



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

November 4, 2021

Administrator
Park Health A Villa Center
4415 West 36 1/2 Street
Saint Louis Park, MN 55416

RE: CCN: 245083
Cycle Start Date: October 14, 2021

Dear Administrator:

On October 14, 2021, a 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 constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

ELECTRONIC PLAN OF CORRECTION (ePoC)

Within **ten (10) calendar days** after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved.

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

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.
- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

The state agency may, in lieu of an onsite revisit, determine correction and compliance by accepting the facility's ePoC if the ePoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

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

- Denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417);
- Civil money penalty (42 CFR 488.430 through 488.444).
- Termination of your facility's Medicare and/or Medicaid agreement (488.456(b)).

DEPARTMENT CONTACT

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

**Jamie Perell, Unit Supervisor
Metro B District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
85 East Seventh Place, Suite 220
P.O. Box 64900
Saint Paul, Minnesota 55164-0900
Email: jamie.perell@state.mn.us
Office: (651) 245-8094**

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, 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, a Post Certification Revisit (PCR), of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

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

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

If substantial compliance with the regulations is not verified by January 14, 2022 (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).

In addition, if substantial compliance with the regulations is not verified by April 14, 2022 (six months after the identification of noncompliance) your provider agreement will be terminated. 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.

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.

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

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

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

This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: https://mdhprovidercontent.web.health.state.mn.us/lrc_idr.cfm

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

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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:

**William Abderhalden, Fire Safety Supervisor
Deputy State Fire Marshal
Health Care/Corrections Supervisor – Interim
Minnesota Department of Public Safety
445 Minnesota Street, Suite 145
St. Paul, MN 55101-5145
Cell: (507) 361-6204
Email: william.abderhalden@state.mn.us
Fax: (651) 215-0525**

Feel free to contact me if you have questions.

Sincerely,



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



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November 4, 2021

Administrator
Park Health A Villa Center
4415 West 36 1/2 Street
Saint Louis Park, MN 55416

Re: State Nursing Home Licensing Orders
Event ID: POE511

Dear Administrator:

The above facility was surveyed on October 11, 2021 through October 14, 2021 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. 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 or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 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 and/or statute 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 order 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 https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html. The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered 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 or rule after the statement, "This MN Requirement 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.

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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 immediately contact:

Jamie Perell, Unit Supervisor
Metro B District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
85 East Seventh Place, Suite 220
P.O. Box 64900
Saint Paul, Minnesota 55164-0900
Email: jamie.perell@state.mn.us
Office: (651) 245-8094

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

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00129	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 10/14/2021
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NAME OF PROVIDER OR SUPPLIER PARK HEALTH A VILLA CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 4415 WEST 36 1/2 STREET SAINT LOUIS PARK, MN 55416
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(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) COMPLETE DATE
2 000	<p>Initial Comments</p> <p>*****ATTENTION*****</p> <p>NH LICENSING CORRECTION ORDER</p> <p>In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.</p> <p>Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected.</p> <p>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.</p> <p>INITIAL COMMENTS: On 10/11/21, through 10/14/21, a licensing survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was found NOT in compliance with the MN State Licensure and the following correction orders are issued. Please indicate in your electronic plan of correction you have reviewed</p>	2 000		

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

Electronically Signed

TITLE

(X6) DATE
11/10/21

Minnesota Department of Health

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2 000	<p>Continued From page 1</p> <p>these orders and identify the date when they will be completed.</p> <p>The following complaints were found to be UNSUBSTANTIATED: H5083110C (MN00057187) H5083111C (MN00057706) H5083112C (MN00058044) H5083113C (MN00058473) H5083114C (MN00062141) H5083115C (MN00063457) H5083116C (MN00068393)</p> <p>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 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 which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction.</p> <p>You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for</p>	2 000		

Minnesota Department of Health

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2 000	Continued From page 2 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. 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.	2 000		
2 565	MN Rule 4658.0405 Subp. 3 Comprehensive Plan of Care; Use Subp. 3. Use. A comprehensive plan of care must be used by all personnel involved in the care of the resident. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to develop comprehensive person-centered care plans to reflect individualized goals for 2 of 5 residents (R36, R44) reviewed for care planning. Findings include: R36's admission Minimum Data Set (MDS) dated 9/9/21, indicated R36 had a mild cognitive impairment and diagnoses which included schizoaffective disorder, liver failure, and	2 565	corrected.	11/29/21

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2 565	<p>Continued From page 3</p> <p>weakness. R36 required extensive assistance with bed mobility, transfers, dressing, and toileting.</p> <p>R36's care plan dated 9/3/21, indicated R36 had an, "alteration in gastrointestinal status (SPECIFY)" and would remain free of discomfort or complications. Further, R36 had an actual activity of daily living (ADL) deficit with a goal to, "demonstrate the appropriate use of (SPECIFY) adaptive devices to increase ability in (SPECIFY) through review date." Additionally, R36 had, "limited physical mobility related to (blank) with a goal to demonstrate the appropriate use of (specify) adaptive devices to increase mobility through review date." Also, R36 had bowel incontinence related to "(blank)" and was at risk of falls related to "(blank)." R36 had a mood problem related to "(blank)" with a goal to have improved "(SPECIFY)" through the review date. All goals outlined for R36 were highlighted red and indicated "(OVERDUE)."</p> <p>R44's admission MDS dated 9/21/21, indicated R44 was cognitively intact and had diagnoses which included compression fracture of lumbar (lower) back, back pain, and major depressive disorder. R44 was independent with bed mobility and transfers. R44 required supervision with dressing.</p> <p>R44's care plan dated 9/15/21, indicated R36 had limited physical mobility related to "(BLANK)" and would use, "(SPECIFY adaptive equipment used) to increase mobility through review date." Further, R36's care plan indicated R36 was, "(SPECIFY) risk for falls related to (BLANK)." R36 had an alteration in musculoskeletal status related to "(BLANK) with interventions to "(SPECIFY) the resident with the use of</p>	2 565		

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2 565	<p>Continued From page 4</p> <p>supportive devices (SPECIFY) as recommended". All resident goals included on the care plan were highlighted in red and indicated (OVERDUE)."</p> <p>During an interview on 10/12/21, 12:01 p.m. the director of nursing (DON) stated there was an interim DON, prior to them starting at the facility and they were, "trying to pick up where things had been dropped." The DON explained the facility was, "trying to find a system" to get the care plans caught up and updated to reflect current and accurate individualized needs for the residents.</p> <p>During an interview on 10/14/21, at 9:35 a.m. the administrator stated their expectation was for care plans to be updated to reflect the needs of residents. The administrator further stated each department was responsible for updating their portion the care plans by the due date.</p> <p>Facility policy titled Care Plan Guidelines dated 11/28/17, indicated the facility must develop and implement a comprehensive person-centered care plan for the needs of the resident identified on the comprehensive assessment. The care plan must include measurable objectives and timeframes to meet a resident's needs.</p> <p>SUGGESTED METHOD OF CORRECTION: The director of nursing (DON), or designee, could review and/or revise applicable policies and procedures to ensure resident care plans are individualized. The DON, or designee, could educate staff to ensure each residents care plan is individualized. The DON, or designee, could then perform audits to ensure each residents care plan is individualized.</p>	2 565		

Minnesota Department of Health

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2 565	Continued From page 5 TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 565		
21426	<p>MN St. Statute 144A.04 Subd. 3 Tuberculosis Prevention And Control</p> <p>(a) A nursing home provider must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in CDC's Morbidity and Mortality Weekly Report (MMWR). This program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, residents, and volunteers. The Department of Health shall provide technical assistance regarding implementation of the guidelines.</p> <p>(b) Written compliance with this subdivision must be maintained by the nursing home.</p> <p>This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure tuberculosis (TB) symptom screenings and/or tuberculin skin tests (TST) were completed for 5 of 5 residents (R3, R25, R29, R44 and R51). Further, the facility failed to ensure TST and/or TB symptom screenings were completed for 3 of 5 employees (assistant director of nursing [ADON], registered nurse</p>	21426	Corrected	11/29/21

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21426	<p>Continued From page 6</p> <p>[RN]-B, and nursing assistant [NA]-B) whose personnel records were reviewed.</p> <p>Findings include:</p> <p>RESIDENTS</p> <p>R3 was admitted to the facility on 5/19/21. R3's medical record lacked evidence of a TB symptom screening had been completed.</p> <p>R25 was admitted to the facility on 8/18/21. R25's medical record lacked evidence of a TB symptom screening had been completed.</p> <p>R29 was admitted to the facility on 7/29/21. R29's medical record lacked evidence of a TB symptom screening had been completed. Further, R29's medical record lacked documentation a first step TST was read.</p> <p>R44 was admitted to the facility on 9/15/21. R44's medical record lacked evidence of a TB symptom screening had been completed.</p> <p>R51 was admitted to the facility on 9/20/21. R51's medical record lacked evidence of a TB symptom screening had been completed. R51's medical record lacked documentation a first step TST was read.</p> <p>EMPLOYEES</p> <p>The ADON was hired 7/21/21, and worked full-time. The ADON's record lacked evidence a TB symptom screening was completed. The ADON's record lacked evidence a two step TST had been completed.</p> <p>RN-B was hired 8/4/21, and worked 64 hours a</p>	21426		

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21426	<p>Continued From page 7</p> <p>pay period (every two weeks). RN-B's record lacked evidence a TB symptom screening was completed. RN-B record lacked evidence a two step TST had been completed.</p> <p>NA-B was hired 7/28/21 and worked 24 hours a pay period. NA-B's record lacked evidence a TB symptom screen was completed. NA-B's record lacked evidence the first and second step TST were completed.</p> <p>On 10/13/21, at 1:16 p.m. the director of nursing (DON) confirmed the above employees had worked since their date of hires. The DON stated all TB screenings for residents should be completed on paper and the evening nurse administered the TST in the first 24 hours of admission. The DON stated there was a place in the computer to document</p> <p>On 10/13/21, at 1:50 p.m. the administrator stated the DON oversaw the TST's and TB symptom screening and made sure they get done.</p> <p>On 10/14/21, at 9:50 a.m. the administrator confirmed there was no information for NA-B regarding the TST or symptom screening.</p> <p>The facility policy Tuberculosis Exposure Control Plan dated 2020, indicated documentation in the medical record should include the date, time, exact millimeters of induration, presence or absence of any adverse effects and signature. In addition, the policy indicated all employees would have an initial two-step Tuberculin Skin Test (TST) upon hire or an IGRA (interferon-gamma release assays) unless otherwise indicated, a symptom evaluation for those without documented prior TB disease or latent TB</p>	21426		

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(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) COMPLETE DATE
21426	Continued From page 8 infection, and an individual TB risk assessment. SUGGESTED METHOD OF CORRECTION: The Director of Nursing (DON) or designee could review and revise policies and procedures to ensure tuberculosis screening and testing is done on all residents and employees according to regulations. The (DON) or designee could educate all appropriate staff on the policies and procedures. The Director of Nursing or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21426		
21665	MN Rule 4658.1400 Physical Environment A nursing home must provide a safe, clean, functional, comfortable, and homelike physical environment, allowing the resident to use personal belongings to the extent possible. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure 2 of 3 resident (R41, R353) wall fans were clean and free from debris. Findings include: During an observation on 10/11/21, at 1:38 p.m. R41's wall fan guard had visible gray debris all over it. During an observation on 10/11/21, at 1:39 p.m. R353's wall fan guard had visible gray debris all	21665	corrected.	11/29/21

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00129	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 10/14/2021
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NAME OF PROVIDER OR SUPPLIER PARK HEALTH A VILLA CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 4415 WEST 36 1/2 STREET SAINT LOUIS PARK, MN 55416
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21665	<p>Continued From page 9</p> <p>over it.</p> <p>During a tour of R41 and R353's rooms on 10/13/21, at 12:06 p.m. housekeeper account lead (HAL) verified there was visible gray debris on R41 and R353's wall fans. HAL stated room R353's wall fan was worse than R41's. HAL stated it was housekeeping's responsibility to clean fans when rooms were cleaned every day. HAL stated there was no excuse for the fans not being cleaned. HAL stated she would have to start auditing fan cleaning.</p> <p>The facility procedure 5-Step Daily Room Cleaning, undated, indicated vertical surfaces are not completely wiped down daily, but must be spot cleaned daily.</p> <p>SUGGEST METHOD OF CORRECTION: The administrator, maintenance supervisor, or designee, could ensure an environmental cleaning program was developed to accurately reflect ongoing housekeeping scheduled or needed in the facility on a routine basis. The facility could create policies and procedures, educate staff on these changes and perform environmental rounds/audits periodically. The facility could report those findings to the quality assurance performance improvement (QAPI) committee for further recommendations to ensure ongoing compliance.</p> <p>TIME PERIOD FOR CORRECTION: Twenty-one (21) days.</p>	21665		

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

PRINTED: 11/12/2021
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245083	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 10/14/2021
NAME OF PROVIDER OR SUPPLIER PARK HEALTH A VILLA CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 4415 WEST 36 1/2 STREET SAINT LOUIS PARK, MN 55416		
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E 000	Initial Comments	E 000			
F 000	<p>A survey for compliance with CMS Appendix Z Emergency Preparedness Requirements, was conducted on 10/11/21, through 10/14/21, during a recertification survey. The agency is in compliance with the Appendix Z Emergency Preparedness Requirements.</p> <p>INITIAL COMMENTS</p> <p>On 10/11/21, through 10/14/21, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was found to be NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities.</p> <p>The following complaints were found to be UNSUBSTANTIATED: H5083110C (MN00057187) H5083111C (MN00057706) H5083112C (MN00058044) H5083113C (MN00058473) H5083114C (MN00062141) H5083115C (MN00063457) H5083116C (MN00068393)</p> <p>The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments 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.</p> <p>Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the</p>	F 000			

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

TITLE

(X6) DATE

Electronically Signed

11/10/2021

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

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F 000	Continued From page 1 regulations has been attained.	F 000			
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv) In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to	F 656		11/29/21	

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F 656	<p>Continued From page 2</p> <p>local contact agencies and/or other appropriate entities, for this purpose.</p> <p>(C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on interview and document review, the facility failed to develop comprehensive person-centered care plans to reflect individualized goals for 2 of 5 residents (R36, R44) reviewed for care planning.</p> <p>Findings include:</p> <p>R36's admission Minimum Data Set (MDS) dated 9/9/21, indicated R36 had a mild cognitive impairment and diagnoses which included schizoaffective disorder, liver failure, and weakness. R36 required extensive assistance with bed mobility, transfers, dressing, and toileting.</p> <p>R36's care plan dated 9/3/21, indicated R36 had an, "alteration in gastrointestinal status (SPECIFY)" and would remain free of discomfort or complications. Further, R36 had an actual activity of daily living (ADL) deficit with a goal to, "demonstrate the appropriate use of (SPECIFY) adaptive devices to increase ability in (SPECIFY) through review date." Additionally, R36 had, "limited physical mobility related to (blank) with a goal to demonstrate the appropriate use of (specify) adaptive devices to increase mobility through review date." Also, R36 had bowel incontinence related to "(blank)" and was at risk of falls related to "(blank)." R36 had a mood problem related to "(blank)" with a goal to have</p>	F 656	<p>This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to develop comprehensive person-centered care plans to reflect individualized goals for 2 of 5 residents (R36, R44) reviewed for care planning.</p> <ol style="list-style-type: none"> 1. R36 plan of care was reviewed and updated to reflect person-centered care. R44 no longer resides at facility. 2. All residents have the potential to be affected by the deficient practice and care plans will be reviewed to ensure care plans are person centered. 3. Care Planning policy was reviewed and remains current. Education will be provided to department head and nursing management on development and of person-centered care plans following care planning policy, upon admission, quarterly, annually and significant change of condition. 4. Audits will be completed by the DON and/or designee on the development of person centered care plans. Audits of 4 residents care plans will be completed weekly and will be reviewed at Quality Assurance Meeting (QAPI) monthly to determine if any trends are identified and recommendations made for continued audits and monitoring needs. 		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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F 656	<p>Continued From page 3 improved "(SPECIFY)" through the review date. All goals outlined for R36 were highlighted red and indicated "(OVERDUE)."</p> <p>R44's admission MDS dated 9/21/21, indicated R44 was cognitively intact and had diagnoses which included compression fracture of lumbar (lower) back, back pain, and major depressive disorder. R44 was independent with bed mobility and transfers. R44 required supervision with dressing.</p> <p>R44's care plan dated 9/15/21, indicated R36 had limited physical mobility related to "(BLANK)" and would use, "(SPECIFY adaptive equipment used) to increase mobility through review date." Further, R36's care plan indicated R36 was, "(SPECIFY) risk for falls related to (BLANK)." R36 had an alteration in musculoskeletal status related to "(BLANK) with interventions to "(SPECIFY) the resident with the use of supportive devices (SPECIFY) as recommended". All resident goals included on the care plan were highlighted in red and indicated (OVERDUE)."</p> <p>During an interview on 10/12/21, 12:01 p.m. the director of nursing (DON) stated there was an interim DON, prior to them starting at the facility and they were, "trying to pick up where things had been dropped." The DON explained the facility was, "trying to find a system" to get the care plans caught up and updated to reflect current and accurate individualized needs for the residents.</p> <p>During an interview on 10/14/21, at 9:35 a.m. the administrator stated their expectation was for care plans to be updated to reflect the needs of residents. The administrator further stated each</p>	F 656	5. Completion date: 11/29/2021		

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F 656	Continued From page 4 department was responsible for updating their portion the care plans by the due date.	F 656			
F 921 SS=D	<p>Facility policy titled Care Plan Guidelines dated 11/28/17, indicated the facility must develop and implement a comprehensive person-centered care plan for the needs of the resident identified on the comprehensive assessment. The care plan must include measurable objectives and timeframes to meet a resident's needs.</p> <p>Safe/Functional/Sanitary/Comfortable Environ CFR(s): 483.90(i)</p> <p>§483.90(i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure 2 of 3 resident (R41, R353) wall fans were clean and free from debris.</p> <p>Findings include:</p> <p>During an observation on 10/11/21, at 1:38 p.m. R41's wall fan guard had visible gray debris all over it.</p> <p>During an observation on 10/11/21, at 1:39 p.m. R353's wall fan guard had visible gray debris all over it.</p> <p>During a tour of R41 and R353's rooms on 10/13/21, at 12:06 p.m. housekeeper account lead (HAL) verified there was visible gray debris on R41 and R353's wall fans. HAL stated room</p>	F 921	<p>F921 This MN REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure 2 of 3 resident (R41, R353) wall fans were clean and free from debris.</p> <ol style="list-style-type: none"> 1. Resident R41 and R353 wall fans have been cleaned and are free from debris. R41 and R353 had no adverse effects from deficient practice. 2. All residents have the potential to be affected by the deficient practice. 3. Facility procedure 5- Step Daily Room Cleaning was reviewed and remains current. Education will be provided to housekeepers related to the facility procedure and ensuring fans are dusted. 4. Audits will be completed by the 	11/29/21	

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F 921	Continued From page 5 R353's wall fan was worse than R41's. HAL stated it was housekeeping's responsibility to clean fans when rooms were cleaned every day. HAL stated there was no excuse for the fans not being cleaned. HAL stated she would have to start auditing fan cleaning. The facility procedure 5-Step Daily Room Cleaning, undated, indicated vertical surfaces are not completely wiped down daily, but must be spot cleaned daily.	F 921	housekeeping manager/designee on the cleanliness of resident fans. Audits will be completed weekly and will be reviewed at Quality Assurance Meeting (QAPI) monthly to determine if any trends are identified and recommendations made for continued audits and monitoring needs. 5. Completion date: 11/29/2021		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245083	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 10/12/2021
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NAME OF PROVIDER OR SUPPLIER PARK HEALTH A VILLA CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 4415 WEST 36 1/2 STREET SAINT LOUIS PARK, MN 55416
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K 000	<p>INITIAL COMMENTS</p> <p>FIRE SAFETY</p> <p>An annual Life Safety Code survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 10/12/2021. At the time of this survey, Park Health A Villa Center was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code.</p> <p>THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE.</p> <p>UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION.</p> <p>PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO:</p> <p>IF PARTICIPATING IN THE E-POC PROCESS, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED.</p>	K 000		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Electronically Signed	TITLE	(X6) DATE 11/12/2021
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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K 000	<p>Continued From page 1 Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR</p> <p>By email to: FM.HC.Inspections@state.mn.us</p> <p>THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION:</p> <ol style="list-style-type: none"> 1. A detailed description of the corrective action taken or planned to correct the deficiency. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. 4. Identify who is responsible for the corrective actions and monitoring of compliance. 5. The actual or proposed date for completion of the remedy. <p>Park Health a Villa Center is a 2-story building without a basement that was built in 1960 and was determined to be of Type II (111) construction. In 1970 an addition was constructed and was determined to be of Type II (000) construction. In 1998 an addition was constructed and was determined to be of Type II (111) construction. Each floor containing resident sleeping rooms is divided into smoke compartments. This facility is fully protected throughout by an automatic fire sprinkler system</p>	K 000		

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K 321	Continued From page 3 (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to manage hazardous storage per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.2.1 and 19.3.2.1.3. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 10/12/2021 at 11:20 AM, observation revealed that the lower level resident rooms are being used as storage rooms but do not have self-closing doors. An interview with the Administrator and Maintenance Supervisor verified this deficiency finding at the time of discovery.	K 321	The downstairs storage areas will be gone through and items found to be not needed anymore will be disposed of. Any remaining combustible materials will be moved to a room that has a door closer on the door. These downstairs rooms will be audited monthly for a period of 6 months by the maintenance supervisor and facility administrator, with the results of the audits brought forward to the monthly QAPI meetings for discussion and corrective action.		
K 914 SS=F	Electrical Systems - Maintenance and Testing CFR(s): NFPA 101 Electrical Systems - Maintenance and Testing Hospital-grade receptacles at patient bed locations and where deep sedation or general anesthesia is administered, are tested after initial installation, replacement or servicing. Additional testing is performed at intervals defined by documented performance data. Receptacles not listed as hospital-grade at these locations are tested at intervals not exceeding 12 months. Line isolation monitors (LIM), if installed, are tested at intervals of less than or equal to 1 month by	K 914		11/29/21	

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NAME OF PROVIDER OR SUPPLIER PARK HEALTH A VILLA CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 4415 WEST 36 1/2 STREET SAINT LOUIS PARK, MN 55416		
(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 914	<p>Continued From page 4</p> <p>actuating the LIM test switch per 6.3.2.6.3.6, which activates both visual and audible alarm. For LIM circuits with automated self-testing, this manual test is performed at intervals less than or equal to 12 months. LIM circuits are tested per 6.3.3.3.2 after any repair or renovation to the electric distribution system. Records are maintained of required tests and associated repairs or modifications, containing date, room or area tested, and results.</p> <p>6.3.4 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to test and inspect electrical receptacles at resident bed locations per NFPA 99 (2012 edition), Health Care Facilities Code, section 6.3.4.1.3. This deficient finding could have a widespread impact on the residents within the facility.</p> <p>Findings include:</p> <p>On 10/12/2021 at 9:45 AM, it was revealed by a review of available documentation the facility had not conducted annual outlet testing within the past 12 months.</p> <p>An interview with the Facility Administrator and Maintenance Supervisor verified this deficiency finding at the time of discovery.</p>	K 914	<p>The electrical outlets will have a test performed right away and also annually per life safety code. This test will be identified as needing to be done in the TELS building management program. The results of these tests will be retained in the Life Safety Book in the maintenance office. The maintenance supervisor will bring the results to the QAPI meeting following the next performed electrical outlet test. The maintenance supervisor will also bring the life safety book to QAPI meetings monthly to update meeting participants on completed tests/inspections.</p>		

FIRE SAFETY SURVEY REPORT - 2012 LIFE SAFETY CODE HEALTHCARE	1. (A) PROVIDER NUMBER <small>K1</small>	1. (B) MEDICAID I.D. NO. <small>K2</small>
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PART I — Life Safety Code, New and Existing
PART II — Health Care Facilities Code, New and Existing
PART III — Recommendation for Waiver
PART IV – Crucial Data Extract

OPTIONAL — Chapter 4 – NFPA 101A - Fire Safety Evaluation System for Health Care Occupancies – CMS-2786T

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

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

1. HOSPITAL 2. SKILLED/NURSING FACILITY 4. ICF/IID UNDER HEALTH CARE 5. HOSPICE

IF "2" OR "5" ABOVE IS MARKED, CHECK APPROPRIATE ITEM(S) BELOW

1. <input type="checkbox"/> ENTIRE FACILITY 2. <input type="checkbox"/> DISTINCT PART OF (SPECIFY) _____	3. <input type="checkbox"/> IF DISTINCT PART OF HOSPITAL, IS HOSPITAL ACCREDITED? a. <input type="checkbox"/> YES b. <input type="checkbox"/> NO
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6. BED COMPOSITION	a. TOTAL NO. OF BEDS IN THE FACILITY _____	b. NUMBER OF HOSPITAL BEDS CERTIFIED FOR MEDICARE _____	c. NUMBER OF SKILLED BEDS CERTIFIED FOR MEDICARE _____	d. NUMBER OF SKILLED BEDS CERTIFIED FOR MEDICAID _____	e. NUMBER OF NF or ICF/IID BEDS CERTIFIED FOR MEDICAID _____
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7. A. THE FACILITY MEETS THE STANDARD, BASED UPON (CHECK ALL APPROPRIATE BOXES)

1. COMPLIANCE WITH ALL PROVISIONS 2. ACCEPTANCE OF A PLAN OF CORRECTION 3. RECOMMENDED WAIVERS 4. FSES 5. PERFORMANCE BASED DESIGN

B. THE FACILITY DOES NOT MEET THE STANDARD

<small>K9</small> SURVEYOR (Signature) <i>Roy M Kingsley</i>	TITLE	OFFICE	DATE
<small>K10</small> SURVEYOR ID			
FIRE AUTHORITY OFFICER <i>William Aderhalden 37009</i>	TITLE	OFFICE	DATE

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

ID PREFIX		MET	NOT MET	N/A	REMARKS
	PART I – NFPA 101 LSC REQUIREMENTS <i>(Items in italics relate to the FSES)</i>				
	SECTION 1 – GENERAL REQUIREMENTS				
K100	General Requirements – Other List in the REMARKS section any LSC Section 18.1 and 19.1 General Requirements that are not addressed by the provided K-tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567.				
K111	Building Rehabilitation <i>Repair, Renovation, Modification, or Reconstruction</i> Any building undergoing repair, renovation, modification, or reconstruction complies with both of the following: <ul style="list-style-type: none"> • Requirements of Chapter 18 and 19. • Requirements of the applicable Sections 43.3, 43.4, 43.5, and 43.6. 18.1.1.4.3, 19.1.1.4.3, 43.1.2.1 Change of Use or Change of Occupancy Any building undergoing change of use or change of occupancy classification complies with the requirements of Section 43.7, unless permitted by 18.1.1.4.2 or 19.1.1.4.2. 18.1.1.4.2 (4.6.7 and 4.6.11), 19.1.1.4.2 (4.6.7 and 4.6.11), 43.1.2.2 (43.7) Additions Any building undergoing an addition shall comply with the requirements of Section 43.8. If the building has a common wall with a nonconforming building, the common wall is a fire barrier having at least a two hour fire resistance rating constructed of materials as required for the addition. Communicating openings occur only in corridors and are protected by approved self-closing fire doors with at least a 1-1/2 hour fire resistance rating. Additions comply with the requirements of Section 43.8. 18.1.1.4.1 (4.6.7 and 4.6.11), 18.1.1.4.1.1 (8.3), 18.1.1.4.1.2, 18.1.1.4.1.3, 19.1.1.4.1 (4.6.7 and 4.6.11), 19.1.1.4.1.1 (8.3), 19.1.1.4.1.2, 19.1.1.4.1.3, 43.1.2.3(43.8)				

ID PREFIX		MET	NOT MET	N/A	REMARKS
K112	<p>Sprinkler Requirements for Major Rehabilitation</p> <p>If a nonsprinklered smoke compartment has undergone major rehabilitation the automatic sprinkler requirements of 18.3.5 have been applied to the smoke compartment.</p> <p>In cases where the building is not protected throughout by a sprinkler system, the requirements of 18.4.3.2, 18.4.3.3, and 18.4.3.8 are also met.</p> <p>Note: Major rehabilitation involves the modification of more than 50 percent, or more than 4500 ft² of the area of the smoke compartment.</p> <p>18.1.1.4.3.3, 19.1.1.4.3.3</p>				
K131	<p>Multiple Occupancies – Sections of Health Care Facilities</p> <p>Sections of health care facilities classified as other occupancies meet all of the following:</p> <ul style="list-style-type: none"> • They are not intended to serve four or more inpatients for purposes of housing, treatment, or customary access. • They are separated from areas of health care occupancies by construction having a minimum two hour fire resistance rating in accordance with Chapter 8. • The entire building is protected throughout by an approved, supervised automatic sprinkler system in accordance with Section 9.7. <p>Hospital outpatient surgical departments are required to be classified as an Ambulatory Health Care Occupancy regardless of the number of patients served.</p> <p>18.1.3.3, 19.1.3.3, 42 CFR 482.41, 42 CFR 485.623</p>				
K132	<p>Multiple Occupancies – Contiguous Non-Health Care Occupancies</p> <p>Non-health care occupancies that are located immediately next to a Health Care Occupancy, but are primarily intended to provide outpatient services are permitted to be classified as Business or Ambulatory Health Care Occupancies, provided the facilities are separated by construction having not less than two hour fire resistance-rated construction, and are not intended to provide services simultaneously for four or more inpatients. Outpatient surgical departments must be classified as Ambulatory Health Care Occupancy regardless of the number of patients served.</p> <p>18.1.3.4.1, 19.1.3.4.1</p>				

ID PREFIX		MET	NOT MET	N/A	REMARKS																							
K133	<p>Multiple Occupancies – Construction Type</p> <p>Where separated occupancies are in accordance with 18/19.1.3.2 or 18/19.1.3.4, the most stringent construction type is provided throughout the building, unless a two hour separation is provided in accordance with 8.2.1.3, in which case the construction type is determined as follows:</p> <ul style="list-style-type: none"> The construction type and supporting construction of the health care occupancy is based on the story in which it is located in the building in accordance with 18/19.1.6 and Tables 18/19.1.6.1. The construction type of the areas of the building enclosing the other occupancies shall be based on the applicable occupancy chapters. <p>18.1.3.5, 19.1.3.5, 8.2.1.3</p>																											
K161	<p>Building Construction Type and Height</p> <p>2012 EXISTING</p> <p>Building construction type and stories meets Table 19.1.6.1, unless otherwise permitted by 19.1.6.2 through 19.1.6.7</p> <p>19.1.6.4, 19.1.6.5</p> <table border="1" data-bbox="222 813 1100 1273"> <thead> <tr> <th></th> <th>Construction Type</th> <th></th> </tr> </thead> <tbody> <tr> <td>1</td> <td>I (442), I (332), II (222)</td> <td>Any number of stories non-sprinklered or sprinklered</td> </tr> <tr> <td>2</td> <td>II (111)</td> <td>One story non-sprinklered Maximum 3 stories sprinklered</td> </tr> <tr> <td>3</td> <td>II (000)</td> <td rowspan="4">Not allowed non-sprinklered Maximum 2 stories sprinklered</td> </tr> <tr> <td>4</td> <td>III (211)</td> </tr> <tr> <td>5</td> <td>IV (2HH)</td> </tr> <tr> <td>6</td> <td>V (111)</td> </tr> <tr> <td>7</td> <td>III (200)</td> <td rowspan="2">Not allowed non-sprinklered Maximum 1 story sprinklered</td> </tr> <tr> <td>8</td> <td>V (000)</td> </tr> </tbody> </table> <p><i>Sprinklered stories must be sprinklered throughout by an approved, supervised automatic system in accordance with section 9.7. (See 19.3.5)</i></p> <p><i>Give a brief description, in REMARKS, of the construction, the number of stories, including basements, floors on which patients are located, location of smoke or fire barriers and dates of approval. Complete sketch or attach small floor plan of the building as appropriate.</i></p>		Construction Type		1	I (442), I (332), II (222)	Any number of stories non-sprinklered or sprinklered	2	II (111)	One story non-sprinklered Maximum 3 stories sprinklered	3	II (000)	Not allowed non-sprinklered Maximum 2 stories sprinklered	4	III (211)	5	IV (2HH)	6	V (111)	7	III (200)	Not allowed non-sprinklered Maximum 1 story sprinklered	8	V (000)				
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K161	<p>2012 NEW</p> <p>Building construction type and stories meets Table 18.1.6.1, unless otherwise permitted by 18.1.6.2 through 18.1.6.7</p> <p>18.1.6.4, 18.1.6.5</p> <table border="1" data-bbox="222 396 1100 849"> <thead> <tr> <th></th> <th>Construction Type</th> <th></th> </tr> </thead> <tbody> <tr> <td>1</td> <td>I (442), I (332), II (222)</td> <td>Not allowed non-sprinklered Any number of stories sprinklered</td> </tr> <tr> <td>2</td> <td>II (111)</td> <td>Not allowed non-sprinklered Maximum 3 stories sprinklered</td> </tr> <tr> <td>3</td> <td>II (000)</td> <td rowspan="4">Not allowed non-sprinklered Maximum 1 story sprinklered</td> </tr> <tr> <td>4</td> <td>III (211)</td> </tr> <tr> <td>5</td> <td>IV (2HH)</td> </tr> <tr> <td>6</td> <td>V (111)</td> </tr> <tr> <td>7</td> <td>III (200)</td> <td rowspan="2">Not allowed non-sprinklered</td> </tr> <tr> <td>8</td> <td>V (000)</td> </tr> </tbody> </table> <p><i>Sprinklered stories must be sprinklered throughout by an approved, supervised automatic system in accordance with section 9.7. (See 18.3.5)</i></p> <p><i>Give a brief description, in REMARKS, of the construction, the number of stories, including basements, floors on which patients are located, location of smoke or fire barriers and dates of approval. Complete sketch or attach small floor plan of the building as appropriate.</i></p>		Construction Type		1	I (442), I (332), II (222)	Not allowed non-sprinklered Any number of stories sprinklered	2	II (111)	Not allowed non-sprinklered Maximum 3 stories sprinklered	3	II (000)	Not allowed non-sprinklered Maximum 1 story sprinklered	4	III (211)	5	IV (2HH)	6	V (111)	7	III (200)	Not allowed non-sprinklered	8	V (000)				
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K162	<p>Roofing Systems Involving Combustibles</p> <p>2012 EXISTING</p> <p>Buildings of Type I (442), Type I (332), Type II (222), or Type II (111) having roof systems employing combustible roofing supports, decking or roofing meet the following:</p> <ol style="list-style-type: none"> 1. roof covering meets Class C requirements. 2. roof is separated from occupied building portions with a noncombustible floor assembly using not less than 2½ inches concrete or gypsum fill. 3. attic or other space is either unoccupied or protected throughout by an approved automatic sprinkler system. <p>19.1.6.2*, ASTM E108, ANSI/UL 790</p>																											

ID PREFIX		MET	NOT MET	N/A	REMARKS
K162	<p>2012 NEW</p> <p>Buildings of Type I (442), Type I (332), Type II (222), Type II (111) having roof systems employing combustible roofing supports, decking or roofing meet the following:</p> <ol style="list-style-type: none"> 1. roof covering meets Class A requirements. 2. roof is separated from occupied building portions with 2 hour fire resistive noncombustible floor assembly using not less than 2½ inches concrete or gypsum fill. 3. the structural elements supporting the rated floor assembly meet the required fire resistance rating of the building. <p>18.1.6.2, ASTM E108, ANSI/UL 790</p>				
K163	<p>Interior Nonbearing Wall Construction</p> <p>Interior nonbearing walls in Type I or II construction are constructed of noncombustible or limited-combustible materials.</p> <p>Interior nonbearing walls required to have a minimum 2 hour fire resistance rating are permitted to be fire-retardant-treated wood enclosed within noncombustible or limited-combustible materials, provided they are not used as shaft enclosures.</p> <p>18.1.6.4, 18.1.6.5, 19.1.6.4, 19.1.6.5</p>				
SECTION 2 – MEANS OF EGRESS REQUIREMENTS					
K200	<p>Means of Egress Requirements – Other</p> <p>List in the REMARKS section any LSC Section 18.2 and 19.2 Means of Egress requirements that are not addressed by the provided K-tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567.</p> <p>18.2, 19.2</p>				
K211	<p>Means of Egress – General</p> <p>Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11.</p> <p>18.2.1, 19.2.1, 7.1.10.1</p>				

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

ID PREFIX		MET	NOT MET	N/A	REMARKS
K222	<p><input type="checkbox"/> DELAYED-EGRESS LOCKING ARRANGEMENTS Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4</p> <p><input type="checkbox"/> ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted. 18.2.2.2.4, 19.2.2.2.4</p> <p><input type="checkbox"/> ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4</p>				
K223	<p>Doors with Self-Closing Devices Doors in an exit passageway, stairway enclosure, or horizontal exit, smoke barrier, or hazardous area enclosure are self-closing and kept in the closed position, unless held open by a release device complying with 7.2.1.8.2 that automatically closes all such doors throughout the smoke compartment or entire facility upon activation of:</p> <ul style="list-style-type: none"> • Required manual fire alarm system; and • Local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system; and • Automatic sprinkler system, if installed; and • Loss of power. <p>18.2.2.2.7, 18.2.2.2.8, 19.2.2.2.7, 19.2.2.2.8</p>				

ID PREFIX		MET	NOT MET	N/A	REMARKS
K224	<p>Horizontal-Sliding Doors</p> <p>Horizontal-sliding doors permitted by 7.2.1.14 that are not automatic-closing are limited to a single leaf and shall have a latch or other mechanism to ensure the door will not rebound.</p> <p>Horizontal-sliding doors serving an occupant load fewer than 10 shall be permitted, providing all of the following criteria are met:</p> <ul style="list-style-type: none"> • Area served by the door has no high hazard contents. • Door is operable from either side without special knowledge or effort. • Force required to operate the door in the direction of travel is ≤ 30 lbf to set the door in motion and ≤ 15 lbf to close or open to the required width. • Assembly is appropriately fire rated, and where rated, is self-or automatic-closing by smoke detection per 7.2.1.8, and installed per NFPA 80. • Where required to latch, the door has a latch or other mechanism to ensure the door will not rebound. <p>18.2.2.2.10, 19.2.2.2.10</p>				
K225	<p>Stairways and Smokeproof Enclosures</p> <p>Stairways and Smokeproof enclosures used as exits are in accordance with 7.2.</p> <p>18.2.2.3, 18.2.2.4, 19.2.2.3, 19.2.2.4, 7.2</p>				
K226	<p>Horizontal Exits</p> <p>Horizontal exits, if used, are in accordance with 7.2.4 and the provisions of 18.2.2.5.1 through 18.2.2.5.7, or 19.2.2.5.1 through 19.2.2.5.4.</p> <p>18.2.2.5, 19.2.2.5</p>				
K227	<p>Ramps and Other Exits</p> <p>Ramps, exit passageways, fire and slide escapes, alternating tread devices, and areas of refuge are in accordance with the provisions 7.2.5 through 7.2.12.</p> <p>18.2.2.6 to 18.2.2.10 or 19.2.2.6 to 19.2.2.10</p>				
K231	<p>Means of Egress Capacity</p> <p>The capacity of required means of egress is in accordance with 7.3.</p> <p>18.2.3.1, 19.2.3.1</p>				

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

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

ID PREFIX		MET	NOT MET	N/A	REMARKS
K256	<p>Sleeping Suites</p> <p>Occupants shall have exit access to a corridor or direct access to a horizontal exit. Where ≥ 2 exits are required, one exit access door may be to a stairway, passageway or to the exterior. Suites shall be provided with constant staff supervision. Staff shall have direct visual supervision of patient sleeping rooms, from a constantly attended location or the room shall be provided with an automatic smoke detection system.</p> <p>Suites more than 1,000 ft² shall have 2 or more remote exits. One means of egress from the suite shall be to a corridor and one may be into an adjacent suite separated in accordance with corridor requirements.</p> <p>Suites shall not exceed the following size limitations:</p> <ul style="list-style-type: none"> • 5,000 square feet if the suite is not fully smoke detected or fully sprinklered. • 7,500 square feet if the suite is either fully smoke detected or fully sprinklered. • 10,000 square feet if the suite is both fully smoke detected and fully sprinklered and the sleeping rooms have direct supervision from a constantly attended location. <p>Travel distance between any point in a suite to exit access shall not exceed 100 feet and distance to an exit shall not exceed 150 feet (200 feet if building is fully sprinklered).</p> <p>18.2.5.7.2, 19.2.5.7.2</p>				
K257	<p>Non-Sleeping Suites</p> <p>Occupants shall have exit access to a corridor or direct access to a horizontal exit. Where ≥ 2 exits are required, one exit access door may be to a stairway, passageway or to the exterior.</p> <p>Suites more than 2,500 ft² shall have 2 or more remote exits. One means of egress from the suite shall be to a corridor and one may be into an adjacent suite separated in accordance with corridor requirements.</p> <p>Suites shall not exceed 10,000 ft².</p> <p>Travel distance between any point in a suite to exit access shall not exceed 100 feet and distance to an exit shall not exceed 150 feet (200 feet if building is fully sprinklered).</p> <p>18.2.5.7.3, 19.2.5.7.3</p>				

ID PREFIX		MET	NOT MET	N/A	REMARKS
K261	<p>Travel Distance to Exits</p> <p>Travel distance (excluding suites) to exits are measured in accordance with 7.6.</p> <ul style="list-style-type: none"> From any point in the room or suite to exit less than or equal to 150 feet (less than or equal to 200 feet if the building is fully sprinklered). Point in a room to room door less than or equal to 50 feet. <p>18.2.6, 19.2.6</p>				
K271	<p>Discharge from Exits</p> <p>Exit discharge is arranged in accordance with 7.7, provides a level walking surface meeting the provisions of 7.1.7 with respect to changes in elevation and shall be maintained free of obstructions. Additionally, the exit discharge shall be a hard packed all-weather travel surface.</p> <p>18.2.7, 19.2.7</p>				
K281	<p>Illumination of Means of Egress</p> <p>Illumination of means of egress, including exit discharge, is arranged in accordance with 7.8 and shall be either continuously in operation or capable of automatic operation without manual intervention.</p> <p>18.2.8, 19.2.8</p>				
K291	<p>Emergency Lighting</p> <p>Emergency lighting of at least 1-1/2 hour duration is provided automatically in accordance with 7.9.</p> <p>18.2.9.1, 19.2.9.1</p>				
K292	<p>Life Support Means of Egress</p> <p>2012 NEW (INDICATE N/A FOR EXISTING)</p> <p>Buildings equipped with or requiring the use of life support systems (electro-mechanical or inhalation anesthetics) have illumination of means of egress, emergency lighting equipment, exit, and directional signs supplied by the life safety branch of the electrical system described in NFPA 99.</p> <p>(Indicate N/A if life support equipment is for emergency purposes only.)</p> <p>18.2.9.2, 18.2.10.5</p>				

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

ID PREFIX		MET	NOT MET	N/A	REMARKS																																
K321	<p>Hazardous Areas – Enclosure 2012 EXISTING Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with ¾ hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. <i>Describe the floor and zone locations of hazardous areas that are deficient in REMARKS.</i> 19.3.2.1, 19.3.5.9</p> <table border="1" data-bbox="210 743 1045 1222"> <thead> <tr> <th data-bbox="210 743 615 800">Area</th> <th data-bbox="615 743 842 800">Automatic Sprinkler</th> <th data-bbox="842 743 972 800">Separation</th> <th data-bbox="972 743 1045 800">N/A</th> </tr> </thead> <tbody> <tr> <td data-bbox="210 800 615 857">a. Boiler and Fuel-Fired Heater Rooms</td> <td data-bbox="615 800 842 857"></td> <td data-bbox="842 800 972 857"></td> <td data-bbox="972 800 1045 857"></td> </tr> <tr> <td data-bbox="210 857 615 914">b. Laundries (larger than 100 sq. ft.)</td> <td data-bbox="615 857 842 914"></td> <td data-bbox="842 857 972 914"></td> <td data-bbox="972 857 1045 914"></td> </tr> <tr> <td data-bbox="210 914 615 971">c. Repair, Maintenance, and Paint Shops</td> <td data-bbox="615 914 842 971"></td> <td data-bbox="842 914 972 971"></td> <td data-bbox="972 914 1045 971"></td> </tr> <tr> <td data-bbox="210 971 615 1044">d. Soiled Linen Rooms (exceeding 64 gal.)</td> <td data-bbox="615 971 842 1044"></td> <td data-bbox="842 971 972 1044"></td> <td data-bbox="972 971 1045 1044"></td> </tr> <tr> <td data-bbox="210 1044 615 1109">e. Trash Collection Rooms (exceeding 64 gal.)</td> <td data-bbox="615 1044 842 1109"></td> <td data-bbox="842 1044 972 1109"></td> <td data-bbox="972 1044 1045 1109"></td> </tr> <tr> <td data-bbox="210 1109 615 1166">f. Combustible Storage Rooms/Spaces (over 50 sq. ft.)</td> <td data-bbox="615 1109 842 1166"></td> <td data-bbox="842 1109 972 1166"></td> <td data-bbox="972 1109 1045 1166"></td> </tr> <tr> <td data-bbox="210 1166 615 1222">g. Laboratories (if classified as Severe Hazard - see K322)</td> <td data-bbox="615 1166 842 1222"></td> <td data-bbox="842 1166 972 1222"></td> <td data-bbox="972 1166 1045 1222"></td> </tr> </tbody> </table>	Area	Automatic Sprinkler	Separation	N/A	a. Boiler and Fuel-Fired Heater Rooms				b. Laundries (larger than 100 sq. ft.)				c. Repair, Maintenance, and Paint Shops				d. Soiled Linen Rooms (exceeding 64 gal.)				e. Trash Collection Rooms (exceeding 64 gal.)				f. Combustible Storage Rooms/Spaces (over 50 sq. ft.)				g. Laboratories (if classified as Severe Hazard - see K322)							
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K321	<p>2012 NEW</p> <p>Hazardous areas are protected in accordance with 18.3.2.1. The areas shall be enclosed with a 1-hour fire-rated barrier, with a ¾ hour fire-rated door without windows (in accordance with 8.7.1.1). Doors shall be self-closing or automatic-closing in accordance with 7.2.1.8. Hazardous areas are protected by a sprinkler system in accordance with 9.7, 18.3.2.1, and 8.4.</p> <p><i>Describe the floor and zone locations of hazardous areas that are deficient in REMARKS.</i></p> <p>18.3.2.1, 7.2.1.8, 8.4, 8.7, 9.7</p> <table border="1" data-bbox="210 625 1043 1182"> <thead> <tr> <th data-bbox="210 625 613 682">Area</th> <th data-bbox="613 625 840 682">Automatic Sprinkler</th> <th data-bbox="840 625 970 682">Separation</th> <th data-bbox="970 625 1043 682">N/A</th> </tr> </thead> <tbody> <tr> <td data-bbox="210 682 613 738">a. Boiler and Fuel-Fired Heater Rooms</td> <td data-bbox="613 682 840 738"></td> <td data-bbox="840 682 970 738"></td> <td data-bbox="970 682 1043 738"></td> </tr> <tr> <td data-bbox="210 738 613 795">b. Laundries (larger than 100 sq. ft.)</td> <td data-bbox="613 738 840 795"></td> <td data-bbox="840 738 970 795"></td> <td data-bbox="970 738 1043 795"></td> </tr> <tr> <td data-bbox="210 795 613 852">c. Repair, Maintenance, and Paint Shops</td> <td data-bbox="613 795 840 852"></td> <td data-bbox="840 795 970 852"></td> <td data-bbox="970 795 1043 852"></td> </tr> <tr> <td data-bbox="210 852 613 933">d. Soiled Linen Rooms (exceeding 64 gal.)</td> <td data-bbox="613 852 840 933"></td> <td data-bbox="840 852 970 933"></td> <td data-bbox="970 852 1043 933"></td> </tr> <tr> <td data-bbox="210 933 613 998">e. Trash Collection Rooms (exceeding 64 gal.)</td> <td data-bbox="613 933 840 998"></td> <td data-bbox="840 933 970 998"></td> <td data-bbox="970 933 1043 998"></td> </tr> <tr> <td data-bbox="210 998 613 1063">f. Combustible Storage Rooms/Spaces (over 50 and less than 100 sq. ft.)</td> <td data-bbox="613 998 840 1063"></td> <td data-bbox="840 998 970 1063"></td> <td data-bbox="970 998 1043 1063"></td> </tr> <tr> <td data-bbox="210 1063 613 1128">g. Combustible Storage Rooms/Spaces (over 100 sq. ft.)</td> <td data-bbox="613 1063 840 1128"></td> <td data-bbox="840 1063 970 1128"></td> <td data-bbox="970 1063 1043 1128"></td> </tr> <tr> <td data-bbox="210 1128 613 1182">h. Laboratories (if classified as Severe Hazard - see K322)</td> <td data-bbox="613 1128 840 1182"></td> <td data-bbox="840 1128 970 1182"></td> <td data-bbox="970 1128 1043 1182"></td> </tr> </tbody> </table>	Area	Automatic Sprinkler	Separation	N/A	a. Boiler and Fuel-Fired Heater Rooms				b. Laundries (larger than 100 sq. ft.)				c. Repair, Maintenance, and Paint Shops				d. Soiled Linen Rooms (exceeding 64 gal.)				e. Trash Collection Rooms (exceeding 64 gal.)				f. Combustible Storage Rooms/Spaces (over 50 and less than 100 sq. ft.)				g. Combustible Storage Rooms/Spaces (over 100 sq. ft.)				h. Laboratories (if classified as Severe Hazard - see K322)							
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ID PREFIX		MET	NOT MET	N/A	REMARKS
K322	<p>Laboratories</p> <p>Laboratories employing quantities of flammable, combustible, or hazardous materials that are considered a severe hazard are protected by 1-hour fire resistance-rated separation, automatic sprinkler system, and are in accordance with 8.7 and with NFPA 99.</p> <p>Laboratories not considered a severe hazard are protected as hazardous areas (see K321).</p> <p>Laboratories using chemicals are in accordance with NFPA 45, <i>Standard on Fire Protection for Laboratories Using Chemicals</i>.</p> <p>Gas appliances are of appropriate design and installed in accordance with NFPA 54. Shutoff valves are marked to identify material they control.</p> <p>Devices requiring medical grade oxygen from the piped distribution system meet the requirements under 11.4.2.2 (NFPA 99).</p> <p>18.3.2.2, 19.3.2.2, 8.7, 8.7.4.1 (LSC)</p> <p>9.3.1.2, 11.4.3.2, 15.4 (NFPA 99)</p>				

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

ID PREFIX		MET	NOT MET	N/A	REMARKS
K324	<p>Cooking Facilities</p> <p>Cooking equipment is protected in accordance with NFPA 96, <i>Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations</i>, unless:</p> <ul style="list-style-type: none"> • residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2. • cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or • cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. <p>Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor.</p> <p>18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2</p>				
K325	<p>Alcohol Based Hand Rub Dispenser (ABHR)</p> <p>ABHRs are protected in accordance with 8.7.3.1, unless all conditions are met:</p> <ul style="list-style-type: none"> • Corridor is at least 6 feet wide. • Maximum individual dispenser capacity is 0.32 gallons (0.53 gallons in suites) of fluid and 18 ounces of Level 1 aerosols. • Dispensers shall have a minimum of four foot horizontal spacing. • Not more than an aggregate of 10 gallons of fluid or 1135 ounces of aerosol are used in a single smoke compartment outside a storage cabinet, excluding one individual dispenser per room. • Storage in a single smoke compartment greater than 5 gallons complies with NFPA 30. • Dispensers are not installed within 1 inch of an ignition source. • Dispensers over carpeted floors are in sprinklered smoke compartments. • ABHR does not exceed 95 percent alcohol. • Operation of the dispenser shall comply with Section 18.3.2.6(11) or 19.3.2.6(11). • ABHR is protected against inappropriate access. <p>18.3.2.6, 19.3.2.6, 42 CFR Parts 403, 418, 460, 482, 483, and 485</p>				

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

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

ID PREFIX		MET	NOT MET	N/A	REMARKS
K345	<p>Fire Alarm System – Testing and Maintenance</p> <p>A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, <i>National Electric Code</i>, and NFPA 72, <i>National Fire Alarm and Signaling Code</i>. Records of system acceptance, maintenance and testing are readily available.</p> <p>9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72</p>				
K346	<p>Fire Alarm – Out of Service</p> <p>Where required fire alarm system is out of services for more than 4 hours in a 24 hour period, the authority having jurisdiction shall be notified, and the building shall be evacuated or an approved fire watch shall be provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service.</p> <p>9.6.1.6</p>				
K347	<p>Smoke Detection</p> <p>2012 EXISTING</p> <p>Smoke detection systems are provided in spaces open to corridors as required by 19.3.6.1.</p> <p>19.3.4.5.2</p>				
	<p>2012 NEW</p> <p>Smoke detection systems are provided in spaces open to corridors as required by 18.3.6.1</p> <p>In nursing homes, an automatic smoke detection system is installed in the corridors of all smoke compartments containing resident sleeping rooms, unless the resident sleeping rooms have:</p> <ul style="list-style-type: none"> • smoke detection, or • automatic door closing devices with integral smoke detectors on the room side that provide occupant notification. <p>Such detectors are electrically interconnected to the fire alarm system.</p> <p>18.3.4.5.2, 18.3.4.5.3</p>				

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

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

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

ID PREFIX		MET	NOT MET	N/A	REMARKS
K363	<p>Corridor – Doors 2012 EXISTING</p> <p>Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1¾ inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material.</p> <p>Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5lbf is applied, whether or not power is applied.</p> <p>Clearance between bottom of door and floor covering is not exceeding 1 inch. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies.</p> <p>19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485</p> <p>Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc.</p>				
	<p>2012 NEW</p> <p>Doors protecting corridor openings shall be constructed to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have self-latching and positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material.</p> <p>Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5lbf is applied, whether or not power is applied.</p> <p>Clearance between bottom of door and floor covering is not exceeding 1 inch. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 18.3.6.3.6 are permitted.</p> <p>18.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485</p> <p>Show in REMARKS details of doors such as fire protection ratings, automatic closing devices, etc.</p>				

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

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

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

ID PREFIX		MET	NOT MET	N/A	REMARKS
K421	High-Rise Buildings 2012 EXISTING High-rise buildings are protected throughout by an approved, supervised automatic sprinkler system in accordance with Section 9.7 within 12 years of LSC final rule effective date. 19.4.2				
	2012 NEW High-rise buildings comply with section 11.8. 18.4.2				
SECTION 5 – BUILDING SERVICES					
K500	Building Services – Other List in the REMARKS section any LSC Section 18.5 and 19.5 Building Services requirements that are not addressed by the provided K-tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567.				
K511	Utilities – Gas and Electric Equipment using gas or related gas piping complies with NFPA 54, <i>National Fuel Gas Code</i> , electrical wiring and equipment complies with NFPA 70, <i>National Electric Code</i> . Existing installations can continue in service provided no hazard to life. 18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2				
K521	HVAC Heating, ventilation, and air conditioning shall comply with 9.2 and shall be installed in accordance with the manufacturer's specifications. 18.5.2.1, 19.5.2.1, 9.2				
K522	HVAC – Any Heating Device Any heating device, other than a central heating plant, is designed and installed so combustible materials cannot be ignited by device, and has a safety feature to stop fuel and shut down equipment if there is excessive temperature or ignition failure. If fuel fired, the device also: <ul style="list-style-type: none"> • is chimney or vent connected. • takes air for combustion from outside. • provides for a combustion system separate from occupied area atmosphere. 18.5.2.2, 19.5.2.2				

ID PREFIX		MET	NOT MET	N/A	REMARKS
K523	<p>HVAC – Suspended Unit Heaters</p> <p>Suspended unit heaters are permitted provided the following are met:</p> <ul style="list-style-type: none"> • Not located in means of egress or in patient rooms. • Located high enough to be out of reach of people in the area. • Has a safety feature to stop fuel and shut down equipment if there is excessive temperature or ignition failure. <p>18.5.2.3(1), 19.5.2.3(1)</p>				
K524	<p>HVAC – Direct-Vent Gas Fireplaces</p> <p>Direct-vent gas fireplaces, as defined in NFPA 54, inside of all smoke compartments containing patient sleeping areas comply with the requirements of 18.5.2.3(2), 19.5.2.3(2).</p> <p>18.5.2.3(2), 19.5.2.3(2), NFPA 54</p>				
K525	<p>HVAC – Solid Fuel-Burning Fireplaces</p> <p>Solid fuel-burning fireplaces are permitted in other than patient sleeping areas provided:</p> <ul style="list-style-type: none"> • Areas are separated by 1-hour fire resistance construction. • Fireplace complies with 9.2.2. • Fireplace enclosure resists breakage up to 650°F and has heat-tempered glass. • Room has supervised CO detection per 9.8. <p>18.5.2.3(3) and 19.5.2.3(3)</p>				
K531	<p>Elevators</p> <p>2012 EXISTING</p> <p>Elevators comply with the provision of 9.4. Elevators are inspected and tested as specified in ASME A17.1, <i>Safety Code for Elevators and Escalators</i>. Firefighter’s Service is operated monthly with a written record. Existing elevators conform to ASME/ANSI A17.3, <i>Safety Code for Existing Elevators and Escalators</i>. All existing elevators, having a travel distance of 25 feet or more above or below the level that best serves the needs of emergency personnel for firefighting purposes, conform with Firefighter’s Service Requirements of ASME/ANSI A17.3. (Includes firefighter’s service Phase I key recall and smoke detector automatic recall, firefighter’s service Phase II emergency in-car key operation, machine room smoke detectors, and elevator lobby smoke detectors.)</p> <p>19.5.3, 9.4.2, 9.4.3</p>				

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

ID PREFIX		MET	NOT MET	N/A	REMARKS
K541	<p>Rubbish Chutes, Incinerators, and Laundry Chutes</p> <p>2012 EXISTING</p> <p>(1) Any existing linen and trash chute, including pneumatic rubbish and linen systems, that opens directly onto any corridor shall be sealed by fire resistive construction to prevent further use or shall be provided with a fire door assembly having a fire protection rating of 1-hour. All new chutes shall comply with 9.5.</p> <p>(2) Any rubbish chute or linen chute, including pneumatic rubbish and linen systems, shall be provided with automatic extinguishing protection in accordance with 9.7.</p> <p>(3) Any trash chute shall discharge into a trash collection room used for no other purpose and protected in accordance with 8.4. (Existing laundry chutes permitted to discharge into same room are protected by automatic sprinklers in accordance with 19.3.5.9 or 19.3.5.7.)</p> <p>(4) Existing fuel-fed incinerators shall be sealed by fire resistive construction to prevent further use.</p> <p>19.5.4, 9.5, 8.4, NFPA 82</p>				
	<p>2012 NEW</p> <p>Rubbish chutes, incinerators, and laundry chutes shall comply with the provisions of Section 9.5, unless otherwise specified in 18.5.4.2.</p> <ul style="list-style-type: none"> • The fire resistance rating of chute charging room shall not be required to exceed 1-hour. • Any rubbish chute or linen chute shall be provided with automatic extinguishing protection in accordance with Section 9.7. • Chutes shall discharge into a trash collection room used for no other purpose and shall be protected in accordance with 8.7. <p>18.5.4.2, 8.7, 9.5, 9.7, NFPA 82</p>				
	SECTION 6 – RESERVED				
	SECTION 7 – OPERATING FEATURES				
K700	<p>Operating Features – Other</p> <p>List in the REMARKS section any LSC Section 18.7 and 19.7 Operating Features requirements that are not addressed by the provided K-tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included in Form CMS-2567.</p>				

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

ID PREFIX		MET	NOT MET	N/A	REMARKS
K741	<p>Smoking Regulations</p> <p>Smoking regulations shall be adopted and shall include not less than the following provisions:</p> <ol style="list-style-type: none"> (1) Smoking shall be prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area shall be posted with signs that read NO SMOKING or shall be posted with the international symbol for no smoking. (2) In health care occupancies where smoking is prohibited and signs are prominently placed at all major entrances, secondary signs with language that prohibits smoking shall not be required. (3) Smoking by patients classified as not responsible shall be prohibited. (4) The requirement of 18.7.4(3) shall not apply where the patient is under direct supervision. (5) Ashtrays of noncombustible material and safe design shall be provided in all areas where smoking is permitted. (6) Metal containers with self-closing cover devices into which ashtrays can be emptied shall be readily available to all areas where smoking is permitted. <p>18.7.4, 19.7.4</p>				
K751	<p>Draperies, Curtains, and Loosely Hanging Fabrics</p> <p>Draperies, curtains including cubicle curtains and loosely hanging fabric or films shall be in accordance with 10.3.1. Excluding curtains and draperies: at showers and baths; on windows in patient sleeping room located in sprinklered compartments; and in non-patient sleeping rooms in sprinklered compartments where individual drapery or curtain panels do not exceed 48 square feet or total area does not exceed 20 percent of the wall.</p> <p>18.7.5.1, 18.3.5.11, 19.7.5.1, 19.3.5.11, 10.3.1</p>				

ID PREFIX		MET	NOT MET	N/A	REMARKS
K752	<p>Upholstered Furniture and Mattresses</p> <p>Newly introduced upholstered furniture meets Class I or char length, and heat release criteria in accordance with 10.3.2.1 and 10.3.3, unless the building is fully sprinklered.</p> <p>Newly introduced mattresses shall meet char length and heat release criteria in accordance with 10.3.2.2 and 10.3.4, unless the building is fully sprinklered.</p> <p>Upholstered furniture and mattresses belonging to nursing home residents do not have to meet these requirements as all nursing homes are required to be fully sprinklered.</p> <p>Newly introduced upholstered furniture and mattresses means purchased on or after the LSC final rule effective date.</p> <p>18.7.5.2, 18.7.5.4, 19.7.5.2, 19.7.5.4</p>				
K753	<p>Combustible Decorations</p> <p>Combustible decorations shall be prohibited unless one of the following is met:</p> <ul style="list-style-type: none"> • Flame retardant or treated with approved fire-retardant coating that is listed and labeled for product. • Decorations meet NFPA 701. • Decorations exhibit heat release less than 100 kilowatts in accordance with NFPA 289. • Decorations, such as photographs, paintings and other art are attached to the walls, ceilings and non-fire-rated doors in accordance with 18.7.5.6(4) or 19.7.5.6(4). • The decorations in existing occupancies are in such limited quantities that a hazard of fire development or spread is not present. <p>18.7.5.6, 19.7.5.6</p>				
K761	<p>Maintenance, Inspection & Testing - Doors</p> <p>Fire doors assemblies are inspected and tested annually in accordance with NFPA 80 <i>Standard for Fire Doors and Other Opening Protectives</i>.</p> <p>Fire doors that are not located in required fire barriers, including corridor doors to patient rooms and smoke barrier doors, are routinely inspected as part of the facility maintenance program.</p> <p>Individuals performing the door inspection and testing have an understanding of the operating components of the doors. Written records of inspection and testing are maintained and are available for review.</p> <p>18.7.6, 19.7.6, 8.3.3.1 (LSC), 5.2, 5.2.3 (NFPA 80)</p>				

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

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

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

ID PREFIX		MET	NOT MET	N/A	REMARKS
K908	<p>Gas and Vacuum Piped Systems – Inspection and Testing Operations</p> <p>The gas and vacuum systems are inspected and tested as part of a maintenance program and include the required elements. Records of the inspections and testing are maintained as required.</p> <p>5.1.14.2.3, B.5.2, 5.2.13, 5.3.13, 5.3.13.4 (NFPA 99)</p>				
K909	<p>Gas and Vacuum Piped Systems – Information and Warning Signs</p> <p>Piping is labeled by stencil or adhesive markers identifying the gas or vacuum system, including the name of system or chemical symbol, color code (Table 5.1.11), and operating pressure if other than standard. Labels are at intervals not more than 20 feet, are in every room, at both sides of wall penetrations, and on every story traversed by riser. Piping is not painted. Shutoff valves are identified with the name or chemical symbol of the gas or vacuum system, room or area served, and caution to not use the valve except in emergency.</p> <p>5.1.14.3, 5.1.11.1, 5.1.11.2, 5.2.11, 5.3.13.3, 5.3.11 (NFPA 99)</p>				
K910	<p>Gas and Vacuum Piped Systems – Modifications</p> <p>Whenever modifications are made that breach the pipeline, any necessary installer and verification test specified in 5.1.2 is conducted on the downstream portion of the medical gas piping system. Permanent records of all tests required by system verification tests are maintained.</p> <p>5.1.14.4.1, 5.1.14.4.6, 5.2.13, 5.3.13.4.3 (NFPA 99)</p>				
K911	<p>Electrical Systems – Other</p> <p>List in the REMARKS section any NFPA 99 Chapter 6 Electrical Systems requirements that are not addressed by the provided K-Tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567.</p> <p>Chapter 6 (NFPA 99)</p>				
K912	<p>Electrical Systems – Receptacles</p> <p>Power receptacles have at least one, separate, highly dependable grounding pole capable of maintaining low-contact resistance with its mating plug. In pediatric locations, receptacles in patient rooms, bathrooms, play rooms, and activity rooms, other than nurseries, are listed tamper-resistant or employ a listed cover.</p> <p>If used in patient care room, ground-fault circuit interrupters (GFCI) are listed.</p> <p>6.3.2.2.6.2 (F), 6.3.2.2.4.2 (NFPA 99)</p>				

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

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

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

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

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

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

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

ID PREFIX		MET	NOT MET	N/A	REMARKS
K933	<p>Features of Fire Protection – Fire Loss Prevention in Operating Rooms</p> <p>Periodic evaluations are made of hazards that could be encountered during surgical procedures, and fire prevention procedures are established. When flammable germicides or antiseptics are employed during surgeries utilizing electrosurgery, cautery or lasers:</p> <ul style="list-style-type: none"> • packaging is non-flammable. • applicators are in unit doses. • Preoperative "time-out" is conducted prior the initiation of any surgical procedure to verify: <ul style="list-style-type: none"> ○ application site is dry prior to draping and use of surgical equipment. ○ pooling of solution has not occurred or has been corrected. ○ solution-soaked materials have been removed from the OR prior to draping and use of surgical devices. ○ policies and procedures are established outlining safety precautions related to the use of flammable germicide or antiseptic use. <p>Procedures are established for operating room emergencies including alarm activation, evacuation, equipment shutdown, and control operations. Emergency procedures include the control of chemical spills, and extinguishment of drapery, clothing and equipment fires. Training is provided to new OR personnel (including surgeons), continuing education is provided, incidents are reviewed monthly, and procedures are reviewed annually.</p> <p>15.13 (NFPA 99)</p>				

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

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

PROVISION NUMBER(S)

JUSTIFICATION

K400

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

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

Provider Number K1	Facility Name	Survey Date *K4
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K6 DATE OF PLAN APPROVAL	K3 MULTIPLE CONSTRUCTION TOTAL NUMBER OF BUILDINGS _____ NUMBER OF THIS BUILDING _____	<input type="checkbox"/> A. BUILDING <input type="checkbox"/> B. WING <input type="checkbox"/> C. FLOOR <input type="checkbox"/> D. APARTMENT UNIT
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LSC FORM INDICATOR

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

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

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

*K7 SELECT NUMBER OF FORM USED FROM ABOVE

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

SMALL (16 BEDS OR LESS)

K8 1. PROMPT
2. SLOW
3. IMPRACTICAL

LARGE

K8 4. PROMPT
5. SLOW
6. IMPRACTICAL

APARTMENT HOUSE

K8 7. PROMPT
8. SLOW
9. IMPRACTICAL

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

K321: K351:

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

ENTER E – SCORE

K5: e.g. 2.5

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

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

FACILITY DOES NOT MEET LSC

B.

K0180

A. <input type="checkbox"/>	B. <input type="checkbox"/>	C. <input type="checkbox"/>
FULLY SPRINKLERED <small>(All required areas are sprinklered)</small>	PARTIALLY SPRINKLERED <small>(Not all required areas are sprinklered)</small>	NONE <small>(No sprinkler system)</small>

*MANDATORY

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

PROVIDER NUMBER K1 245083	FACILITY NAME PARK HEALTH A VILLA CENTER	SURVEY DATE *K4 10/12/2021
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K6 DATE OF PLAN APPROVAL	K3 : MULTIPLE CONSTRUCTION TOTAL NUMBER OF BUILDINGS <u>1</u> NUMBER OF THIS BUILDING <u>01</u>	<input checked="" type="checkbox"/> A BUILDING <input type="checkbox"/> B WING <input type="checkbox"/> C FLOOR <input type="checkbox"/> D APARTMENT UNIT
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<p>LSC FORM INDICATOR</p> <table border="1" style="width:100%; border-collapse: collapse;"> <tr><th align="center" colspan="3">Health Care Form</th></tr> <tr><td>12</td><td>2786 R</td><td>2012 EXISTING</td></tr> <tr><td>13</td><td>2786 R</td><td>2012 NEW</td></tr> </table> <table border="1" style="width:100%; border-collapse: collapse;"> <tr><th align="center" colspan="3">ASC Form</th></tr> <tr><td>14</td><td>2786 U</td><td>2012 EXISTING</td></tr> <tr><td>15</td><td>2786 U</td><td>2012 NEW</td></tr> </table> <table border="1" style="width:100%; border-collapse: collapse;"> <tr><th align="center" colspan="3">ICF/MR Form</th></tr> <tr><td>16</td><td>2786 V, W, X</td><td>2012 EXISTING</td></tr> <tr><td>17</td><td>2786 V, W, X</td><td>2012 NEW</td></tr> </table> <p>*K7 <input type="checkbox"/> 12 SELECT NUMBER OF FORM USED FROM ABOVE</p> <p><i>(Check if K321 or K351 are marked as not applicable in the 2786 M, R, T, U, V, W, X, Y and Z.)</i></p> <p>K321: <input type="checkbox"/> 3 K351: <input type="checkbox"/> 3</p>	Health Care Form			12	2786 R	2012 EXISTING	13	2786 R	2012 NEW	ASC Form			14	2786 U	2012 EXISTING	15	2786 U	2012 NEW	ICF/MR Form			16	2786 V, W, X	2012 EXISTING	17	2786 V, W, X	2012 NEW	<p>COMPLETE IF ICF/MR IS SURVEYED UNDER CHAPTER 21</p> <p>SMALL (16 BEDS OR LESS)</p> <p>K8: <input type="checkbox"/> 1 PROMPT 2 SLOW 3 IMPRACTICAL</p> <hr/> <p>LARGE</p> <p>K8: <input type="checkbox"/> 4 PROMPT 5 SLOW 6 IMPRACTICAL</p> <hr/> <p>APARTMENT HOUSE</p> <p>K8: <input type="checkbox"/> 7 PROMPT 8 SLOW 9 IMPRACTICAL</p> <hr/> <p>ENTER E-SCORE HERE</p> <p>K5: <input type="checkbox"/> e.g 2.5</p>
Health Care Form																												
12	2786 R	2012 EXISTING																										
13	2786 R	2012 NEW																										
ASC Form																												
14	2786 U	2012 EXISTING																										
15	2786 U	2012 NEW																										
ICF/MR Form																												
16	2786 V, W, X	2012 EXISTING																										
17	2786 V, W, X	2012 NEW																										

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

A1 <input type="checkbox"/> (COMP. WITH ALL PROVISIONS)	A2 <input checked="" type="checkbox"/> (ACCEPTABLE POC)	A3 <input type="checkbox"/> (WAIVERS)	A4 <input type="checkbox"/> (FSSES)	A5 <input type="checkbox"/> (PERFORMANCE BASED DESIGN)
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FACILITY DOES NOT MEET LSC: B. <input type="checkbox"/>	K180: A. <input checked="" type="checkbox"/> FULLY SPRINKLERED (All required areas are sprinklered) B. <input type="checkbox"/> PARTIALLY SPRINKLERED (Not all required areas are sprinklered) C. <input type="checkbox"/> NONE (No sprinkler system)
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*MANDATORY