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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: PKEG

Facility ID: 00578N

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245616**

2.STATE VENDOR OR MEDICAID NO.
(L2) **850026600**

3. NAME AND ADDRESS OF FACILITY
(L3) **LIFECARE GREENBUSH MANOR**
(L4) **19120 200TH STREET**
(L5) **GREENBUSH, MN** (L6) **56726**

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **10/20/2016** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 03 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

12.Total Facility Beds **40** (L18)

13.Total Certified Beds **40** (L17)

10.THE FACILITY IS CERTIFIED AS:

A. In Compliance With Program Requirements Compliance Based On:
___1. Acceptable POC

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	20	20		
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Yvonne Switajewski, HFE NEII 11/07/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath, Enforcement Specialist 12/05/2016 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
04/13/2009
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30)

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

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

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

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

CCN: 24 5616

At the time of the October 20, 2016 standard survey the facility was not in substantial compliance with Federal participation requirements. The facility has been given an opportunity to correct before remedies would be imposed. The most serious deficiency is a widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), whereby corrections are required. In addition at the time of the survey, the facility requested a Fire Safety Evaluation System (FSES) survey be conducted to determine compliance of life safety code deficiency cited at K0025. Please refer to the CMS-2567 for both health and life safety code along with the facility's plan of correction. Post Certification Revisit and FSES survey to follow.

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
October 27, 2016

Ms. Emily Straw, Administrator
Lifecare Greenbush Manor
19120 200th Street
Greenbush, Minnesota 56726

RE: Project Number S5616010

Dear Ms. Straw:

On October 20, 2016, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

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

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

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

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

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

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

DEPARTMENT CONTACT

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

Lyla Burkman, Unit Supervisor
Bemidji Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health

Email: Lyla.burkman@state.mn.us
Phone: (218) 308-2104
Fax: (218) 308-2122

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by November 29, 2016, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by November 29, 2016 the following remedy will be imposed:

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

been affected by the deficient practice;

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

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

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

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

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

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by January 20, 2017 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the

result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by April 20, 2017 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

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

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

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

Feel free to contact me if you have questions related to this eNotice.

Sincerely,

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health

Email: mark.meath@state.mn.us
Telephone: (651) 201-4118
Fax: (651) 215-9697

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245616	A. BUILDING ______ B. WING ______	10/20/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFECARE GREENBUSH MANOR	**19120 200TH STREET GREENBUSH, MN 56726**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 164 SS=D	483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS The resident has the right to personal privacy and confidentiality of his or her personal and clinical records. Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility. The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law.	F 164		10/31/16

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

Electronically Signed | 11/03/2016

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

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F 164 — F 164

Continued From page 1

The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident.

This REQUIREMENT is not met as evidenced by:
Based on observation, interview and document review, the facility failed to provide personal privacy for 2 of 2 residents (R36, R34) observed to have live feed video cameras placed in their rooms and turned on 24 hours a day, 7 days a week without defined structured use.

Findings included:

R36's quarterly Minimum Data Set (MDS) dated 8/28/16, indicated R36 was diagnosed with dementia, anxiety and a psychotic disorder. The MDS also indicated R36 had severe cognitive impairment, required extensive assistance of one staff for bed mobility, toileting, hygiene and bathing. Extensive assist of two staff for transferring. R36 did not ambulate.

R36's progress note dated 3/7/16, indicated a video monitoring system was implemented due to R36 not remembering to ask for help with mobility which resulted in frequent falls. The note indicated the receiving monitor would be kept at the nurses station.

R36's progress notes dated 6/4/16, and 6/26/16,

Provider's Plan of Correction:

1. R34 and R36 Video monitoring devices were removed.

2. No video monitoring devices will be utilized without proper assessment, structure, and monitoring and legal counsel review prior to implementation.

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F 164	Continued From page 2 indicated nursing staff had visualized R36 on the video monitoring system attempting self-transfers and were able to intervene prior to an incident occurring. R36's medical record lacked an assessment and individualized parameters related to the use of the continual video monitoring system such as when to turn on, turn off and when/how to provide personal privacy. On 10/17/16, at 7:38 p.m. a small Motorola video monitor was observed in the Edgewood nurses station. R36's room was visible on the screen, however, no persons were visible on the screen, at that time. On 10/18/16, at 8:26 a.m. while seated at the Edgewood's nurses station, R36 was observed on the Motorola video monitor in her room, seated in her wheelchair. -At 9:27 a.m. while seated at the Edgewood's nurses station, R36 was observed on the video monitor to be seated in her room, in a recliner with legs elevated and covered with a blanket. A surveyor was also observed next to her. The Edgewood's nurse's station had a window to the right of the monitor, however, the persons seen on the monitor, from the window, were not identifiable. On 10/19/16, at 7:09 a.m. nursing assistant (NA)-G stated the reason for R36 to be video monitored was due to R36 having frequent falls because the nurse's could monitor R36 while at the nurse's station and intervene more quickly if they noticed attempts of self-transfer. NA-G also	F 164		

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F 164	Continued From page 3	F 164		

stated when personal cares were provided, the monitor was turned away. NA-G verified the monitors were on all the time. NA-G confirmed housekeepers had access and visual ability of the monitor when in the nurse's station.

At 7:24 a.m. licensed practical nurse (LPN)-D stated the reason for personal video monitoring was R36's frequent falls. LPN-D stated she did not think the monitor was ever turned off and utilized as a prevention mechanism. LPN-D reported housekeepers, maintenance workers, and pharmacist had access to the area where the monitor was located and could visualize R36's room when in the nurse's station.

On 10/19/16, at 7:33 a.m. while seated at the Edgewood's nurse's station, R36 was viewed seated in the wheelchair while a NA was wheeling her towards the bathroom. Another NA was viewed picking up R36's sweater.

R34's quarterly Minimum Data set dated 8/1/16, indicated R34 was diagnosed with dementia, diabetes, heart failure, a stroke, dementia and hemiplegia (paralysis of one side of the body). The MDS also indicated R34 had intact cognition and required total assistance of one staff for hygiene, extensive assist of two staff for bed mobility, transfers and toileting and extensive assist for dressing and bathing. However, R34's significant change MDS dated 5/19/16, indicated R34 had moderate cognitive impairment.

R34's progress note dated 5/13/16, indicated the director of nursing (DON) had ordered a video monitoring system as an intervention to prevent/reduce the number of times R34 fell.

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F 164	Continued From page 4	F 164		

R34's medical record lacked an assessment and individualized parameters related to the use of the continual video monitoring system such as when to turn on, turn off and when/how to provide personal privacy.

On 10/19/18, at 7:45 a.m. a video monitor was observed positioned on the right side of a wooden desk in the Rosewood hallway near the main nurse's station. The desk was not marked, however, contained nursing materials. The monitor was covered with a bright pink laminated paper flip cover which indicated staff only. Behind the cover, R34's bedroom could be visualized. No staff noted to be around the desk at this time. This desk area is accessible to all residents, visitors, and staff.

On 10/19/16, at 7:50 a.m. LPN-D confirmed R34's monitor was essentially accessible to everybody and stated staff turned the monitor off during cares in the morning but did not know if R34 knew he was on video at all times related to R34's impaired cognition. LPN-D stated R34's monitoring system was implemented because of frequent falls and R34 not remembering to use the call light for help.

-At 8:00 a.m. NA-D stated the camera was moved during personal cares and was not aware if the monitoring system had audio function or not. NA-D stated the monitor never got turned off.

-At 10:19 a.m. the DON verified the facility did not have a policy or procedure related to the use of the video monitoring system nor were assessments completed to determine the appropriate use. The DON had provided a policy for Security Management, however, this failed to

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F 164	Continued From page 5 address the use of personal video monitoring. The DON stated the resident's privacy was protected by turning the monitors around during personal cares or only providing personal cares in the restroom and by placing the monitors in the nurse's stations so they were not accessible to all. However, this directive was not identified on the individual residents care plans. On 10/19/16, at 8:12 p.m. the licensed social worker (LSW), stated the video monitoring system was put in place for R36 related to frequent falls and family request due to falls. The LSW explained prior to the implementation, the interdisciplinary team (IDT) discussed privacy concerns related to use of the monitoring system however, concluded by not providing personal cares in the direct line of the camera would protect the resident's privacy. When asked if the facility attempted to identify specific times the camera could be turned off and had the facility developed a removal plan for the use of the cameras, the LSW stated both R36 and R34 were very unpredictable with no identifiable pattern of the falls therefore, the cameras were not to be turned off. The LSW stated the monitoring system would be discontinued when the individual resident no longer benefited from the use such as when their risk for falls or the number of falls decreased. The facility provided a copy of the resident Combined Federal and State Bill of Rights dated January 2016. The Bill of Rights explained personal privacy included accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups.	F 164		

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F 225	Continued From page 6	F 225		
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.	F 225		11/4/16

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LIFECARE GREENBUSH MANOR	**19120 200TH STREET** **GREENBUSH, MN 56726**

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F 225	Continued From page 7 This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to immediately report an allegation of misappropriation of funds to the State agency for 1 of 4 residents (R4) reviewed for abuse prohibition who had reported missing money which was not reported to the State agency timely. Findings include: R4's quarterly Minimum Data Set (MDS) dated 9/14/16, indicated R4 was cognitively intact and had diagnoses which included chronic obstructive pulmonary disease and heart failure. The MDS also indicated R4 required extensive assistance of one person for dressing and was independent with other activities of daily living. The facility submitted an Incident Report to the Office of Health Facility Complaints (OHFC) on 7/5/16, which indicated on 6/30/16, R4 reported she was missing $30. The report indicated the director of nursing (DON) and licensed social worker (LSW) were notified on 6/30/16, that a nurse had been in R4's room rummaging in her purses. The report further indicated the LSW interviewed R4 on 7/5/16, who stated she didn't think much of it as she trusted everybody. However, after the nurse had left R4's room, R4 had looked in her purse and $30 (10-$1, 2-$5, and 1-$10) was missing from a snap billfold. On	F 225	1. All incidents of suspected abuse will be reported immediately. 2. Licensed staff will receive education on Vulnerable Adult policy and reporting procedures. 3. Administrator or designee will audit all future Vulnerable Adult Reports for the next three months to ensure timely reporting. Quality Assurance and Performance Improvement committee will review findings for compliance, necessary follow up or recommendations.	

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F 225	Continued From page 8 7/7/16, LSW and DON spoke with the nurse who denied the allegation. R4 reported missing money to staff on 6/30/16, however, this allegation had not been reported to the State agency (SA) until 7/5/16, five days later. On 10/20/2016, at 7:59 a.m. the administrator stated she did not know why the incident had not been reported to the state agency immediately. The administrator verified the facility policy directed to report immediately. The administrator stated the employee may have been off duty and they had waited until they could speak with her, however, confirmed the incident should have been reported first. On 10/20/16, at 8:06 a.m. the DON stated she did not recall why there was a delay in reporting. On 10/20/16, at 8:08 a.m. the LSW was interviewed via telephone with the administrator. The LSW stated she did not remember why there was a delay in reporting the allegation. The adminstrator indicated the Internal Review Investigation Assessment indicated the time reported was 7/5/16, due to miscommunication. The LSW stated she could not recall the specific details of the miscommunication and confirmed the incident should have been reported immediately. The undated Suspected Abuse or Neglect of a Vulnerable Adult Policy and Procedure identified theft of a patient's property as an indicator of	F 225		

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F 225	Continued From page 9 maltreatment of a vulnerable adult. The policy indicated incidents of maltreatment of a vulnerable adult by anyone should be reported immediately to the supervisor, DON or LSW. The licensed staff would report immediately to OHFC.	F 225		
F 226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to implement their abuse prohibition policy and procedures related to the immediate reporting of potential financial exploitation to the State agency for 1 of 4 residents (R4) reviewed for abuse prohibition who had an allegation of missing money which was not reported to the State agency timely. Findings include: The undated Suspected Abuse or Neglect of a Vulnerable Adult Policy and Procedure identified theft of a patient's property as an indicator of maltreatment of a vulnerable adult. The policy indicated incidents of maltreatment of a vulnerable adult by anyone should be reported immediately to the supervisor, DON or LSW. The licensed staff would report immediately to the	F 226	1. All incidents of suspected abuse will be reported immediately. 2. Licensed staff will receive education on Vulnerable Adult policy and reporting procedures. 3. Administrator or designee will audit all future Vulnerable Adult Reports for the next three months to ensure timely reporting. The Quality Assurance and Performance Improvement committee will review findings for compliance, necessary follow up or recommendations.	11/4/16

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F 226	Continued From page 10	F 226		

Office of Health Facilty Complaints (OHFC).

The facility submitted an Incident Report to OHFC on 7/5/16, which indicated on 6/30/16, R4 reported she was missing $30. The report indicated the director of nursing (DON) and licensed social worker (LSW) were notified on 6/30/16, that a nurse had been in R4's room rummaging in her purses. The report further indicated the LSW interviewed R4 on 7/5/16, who stated she didn't think much of it as she trusted everybody. However, after the nurse had left R4's room, R4 had looked in her purse and $30 (10-$1, 2-$5, and 1-$10) was missing from a snap billfold. On 7/7/16, LSW and DON spoke with the nurse who denied the allegation.

On 10/20/2016, at 7:59 a.m. the administrator stated she did not know why the incident had not been reported to the state agency immediately. The administrator verified the facility policy directed to report immediately. The administrator stated the employee may have been off duty and they had waited until they could speak with her, however, confirmed the incident should have been reported first.

On 10/20/16, at 8:06 a.m. the DON stated she could not recall why there was a delay in reporting the allegation.

On 10/20/16, at 8:08 a.m. the LSW was interviewed via telephone with the administrator. The LSW stated she did not remember why there

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F 226	Continued From page 11 was a delay in reporting the allegation. The adminstrator indicated the Internal Review Investigation Assessment indicated the time reported was 7/5/16, due to miscommunication. The LSW stated she could not recall the specific details of the miscommunication and confirmed the incident should have been reported immediately.	F 226		
F 242 SS=D	483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to honor resident request related to morning wake/rising time for 1 of 3 residents (R10) reviewed for choices whose request to sleep in was denied. Findings include: On 10/19/16, at 7:40 a.m. nursing assistant (NA)-A was observed to enter R10's room, turn on the light and inform R10 it was time to get up for the day. R10 stated she did not want to get up. NA-A informed R10 she had to get up for breakfast. R10 replied "I don't want to get up."	F 242	1. All resident□s choices will be respected when requested by resident. 2. All staff received education on 10/28 relating to resident choices and rights. 3. Resident preferences will be discussed and documented with the resident and/or family on admission and quarterly at care conferences. 4. Director of Nursing or designee will conduct audits on all new admissions within 14 days to assure that preferences are being identified and documented. Observational audits will be conducted on	11/7/16

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F 242	Continued From page 12 NA-A stated let's get motivated, you are going to be mad in which R10 stated, "yes I am." R10 asked NA-A why she was in so early to get her up in which NA-A asked R10 if she wanted to get up at lunch time? R10 stated "yes." NA-A stated this was the normal routine and with NA-B's assistance, proceeded to assist R10 out of bed, into a wheelchair and wheeled into the bathroom. -At 7:45 a.m. R10 stated "I wish you could let me sleep." NA-A told R10 she always felt better once she got up. NA-A proceeded to provide morning cares and dressing. -At 7:49 a.m. R10 asked NA-A why she had to get up. NA-A stated because you can go back to bed later. NA-A continued to provide morning cares and dressing. -At 7:52 a.m. R10 again stated, "Why can't I sleep?" NA-A stated because you have to eat breakfast. NA-A finished providing morning cares and dressed R10 and proceeded to wheel R10 to the dining room for breakfast. On 10/19/16, at 12:45 p.m. NA-A stated she wakes R10 up because otherwise, R10 would stay in bed. -At 12:50 p.m. registered nurse (RN)-A stated R10 could stay in bed and sleep longer if she desired and confirmed R10's request to stay in bed/sleep should have been respected. -At 2:05 p.m. the director of nursing (DON) verified R10's request to stay in bed/sleep should have been respected.	F 242	3 variable residents at variable times and shifts 3 times a week for three months to ensure resident choices are being respected. 5. The Quality Assurance and Performance Improvement committee will review findings for compliance, necessary follow up or recommendations.	

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F 242	Continued From page 13 The facility's undated, Caring for Generation booklet indicated the nursing home created an environment of care which met the individual needs of each of the residents.	F 242		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure oral hygiene was provided as directed by the care plan for 1 of 1 resident (R10) who was dependent on staff for oral hygiene. Findings include: R10's care plan edited on 8/26/16, indicated R10 was totally dependent on staff for oral hygiene and was to receive oral hygiene two times a day. On 10/19/16, at 7:40 a.m. R10's personal cares were observed. Nursing assistant (NA)-A entered R10's room, turned on the light and stated it was time to get up for the day. NA-A transferred R10 into wheelchair (w/c) with assist from NA-B. R10	F 282	1. Appropriate oral cares will be completed for R10 and all other residents as directed by the residents plan of care. 2. All nursing staff will be educated on facility policy (last reviewed 7/2015) regarding following the plan of care for all residents. 3. The Director of Nursing or designee will conduct observational audits on three variable residents on either morning or evening shift three times per week for three months to ensure plans of care are being followed appropriately. 4. The Quality Assurance and Performance Improvement committee will review findings for compliance, necessary follow up or recommendations.	11/7/16

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F 282	Continued From page 14 was wheeled into bathroom. NA-A put R10's dentures into her mouth without providing any oral hygiene. On 10/19/16, at 12:45 p.m. NA-A confirmed she had not provided R10 with any oral hygiene prior to inserting R10's dentures into her mouth. -At 12:50 p.m. registered nurse (RN)-A verfied R10's care plan was correct and oral hygiene was to be completed two times a day. -At 2:05 p.m. the director of nursing (DON) verified NA-A should have provided oral hygiene as directed by R10's plan of care. A facility policy on care planning implementation was requested however, no policy was received. The facility's Oral Cares policy, revised 6/09, indicated oral care would be provided to each resident.	F 282		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.	F 309		11/7/16

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F 309	Continued From page 15 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure consistent monitoring of a chronic health condition which required diuresis for 1 of 1 resident (R34) who received a diuretic without adequate and consistent fluid monitoring and observed to show signs and symptoms of the onset of respiratory distress/fluid overload. Findings included; R34's Diagnosis Listing report indicated R34 was diagnosed with heart failure, atrial fibrillation, chronic obstructive pulmonary disease (COPD), history of stroke, hypertension, diabetes, and dementia. R34's quarterly Minimum Data Set (MDS) dated 8/1/16, also indicated R34 was diagnosed with heart failure, hypertension, COPD, and had intact cognition. At the time of the assessment, the MDS indicated R34 received a diuretic medication and weighed 188 pounds. R34's physician visit note dated 10/3/16, indicated R34 had been gaining weight, however it was not clear if the weight gain was related to fluid retention or dietary gains. The physical also noted R34 had more respiratory wheezing, decreased lung sounds, and moist lung sounds in the left and right bases of the lungs. The presence of adventitious breath sounds on exam	F 309	1. Nursing staff contacted R34s physician for guidance on increased monitoring related to diuresis. MD Orders received for clarification were 1. Weight monitoring daily starting 10/19/16. (Decreased 10/24 to weekly) and 2. Lung sounds started daily on 10/15/16. Orders were implemented immediately upon their receipt. 2. All residents currently receiving a diuretic will be reviewed for appropriate monitoring and necessary follow up with physician will occur as needed. Residents receiving a new or increased dose of a diuretic will be reviewed for appropriate monitoring and necessary follow up with physician at the time of occurrence. Licensed staff will be educated on the care path for symptoms of congestive heart failure. 3. The Care Coordinator or designee is responsible for auditing orders/recommendations as new or increased diuretics are ordered for three months to ensure appropriate monitoring. 4. The Quality Assurance and Performance Improvement committee will review findings for compliance, necessary follow up or recommendations.	

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was a change from previous physical exams conducted on 6/6/16, and 8/1/16, when the physician noted R34's lungs were clear. The physician ordered a chest X-ray to evaluate for pleural effusions (extra fluid in the lungs).

R34's had a chest X-ray on 10/3/16, which indicated changes to the heart and revealed an enlarged heart and fluid in the lungs. The physician reviewed the chest X-ray results on 10/4/16, and indicated R34 had a very enlarged heart with extra fluid despite the Lasix (diuretic) adminsitered. The physician's plan included increase in diuretic medication and lab follow-up in two weeks.

R34's current physician orders provided by the facility on 10/20/16, included:
-Lasix 80 milligrams (mg) twice a day for heart failure started on 11/10/15
-Zaroxolyn (diuretic medication) 2.5 mg once a day for heart failure which was started 10/5/16.
-Potassium Chloride extended release 20 milli-equals (meq) three times a day. The dose reflects the increase on 10/5/16.
-Oxygen 2 liters per minute (lpm) via nasal cannula at night and as needed.
-Lisinopril 10 mg every day for hypertension which was started on 5/26/15
-Albuterol sulfate nebulizer 2.5mg/ml (milliliter) four times a day which was started on 8/22/16

R34's current electronic care plan printed on 10/21/16, lacked identification of R34's enlarged heart or fluid overload except for the increase of the potassium ordered by the physician. The care plan had identified the diagnoses of congestive heart failure, atrial fibrillation, hypertension, and

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COPD dated 6/8/2015. The care plan informed staff R34 was at risk for peripheral edema, fluid overload, and difficulty with breathing. R34's care plan directed staff to administer the diagnoses associated medications and perform the following interventions:

-weigh on the first day of every month dated 6/25/15
-monitor for edema once a day dated 5/26/15
-oxygen therapy at 2 liters per minute at bedtime and as needed dated 5/26/15
-vital signs every week on Friday dated 5/6/16
-check off if short of breath with exertion as needed dated 2/18/16

R34's October's medication administration record (MAR) reflected daily administration of Zaroxolyn 2.5 mg and Lasix 80 mg together at 8:00 a.m. and then Lasix 80 mg at noon from 10/6/16, through 10/19/16. The MAR also reflected administration of Potassium 20 meq three times a day starting on 10/6/16.

R34's weight record reflected monthly weights were obtained however, did not reflect an increase in the frequency of monitoring the weights after the findings of fluid retention and the initiation of a new diuretic medication. On 8/1/16, R34's weight was 188.2 lbs. and on 9/1/16, his weight was 191lbs, a 2.8 lbs. increase. The last weight recorded in the record was on 10/1/16, 198 lbs which was a 7 lb. increase. On 10/19/16, the surveyor requested R34's weight be obtained which revealed an almost two pound weight increase at 199.8.

R34's progress notes were reviewed from 9/1/16,

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F 309	Continued From page 18 and revealed the following: -9/13/16, increased shortness of breath after ambulation. -10/5/16, reflected the change in physician's orders to include the new diuretic, increase in potassium, and nursing implemented intervention to encourage cough and deep breathing frequently to induce coughing. However, R34's record had not reflected evidence this intervention was monitored for compliance, and assessed/ evaluated for effectiveness. -10/7/16, reflects an unscheduled nurse practitioner visit related to chest pain and labored breathing. Nitro and Maalox were administered which provided relief. -10/14/16, R34 had another episode of chest pain and a respiratory assessment revealed audible wheezes and occasional expiratory wheezes noted which reflected a change from R34's previous physician assessment on 10/3/16. Nursing would monitor R34's lung sounds for three days and if there was a change the physician would be notified. R34's record did not reflect physician notification of the presence and change of lung sounds since last assessed on 10/3/16, by the physician. -10/15/16, at 3:23 p.m. R34 felt like he was choking, had chest discomfort, diminished lung sounds, and expiratory wheezes throughout both upper lobes of the lung. R34 was administered oxygen 4 lpm. At 7:02 p.m. R34 was administered oxygen 3 lpm for oxygen saturations of 88% on room air. The record does not reflect physician notification of change in lung sounds with increased oxygen use or a physician order to administer the increased oxygen amounts. -10/16/16, R34 had diminished breath sounds in both longs with a non-productive cough.	F 309		

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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) COMPLETION DATE
F 309	Continued From page 19	F 309		

-10/17/16, became short of breath after ambulation. Notes do not reflect physician notification.

On 10/18/16, at 11:32 a.m. during an interview, R34's breathing was noted to be rapid and labored. Respirations were 26 per minute. R34 stated he felt short of breath and had just got done with his morning exercises. Registered nurse (RN)-B was asked to assess R34. RN-B obtained R34's vital signs which were within normal limits however, RN-B did not listen to R34's lungs. R34's respiration rate went back to normal after instruction from nurse to take some deep breaths. The shortness of breath episode lasted 7 minutes.

On 10/19/16, at 8:46 a.m. RN-B verified R34 had a history of COPD, had not had respiratory status changes, and confirmed the physician had not been notified regarding his respiratory status since the findings of the chest X-ray and implementation of new medications. RN-B confirmed the facility had not implemented more frequent weight checks, full respiratory assessments which would include lung sounds, or intake and output monitoring. RN-B stated nursing continued to monitor for edema, vital signs, and shortness of breath which were interventions that had already been in place prior to the new medical condition. RN-B stated Zaroxolyn ideally should not be administered with Lasix, however the physician had not ordered the medication that way so it was scheduled with the other medication.

On 10/19/16, at 1:20 p.m. the director of nursing (DON) confirmed R34 did get short of breath when he walked and required rest breaks. The

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	245616	A. BUILDING ______ B. WING ______	10/20/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFECARE GREENBUSH MANOR	**19120 200TH STREET GREENBUSH, MN 56726**

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F 309 Continued From page 20 F 309

DON stated she expected nursing to monitor for edema, excessive shortness of breath (more than usual), and listen to lung sounds. The DON also stated R34's family did not want him to be aggressively treated and if the physician did not want the Zaroxolyn administered with the Lasix, they would specifically indicate that otherwise the medication was scheduled at the standard dosing times despite manufacturer's recommendations.

On 10/20/16, at 8:15 a.m. consulting pharmacist (CP)-A stated the Zaroxolyn's recommendations for administering literature indicated to give the medication 30 minutes earlier than the other diuretics for ideal effectiveness, however, it would also depend on the individual and their clinical status. CP-A stated follow-up lab tests should include potassium and creatinine and should be obtained between a couple of days, if unstable, to a couple of weeks (but noted a couple of weeks is getting to the end of the ideal time to reassess). CP-A stated weights should be monitored at the very least weekly, R34 should be monitored for signs and symptoms of dehydration as well as R34's intake and output. CP-A stated education pertaining congestive heart failure was probably needed.

The facility Resident Condition Updates policy last reviewed 7/99, indicated the residents primary care physician would be notified of a change of status of non-urgent matters during clinic hours. The policy did not include parameters or outline reasons for physician notification.

The facility Weight Monitoring in LTC policy, last reviewed 2/16, indicated resident weights would be monitored monthly to ensure the residents

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F 309	Continued From page 21 were maintaining acceptable parameters of nutritional status. The policy indicated a change in frequency of weight collection would only occur if there was a significant weight change (loss or gain) of 5% or more in one month or 10% or more in six months. The policy lacked adjusting frequency in weight monitoring for medication monitoring purposes where waiting for that degree of a weight change could be potentially fatal. A facility policy on monitoring for management of fluid overload was requested and not received.	F 309		
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide oral hygiene prior to the insertion of dentures for 1 of 1 resident (R10) observed who was dependent on staff for oral hygiene. Findings include: R10's quarterly Minimum Data Set (MDS) dated 8/30/16, indicated R10's diagnoses included dementia, heart failure and anxiety disorder. The	F 312	1. Appropriate oral cares will be completed for R10 and all other residents as directed by the residents plan of care. 2. All nursing staff will be educated on facility policy (last reviewed 7/2015) regarding following the plan of care for all residents. 3. The Director of Nursing or designee will conduct observational audits on three variable resents on either morning or evening shift three times per week for	11/7/16

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F 312	Continued From page 22 MDS indicated R10 required extensive assistance of one staff for all activities of daily living (ADL) which included grooming/hygiene. R10's Activity of Daily Living Care Area Assessment dated 3/15/16, indicated R10 had dementia and required assist from staff for ADL's. R10's care plan edited on 8/26/16, indicated R10 was totally dependent on staff for oral hygiene and directed staff to provide oral hygiene two times a day. On 10/19/16, at 7:20 a.m. nursing assistant (NA)-A was observed to provide R10 morning cares. NA-A and NA-B transferred R10 into the wheelchair, wheeled R10 into the bathroom and onto the toilet. shortly thereafter, R10 was assisted back into the wheelchair and assisted over to the sink. NA-A proceeded to insert R10's dentures, however failed to provide oral hygiene prior to inserting the dentures. NA-A wheeled R10 from the room and returned to bag the garbage and tidy the room. On 10/19/16, at 12:45 p.m. NA-A confirmed she had not provided R10 with any oral hygiene prior to inserting the dentures into R10's mouth. -At 12:50 p.m. registered nurse (RN)-A verfied she would expect R10 to receive oral hygiene before having dentures put into mouth and stated oral hygiene should be completed morning and night.	F 312	three months to ensure plans of care are being followed appropriately. 4. The Quality Assurance and Performance Improvement committee will review findings for compliance, necessary follow up or recommendations.	

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F 312	Continued From page 23 -At 2:05 p.m. the director of nursing (DON) verified NA-A should have provided oral hygiene to R10 before putting the dentures into her mouth. The facility's Oral Cares policy, revised 6/09, indicated oral healthcare and dental services would be provided to each resident.	F 312		
F 431 SS=E	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of	F 431		11/7/16

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F 431	Continued From page 24 controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure proper storage of medications for 5 of 20 residents (R30, R27, R2, R35, R13) reviewed for medication storage who had medications preset up in unlabeled containers. In addition, the facility failed to properly label 2 of 3 insulin pens with a "when opened" dates in order to determine expiration date which had the potential to affect 1 of 2 residents (R43) who received insulin. Findings include: On 10/20/16, at 8:29 a.m. the Edgewood medication cart was reviewed with licensed practical nurse (LPN)-B and the following was observed: -The compartment for R20's medications contained an unlabeled paper medication cup with pills. LPN-B identified the cup to contain: Paxil 10 milligram (mg) (treats depression), Celebrex 100 mg (non-steroidal anti-inflammatory), Multivitamin and Tylenol 1000	F 431	1. All resident□s medications will be passed to the resident from their original and properly labeled containers. All insulin pens will be labeled with date open and appropriate expiration date. 2. All licensed nurses will be educated on the medication administration and storage policy. 3. The Director of Nursing or designee will conduct audits three times per week on various shifts and times by asking the nurse to show them all the drawers in their medication cart to assure no medications are being set up prior to administration for three months. The night nurse will audit all medications requiring dates when opened once a week for three months while ordering medications. Licensed staff will receive education on the medication administration and storage policy. 4. The Quality Assurance and Performance Improvement committee will review findings for compliance, necessary	

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F 431	Continued From page 25 mg. LPN-B stated R20 did not want to take her medication when offered. -The compartment for R27 medications contained an unlabeled paper medication cup with pills. LPN-B identified the cup to contain: Baclofen 5 mg (muscle relaxant). LPN-B stated R27 wanted to wait to take his medication -The compartment for R35's medications contained an unlabeled paper medication cup with pills. LPN-B identified the cup to contain: Diltiazem CD 120 mg (treats high blood pressure), Indapamide 2.5 mg (treats high blood pressure and fluid retention) , Lasix 20 mg (treats fluid retention), Zoloft 25 mg (antidepressant), Toprol XL 100 mg (treats high blood pressure), Vitamin D 1000 units (vitamin supplement), Tylenol 1000 mg, Zyrtec 10 mg (treats allergy symptoms), PreserVision (supplement for vision), and Citrocal (calcium supplement with vitamin D). The compartment also contained a plastic medication cup with powder. LPN-B identified the powder as MiraLax 17 gm (laxative). LPN-B stated R35 was going to the bathroom when she brought her the medications so they were not administered. -The compartment for R13's medication contained an unlabeled paper medication cup with pills. LPN-B identified the cup to contain Tylenol 650 mg, Xanax 0.125 mg (anti-anxiety), and Seroquel 50 mg (antipsychotic). LPN-B stated R13 was going to go get her hair done when she had brought her the medications so they were not administered. -The compartment for R2's medications contained an unlabeled paper medication cup	F 431	follow up or recommendations.	

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F 431	Continued From page 26 with one pill. LPN-B identified the cup to contain: Norco 5/325 mg (schedule II narcotic pain medication). LPN-B stated the medication was not due to be given to R2 until 10:00 a.m. When asked, LPN-B stated she usually did not dish up medications ahead of time and store them in the medication cart. On 10/20/2016, at 8:53 a.m. the Rosewood medication cart was reviewed with LPN-A. R43's open Novolog Flexpen and open Lantus Flexpen lacked labels or markings which indicated when the insulin pens had been opened. LPN-A verified the flexpens had been used for R43 and were not labeled with a "when opened" date. LPN-A stated the flexpen should have been labeled with the date they were opened. On 10/20/2016, at 9:15 a.m. the director of nursing (DON) confirmed medications should not be dispensed into a medication cup in advance and stored in the medication cart for later administration. The DON also confirmed insulin pens should be dated when opened. The undated Labeling and Storing of Medication policy directed the medications of each patient shall be kept and stored in their originally received containers. Schedule II drugs were to be separately locked with double locks on the medication cart.	F 431		
F 441	483.65 INFECTION CONTROL, PREVENT	F 441		11/7/16

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F 441 SS=D	Continued From page 27	F 441		

SPREAD, LINENS

The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.

(a) Infection Control Program
The facility must establish an Infection Control Program under which it -
(1) Investigates, controls, and prevents infections in the facility;
(2) Decides what procedures, such as isolation, should be applied to an individual resident; and
(3) Maintains a record of incidents and corrective actions related to infections.

(b) Preventing Spread of Infection
(1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.
(2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.
(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.

(c) Linens
Personnel must handle, store, process and transport linens so as to prevent the spread of infection.

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F 441	Continued From page 28 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure hand hygiene was performed following the provision of personal cares for 1 of 1 resident (R10) observed to receive personal cares without staff performing proper hand hygiene. Findings include: On 10/19/16, at 7:20 a.m. nursing assistant (NA)-A entered R10's room, turned on the light and stated it was time to get up for the day. NA-A and NA-B proceeded to transfer R10 into the wheelchair. R10 was wheeled into bathroom and transferred on to toilet. When R10 was done using toilet, NA-A applied rubber glove and proceeded to cleanse R10's bottom repeating the process three times due to R10 having had a bowel movement. NA-A removed and discarded her gloves and without performing hand hygiene, donned clean gloves. R10 was transferred back into the wheelchair and wheeled to the sink. With the same gloved hands, NA-A placed her gloved fingers inside R10's mouth to assist her with inserting R10's dentures. NA-A wheeled R10 from the room and returned to bag the garbage and tidy the room. On 10/19/16, at 12:45 p.m. NA-A confirmed she had not washed her hands after removing her gloves after providing toileting care and stated she should have done so.	F 441	1. R10 and all residents will receive all cares appropriately and staff will perform proper hand hygiene during all cares. 2. All staff will be educated on the infection control policy and proper hand hygiene. 3. Director of Nursing or designee will conduct observational audits three times per week on three variable residents on either morning or evening shift for three months to ensure proper hand hygiene is completed before, during or after all direct cares that are performed.	

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F 441	Continued From page 29 -At 12:50 p.m. registered nurse (RN)-A verfied she would expect handwashing to be done after removing gloves and before putting on new gloves during personal cares. -At 2:05 p.m. the director of nursing verified NA-A should have washed her hands before applying another pair of gloves. The facility's Long Term Care Infection Control policy, revised 1/09, indicated handwashing was the most important means of interrupting transmission of infection to residents and employees.	F 441		

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

F5616010

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FORM APPROVED
OMB NO. 0938-0391

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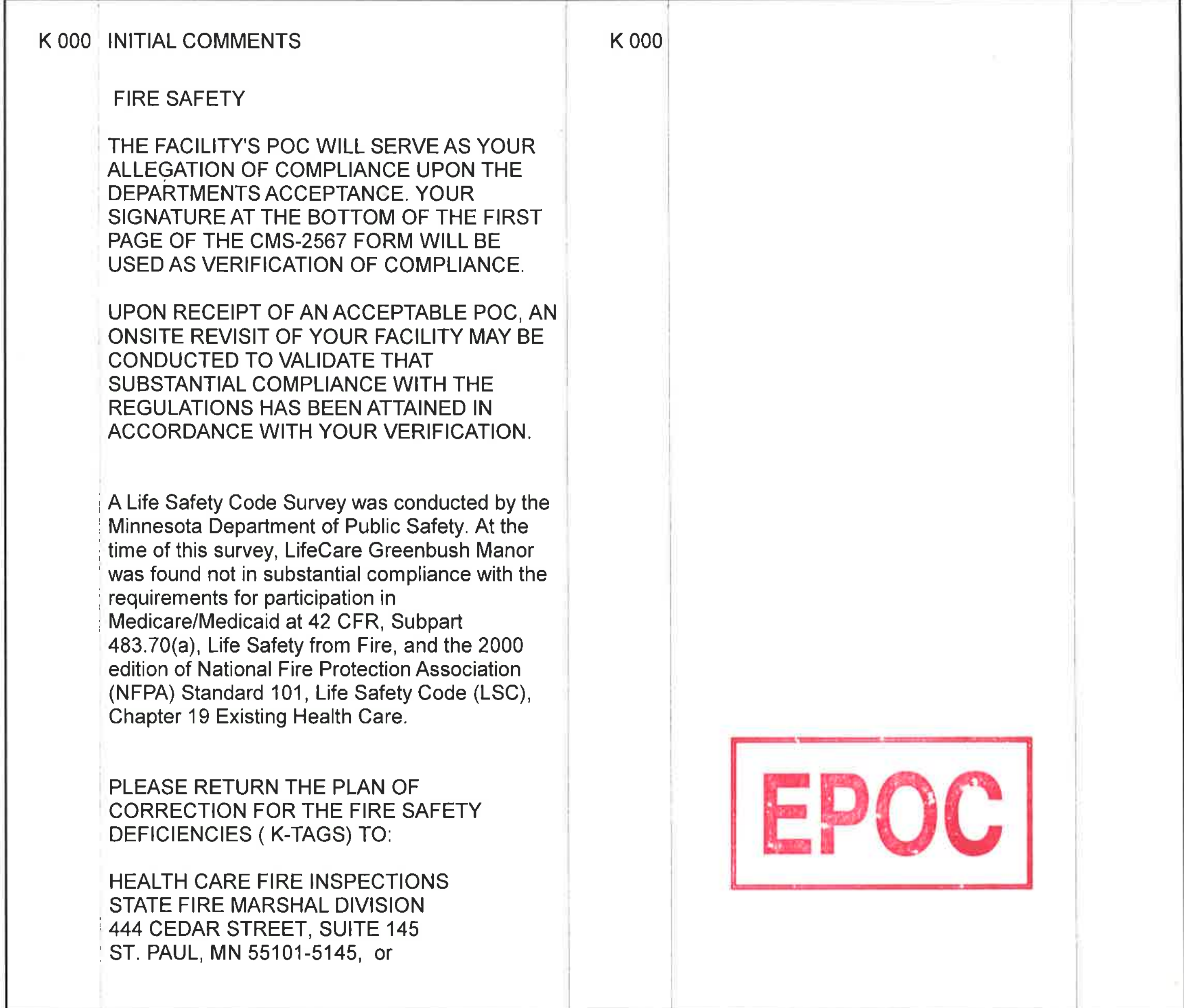
	245616	A. BUILDING **02 - GREENBUSH MANOR** B. WING ______	**10/18/2016**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFECARE GREENBUSH MANOR	**19120 200TH STREET** **GREENBUSH, MN 56726**



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K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENTS ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety. At the time of this survey, LifeCare Greenbush Manor was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: HEALTH CARE FIRE INSPECTIONS STATE FIRE MARSHAL DIVISION 444 CEDAR STREET, SUITE 145 ST. PAUL, MN 55101-5145, or	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		11/04/2016

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

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K 000	Continued From page 1	K 000		

By e-mail to:
Marian.Whitney@state.mn.us
and
Angela.Kappenman@state.mn.us

THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION:

1. A description of what has been, or will be, done to correct the deficiency.

2. The actual, or proposed, completion date.

3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency.

LifeCare Greenbush Manor was built in 2010, is a 1-story building without a basement and was determined to be Type V(111) construction, A clinic and an assisted living building are attached and separated with 2-hour fire barriers between the Manor and the clinic, and the Manor and the assisted living building.

The facility is divided into 4 smoke compartments with 1-hour and 2-hour fire barriers. The facility is fully protected with an automatic sprinkler system installed in accordance with NFPA 13 The Standard for the Installation of Sprinkler Systems 1999 edition. The facility has a fire alarm system which includes corridor smoke detection throughout and in all common areas, installed in accordance with NFPA 72 "The National Fire Alarm Code" 1999 edition. All sleeping rooms have smoke detection and hazardous areas have automatic fire detection in accordance with the

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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) COMPLETION DATE
K 000	Continued From page 2 Minnesota State Fire Code 2007 edition. The fire alarm system is monitored for automatic fire department notification. The facility has a capacity of 40 beds and had a census of 40 at the time of the survey. The facility was surveyed as one building. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 025 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers shall be constructed to provide at least a one hour fire resistance rating and constructed in accordance with 8.3. Smoke barriers shall be permitted to terminate at an atrium wall. Windows shall be protected by fire-rated glazing or by wired glass panels in approved frames. 8.3, 18.3.7.3, 18.3.7.5 This STANDARD is not met as evidenced by: Based on observations and staff interview, it was determined that the facility failed to maintain smoke barrier walls in accordance with NFPA 101-2000 edition, Sections 18.3.7, 18.3.7.1, 18.3.7.3, 8.3.2, and 8.3.6. This deficient practice could allow the products of combustion spread throughout the facility in the event of a fire which could affect all 40 residents, staff and visitors. Findings include: On facility tour between 8:00 am to 12:00 pm on 10/18/2016, it was observed that the smoke barrier walls do not extend thought the attic space above the ceiling. This condition is not covered by the NFPA 101 (00) 8-3.2 exceptions and does not meet the requirement for a smoke barrier wall.	K 025	Correction not needed. LifeCare Greenbush Manor has achieved a passing FSES score. Reports emailed to Tom Linhoff at the State Fire Marshal's office.	11/3/16

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245616	A. BUILDING 02 - GREENBUSH MANOR B. WING	10/18/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFECARE GREENBUSH MANOR	19120 200TH STREET GREENBUSH, MN 56726

(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 025	Continued From page 3 This deficient practice was confirmed by the Maintenance Supervisor.	K 025		

ZONE 1 OF 4 ZONES

FIRE/SMOKE ZONE* EVALUATION WORKSHEET FOR HEALTH CARE FACILITIES

2000 LIFE SAFETY CODE

FACILITY LifeCare Greenbush Manor	BUILDING 02-Greenbush Manor
ZONE(S) EVALUATED Rosewood	
PROVIDER/VENDOR NO. 245616	DATE OF SURVEY 11/02/2016

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

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

TABLE 1. OCCUPANCY RISK PARAMETER FACTORS

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

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

TABLE 2. OCCUPANCY RISK FACTOR CALCULATION

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

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

TABLE 3A. (NEW BUILDINGS)	TABLE 3B. (EXISTING BUILDINGS)
1.0 x F [7.6] = R [7.6] = 8	0.6 x F [ ] = R [ ]

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

SURVEYOR SIGNATURE Robert L. [signature] – Fire Safety Resources, LLC	TITLE President	DATE 11/03/2016
FIRE AUTHORITY SIGNATURE Thomas Linhoff 12424 [signature]	TITLE Fire Safety Supervisor	DATE 11-07-2016

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

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

TABLE 4.

Safety Parameters — **Safety Parameters Values**

1. Construction

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

Safety Parameters					
2. Interior Finish (Corridors and Exits)	Class C	Class B	Class A		
	-5(0)[f]	0(3)[f]	3		
3. Interior Finish (Rooms)	Class C	Class B	Class A		
	-3(1)[f]	1(3)[f]	3		
4. Corridor Partitions/Walls	None or Incomplete	<½ hour	≥½ to <1 hour	≥1 hour	
	-10(0)[a]	0	1(0)[a]	2(0)[a]	
5. Doors to Corridor	No Door	<20 min FPR	≥20 min FPR	≥20 min FPR and Auto Clos.	
	-10	0	1(0)[d]	2(0)[d]	

6. Zone Dimensions

Dead End: >100 ft	>50 ft to 100 ft	30 ft to 50 ft	No Dead Ends >30 ft and Zone Length Is: >150 ft	100 ft to 150 ft	<100 ft
-6(0)[b]	-4(0)[b]	-2(0)[b]	-2(0)[c]	0	1

7. Vertical Openings

Open 4 or More Floors	Open 2 or 3 Floors	Enclosed with Indicated Fire Resist.: <1 hr	≥1 hr to <2 hr	≥2 hr
-14	-10	0	2(0)[e]	3(0)[e]

8. Hazardous Areas

Double Deficiency: In Zone	Outside Zone	Single Deficiency: In Zone	In Adjacent Zone	No Deficiencies
-11	-5	-6	-2	0

9. Smoke Control

No Control	Smoke Barrier Serves Zone	Mech. Assisted Systems by Zone
-5(0)[c]	0	3

10. Emergency Movement Routes

<2 Routes	Multiple Routes: Deficient	W/O Horizontal Exit(s)	Horizontal Exit(s)	Direct Exit(s)
-8	-2	0	1	5

11. Manual Fire Alarm

No Manual Fire Alarm	Manual Fire Alarm: W/O F.D. Conn.	W/F.D. Conn
-4	1	2

12. Smoke Detection and Alarm

None	Corridor Only	Rooms Only	Corridor and Habit. Spaces	Total Spaces In Zone
0(3)[g]	2(3)[g]	3(3)[g]	4	5

13. Automatic Sprinklers

None	Corridor and Habit. Space	Entire Building
0	8	10

NOTE:

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

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

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

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

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

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

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

For SI units: 1 ft = 0.3048 m

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

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

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

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

TABLE 5. INDIVIDUAL SAFETY EVALUATIONS

Safety Parameters	Containment Safety (S_1)	Extinguishment Safety (S_2)	People Movement Safety (S_3)	General Safety (S_4)
1. Construction	0	0		0
2. Interior Finish (Corr. and Exit)	3		3	3
3. Interior Finish (Rooms)	3			3
4. Corridor Partitions/Walls	1			1
5. Doors to Corridor	1		1	1
6. Zone Dimensions			0	0
7. Vertical Openings	0		0	0
8. Hazardous Areas	0	0		0
9. Smoke Control			-5	-5
10. Emergency Movement Routes			0	0
11. Manual Fire Alarm		2		2
12. Smoke Detection and Alarm		4	4	4
13. Automatic Sprinklers	10	10	10 ÷ 2 = 5	10
Total Value	**S_1=** 18	**S_2=** 16	**S_3=** 8	**S_4=** 19

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

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

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

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

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

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

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

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

TABLE 7. ZONE FIRE SAFETY EQUIVALENCY EVALUATION					Yes	No
Containment Safety (S_1)	minus	Mandatory Containment (S_a)	≥ 0	S_1 18 − S_a 11 = C 7	√	
Extinguishment Safety (S_2)	minus	Mandatory Extinguishment (S_b)	≥ 0	S_2 16 − S_b 15 = E 1	√	
People Movement Safety (S_3)	minus	Mandatory People Movement (S_c)	≥ 0	S_3 8 − S_c 8 = P 0	√	
General Safety (S_4)	minus	Occupancy Risk (R)	≥ 0	S_4 19 − R 8 = G 11	√	

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

CONCLUSIONS

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

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

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

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

Form Approved
OMB Exempt

ZONE 2 OF 4 ZONES

FIRE/SMOKE ZONE* EVALUATION WORKSHEET FOR HEALTH CARE FACILITIES

2000 LIFE SAFETY CODE

FACILITY: LIFECARE GREENBUSH MANOR
BUILDING: 02-GREENBUSH MANOR
ZONE(S) EVALUATED: EDGEWOOD
PROVIDER/VENDOR NO.: 245616
DATE OF SURVEY: 11/02/2016

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

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

TABLE 1. OCCUPANCY RISK PARAMETER FACTORS

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

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

TABLE 2. OCCUPANCY RISK FACTOR CALCULATION

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

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

TABLE 3A. (NEW BUILDINGS)

1.0 X F [7.6] = R [7.6] = 8

TABLE 3B. (EXISTING BUILDINGS)

0.6 X F [ ] = R [ ]

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

SURVEYOR SIGNATURE	TITLE	DATE
[signature], FIRE SAFETY RESOURCES, LLC	PRESIDENT	11/03/2016
FIRE AUTHORITY SIGNATURE	**TITLE**	**DATE**
Thomas Linhoff 12424 [signature]	Fire Safety Supervisor	11-07-2016

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

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

TABLE 4.

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

NOTE:

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

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

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

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

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

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

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

For SI units: 1 ft = 0.3048 m

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

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

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

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

TABLE 5. INDIVIDUAL SAFETY EVALUATIONS

Safety Parameters	Containment Safety (S_1)	Extinguishment Safety (S_2)	People Movement Safety (S_3)	General Safety (S_4)
1. Construction	0	0		0
2. Interior Finish (Corr. and Exit)	3		3	3
3. Interior Finish (Rooms)	3			3
4. Corridor Partitions/Walls	1			1
5. Doors to Corridor	1		1	1
6. Zone Dimensions			0	0
7. Vertical Openings	0		0	0
8. Hazardous Areas	0	0		0
9. Smoke Control			-5	-5
10. Emergency Movement Routes			0	0
11. Manual Fire Alarm		2		2
12. Smoke Detection and Alarm		4	4	4
13. Automatic Sprinklers	10	10	10 ÷ 2 = 5	10
Total Value	S_1= 18	S_2= 16	S_3= 8	S_4= 19

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

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

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

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

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

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

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

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

TABLE 7. ZONE FIRE SAFETY EQUIVALENCY EVALUATION					Yes	No
Containment Safety (S_1)	minus	Mandatory Containment (S_a)	≥ 0	S_1 18 − S_a 11 = C 7	√	
Extinguishment Safety (S_2)	minus	Mandatory Extinguishment (S_b)	≥ 0	S_2 16 − S_b 15 = E 1	√	
People Movement Safety (S_3)	minus	Mandatory People Movement (S_c)	≥ 0	S_3 8 − S_c 8 = P 0	√	
General Safety (S_4)	minus	Occupancy Risk (R)	≥ 0	S_4 19 − R 8 = G 11	√	

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

CONCLUSIONS

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

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

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

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

Form Approved
OMB Exempt

ZONE 3 OF 4 ZONES

FIRE/SMOKE ZONE* EVALUATION WORKSHEET FOR HEALTH CARE FACILITIES

2000 LIFE SAFETY CODE

FACILITY: LifeCare Greenbush Manor	BUILDING: 02- Greenbush Manor
ZONE(S) EVALUATED: Administrative/Community Room Wing	
PROVIDER/VENDOR NO.: 245616	DATE OF SURVEY: 11/02/2016

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

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

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

TABLE 1. OCCUPANCY RISK PARAMETER FACTORS

Risk Parameters	Risk Factors Values				
1. Patient Mobility *(M)*	Mobility Status	Mobile	Limited Mobility	Not Mobile	Not Movable
	Risk Factor	1.0	1.6	(3.2)	4.5
2. Patient Density *(D)*	No. of Patients	1–5	6–10	11–30	>30
	Risk Factor	1.0	1.2	1.5	(2.0)

Risk Parameters						
3. Zone Location *(L)*	Floor	1st	2nd or 3rd	4th to 6th	7th and Above	Basements
	Risk Factor	(1.1)	1.2	1.4	1.6	1.6
4. Ratio of Patients to Attendants *(T)*	Patients / Attendant	1–2 / 1	3–5 / 1	6–10 / 1	>10 / 1	One or More / None
	Risk Factor	1.0	1.1	(1.2)	1.5	4.0

Risk Parameters			
5. Patient Average Age *(A)*	Age	Under 65 Years and Over 1 year	65 Years and Over 1 Year and Younger
	Risk Factor	1.0	(1.2)

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

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

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

TABLE 2. OCCUPANCY RISK FACTOR CALCULATION

	M		D		L		T		A		F
OCCUPANCY RISK	3.2	X	2.0	X	1.1	X	1.2	X	1.2	=	10.1

Step 3: Compute Adjusted Building Status (R) - Use Table 2.

A. If building is classified as "NEW" use Table 3A. If building is classified as "Existing" use Table 3B.

B. Transfer the value of F from Table 2 to Table 3A or Table 3B as appropriate. Calculate R.

C. Transfer R to the block labeled R in Table 7 on page 4 of the work sheet.

TABLE 3A. (NEW BUILDINGS)	TABLE 3B. (EXISTING BUILDINGS)
1.0 X F [10.1] = R [10.1] = 11	0.6 X F [ ] = R [ ]

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

SURVEYOR SIGNATURE	TITLE	DATE
Robert J. Imhulte [signature] Fire Safety Resources, LLC	President	11/03/2016
FIRE AUTHORITY SIGNATURE: Thomas Linhoff 12424 [signature]	TITLE: Fire Safety Supervisor	DATE: 11-07-2016

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

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

TABLE 4.

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

NOTE:

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

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

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

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

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

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

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

For SI units: 1 ft = 0.3048 m

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

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

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

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

TABLE 5. INDIVIDUAL SAFETY EVALUATIONS

Safety Parameters	Containment Safety (S_1)	Extinguishment Safety (S_2)	People Movement Safety (S_3)	General Safety (S_4)
1. Construction	0	0		0
2. Interior Finish (Corr. and Exit)	3		3	3
3. Interior Finish (Rooms)	3			3
4. Corridor Partitions/Walls	1			1
5. Doors to Corridor	1		1	1
6. Zone Dimensions			-2	-2
7. Vertical Openings	0		0	0
8. Hazardous Areas	0	0		0
9. Smoke Control			-5	-5
10. Emergency Movement Routes			0	0
11. Manual Fire Alarm		2		2
12. Smoke Detection and Alarm		3	3	3
13. Automatic Sprinklers	10	10	10 ÷ 2 = 5	10
Total Value	S_1= 18	S_2= 15	S_3= 5	S_4= 16

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

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

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

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

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

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

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

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

TABLE 7. ZONE FIRE SAFETY EQUIVALENCY EVALUATION					Yes	No
Containment Safety (S_1)	minus	Mandatory Containment (S_a)	≥ 0	S_1 18 − S_a 11 = C 7	√	
Extinguishment Safety (S_2)	minus	Mandatory Extinguishment (S_b)	≥ 0	S_2 15 − S_b 12 = E 3	√	
People Movement Safety (S_3)	minus	Mandatory People Movement (S_c)	≥ 0	S_3 5 − S_c 5 = P 0	√	
General Safety (S_4)	minus	Occupancy Risk (R)	≥ 0	S_4 16 − R 11 = G 5	√	

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

CONCLUSIONS

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

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

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

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

ZONE 4 OF 4 ZONES

FIRE/SMOKE ZONE* EVALUATION WORKSHEET FOR HEALTH CARE FACILITIES

2000 LIFE SAFETY CODE

FACILITY LifeCare Greenbush Manor	BUILDING 02-Greenbush Manor
ZONE(S) EVALUATED Support Services Wing	
PROVIDER/VENDOR NO. 245616	DATE OF SURVEY 11/02/2016

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

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

TABLE 1. OCCUPANCY RISK PARAMETER FACTORS

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

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

TABLE 2. OCCUPANCY RISK FACTOR CALCULATION

	M		D		L		T		A		F
OCCUPANCY RISK	3.2	X	1.2	X	1.1	X	1.2	X	1.2	=	6.1

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

TABLE 3A. (NEW BUILDINGS)	TABLE 3B. (EXISTING BUILDINGS)
1.0 X F [6.1] = R [6.1] = 7	0.6 X F [ ] = R [ ]

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

SURVEYOR SIGNATURE [signature] Fire Safety Resources, LLC	TITLE President	DATE 11/03/2016
FIRE AUTHORITY SIGNATURE Thomas Linhoff 12424 [signature]	TITLE Fire Safety Supervisor	DATE 11-07-2016

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

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

TABLE 4.

Safety Parameters / Safety Parameters Values

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

Safety Parameters					
2. Interior Finish (Corridors and Exits)	Class C	Class B	Class A		
	-5(0)[f]	0(3)[f]	3		
3. Interior Finish (Rooms)	Class C	Class B	Class A		
	-3(1)[f]	1(3)[f]	3		
4. Corridor Partitions/Walls	None or Incomplete	<½ hour	≥½ to <1 hour	≥1 hour	
	-10(0)[a]	0	1(0)[a]	2(0)[a]	
5. Doors to Corridor	No Door	<20 min FPR	≥20 min FPR	≥20 min FPR and Auto Clos.	
	-10	0	1(0)[d]	2(0)[d]	

6. Zone Dimensions	Dead End			No Dead Ends >30 ft and Zone Length Is		
	>100 ft	>50 ft to 100 ft	30 ft to 50 ft	>150 ft	100 ft to 150 ft	<100 ft
	-6(0)[b]	-4(0)[b]	-2(0)[b]	-2(0)[c]	0	1

Safety Parameters					
7. Vertical Openings	Open 4 or More Floors	Open 2 or 3 Floors	Enclosed with Indicated Fire Resist. <1 hr	≥1 hr to <2 hr	≥2 hr
	-14	-10	0	2(0)[e]	3(0)[e]
8. Hazardous Areas	Double Deficiency In Zone	Double Deficiency Outside Zone	Single Deficiency In Zone	Single Deficiency In Adjacent Zone	No Deficiencies
	-11	-5	-6	-2	0
9. Smoke Control	No Control	Smoke Barrier Serves Zone	Mech. Assisted Systems by Zone		
	-5(0)[c]	0	3		
10. Emergency Movement Routes	<2 Routes	Multiple Routes: Deficient	W/O Horizontal Exit(s)	Horizontal Exit(s)	Direct Exit(s)
	-8	-2	0	1	5
11. Manual Fire Alarm	No Manual Fire Alarm		Manual Fire Alarm: W/O F.D. Conn.	W/F.D. Conn	
	-4		1	2	
12. Smoke Detection and Alarm	None	Corridor Only	Rooms Only	Corridor and Habit. Spaces	Total Spaces In Zone
	0(3)[g]	2(3)[g]	3(3)[g]	4	5
13. Automatic Sprinklers	None	Corridor and Habit. Space	Entire Building		
	0	8	10		

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

For SI units: 1 ft = 0.3048 m

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

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

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

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

TABLE 5. INDIVIDUAL SAFETY EVALUATIONS

Safety Parameters	Containment Safety (S_1)	Extinguishment Safety (S_2)	People Movement Safety (S_3)	General Safety (S_4)
1. Construction	0	0		0
2. Interior Finish (Corr. and Exit)	3		3	3
3. Interior Finish (Rooms)	3			3
4. Corridor Partitions/Walls	1			1
5. Doors to Corridor	1		1	1
6. Zone Dimensions			-2	-2
7. Vertical Openings	0		0	0
8. Hazardous Areas	0	0		0
9. Smoke Control			-5	-5
10. Emergency Movement Routes			0	0
11. Manual Fire Alarm		2		2
12. Smoke Detection and Alarm		4	4	4
13. Automatic Sprinklers	10	10	10 ÷ 2 = 5	10
Total Value	S_1= 18	S_2= 16	S_3= 6	S_4= 17

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

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

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

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

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

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

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

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

TABLE 7. ZONE FIRE SAFETY EQUIVALENCY EVALUATION					Yes	No
Containment Safety (S_1)	minus	Mandatory Containment (S_a)	≥ 0	S_1 18 − S_a 11 = C 7	√	
Extinguishment Safety (S_2)	minus	Mandatory Extinguishment (S_b)	≥ 0	S_2 16 − S_b 12 = E 4	√	
People Movement Safety (S_3)	minus	Mandatory People Movement (S_c)	≥ 0	S_3 6 − S_c 5 = P 1	√	
General Safety (S_4)	minus	Occupancy Risk (R)	≥ 0	S_4 17 − R 7 = G 10	√	

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

CONCLUSIONS

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

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

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

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

Report of Consultant FSES Findings

LifeCare Greenbush Manor

19120 – 200th Street

Greenbush, MN 56726

Provider No. 245616

Date of Survey: November 02, 2016

Prepared by:
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November 03, 2016

Ms. Emily Straw
Administrator
LifeCare Greenbush Manor
19120 – 200th Street
Greenbush, Minnesota 56726

RE: FSES at LifeCare Greenbush Manor

Dear Ms. Straw:

Enclosed please find the survey information relating to the fire safety evaluation of LifeCare Greenbush Manor, 19120 – 200th Street, Greenbush, MN conducted on 11/02/2016. This evaluation was conducted in accordance with the Fire Safety Evaluation System (FSES) specified in Chapter 4 of NFPA 101A(01), *Guide to Alternative Approaches to Life Safety*.

As you're aware, the FSES is a rating system designed to evaluate the level of fire/life safety in health care facilities and serves as a method to demonstrate alternative compliance with the 2000 edition of the *Life Safety Code*® (NFPA 101). An FSES was made necessary in this case because of a smoke barrier wall (K025) deficiency cited during a state fire/life safety recertification survey conducted on 10/18/2016.

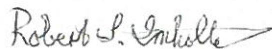
The following factors served as the basis for this evaluation:

- Because the building was constructed after 03/11/2003, LifeCare Greenbush Manor was considered a new building.
- LifeCare Greenbush Manor is one story in height and has no basement. For purposes of this FSES, the building was divided into four (4) separate smoke zones.

Based on the conditions found during the 11/02/2016 FSES survey, all four parameters in Table 7 of the FSES worksheets, ZONE FIRE SAFETY EQUIVALENCY EVALUATION, in all four (4) zones evaluated were found to have a score of zero or greater. *Fire Safety Resources* finds, therefore, that LifeCare Greenbush Manor has achieved a passing FSES score.

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

Wishing you a safe day!



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

Enclosures
RLI/rli

FIRE SAFETY EVALUATION

Name of Facility: LifeCare Greenbush Manor
Address: 19120 – 200th Street, Greenbush, MN 56726
Phone: 218-782-2131
Licensed capacity: 40
Census at time of survey: 40

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

What follows is a report on the findings of a fire safety evaluation of the above-named facility that was conducted during an on-site visit to the facility between 0900 hours and 1345 hours on 11/02/2016. This evaluation was conducted in accordance with the Fire Safety Evaluation System (FSES) specified in Chapter 4 of NFPA 101A(01), *Guide to Alternative Approaches to Life Safety*. Based on this evaluation, LifeCare Greenbush Manor has achieved a passing score on the FSES.

In addition to the 11/02/2016 on-site visit the findings outlined herein are based on:

- Information provided by Mr. Brett Dallager, Maintenance Supervisor, and Mr. Brian Grafstrom, Director of Facilities; and
- A review of the Statement of Deficiencies (Form CMS-2567) from a fire/life safety recertification survey conducted on 10/18/2016.

Initial Comments:
The building housing LifeCare Greenbush Manor was constructed in 2010. Because the building was constructed after 03/11/2003, it is considered a new building for federal certification purposes and was, therefore, treated as such for assigning values on the FSES worksheets.

The building is one story in height and has no basement. There are four fully enclosed mechanical spaces located in the building attic space. Because the spaces were found to be used exclusively for mechanical equipment rooms and the occupant load of the aggregate area of the enclosed spaces does not exceed 10, the spaces were treated as mezzanines in accordance with NFPA 101(00), Sec. 8.2.6 and were not considered a factor in the determination of building height.

Based on observation, staff interview and review of the Code Summary attached to the building construction drawings, the building's wood frame structural members (exterior walls and roof/ceiling assembly) are protected with materials providing a fire resistance rating of one hour. As a result, the building was assigned a Type V(111) construction type in accordance with NFPA 220(99), Sec. 3-5 and Table 3-1.

At the northeast corner of the building, the nursing home is connected to a medical clinic. At the southeast corner of the building, the nursing home is connected to a senior assisted living facility. Because neither the clinic nor the assisted living building are used for purposes of housing, treatment or customary access by the facility's residents and because they are both separated from the nursing home by a 2-hour-rated fire barrier, these buildings were not included in this evaluation.

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

The facility is protected throughout by a supervised, wet-pipe automatic fire sprinkler system. A dry-pipe automatic fire sprinkler system, however, protects the attic space and combustible exterior canopy at the main entrance.

Based on staff interview and review of building floor plan drawings, the building is divided into four (4) zones designated as Areas A, B, C and E:

- Area A houses a resident "neighborhood" called Rosewood. This zone consists of two wings containing resident sleeping rooms, one called Lady Slipper Drive, the other called Cedar Boulevard. The two wings share a common resident dining space.
- Area B houses a resident "neighborhood" called Edgewood. This zone, too, consists of two wings containing resident sleeping rooms, one called Whitetail Trail, the other called Eagle's Nest. The two wings share a common resident dining space.
- Area C houses offices, administrative areas, the facility barber/beauty salon, community room/chapel and wellness center. The medical clinic is attached to this zone.
- Area E houses facility support services. The assisted living building is attached to this zone.

For purposes of this FSES, the building was divided into four (4) separate smoke zones as follows:

Zone 1 – Rosewood
Zone 2 – Edgewood
Zone 3 – Administrative/Community Room Wing
Zone 4 – Support Services Wing

This report is intended to serve as an explanation of the scores entered on Tables 1, 4 and 8 of the FSES worksheets (i.e. Forms CMS-2786T) for the facility as it was found during the on-site visit on 11/02/2016. The score assigned to each item is noted in brackets ([ ]). It must be noted that numbers were rounded to the nearest tenth of a point and that measurements of over one-half inch were rounded to the nearest inch. To ensure that the FSES addresses the "worst-case scenario", the product of the multiplication in Table 3A (i.e. value of "R") was rounded up to the nearest whole number. Code references are provided where appropriate. Codes referenced include the 2001 edition of NFPA 101A and the 2000 edition of the *Life Safety Code*® (NFPA 101).

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

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

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

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

- Building utilities and heating and air conditioning systems appeared to be in conformance with NFPA 101(00), Sections 9.1 and 9.2.
- Alarms, emergency communication systems and illumination of generator set locations appeared to be powered as prescribed by NFPA 101(00), Sec. 18.5.1.2. It was reported that there are no residents on life support at LifeCare Greenbush Manor.
- No incinerator or space heaters were found.
- The facility's evacuation plan and fire drill records were reviewed and appeared to be in order.
- The facility's smoking regulations were reviewed and appeared to be in order. LifeCare Greenbush Manor is a smoke-free campus.
- Documentation review showed all draperies, cubicle curtains, upholstered furniture, mattresses and decorations to be in accordance with NFPA 101(00), Sec. 18.7.5.
- Portable fire extinguishers, EXIT signage and emergency lighting appeared to be provided in accordance with applicable requirements.

<u>Zone 1 – Rosewood</u>:

TABLE 1. OCCUPANY RISK PARAMETER FACTORS

1. Resident Mobility (*M*) [Value assigned = 3.2]: It was reported that some residents in this zone may need assistance with evacuation.
2. Patient Density (*D*) [Value assigned = 1.5]: There is bed capacity for up to 20 residents in this zone.
3. Zone Location (*L*) [Value assigned = 1.1]: This zone is less than one-half floor height above grade.
4. Ratio of Patients to Attendants (*T*) [Value assigned = 1.2]: This score was assigned to ensure that the FSES addresses the "worst-case scenario". It was reported that there are two (2) staff persons on duty in this zone on the night shift. In addition, there is one (1) staff person who floats between this zone and the adjacent zone (Edgewood).
5. Patient Average Age (*A*) [Value assigned = 1.2]: Residents housed in this zone average over 65 years of age.

TABLE 4. SAFETY PARAMETERS and SAFETY PARAMETER VALUES

1. Construction [Score: 0]:
   The building was assigned a Type V(111) construction type.
2. Interior Finish (Corridors and Exits) [Score: +3]:
   A rigid material approximately 8 inches in width and identified as "Acrovyn 4000 Rub Strips" was found mounted behind the handrails and extending the full length of the corridors. Documentation was provided certifying that this material as well as the acoustical ceiling tile carry a Class A (25 or less) flame spread rating.
3. Interior Finish (Rooms) [Score: +3]:
   Documentation was provided certifying that approximately 8-in. wide "Acrovyn 4000 Rub Strips" installed as a wainscot in some rooms and the acoustical ceiling tile carry a Class A (25 or less) flame spread rating.

4. Corridor Partitions/Walls [Score: +1]:
   Corridor walls were determined to be constructed of 5/8-inch-thick gypsum wallboard installed on both sides of wood studs and extend up through the suspended ceiling to the bottom of a fire-rated roof/ceiling assembly per UL Design P522. Because it could not be confirmed that the ceiling provides a fire resistance rating of 1-hour or better, it was graded as "≥½ hour to <1 hour" in accordance with NFPA 101A(01), Sec. 4.6.4.2. Pass-through openings between the serving kitchen and the adjacent dining/lounge spaces in this zone were found to be protected with listed and labeled fire shutter assemblies that carry a 90-minute fire protection rating and are automatic-closing upon detection of smoke.
5. Doors to Corridor [Score: +1]:
   Corridor doors in this zone were found to be a mixture of 1¾-inch-thick solid wood construction and 60-minute and 90-minute fire-rated doors, all in steel frames.
6. Zone Dimensions [Score: 0]:
   Based on review of construction plan drawings, this zone was found to measure a maximum of approximately 125 ft in length and has no dead ends over 30 ft.
7. Vertical Openings [Score: 0]:
   This score was assigned per Footnote *e* to this Table – Parameter 1 is based on a first floor zone. The building has no basement.
8. Hazardous Areas [Score: 0]:
   No hazardous area deficiencies were found in this zone.
9. Smoke Control [Score: -5]:
   This score was assigned because the smoke barrier walls do not extend through the attic space to the roof deck above. It could not be confirmed that the construction design of the ceiling assembly at which the smoke barrier walls terminate meets the exception to NFPA 101(00), Sec. 8.3.2 and the requirements of NFPA 101(00), Sec. 18.3.7.3.
10. Emergency Movement Routes [Score: 0]:
    There are multiple emergency movement routes from this zone.
11. Manual Fire Alarm [Score: +2]:
    Manual fire alarm pull stations are provided in accordance with NFPA 101(00), Sec. 18.3.4.2. The fire alarm system is monitored by Rapid Response.
12. Smoke Detection and Alarm [Score: +4]:
    System-connected smoke detectors were found in the egress corridor, spaces open to the corridor and in all habitable rooms.
13. Automatic Sprinklers [Score: +10]:
    The building is protected throughout by a supervised automatic fire sprinkler system.

Zone 2 – Edgewood:

TABLE 1. OCCUPANY RISK PARAMETER FACTORS

1. Resident Mobility (*M*) [Value assigned = 3.2]: It was reported that some residents in this zone may need assistance with evacuation.
2. Patient Density (*D*) [Value assigned = 1.5]: There is bed capacity for up to 20 residents in this zone.
3. Zone Location (*L*) [Value assigned = 1.1]: This zone is less than one-half floor height above grade.
4. Ratio of Patients to Attendants (*T*) [Value assigned = 1.2]: This score was assigned to ensure that the FSES addresses the "worst-case scenario". It was reported that there are two (2) staff persons on duty in this zone on the night shift. In addition, there is one (1) staff person who floats between this zone and the adjacent zone (Rosewood).
5. Patient Average Age (*A*) [Value assigned = 1.2]: Residents housed in this zone average over 65 years of age.

TABLE 4. SAFETY PARAMETERS and SAFETY PARAMETER VALUES

1. Construction [Score: 0]:
   The building was assigned a Type V(111) construction type.
2. Interior Finish (Corridors and Exits) [Score: +3]:
   A rigid material approximately 8 inches in width and identified as "Acrovyn 4000 Rub Strips" was found mounted behind the handrails and extending the full length of the corridors. Documentation was provided certifying that this material as well as the acoustical ceiling tile carry a Class A (25 or less) flame spread rating.
3. Interior Finish (Rooms) [Score: +3]:
   Documentation was provided certifying that approximately 8-in. wide "Acrovyn 4000 Rub Strips" installed as a wainscot in some rooms and the acoustical ceiling tile carry a Class A (25 or less) flame spread rating.
4. Corridor Partitions/Walls [Score: +1]:
   Corridor walls were determined to be constructed of 5/8-inch-thick gypsum wallboard installed on both sides of wood studs and extend up through the suspended ceiling to the bottom of a fire-rated roof/ceiling assembly per UL Design P522. Because it could not be confirmed that the ceiling provides a fire resistance rating of 1-hour or better, it was graded as "≥½ hour to <1 hour" in accordance with NFPA 101A(01), Sec. 4.6.4.2. Pass-through openings between the serving kitchen and the adjacent dining/lounge spaces in this zone were found to be protected with listed and labeled fire shutter assemblies that carry a 90-minute fire protection rating and are automatic-closing upon detection of smoke.
5. Doors to Corridor [Score: +1]:
   Corridor doors in this zone were found to be a mixture of 1¾-inch-thick solid wood construction and 60-minute and 90-minute fire-rated doors, all in steel frames.
6. Zone Dimensions [Score: 0]:
   Based on review of construction plan drawings, this zone was found to measure a maximum of approximately 125 ft in length and has no dead ends over 30 ft.
7. Vertical Openings [Score: 0]:
   This score was assigned per Footnote *e* to this Table – Parameter 1 is based on a first floor zone. The building has no basement.
8. Hazardous Areas [Score: 0]:
   No hazardous area deficiencies were found in this zone.

9. Smoke Control [Score: -5]:
   This score was assigned because the smoke barrier walls do not extend through the attic space to the roof deck above. It could not be confirmed that the construction design of the ceiling assembly at which the smoke barrier walls terminate meets the exception to NFPA 101(00), Sec. 8.3.2 and the requirements of NFPA 101(00), Sec. 18.3.7.3.
10. Emergency Movement Routes [Score: 0]:
    There are multiple emergency movement routes from this zone.
11. Manual Fire Alarm [Score: +2]:
    Manual fire alarm pull stations are provided in accordance with NFPA 101(00), Sec. 18.3.4.2. The fire alarm system is monitored by Rapid Response.
12. Smoke Detection and Alarm [Score: +4]:
    System-connected smoke detectors were found in the egress corridor, spaces open to the corridor and in all habitable rooms.
13. Automatic Sprinklers [Score: +10]:
    The building is protected throughout by a supervised automatic fire sprinkler system.

Zone 3 – Administrative/Community Room Wing:

TABLE 1. OCCUPANY RISK PARAMETER FACTORS

1. Resident Mobility (*M*) [Value assigned = 3.2]: It was reported that some residents in this zone may need assistance with evacuation.
2. Patient Density (*D*) [Value assigned = 2.0]: This score was assigned to ensure that the FSES addresses the "worst-case scenario". There are no sleeping rooms in this zone, but it contains the facility's Community Room/Chapel, Wellness Center and therapy spaces, barber/beauty salon, and staff and administrative offices, which are available for use by all residents.
3. Zone Location (*L*) [Value assigned = 1.1]: This zone is less than one-half floor height above grade.
4. Ratio of Patients to Attendants (*T*) [Value assigned = 1.2]: This score was assigned to ensure that the FSES addresses the "worst-case scenario". It was reported that when the Community Room/Chapel area is occupied by all 40 residents, sufficient staff is present to maintain a resident/staff ratio of not more than seven (7) to one (1).
5. Patient Average Age (*A*) [Value assigned = 1.2]: Residents housed in this zone average over 65 years of age.

TABLE 4. SAFETY PARAMETERS and SAFETY PARAMETER VALUES

1. Construction [Score: 0]:
   The building was assigned a Type V(111) construction type.
2. Interior Finish (Corridors and Exits) [Score: +3]:
   A rigid material approximately 8 inches in width and identified as "Acrovyn 4000 Rub Strips" was found mounted behind the handrails and extending the full length of the corridors. Documentation was provided certifying that this material as well as the acoustical ceiling tile carry a Class A (25 or less) flame spread rating.
3. Interior Finish (Rooms) [Score: +3]:
   Documentation was provided certifying that the acoustical ceiling tile carries a Class A (25 or less) flame spread rating.

4. Corridor Partitions/Walls [Score: +1]:
   Corridor walls were determined to be constructed of 5/8-inch-thick gypsum wallboard installed on both sides of wood studs and extend up through the suspended ceiling to the bottom of a fire-rated roof/ceiling assembly per UL Design P522. Because it could not be confirmed that the ceiling provides a fire resistance rating of 1-hour or better, it was graded as "≥½ hour to <1 hour" in accordance with NFPA 101A(01), Sec. 4.6.4.2. A pass-through opening between the administrative office and the adjacent corridor in this zone was found to be protected with a listed and labeled fire shutter assembly that carries a 90-minute fire protection rating and is automatic-closing upon detection of smoke.
5. Doors to Corridor [Score: +1]:
   Corridor doors in this zone were found to be a mixture of 1¾-inch-thick solid wood construction and 60-minute and 90-minute fire-rated doors, all in steel frames.
6. Zone Dimensions [Score: -2]:
   Based on review of construction plan drawings, this zone was found to measure over 150 ft in length and has no dead ends.
7. Vertical Openings [Score: 0]:
   This score was assigned per Footnote *e* to this Table – Parameter 1 is based on a first floor zone. The building has no basement.
8. Hazardous Areas [Score: 0]:
   No hazardous area deficiencies were found in this zone.
9. Smoke Control [Score: -5]:
   This score was assigned because the smoke barrier walls do not extend through the attic space to the roof deck above. It could not be confirmed that the construction design of the ceiling assembly at which the smoke barrier walls terminate meets the exception to NFPA 101(00), Sec. 8.3.2 and the requirements of NFPA 101(00), Sec. 18.3.7.3.
10. Emergency Movement Routes [Score: 0]:
    There are multiple emergency movement routes from this zone.
11. Manual Fire Alarm [Score: +2]:
    Manual fire alarm pull stations are provided in accordance with NFPA 101(00), Sec. 18.3.4.2. The fire alarm system is monitored by Rapid Response.
12. Smoke Detection and Alarm [Score: +3]:
    This score was assigned per instruction in Footnote *g* to this Table. The zone is protected with quick-response sprinklers. System-connected smoke detectors were found in the egress corridor, spaces open to the corridor and in all habitable rooms except the Wellness Center treatment rooms and Home Health Room C110. Because this condition does not meet the criteria specified in NFPA 101A(01), Sections 4.6.12.3 and 4.6.12.4, this parameter was required to be scored as "Corridor Only".
13. Automatic Sprinklers [Score: +10]:
    The building is protected throughout by a supervised automatic fire sprinkler system.

Zone 4 – Support Services Wing:

TABLE 1. OCCUPANY RISK PARAMETER FACTORS

1. Resident Mobility (*M*) [Value assigned = 3.2]: It was reported that some residents in this zone may need assistance with evacuation.
2. Patient Density (*D*) [Value assigned = 1.2]: There are no sleeping rooms in this zone. The zone houses the facility's main kitchen, laundry, maintenance and mechanical spaces, and the employee lounge. It was reported that facility residents use the main corridor that surrounds the enclosed courtyard as a "walking path" as part of the facility's physical fitness program. It was reported that there are a maximum of eight (8) residents in this zone at any one time.
3. Zone Location (*L*) [Value assigned = 1.1]: This zone is less than one-half floor height above grade.
4. Ratio of Patients to Attendants (*T*) [Value assigned = 1.2]: It was reported that when residents are present, sufficient staff is present to maintain a resident/staff ratio of not more than eight (8) to one (1).
5. Patient Average Age (*A*) [Value assigned = 1.2]: Residents housed in this zone average over 65 years of age.

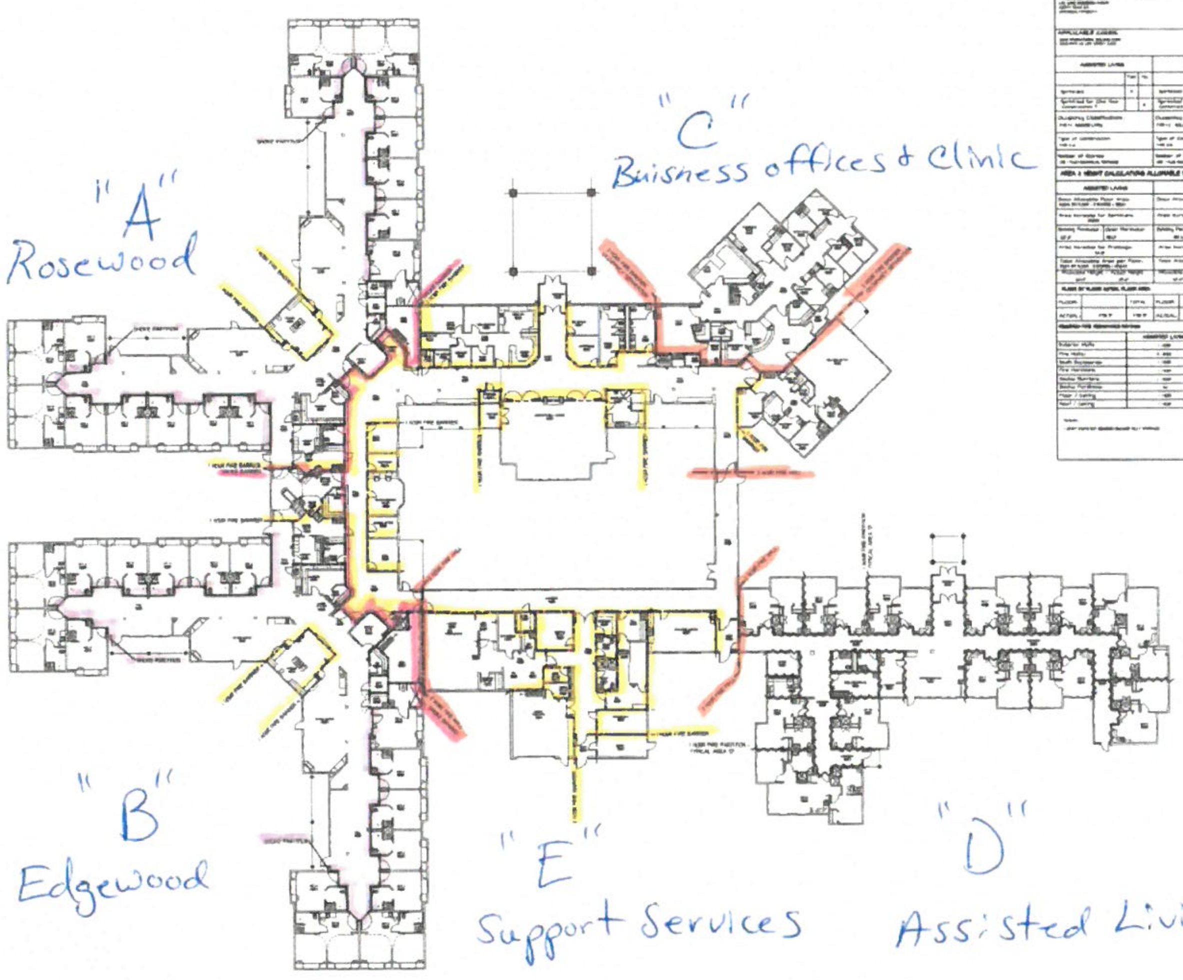
TABLE 4. SAFETY PARAMETERS and SAFETY PARAMETER VALUES

1. Construction [Score: 0]:
   The building was assigned a Type V(111) construction type.
2. Interior Finish (Corridors and Exits) [Score: +3]:
   A rigid material approximately 8 inches in width and identified as "Acrovyn 4000 Rub Strips" was found mounted behind the handrails and extending the full length of the corridors. Documentation was provided certifying that this material as well as the acoustical ceiling tile carry a Class A (25 or less) flame spread rating.
3. Interior Finish (Rooms) [Score: +3]:
   Documentation was provided certifying that the acoustical ceiling tile carries a Class A (25 or less) flame spread rating.
4. Corridor Partitions/Walls [Score: +1]:
   Corridor walls were determined to be constructed of 5/8-inch-thick gypsum wallboard installed on both sides of wood studs and extend up through the suspended ceiling to the bottom of a fire-rated roof/ceiling assembly per UL Design P522. Because it could not be confirmed that the ceiling provides a fire resistance rating of 1-hour or better, it was graded as "≥½ hour to <1 hour" in accordance with NFPA 101A(01), Sec. 4.6.4.2. The two pass-through openings between the main kitchen and the adjacent corridor in this zone were found to be protected with listed and labeled fire shutter assemblies that carry a 90-minute fire protection rating and are automatic-closing upon detection of smoke.
5. Doors to Corridor [Score: +1]:
   Corridor doors in this zone were found to be a mixture of 1¾-inch-thick solid wood construction and 60-minute and 90-minute fire-rated doors, all in steel frames.
6. Zone Dimensions [Score: -2]:
   Based on review of construction plan drawings, this zone was found to measure over 150 ft in length and has no dead ends.
7. Vertical Openings [Score: 0]:
   This score was assigned per Footnote *e* to this Table – Parameter 1 is based on a first floor zone. The building has no basement.
8. Hazardous Areas [Score: 0]:
   No hazardous area deficiencies were found in this zone.

9. Smoke Control [Score: -5]:
   This score was assigned because the smoke barrier walls do not extend through the attic space to the roof deck above. It could not be confirmed that the construction design of the ceiling assembly at which the smoke barrier walls terminate meets the exception to NFPA 101(00), Sec. 8.3.2 and the requirements of NFPA 101(00), Sec. 18.3.7.3.
10. Emergency Movement Routes [Score: 0]:
    There are multiple emergency movement routes from this zone.
11. Manual Fire Alarm [Score: +2]:
    Manual fire alarm pull stations are provided in accordance with NFPA 101(00), Sec. 18.3.4.2. The fire alarm system is monitored by Rapid Response.
12. Smoke Detection and Alarm [Score: +4]:
    System-connected smoke detectors were found in the egress corridor, spaces open to the corridor and in all habitable spaces.
13. Automatic Sprinklers [Score: +10]:
    The building is protected throughout by a supervised automatic fire sprinkler system.

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

It must be noted that the scores and values assigned to the parameters in the tables on the FSES worksheets are based on conditions found between 0900 hours and 1345 hours on 11/02/2016. Any changes in those conditions after those dates could affect those scores and values, either positively or negatively. Again, based on this evaluation, LifeCare Greenbush Manor **has** achieved a passing score on the FSES. No other assessment of the level of safety in this facility is either intended or implied by *Fire Safety Resources, LLC*.


CODE SUMMARY
LIFE CARE
GREENBUSH
MANOR
GREENBUSH, MINNESOTA
KEYNOTES
"A"
Rosewood
"B"
Edgewood
"C"
Buisness offices & Clinic
"D"
Assisted Living
"E"
Support Services
FIRE RATING LEGEND
Smoke Partition
Smoke Barrier
1 Hr Fire Barrier
2hr
GENERAL NOTES
CODE PLAN - MAIN FLOOR
CODE - R