left foot unsupported causing it to dangle. R19 was

F 309

to ensure proper w/c positioning.

All licensed staff will be educated on proper positioning in w/c and if any change is done to a resident s w/c, the resident will be assessed for proper positioning. OT will also be involved to ensure proper positioning as well.

W/C positioning audits will be completed on residents that propel themselves in wheelchair. A sample of residents will be audited per week x 4 weeks then a sample of residents will be audited per month x2 months then as required thereafter. Results of Audit will be reviewed at Monthly QA meetings for any further recommendations. Staff will be educated as needed based on audit results.

DON or designee will be responsible for ensuring compliance.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245554	A. BUILDING ______ B. WING ______	08/10/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RENVILLA HEALTH CENTER	**205 SOUTHEAST ELM AVENUE RENVILLE, MN 56284**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 6 observed minutes later to have her right foot unsupported and dangling. Registered nurse (RN)-A assisted R19 to put leg back onto foot rest. RN-A asked R19 if her leg (left) gets tired from dangling, R19 responded, "yes it does". R19 then proceeded to try and touch the floor with her left foot and stated, "I can't even touch the floor". On 8/10/16 at 2:20 p.m. R19 was observed in her room seated in the wheelchair with her left leg dangling. R19's foot was not touching the floor. When interviewed on 8/10/16, at 10:49 a.m. RN-A indicated R19 had received a new ROHO cushion, but was unsure of the date. RN-A further indicated R19 does not propel herself in the wheelchair anymore, but previously had been able. RN-A stated R19 was unable to move her right leg due to the stroke and had involuntary movements of the right arm and leg as a result. When interviewed on 8/10/16, at 11:35 a.m. the certified occupational therapy assistant (COTA) reported she replaced the ROHO cushion and adjusted the right foot pedal to the right height. The COTA verified the left foot should not be dangling and should touch the floor or be supported on a foot rest. She further stated, "She [R19] would propel herself with her good leg". The COTA could not verify whether R19 had utilized a different wheelchair and further stated a seating evaluation was needed. When interviewed on 8/10/16, at 1:00 p.m. the director of nursing (DON) reported R19 had a blister on the outside of the heel and a root cause analysis was done 8/2/16. A new footrest with a calf pad was applied to the wheelchair at that time which adequately supported the weak and	F 309		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245554	A. BUILDING ______ B. WING ______	08/10/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 309	Continued From page 7 spastic right leg. The DON verified the left leg was unsupported and dangling while the right leg was supported, and indicated a seating evaluation would be requested. A policy related to wheelchair positioning was requested, none was provided.	F 309		