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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: QSNS

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **02/29/2016** (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

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

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

* Code: **A** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	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):

17. SURVEYOR SIGNATURE Date :
Lyla Burkman, Unit Supervisor 03/02/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath
Enforcement Specialist 03/02/2016 (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
02/22/2016
(L33)

DETERMINATION APPROVAL

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

CCN: 24 5616

At the time of the January 7, 2016 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) Please refer to the CMS-2567 for both health and life safety code along with the facility's plan of correction. Post Certification Revisit to follow.

The life safety code component of the survey evaluated the facility for deficiency cited at K025 and determined the facility to have passed the Fire Safety Evaluation Score (FSES).

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

CMS Certification Number (CCN): 245616

March 2, 2016

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

Dear Ms. Straw:

The Minnesota Department of Health assists the Centers for Medicare and Medicaid Services (CMS) by surveying skilled nursing facilities and nursing facilities to determine whether they meet the requirements for participation. To participate as a skilled nursing facility in the Medicare program or as a nursing facility in the Medicaid program, a provider must be in substantial compliance with each of the requirements established by the Secretary of Health and Human Services found in 42 CFR part 483, Subpart B.

Based upon your facility being in substantial compliance, we are recommending to CMS that your facility be recertified for participation in the Medicare and Medicaid program.

Effective February 8, 2016 the above facility is certified for:

20	Skilled Nursing Facility/Nursing Facility Beds
20	Nursing Facility I Beds

Your facility's Medicare approved area consists of all 20 skilled nursing facility beds.

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

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

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

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Email: mark.meath@state.mn.us
Telephone: (651) 201-4118 Fax: (651) 215-9697

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
March 2, 2016

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

RE: Project Number S5616009

Dear Ms. Straw:

On January 15, 2016, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on January 7, 2016. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), whereby corrections were required.

On February 29, 2016, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on February 19, 2016 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on January 7, 2016. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of February 15, 2016. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on January 7, 2016, effective February 15, 2016 and therefore remedies outlined in our letter to you dated January 15, 2016, will not be imposed.

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

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

Sincerely,

Mark Meath

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

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
245616 Y1	A. Building B. Wing Y2	2/29/2016 Y3

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

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0282	Correction	ID Prefix F0311	Correction	ID Prefix F0315	Correction
Reg. # 483.20(k)(3)(ii)	Completed	Reg. # 483.25(a)(2)	Completed	Reg. # 483.25(d)	Completed
LSC	02/15/2016	LSC	02/15/2016	LSC	02/15/2016
ID Prefix F0431	Correction	ID Prefix F0441	Correction	ID Prefix	Correction
Reg. # 483.60(b), (d), (e)	Completed	Reg. # 483.65	Completed	Reg. #	Completed
LSC	02/15/2016	LSC	02/15/2016	LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
☑	LB/mm	03/02/2016	28035	02/29/2016
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON
1/7/2016

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

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
245616 Y1	A. Building 02 - GREENBUSH MANOR B. Wing Y2	2/19/2016 Y3

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

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix Reg. # NFPA 101 LSC K0025	Correction Completed 01/22/2016	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☑	REVIEWED BY (INITIALS) TL/mm	DATE 03/02/2016	SIGNATURE OF SURVEYOR 36535	DATE 02/19/2016
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	
1/5/2016	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: QSNS

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

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 **01/07/2016** (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 :
Debra Vincent, HFE NEII 01/25/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath, Enforcement Specialist 02/21/2016 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
04/13/2009
(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 January 7, 2016 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) Please refer to the CMS-2567 for both health and life safety code along with the facility's plan of correction. Post Certification Revisit to follow.

The life safety code component of the survey evaluated the facility for deficiency cited at K025 and determined the facility to have passed the Fire Safety Evaluation Score (FSES).

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
January 15, 2016

Ms. Susan Lisell, Administrator
Lifecare Greenbush Manor
19120 200th Street
Greenbush, MN 56726

RE: Project Number S5616009

Dear Ms. Lisell:

On January 7, 2016, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

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

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

Opportunity to Correct - the facility is allowed an opportunity to correct identified deficiencies before remedies are imposed;

Electronic Plan of Correction - when a plan of correction will be due and the information to be contained in that document;

Remedies - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS) if substantial compliance is not attained at the time of a revisit;

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

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

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

DEPARTMENT CONTACT

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

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 February 16, 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 February 16, 2016 the following remedy will be imposed:

- Per instance civil money penalties. (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 April 7, 2016 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was

issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by July 7, 2016 (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.

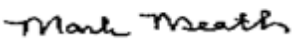
Questions regarding all documents submitted as a response to the Life Safety Code deficiencies (those preceded by a "K" tag), i.e., the plan of correction, request for waivers, should be directed to:

Tom Linhoff, Fire Safety Supervisor
Health Care Fire Inspections
Minnesota Department of Public Safety
State Fire Marshal Division
Email: tom.linhoff@state.mn.us

Phone: (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
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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 _____	01/07/2016

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 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 provide a platform walker exercise program as directed by the care plan for 1 of 1 resident (R44) reviewed for rehabilitation and failed to provide toileting assistance for 1 of 3 residents (R14) who required staff assistance to toilet as directed by the care plan. Findings include:	F 282	For all residents, staff were educated on resident care plan policy and instructed on the importance of following care plans. Reviewed care plan policy, its use, where to access it and its importance at staff meeting on 01-20-16. For staff not able to attend the meeting, notes from the meeting regarding this was posted for staff to read and sign off before February 5, 2016. R44's elimination plan has been reviewed and updated on 1/8/16 and posted in the	2/15/16

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

Electronically Signed | 01/25/2016

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F 282	Continued From page 1 R44 did not receive the recommended elevated arm platform walker (EVA) standing program as directed by the care plan. R44's current mobility care plan dated 11/17/15, indicated R44 had impaired physical mobility related to chronic pain, diabetic complications, left hemiparesis (weakness or paralysis on one side of the body) and required extensive assistance for all activities of daily living. The care plan directed staff to complete passive range of motion to left upper extremities 3-5 times a week, right upper extremity use yellow band 3-5 x's week and standing program with EVA platform walker with assist of two staff 3-5 x's per week for a goal of 5-10 minutes. On 1/7/16, at 9:52 a.m. nursing assistant (NA)-C stated R44 had not been using the standing platform walker since NA-C had taken over the rehabilitation program the first of December. NA-C stated since the recumbent stepper was added to the program on 10/16/15, she thought the platform walker was discontinued therefore R44 had not been doing it. The Nursing Assistant Daily Cares Record and Recreational Program Forms included R44's ROM 3-5 x's week, Thera band exercises and the bicycle 2-3 x's week. However, the form lacked the recommended EVA platform walker 3-5x's a week. On 1/06/16, at 10:10 a.m. the activity aid (AA-A) who was also a nursing assistant was observed to wheel a mechanical standup lift out of R44's room, return and wheel R44 to the activity room. -At 10:16 a.m. AA-A stated R44 could stand up and bear weight with the mechanical lift but had	F 282	daily care book. Bowel and Bladder assessments for all residents will be completed quarterly, annually or with a significant change the next 3 months. Care plans and the daily care assignment sheets will be updated as indicated per assessment. For R14, the rehab aid to-do list was corrected on 1/8/16 to reflect what her care plan states. The current care plan is being followed. DON or designee will do random observation audits 3x weekly x4 weeks to ensure policy is being followed. Results will be reported to the performance improvement committee.	

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F 282	Continued From page 2	F 282		

no feeling in the left leg and leaned forward when assisted to a standing position.

On 1/7/16, at 10:58 a.m. R44 stated she used to stand on the elevated walker when she was at a previous facility but had only done it a few times here. R44 stated it had been months since she had been taken to the standing platform (EVA) walker. R44 stated she would like to be able to exercise for longer periods and use the standing platform walker because it would help keep her stronger.

On 1/07/2016, at 11:11 a.m. the physical therapist (PT) stated her expectation was for R44 to be assisted with the EVA platform walker as directed.

On 1/07/2016, at 11:40 a.m. the director of nursing (DON) verified R44 had not received the EVA platform exercise as directed by the care plan.

R14 was not provided assistance with toileting as directed by the care plan for four hours and 25 minutes on the morning of 1/6/16.

R14's care plan dated 10/28/15, directed staff to provide prompted voiding before and after meals, activities and at night. In addition, the care plan indicated R14 required extensive assistance of one staff for toileting and was incontinent of bladder daily, but will void in toilet also. The care plan directed staff to utilize pull up briefs in place of regular panties.

On 1/6/16, from 7:15 a.m. until 8:16 a.m. R14 was observed seated in a wheelchair at the dining

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F 282	Continued From page 3	F 282		

room table. During this time, R14 had received and consumed her breakfast meal.
-At 8:16 a.m. R14 wheeled out of the dining room heading towards own room.
-At 8:21 a.m. R14 entered own room and proceeded to look for eye glasses. A housekeeper was observed to assist in finding the glasses.
-At 8:37 a.m. NA-B entered R14's room and assisted R14 to bed. R14 was not offered or prompted to use the toilet nor was R14's incontinent brief checked for incontinence or changed. R14 was observed to remain in bed until 11:34 a.m. when the physical therapist entered the room to complete an evaluation.
-At 11:34 a.m. the physical therapist assisted R14 out of bed and proceeded to assist R14 to ambulate in the hallway.
-At 11:40 a.m. the therapist asked R14 if she needed to use the bathroom. R14 stated she might have to. R14 was wheeled back to the room and into the bathroom. R14 did void and R14's brief was wet and had a strong urine smell. The therapist verified R14's brief was wet and had a strong urine smell.

On 1/6/16, at 1:12: p.m. NA-B verified R14 was not offered or taken to the toilet before going to bed and had not been taken to the toilet since she was assisted out of bed over four hours prior. NA-B stated R14 would have told the NA if she needed to go to the bathroom before she was assisted to bed therefore R14 was not asked if she needed to use the toilet.

On 1/6/16, at 3:00 p.m. the DON confirmed R14's care plan directed staff to assist R14 to the toilet before and after meals and R14 should be asked every 2-3 hours if she needed to use the toilet.

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F 282	Continued From page 4 The DON verified R14's care plan was not followed. On 1/7/16, at 11:40 a.m. the DON stated a policy for following the care plan could not be found.	F 282		
F 311 SS=D	483.25(a)(2) TREATMENT/SERVICES TO IMPROVE/MAINTAIN ADLS A resident is given the appropriate treatment and services to maintain or improve his or her abilities specified in paragraph (a)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide an elevated arm platform standing program in order to maintain or minimize the loss of lower extremity strength for 1 of 1 resident (R44) in the sample reviewed for rehabilitation services. Findings include: R44's quarterly Minimum Data Set (MDS) dated 11/29/15, indicated R44 had no cognitive impairment, was diagnosed with hemiplegia (severe weakness on one side of body) and diabetes, had limited range of motion on one side of the upper and lower body and required total staff assistance with all mobility and did not ambulate. The Activities of Daily Living Care Area Assessment (CAA) dated 9/6/15, indicated R44 had left sided hemiparesis which impacted her ability to care for herself. The CAA indicated R44 was alert, able to make own decision and had left	F 311	The facility assesses and implements appropriate treatment and services to maintain or improve his or her abilities. R44's exercise program reviewed 01-08-16 and changes made to reflect that the plan of care recommended by therapy was carried over to the resident's care plan and the Rehab aides to-do list. All residents have the potential to be affected. All residents on the nursing rehab program will be evaluated monthly by the MDS Coordinator or Rehab Licensed Nurse, Occupational Therapy staff, and the rehab aide. Based on the evaluation the team will determine if a resident is maintaining, declining, or has potential to function at a higher level of well being. Care plans and rehab to-do lists will be updated as needed.	2/15/16

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F 311	Continued From page 5 sided weakness due to a cerebral vascular accident (stroke). A Rehabilitation Services Screening form dated and signed by the physical therapist (PT), on 8/25/15, indicated R44's mobility was screened to establish a rehabilitation program. The recommendation included bilateral lower extremity strengthening exercises 3-5 days per week, active range of motion (ROM) on right side and active assisted on left side for hips, knees, and ankles, 3 sets of 10-15 repetitions. Perform all transfers with assist of two. The PT also recommended R44 participate in standing program with elevated arm (EVA) platform walker (all brakes locked) with assist of two with goal of 8-10 minutes 3-5x's week. A Rehabilitation Services Screening form dated 10/16/15, and signed by the PT, indicated R44 was being screened for a recumbent stepper. The recommendation was to use the recumbent stepper 3x's a week with nursing staff with goal of 5-10 minutes with both legs only. R44's current mobility care plan dated 11/17/15, indicated R44 had impaired physical mobility related to chronic pain, diabetic complications and left hemiparesis and required extensive assistance of staff for all activities of daily living. The care plan directed staff to complete the exercise program which consisted of passive range of motion to left upper extremities 3-5 times a week, right upper extremity use yellow band 3-5 x's week and standing program with EVA platform walker with assist of two staff 3-5 x's per week for a goal of 5-10 minutes. However, on 1/7/16, at 9:52 a.m. the nursing	F 311	The Interdisciplinary team will review the rehab nursing program quarterly, annually, and with significant change. The rehab team will refer to therapy when indicated. DON or designee will do random observation audits 3x weekly x4 weeks to ensure policy is being followed. Results will be reported to the performance improvement committee.	

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F 311	Continued From page 6	F 311		

rehabilitation aide, (NA)-C stated R44 had not been using the standing platform walker since NA-C had taken over the rehabilitation program the first of December. NA-C stated since the recumbent stepper was added to the program on 10/16/15, she thought the platform walker was discontinued therefore R44 had not been doing it.

The Nursing Assistant Daily Cares Record and Recreational Program Forms indicated R44's ROM 3-5 x's week, Thera bands exercises and the bicycle 2-3 x's week. The form lacked the recommended EVA platform walker 3-5x's a week.

R44's rehab progress notes were reviewed and revealed the following:

-12/1/15, indicated R44 participated well with exercises.
-12/10/15 indicated R44 used the stepper for 10 minutes and participated well with exercises.
-12/15/15, indicated R44 exercised 10 minutes on the stepper.
-12/31/15, written by NA-C indicated R44 completed and participated in exercises, Theraband and stretches. Was on the stepper for 15 minutes.
-1/5/16, written by NA-C indicated R44 participated in exercises and usually asked for more. R44 had pain in left shoulder and R44 thought it was because of the mechanical stand-up lift staff used to transfer her. The note further indicated R44 enjoyed the stepper and said it benefited her greatly.

On 1/06/16, at 10:10 a.m. the activity aid (AA-A) who was also a nursing assistant was observed to wheel a mechanical standup lift out of R44's

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F 311	Continued From page 7	F 311		

room, return and wheel R44 to the activity room. At 10:16 a.m. AA-A stated R44 could stand up and bear weight with the mechanical lift but had no feeling in the left leg so leaned forward when assisted to a standing position.

On 1/7/16, at 10:58 a.m. R44 stated she used to stand on the elevated walker when she was at a previous facility but had only done it a few times here. R44 stated it had been months since she had been taken to the EVA platform walker. R44 stated the girl that used to provide rehab nursing was really good at it, but was called to kitchen duty so often that she did not have the time to spend in therapy so she did not always get therapy. R44 stated she would like to be able to exercise for longer periods and use the standing platform walker because it would help keep her stronger.

On 1/07/2016, at 11:11 a.m. the physical therapist (PT) stated her expectation was for rehab staff to assist R44 with the EVA platform walker per her recommendation. The PT stated R44 was not walking and needed to have weight bearing activity. The PT added R44 was not happy with the progress and wanted to be able to get better.

On 1/07/2016, at 11:40 a.m. the director of nursing (DON) stated they were in the process of reorganizing their rehabilitation program. The DON stated the MDS nurse was the person the rehab aide went to with questions but currently there was not a person designated to oversee the rehab program. The DON stated the MDS nurse had stepped up and was doing whatever time she had to supervise the program.

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F 311	Continued From page 8 The undated Restorative Nursing Program Policy and Procedure indicated the residents would be placed on a Restorative Nursing Program, when indicated, to achieve and maintain optimal physical, mental and psychosocial functioning. The procedure indicated PT would evaluate and assess each residents' need for therapy service. The Case Manager would complete flow sheets for each specific program for care plan and Restorative Nursing Assistant would document care given. The Case Manager would evaluate each program at least quarterly, and meet with Restorative Aide and therapy to review programs and make recommendations.	F 311		
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to provide timely toileting assistance according to the assessed need for 1 of 3 residents (R14) reviewed for toileting. Findings include:	F 315	For all residents, staff were educated on resident care plans and instructed on the importance of following care plans. Reviewed care plan policy, its use, where to access it and its importance at staff meeting on 01-20-16. For staff not able to attend the meeting, notes from the	2/15/16

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F 315	Continued From page 9 R14's quarterly Minimum Data Set (MDS) dated 11/2/15, indicated R14 was diagnosed with dementia. The MDS indicated R14 was cognitively impaired, required extensive assist of one staff for transferring, toileting, personal hygiene and was frequently incontinent of urine. R14's Urinary Incontinence Care Area Assessment (CAA) dated 5/8/15, indicated R14 had occasional stress incontinence, staff to prompt voiding before/after meals and activities or every 2-3 hours. The CAA also indicated due to R14's cognition, R14 would wait too long in between toileting times and had increased incontinence if not prompted to toilet and assisted. R14's Bowel and Bladder Assessment Form, dated 10/29/15, indicated R14 had functional urinary incontinence related to dementia, required assist with transfers and had impaired balance. The assessment indicated R14 was able to sit on the toilet, had periods of continence and used incontinent pads/briefs. The assessment indicated there would be no change in R14's care plan. R14's care plan dated 10/28/15, directed staff to prompt R14 to void before and after meals, activities and at night. In addition, the care plan indicated R14 required extensive assistance of one staff for toileting and was incontinent of bladder daily, but would also void when assisted on the toilet. The care plan directed staff to utilize pull up incontinent briefs in place of regular panties. On 1/6/16, from 7:15 a.m. until 8:16 a.m. R14	F 315	meeting regarding this was posted for staff to read and sign off before February 5, 2016. Goal is to prevent urinary tract infections and restore as much normal bladder function as possible. R44's elimination plan has been reviewed and updated on 1/8/16 and posted in the daily care book. Bowel and Bladder assessments for all residents will be completed quarterly, annually or with a significant change the next 3 months. Care plans and the daily care assignment sheets will be updated as indicated per assessment. DON or designee will do random observation audits 3x weekly x4 weeks to ensure policy is being followed. Results will be reported to the performance improvement committee.	

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F 315	Continued From page 10	F 315		

was observed seated in a wheelchair at the dining room table. During this time, R14 had received and consumed her breakfast meal.
-At 8:16 a.m. R14 wheeled out of the dining room heading towards own room.
-At 8:21 a.m. R14 entered own room and proceeded to look for eye glasses. A housekeeper was observed to assist in finding the glasses.
-At 8:37 a.m. nursing assistant (NA)-B entered R14's room and assisted R14 to bed. R14 was not offered or prompted to use the toilet nor was R14's incontinent brief checked for incontinence or changed. R14 was observed to remain in bed until 11:34 a.m. when the physical therapist entered the room to complete an evaluation.
-At 11:34 a.m. the physical therapist assisted R14 out of bed and proceeded to assist R14 to ambulate in the hallway.
-At 11:40 a.m. the therapist asked R14 if she needed to use the bathroom. R14 stated she might have to. R14 was wheeled back to the room and into the bathroom. R14 did void and R14's brief was wet with urine and had a strong urine smell. The therapist verified R14's brief was wet and had a strong urine smell.

On 1/6/16, at 1:12: p.m. NA-B verified R14 was not offered or taken to the toilet before going to bed and had not been taken to the toilet since she was assisted out of bed over four hours prior. NA-B confirmed R14 was not provided toileting assistance from 7:15 a.m. until 11:40 a.m. (four hours and 25 minutes). NA-B also stated R14 would have told the NA if she needed to go to the bathroom before she was assisted to bed, therefore R14 was not asked if she needed to use the toilet.

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F 315	Continued From page 11 On 1/6/16, at 3:00 p.m. the director of nursing (DON) confirmed R14's care plan directed staff to assist R14 to the toilet before and after meals and should have been asked to toilet every 2-3 hours. The DON verified R14's care plan was not followed. On 1/7/16, at 11:40 a.m. the DON stated a policy for toileting could not be found.	F 315		
F 431 SS=D	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 controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and	F 431		2/15/16

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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 431	Continued From page 12 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 eye drop medications were properly labeled with prescription medication labels for 1 of 3 (R3) residents who received eye drop medications on the Edgewood wing. Findings include: On 01/07/2016, at 9:02 a.m. the Edgewood medication cart storage review was conducted with licensed practical nurse (LPN)-A. During the review, a bottle of Alphagan brimonidine 1%, and a bottle of Lumigan 0.01% eye drops were observed in the medication cart drawer without a prescription label nor a date when opened identified. LPN-A verified the medications were prescribed for R3. LPN-A confirmed the bottles did not have an appropriate prescription medication label attached, and both eye drop bottles were not dated when opened. LPN-A further verified the prescription eye drop medication boxes also failed to have a prescription label. LPN-A stated all eye drop medications should be labeled with a prescription medication label and a date when the bottle was opened. LPN-A stated she had training on	F 431	The Medication Administration policy states, "the label of each patient's individual medications container shall clearly indicate the patient's full name, physician's name, prescription number, name of drug, strength and quantity of drug, date of original issue, or in case of a refill, the most recent date thereof, and expiration as applicable". R3 eye drops were subsequently labeled and dated on 1/7/16. All nursing staff directed to read and review the Medication Administration policy posted in each medication room. Due by February 5, 2016. DON or designee will do random observation audits 3x weekly x4 weeks to ensure policy is being followed. Results will be reported to the performance improvement committee.	

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 _____	01/07/2016

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 431	Continued From page 13 administering medications safely and confirmed medication labels were to be verified with the medication administration record for accuracy of medication administration. LPN-A stated she would call pharmacy immediately to obtain prescription labels for the eye drops. On 1/07/2016, at 9:18 a.m. the director of nursing (DON) verified all medications including eye drops should have prescription medication labels on them and eye drops should be dated indicating when they were opened. The DON verified it was her expectation staff ensure medications were properly labeled and dated before administering the medications, including eye drops. The facility Medication Administration policy revised 7/13, directed staff to ascertain that the package was completely and properly labeled and to review the medication label for resident name, medication name, strength, dosage, expiration date, physician name and direction for administering and to administer medication from labeled containers.	F 431		
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT 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	F 441		2/15/16

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 _____	01/07/2016

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 441	Continued From page 14 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. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure infection control was maintained during the fresh water distribution on one of two units (Rosewood) with the potential to effect all 19 residents residing on Rosewood. Findings include:	F 441	Ice/Fresh Water Policy and procedure was updated on 01-20-16 to ensure infection control practices are maintained during the fresh water pass. Reviewed changes to the water pass at staff meeting on 01-20-16. For staff not able to attend the meeting, notes from the meeting regarding the fresh water pass	

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 _____	01/07/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 441	Continued From page 15 On 1/6/15, at 10:30 a.m. nursing assistant (NA)-A was observed to obtain a cart with clean water mugs (with handles) from the kitchen, fill them with ice and water, put a lid on the mugs and insert a straw into the hole of each lid. All the clean mugs were placed on the top shelf of the cart. NA-A was observed to enter R44's room with a clean water mug and come out of the room with a dirty water mug. NA-A removed the straw from the dirty mug, placed the used straw on top of the cart next to the clean water mugs and set the dirty mug on the top shelf of the cart next to the clean mugs. With the same hand NA-A used to remove the used straw, NA-A picked up a clean mug and carried it into the next resident room. NA-A proceeded in this manner for the remainder of the water pass. The dirty mugs remained mingled in with clean mugs and the dirty straws were placed on top of the cart. There was no separation of dirty and clean. NA-A was not observed to wash hands or utilize had sanitizer throughout the observation. On 1/6/2016 10:45 a.m. when NA-A was asked how she kept the clean and dirty mugs separated and not get them mixed up, NA-A stated she knew if they still had straws in them they were clean and did not know how else to keep them straight. On 1/6/16 at 3:00 p.m. the director of nursing (DON) stated she was not aware of how the day shift completed the fresh water pass. The DON stated the night staff would always pick up the dirty glasses first and then go around and place	F 441	was posted for staff to read and sign off before February 5, 2016. Updated Water/Ice Pass policy and procedure implemented on January 21, 2016. DON or designee will do random observation audits 3x weekly x4 weeks to ensure policy is being followed. Results will be reported to the performance improvement committee.	

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 _____	01/07/2016

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 441	Continued From page 16	F 441		

clean glasses in all the rooms. The DON stated the observed fresh water pass was probably not the best practice.

On 1/07/2016 at 11:52 a.m. during a telephone interview, the infection control registered nurse (RN)-C stated during the above water pass, there was a breach in infection control. RN-C confirmed there was a potential for cross contamination and the facility's policy was not followed.

The facility Policy and Procedure for Infection Control: Water/Ice Pass dated 2/09, noted:
1. At end of the AM shift, nursing staff will pick up water mugs and send to the kitchen
2. Kitchen staff will sanitize and refill with fresh ice water then cover with a clean cloth.
3. At the beginning of the PM shift, nursing will dispense fresh mugs to residents.
4. All staff to make sure to sanitize hands between water passes if pass was interrupted.
5. When completed, return to kitchen for sanitizing.

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 _____	**01/05/2016**

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 000	INITIAL COMMENTS	K 000		

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

EPOC

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		01/25/2016

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245616	A. BUILDING **02 - GREENBUSH MANOR** B. WING _____	**01/05/2016**

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	Continued From page 1	K 000		

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

or

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

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 _____	**01/05/2016**

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	Continued From page 2 have smoke detection and hazardous areas have automatic fire detection in accordance with the 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 36 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 are constructed to provide at least a one-hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels in approved frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 18.3.7.3, 18.3.7.5, 18.1.6.3 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	K 025	LifeCare Greenbush Manor had a passing score after a Fire Safety Evaluation System (FSES) survey conducted by Fire Safety Resources, LLC. Brett Dallager,Maintenance Supervisor,	1/22/16

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 _____	**01/05/2016**

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K 025	Continued From page 3 throughout the facility in the event of a fire which could affect all 40 residents, staff and visitors. Findings include: On facility tour between 11:00am to 2:00pm on 1/5/2016, 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. This deficient practice was confirmed by the Maintenance Supervisor (BD).	K 025	will be responsible for maintaining the ongoing compliance with the conditions necessary to maintain a passing FSES score.	

REPORT OF CONSULTANT FSES FINDINGS

LifeCare Greenbush Manor

19120 – 200th Street

Greenbush, MN 56726

Provider No. 245616

Date of Survey: January 20 & 22, 2016

Prepared by:
Robert L. Imholte, President
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Cold Spring, MN 56320
320-685-8559
RimholteFiresafe@aol.com

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Consulting, Education & Inspection Services

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E-mail: RImholteFiresafe@aol.com

January 22, 2016

Ms. Susan Lisell
Administrator
LifeCare Greenbush Manor
19120 – 200th Street
Greenbush, Minnesota 56726

RE: FSES at LifeCare Greenbush Manor

Dear Ms. Lisell:

Enclosed please find the survey information relating to the fire safety evaluation of LifeCare Greenbush Manor, 19120 – 200th Street, Greenbush, MN conducted on 01/20/2016. 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 01/05/2016.

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 01/20/2016 FSES survey and as reported in a follow-up e-mail from Mr. Brett Dallager, Maintenance Supervisor received at 1610 hours on 01/22/2016, 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: 36

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 1430 hours on 01/20/2016. 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 01/20/2016 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;
- A review of the Statement of Deficiencies (Form CMS-2567) from a fire/life safety recertification survey conducted on 10/19/2015; and
- A follow-up e-mail communication received from the facility maintenance supervisor at 1610 hours on 01/22/2016 confirming that the building fire sprinkler system gauges have been replaced.

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.

> ***Surveyor Note:*** Based on observation and interview of the maintenance supervisor at the time of the 01/20/2016 on-site visit, it was determined that the sprinkler system gauges have not been recalibrated or replaced within the past 5 years as required by NFPA 25(98), Sec. 2-3.2. In a follow-up e-mail communication received from the facility maintenance supervisor at 1610 hours on 01/22/2016, it was confirmed that the sprinkler system gauges were replaced on 01/22/2016. A copy of the sprinkler contractor's invoice was provided to serve as verification that the gauges were replaced. The findings in this report, therefore, reflect that the building's fire sprinkler system is in conformance with the requirements of NFPA 25(98), Sec. 2-3.2 and is now being inspected, tested and maintained in accordance with NFPA 25.

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 01/20/2016 and as reported by the facility maintenance supervisor in an e-mail communication received on 01/22/2016. 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.

All Zones – TABLE 8. FACILITY FIRE SAFETY REQUIREMENTS WORKSHEET

In accordance with NFPA 101A(01), Sec. 4.7, Step 8, only one copy of this table is required to be filled out for each building. For convenience, however, this table was filled out on the worksheets for all zones evaluated. All items in Table 8 could be checked 'Met' with the exception of 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.

Zone 1 – Rosewood:

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]: It was reported that there are three (3) staff persons on duty in this zone on the night shift.
5. Patient Average Age (*A*) [Value assigned = 1.2]: Residents housed in this zone average over 65 years of age.

TABLE 4. SAFETY PARAMETERS and SAFETY PARAMETER VALUES

1. Construction [Score: 0]:
   The building was assigned a Type V(111) construction type.
2. Interior Finish (Corridors and Exits) [Score: +3]:
   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. A 31-in. x 47-in. tempered glass vision panel was found in the corridor wall at Family/Conference Room A120; however, observation revealed that automatic smoke detection has been added to this space to meet Exception No. 1 to NFPA 101(00), Sec. 18.3.6.1. 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 roof/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]: It was reported that there are three (3) staff persons on duty in this zone on the night shift.
5. Patient Average Age (*A*) [Value assigned = 1.2]: Residents housed in this zone average over 65 years of age.

TABLE 4. SAFETY PARAMETERS and SAFETY PARAMETER VALUES

1. Construction [Score: 0]:
   The building was assigned a Type V(111) construction type.
2. Interior Finish (Corridors and Exits) [Score: +3]:
   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. A 31-in. x 47-in. tempered glass vision panel was found in the corridor wall at Family/Conference Room B120; however, observation revealed that automatic smoke detection has been added to this space to meet Exception No. 1 to NFPA 101(00), Sec. 18.3.6.1. 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 roof/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 roof/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 roof/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 1430 hours on 01/20/2016 and as reported by the facility maintenance supervisor in an e-mail communication received at 1610 hours on 01/22/2016. 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.*

LIFE CARE GREENBUSH MANOR

GREENBUSH, MINNESOTA

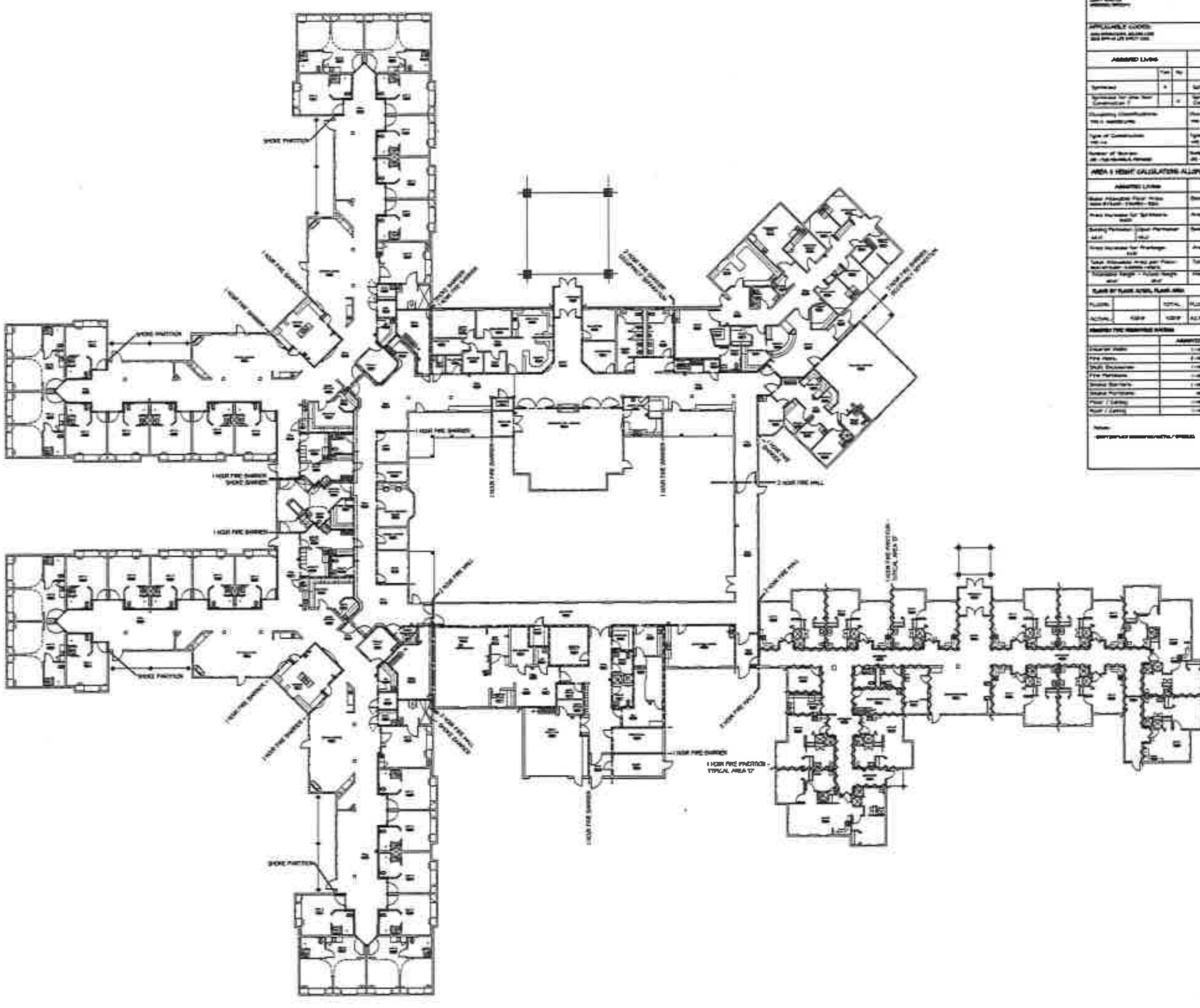
CODE SUMMARY

PROJECT NAME: [illegible]		PROJECT DESCRIPTION: [illegible]
APPLICABLE CODES: [illegible]		JURISDICTION: [illegible]
[illegible]	[illegible]	[illegible]
Occupancy Classification: [illegible]	Occupancy Classification: [illegible]	Occupancy Classification: [illegible]
Type of Construction: [illegible]	Type of Construction: [illegible]	Type of Construction: [illegible]
Number of Stories: [illegible]	Number of Stories: [illegible]	Number of Stories: [illegible]

AREA & HEIGHT CALCULATIONS ALLOWABLE FOR SELECTED CONSTRUCTION TYPE: [illegible]

FLOOR		TOTAL	FLOOR		TOTAL	FLOOR		TOTAL
ACTUAL	[illegible]	[illegible]	ACTUAL	[illegible]	[illegible]	ACTUAL	[illegible]	[illegible]

Notes: [illegible]



CODE PLAN - MAIN FLOOR

KEYNOTES:

FIRE RATING LEGEND

GENERAL NOTES

Project Number: 0711-5

CODE - R

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

Form Approved
OMB Exempt

ZONE 1 OF 4 ZONES

FIRE/SMOKE ZONE* EVALUATION WORKSHEET FOR HEALTH CARE FACILITIES

2000 LIFE SAFETY CODE

FACILITY	BUILDING
LifeCare Greenbush Manor	02- Greenbush Manor
ZONE(S) EVALUATED: Rosewood	
PROVIDER/VENDOR NO.: 245616	DATE OF SURVEY: 01/22/2016

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

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

TABLE 1. OCCUPANCY RISK PARAMETER FACTORS

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

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

TABLE 2. OCCUPANCY RISK FACTOR CALCULATION

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

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

TABLE 3A. (NEW BUILDINGS)

	F		R
1.0 X	7.6	=	7.6 = a

TABLE 3B. (EXISTING BUILDINGS)

	F		R
0.6 X		=	

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

SURVEYOR SIGNATURE: Robert L. Vitkute — Fire Safety Resources, LLC	TITLE: President	DATE: 01/22/2016
FIRE AUTHORITY SIGNATURE: Thomas Linhoff 12424 — Thomas Linhoff	TITLE: Supervisor	DATE: 02-18-2016

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)[d]	0	(1(0))[d]	2(0)[d]	
5. Doors to Corridor	No Door	<20 min FPR	≥20 min FPR	≥20 min FPR and Auto Clos.	
	-10	0	(1(0))[d]	2(0)[d]	

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

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

8. Hazardous Areas	Double Deficiency		Single Deficiency		No Deficiencies
	In Zone	Outside Zone	In Zone	In Adjacent Zone	
	-11	-5	-6	-2	(0)

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

10. Emergency Movement Routes	<2 Routes	Multiple Routes			
		Deficient	W/O Horizontal Exit(s)	Horizontal Exit(s)	Direct Exit(s)
	-8	-2	(0)	1	5

11. Manual Fire Alarm	No Manual Fire Alarm	Manual Fire Alarm	
		W/O F.D. Conn.	W/F.D. Conn
	-4	1	(2)

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

13. Automatic Sprinklers	None	Corridor and Habit. Space	Entire Building	
	0	8	(10)	

NOTE:

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

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

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

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

For SI units: 1 ft = 0.3048 m

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

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

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

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

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

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

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

TABLE 5. INDIVIDUAL SAFETY EVALUATIONS

Safety Parameters	Containment Safety (S_1)	Extinguishment Safety (S_2)	People Movement Safety (S_3)	General Safety (S_4)
1. Construction	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				
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.

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

Form Approved
OMB Exempt

ZONE 2 OF 4 ZONES

FIRE/SMOKE ZONE* EVALUATION WORKSHEET FOR HEALTH CARE FACILITIES

2000 LIFE SAFETY CODE

FACILITY	BUILDING
LIFECARE GREENBUSH MANOR	02-GREENBUSH MANOR
ZONE(S) EVALUATED: ENGLEWOOD	
PROVIDER/VENDOR NO.: 245616	DATE OF SURVEY: 01/22/2016

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

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

TABLE 1. OCCUPANCY RISK PARAMETER FACTORS

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

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

TABLE 2. OCCUPANCY RISK FACTOR CALCULATION

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

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

TABLE 3A. (NEW BUILDINGS)

	F		R
1.0 X	7.6	=	7.6 = 8

TABLE 3B. (EXISTING BUILDINGS)

	F		R
0.6 X		=	

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

SURVEYOR SIGNATURE: Robert L Linhoff — FIRE SAFETY RESOURCES LLC	TITLE: PRESIDENT	DATE: 01/22/2016
FIRE AUTHORITY SIGNATURE: Thomas Linhoff 12424	TITLE: Supervisor	DATE: 02-18-2016

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 60 ft	>150 ft	100 ft to 150 ft	<100 ft
	-6(0)[b]	-4(0)[b]	-2(0)[b]	-2(0)[c]	(0)	1

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

8. Hazardous Areas	Double Deficiency		Single Deficiency		No Deficiencies
	In Zone	Outside Zone	In Zone	In Adjacent Zone	
	-11	-5	-6	-2	(0)

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

10. Emergency Movement Routes	<2 Routes	Multiple Routes			
		Deficient	W/O Horizontal Exit(s)	Horizontal Exit(s)	Direct Exit(s)
	-8	-2	(0)	1	5

11. Manual Fire Alarm	No Manual Fire Alarm	Manual Fire Alarm	
		W/O F.D. Conn.	W/F.D. Conn
	-4	1	(2)

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

13. Automatic Sprinklers	None	Corridor and Habit. Space	Entire Building		
	0	8	(10)		

NOTE:

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

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

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

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

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

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

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

For SI units: 1 ft = 0.3048 m

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

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

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

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

TABLE 5. INDIVIDUAL SAFETY EVALUATIONS

Safety Parameters	Containment Safety (S_1)	Extinguishment Safety (S_2)	People Movement Safety (S_3)	General Safety (S_4)
1. Construction	0	0		0
2. Interior Finish (Corr. and Exit)	3		3	3
3. Interior Finish (Rooms)	3			3
4. Corridor Partitions/Walls	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				
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.

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

Form Approved
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ZONE 3 OF 4 ZONES

FIRE/SMOKE ZONE* EVALUATION WORKSHEET FOR HEALTH CARE FACILITIES

2000 LIFE SAFETY CODE

FACILITY	BUILDING
LIFECARE GREENBUSH MANOR	02-GREENBUSH MANOR
ZONE(S) EVALUATED: ADMINISTRATIVE/COMMUNITY ROOM WING	
PROVIDER/VENDOR NO.: 245616	DATE OF SURVEY: 01/22/2016

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

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

TABLE 1. OCCUPANCY RISK PARAMETER FACTORS

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

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

TABLE 2. OCCUPANCY RISK FACTOR CALCULATION

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

	F		R
1.0 X	10.1	=	10.1 ≈ 11

TABLE 3B. (EXISTING BUILDINGS)

	F		R
0.6 X		=	

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

SURVEYOR SIGNATURE: Robert J. Imbatta, FIRE SAFETY RESOURCES, LLC	TITLE: PRESIDENT	DATE: 01/22/2016
FIRE AUTHORITY SIGNATURE: Thomas Linhoff 12424	TITLE: Supervisor	DATE: 02-18-2016

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

NOTE:

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

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

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

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

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

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

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

For SI units: 1 ft = 0.3048 m

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

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

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

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

TABLE 5. INDIVIDUAL SAFETY EVALUATIONS

Safety Parameters	Containment Safety (S_1)	Extinguishment Safety (S_2)	People Movement Safety (S_3)	General Safety (S_4)
1. Construction	0	0		0
2. Interior Finish (Corr. and Exit)	3		3	3
3. Interior Finish (Rooms)	3			3
4. Corridor Partitions/Walls	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.

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

Form Approved
OMB Exempt

ZONE 4 OF 4 ZONES

FIRE/SMOKE ZONE* EVALUATION WORKSHEET FOR HEALTH CARE FACILITIES

2000 LIFE SAFETY CODE

FACILITY	BUILDING
LIFECARE GREENBUSH MANOR	02 - GREENBUSH MANOR
ZONE(S) EVALUATED: SUPPORT SERVICES WING	
PROVIDER/VENDOR NO.: 245616	DATE OF SURVEY: 01/22/2016

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)

	F		R
1.0 X	6.1	=	6.1 = 7

TABLE 3B. (EXISTING BUILDINGS)

	F		R
0.6 X		=	

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

SURVEYOR SIGNATURE: Robert L. Pintello, FIRE SAFETY RESOURCES, LLC	TITLE: PRESIDENT	DATE: 01/22/2016
FIRE AUTHORITY SIGNATURE: Thomas Linhoff 12424	TITLE: Supervisor	DATE: 02-18-2016

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 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)	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 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.

MDH
Minnesota
Department
of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically submitted
January 15, 2016

Ms. Susan Lisell, Administrator
Lifecare Greenbush Manor
19120 200th Street
Greenbush, Minnesota 56726

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5616009

Dear Ms. Lisell:

The above facility was surveyed on January 4, 2016 through January 7, 2016 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health, Health Regulation Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

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

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

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction

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

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

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

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, **you should immediately contact Lyla Burkman at (218) 308-2104 or email: lyla.burkman@state.mn.us**.

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

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

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

Sincerely,

Mark Meath

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
	00578N	A. BUILDING: _____ B. WING _____	01/07/2016

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) COMPLETE DATE
2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm The State licensing orders are delineated on the attached Minnesota	2 000		

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2 000	Continued From page 1 Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. On January 4th, 5th, 6th, and 7th 2016, surveyors of this Department's staff, visited the above provider and the following correction orders are issued. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed. Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.	2 000		

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2 000	Continued From page 2 THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000		
2 565	MN Rule 4658.0405 Subp. 3 Comprehensive Plan of Care; Use Subp. 3. Use. A comprehensive plan of care must be used by all personnel involved in the care of the resident. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide a platform walker exercise program as directed by the care plan for 1 of 1 resident (R44) reviewed for rehabilitation and failed to provide toileting assistance for 1 of 3 residents (R14) who required staff assistance to toilet as directed by the care plan. Findings include: R44 did not receive the recommended elevated arm platform walker (EVA) standing program as directed by the care plan. R44's current mobility care plan dated 11/17/15, indicated R44 had impaired physical mobility related to chronic pain, diabetic complications, left hemiparesis (weakness or paralysis on one side of the body) and required extensive assistance	2 565	Corrected	2/15/16

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2 565	Continued From page 3	2 565		

for all activities of daily living. The care plan directed staff to complete passive range of motion to left upper extremities 3-5 times a week, right upper extremity use yellow band 3-5 x's week and standing program with EVA platform walker with assist of two staff 3-5 x's per week for a goal of 5-10 minutes.

On 1/7/16, at 9:52 a.m. nursing assistant (NA)-C stated R44 had not been using the standing platform walker since NA-C had taken over the rehabilitation program the first of December. NA-C stated since the recumbent stepper was added to the program on 10/16/15, she thought the platform walker was discontinued therefore R44 had not been doing it.

The Nursing Assistant Daily Cares Record and Recreational Program Forms included R44's ROM 3-5 x's week, Thera band exercises and the bicycle 2-3 x's week. However, the form lacked the recommended EVA platform walker 3-5x's a week.

On 1/06/16, at 10:10 a.m. the activity aid (AA-A) who was also a nursing assistant was observed to wheel a mechanical standup lift out of R44's room, return and wheel R44 to the activity room. -At 10:16 a.m. AA-A stated R44 could stand up and bear weight with the mechanical lift but had no feeling in the left leg and leaned forward when assisted to a standing position.

On 1/7/16, at 10:58 a.m. R44 stated she used to stand on the elevated walker when she was at a previous facility but had only done it a few times here. R44 stated it had been months since she had been taken to the standing platform (EVA) walker. R44 stated she would like to be able to exercise for longer periods and use the standing

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2 565	Continued From page 4 platform walker because it would help keep her stronger. On 1/07/2016, at 11:11 a.m. the physical therapist (PT) stated her expectation was for R44 to be assisted with the EVA platform walker as directed. On 1/07/2016, at 11:40 a.m. the director of nursing (DON) verified R44 had not received the EVA platform exercise as directed by the care plan. R14 was not provided assistance with toileting as directed by the care plan for four hours and 25 minutes on the morning of 1/6/16. R14's care plan dated 10/28/15, directed staff to provide prompted voiding before and after meals, activities and at night. In addition, the care plan indicated R14 required extensive assistance of one staff for toileting and was incontinent of bladder daily, but will void in toilet also. The care plan directed staff to utilize pull up briefs in place of regular panties. On 1/6/16, from 7:15 a.m. until 8:16 a.m. R14 was observed seated in a wheelchair at the dining room table. During this time, R14 had received and consumed her breakfast meal. -At 8:16 a.m. R14 wheeled out of the dining room heading towards own room. -At 8:21 a.m. R14 entered own room and proceeded to look for eye glasses. A housekeeper was observed to assist in finding the glasses. -At 8:37 a.m. NA-B entered R14's room and assisted R14 to bed. R14 was not offered or prompted to use the toilet nor was R14's	2 565		

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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) COMPLETE DATE
2 565	Continued From page 5	2 565		

incontinent brief checked for incontinence or changed. R14 was observed to remain in bed until 11:34 a.m. when the physical therapist entered the room to complete an evaluation.
-At 11:34 a.m. the physical therapist assisted R14 out of bed and proceeded to assist R14 to ambulate in the hallway.
-At 11:40 a.m. the therapist asked R14 if she needed to use the bathroom. R14 stated she might have to. R14 was wheeled back to the room and into the bathroom. R14 did void and R14's brief was wet and had a strong urine smell. The therapist verified R14's brief was wet and had a strong urine smell.

On 1/6/16, at 1:12: p.m. NA-B verified R14 was not offered or taken to the toilet before going to bed and had not been taken to the toilet since she was assisted out of bed over four hours prior. NA-B stated R14 would have told the NA if she needed to go to the bathroom before she was assisted to bed therefore R14 was not asked if she needed to use the toilet.

On 1/6/16, at 3:00 p.m. the DON confirmed R14's care plan directed staff to assist R14 to the toilet before and after meals and R14 should be asked every 2-3 hours if she needed to use the toilet. The DON verified R14's care plan was not followed.

On 1/7/16, at 11:40 a.m. the DON stated a policy for following the care plan could not be found.

SUGGESTED METHOD OF CORRECTION:

The Director of Nursing could schedule an in-service to discuss the importance of following resident care plans. A designated staff member

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00578N	A. BUILDING: _____ B. WING _____	01/07/2016

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2 565	Continued From page 6 could monitor to assure cares are being implemented. The Quality Assurance Committee could randomly audit to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 565		
2 910	MN Rule 4658.0525 Subp. 5 A.B Rehab - Incontinence Subp. 5. Incontinence. A nursing home must have a continuous program of bowel and bladder management to reduce incontinence and the unnecessary use of catheters. Based on the comprehensive resident assessment, a nursing home must ensure that: A. a resident who enters a nursing home without an indwelling catheter is not catheterized unless the resident's clinical condition indicates that catheterization was necessary; and B. a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to provide timely toileting assistance according to the assessed need for 1 of 3 residents (R14) reviewed for toileting. Findings include:	2 910	Corrected	2/15/16

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	00578N	A. BUILDING: _____ B. WING _____	01/07/2016

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2 910	Continued From page 7 R14's quarterly Minimum Data Set (MDS) dated 11/2/15, indicated R14 was diagnosed with dementia. The MDS indicated R14 was cognitively impaired, required extensive assist of one staff for transferring, toileting, personal hygiene and was frequently incontinent of urine. R14's Urinary Incontinence Care Area Assessment (CAA) dated 5/8/15, indicated R14 had occasional stress incontinence, staff to prompt voiding before/after meals and activities or every 2-3 hours. The CAA also indicated due to R14's cognition, R14 would wait too long in between toileting times and had increased incontinence if not prompted to toilet and assisted. R14's Bowel and Bladder Assessment Form, dated 10/29/15, indicated R14 had functional urinary incontinence related to dementia, required assist with transfers and had impaired balance. The assessment indicated R14 was able to sit on the toilet, had periods of continence and used incontinent pads/briefs. The assessment indicated there would be no change in R14's care plan. R14's care plan dated 10/28/15, directed staff to prompt R14 to void before and after meals, activities and at night. In addition, the care plan indicated R14 required extensive assistance of one staff for toileting and was incontinent of bladder daily, but would also void when assisted on the toilet. The care plan directed staff to utilize pull up incontinent briefs in place of regular panties. On 1/6/16, from 7:15 a.m. until 8:16 a.m. R14 was observed seated in a wheelchair at the dining room table. During this time, R14 had received	2 910		

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2 910	Continued From page 8	2 910		

and consumed her breakfast meal.
-At 8:16 a.m. R14 wheeled out of the dining room heading towards own room.
-At 8:21 a.m. R14 entered own room and proceeded to look for eye glasses. A housekeeper was observed to assist in finding the glasses.
-At 8:37 a.m. nursing assistant (NA)-B entered R14's room and assisted R14 to bed. R14 was not offered or prompted to use the toilet nor was R14's incontinent brief checked for incontinence or changed. R14 was observed to remain in bed until 11:34 a.m. when the physical therapist entered the room to complete an evaluation.
-At 11:34 a.m. the physical therapist assisted R14 out of bed and proceeded to assist R14 to ambulate in the hallway.
-At 11:40 a.m. the therapist asked R14 if she needed to use the bathroom. R14 stated she might have to. R14 was wheeled back to the room and into the bathroom. R14 did void and R14's brief was wet with urine and had a strong urine smell. The therapist verified R14's brief was wet and had a strong urine smell.

On 1/6/16, at 1:12: p.m. NA-B verified R14 was not offered or taken to the toilet before going to bed and had not been taken to the toilet since she was assisted out of bed over four hours prior. NA-B confirmed R14 was not provided toileting assistance from 7:15 a.m. until 11:40 a.m. (four hours and 25 minutes). NA-B also stated R14 would have told the NA if she needed to go to the bathroom before she was assisted to bed, therefore R14 was not asked if she needed to use the toilet.

On 1/6/16, at 3:00 p.m. the director of nursing (DON) confirmed R14's care plan directed staff to assist R14 to the toilet before and after meals

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2 910	Continued From page 9 and should have been asked to toilet every 2-3 hours. The DON verified R14's care plan was not followed. On 1/7/16, at 11:40 a.m. the DON stated a policy for toileting could not be found. SUGGESTED METHOD OF CORRECTION: The Director of Nursing could review and revise policies and procedures for toileting care delivery and provide training to involved staff. A designated staff member could monitor the system to assure cares are being delivered. The Quality Assurance Committee could randomly audit to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 910		
2 915	MN Rule 4658.0525 Subp. 6 A Rehab - ADLs Subp. 6. Activities of daily living. Based on the comprehensive resident assessment, a nursing home must ensure that: A. a resident is given the appropriate treatments and services to maintain or improve abilities in activities of daily living unless deterioration is a normal or characteristic part of the resident's condition. For purposes of this part, activities of daily living includes the resident's ability to: (1) bathe, dress, and groom; (2) transfer and ambulate; (3) use the toilet; (4) eat; and (5) use speech, language, or other functional communication systems; and	2 915		2/15/16

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2 915	Continued From page 10 This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide an elevated arm platform standing program in order to maintain or minimize the loss of lower extremity strength for 1 of 1 resident (R44) in the sample reviewed for rehabilitation services. Findings include: R44's quarterly Minimum Data Set (MDS) dated 11/29/15, indicated R44 had no cognitive impairment, was diagnosed with hemiplegia (severe weakness on one side of body) and diabetes, had limited range of motion on one side of the upper and lower body and required total staff assistance with all mobility and did not ambulate. The Activities of Daily Living Care Area Assessment (CAA) dated 9/6/15, indicated R44 had left sided hemiparesis which impacted her ability to care for herself. The CAA indicated R44 was alert, able to make own decision and had left sided weakness due to a cerebral vascular accident (stroke). A Rehabilitation Services Screening form dated and signed by the physical therapist (PT), on 8/25/15, indicated R44's mobility was screened to establish a rehabilitation program. The recommendation included bilateral lower extremity strengthening exercises 3-5 days per week, active range of motion (ROM) on right side	2 915	Corrected	

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2 915	Continued From page 11	2 915		

and active assisted on left side for hips, knees, and ankles, 3 sets of 10-15 repetitions. Perform all transfers with assist of two. The PT also recommended R44 participate in standing program with elevated arm (EVA) platform walker (all brakes locked) with assist of two with goal of 8-10 minutes 3-5x's week.

A Rehabilitation Services Screening form dated 10/16/15, and signed by the PT, indicated R44 was being screened for a recumbent stepper. The recommendation was to use the recumbent stepper 3x's a week with nursing staff with goal of 5-10 minutes with both legs only.

R44's current mobility care plan dated 11/17/15, indicated R44 had impaired physical mobility related to chronic pain, diabetic complications and left hemiparesis and required extensive assistance of staff for all activities of daily living. The care plan directed staff to complete the exercise program which consisted of passive range of motion to left upper extremities 3-5 times a week, right upper extremity use yellow band 3-5 x's week and standing program with EVA platform walker with assist of two staff 3-5 x's per week for a goal of 5-10 minutes.

However, on 1/7/16, at 9:52 a.m. the nursing rehabilitation aide, (NA)-C stated R44 had not been using the standing platform walker since NA-C had taken over the rehabilitation program the first of December. NA-C stated since the recumbent stepper was added to the program on 10/16/15, she thought the platform walker was discontinued therefore R44 had not been doing it.

The Nursing Assistant Daily Cares Record and Recreational Program Forms indicated R44's ROM 3-5 x's week, Thera bands exercises and

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2 915	Continued From page 12	2 915		

the bicycle 2-3 x's week. The form lacked the recommended EVA platform walker 3-5x's a week.

R44's rehab progress notes were reviewed and revealed the following:

-12/1/15, indicated R44 participated well with exercises.
-12/10/15 indicated R44 used the stepper for 10 minutes and participated well with exercises.
-12/15/15, indicated R44 exercised 10 minutes on the stepper.
-12/31/15, written by NA-C indicated R44 completed and participated in exercises, Theraband and stretches. Was on the stepper for 15 minutes.
-1/5/16, written by NA-C indicated R44 participated in exercises and usually asked for more. R44 had pain in left shoulder and R44 thought it was because of the mechanical stand-up lift staff used to transfer her. The note further indicated R44 enjoyed the stepper and said it benefited her greatly.

On 1/06/16, at 10:10 a.m. the activity aid (AA-A) who was also a nursing assistant was observed to wheel a mechanical standup lift out of R44's room, return and wheel R44 to the activity room. At 10:16 a.m. AA-A stated R44 could stand up and bear weight with the mechanical lift but had no feeling in the left leg so leaned forward when assisted to a standing position.

On 1/7/16, at 10:58 a.m. R44 stated she used to stand on the elevated walker when she was at a previous facility but had only done it a few times here. R44 stated it had been months since she had been taken to the EVA platform walker. R44 stated the girl that used to provide rehab nursing

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	00578N	A. BUILDING: _____ B. WING _____	01/07/2016

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2 915	Continued From page 13 was really good at it, but was called to kitchen duty so often that she did not have the time to spend in therapy so she did not always get therapy. R44 stated she would like to be able to exercise for longer periods and use the standing platform walker because it would help keep her stronger. On 1/07/2016, at 11:11 a.m. the physical therapist (PT) stated her expectation was for rehab staff to assist R44 with the EVA platform walker per her recommendation. The PT stated R44 was not walking and needed to have weight bearing activity. The PT added R44 was not happy with the progress and wanted to be able to get better. On 1/07/2016, at 11:40 a.m. the director of nursing (DON) stated they were in the process of reorganizing their rehabilitation program. The DON stated the MDS nurse was the person the rehab aide went to with questions but currently there was not a person designated to oversee the rehab program. The DON stated the MDS nurse had stepped up and was doing whatever time she had to supervise the program. The undated Restorative Nursing Program Policy and Procedure indicated the residents would be placed on a Restorative Nursing Program, when indicated, to achieve and maintain optimal physical, mental and psychosocial functioning. The procedure indicated PT would evaluate and assess each residents' need for therapy service. The Case Manager would complete flow sheets for each specific program for care plan and Restorative Nursing Assistant would document care given. The Case Manager would evaluate each program at least quarterly, and meet with Restorative Aide and therapy to review programs	2 915		

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2 915	Continued From page 14 and make recommendations. SUGGESTED METHOD OF CORRECTION: The Director of Nursing and Administrator could review and revise the policy and procedures and could develop a rehab program to ensure that all residents receive restorative services as recommended. The Quality Assurance Committee could randomly audit the rehab records to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 915		
21375	MN Rule 4658.0800 Subp. 1 Infection Control; Program Subpart 1. Infection control program. A nursing home must establish and maintain an infection control program designed to provide a safe and sanitary environment. This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure infection control was maintained during the fresh water distribution on one of two units (Rosewood) with the potential to effect all 19 residents residing on Rosewood. Findings include: On 1/6/15, at 10:30 a.m. nursing assistant (NA)-A was observed to obtain a cart with clean water	21375	Corrected	2/15/16

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	00578N	A. BUILDING: _____ B. WING _____	01/07/2016

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21375	Continued From page 15	21375		

mugs (with handles) from the kitchen, fill them with ice and water, put a lid on the mugs and insert a straw into the hole of each lid. All the clean mugs were placed on the top shelf of the cart. NA-A was observed to enter R44's room with a clean water mug and come out of the room with a dirty water mug. NA-A removed the straw from the dirty mug, placed the used straw on top of the cart next to the clean water mugs and set the dirty mug on the top shelf of the cart next to the clean mugs. With the same hand NA-A used to remove the used straw, NA-A picked up a clean mug and carried it into the next resident room. NA-A proceeded in this manner for the remainder of the water pass. The dirty mugs remained mingled in with clean mugs and the dirty straws were placed on top of the cart. There was no separation of dirty and clean. NA-A was not observed to wash hands or utilize had sanitizer throughout the observation.

On 1/6/2016 10:45 a.m. when NA-A was asked how she kept the clean and dirty mugs separated and not get them mixed up, NA-A stated she knew if they still had straws in them they were clean and did not know how else to keep them straight.

On 1/6/16 at 3:00 p.m. the director of nursing (DON) stated she was not aware of how the day shift completed the fresh water pass. The DON stated the night staff would always pick up the dirty glasses first and then go around and place clean glasses in all the rooms. The DON stated the observed fresh water pass was probably not the best practice.

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21375	Continued From page 16 On 1/07/2016 at 11:52 a.m. during a telephone interview, the infection control registered nurse (RN)-C stated during the above water pass, there was a breach in infection control. RN-C confirmed there was a potential for cross contamination and the facility's policy was not followed. The facility Policy and Procedure for Infection Control: Water/Ice Pass dated 2/09, noted: 1. At end of the AM shift, nursing staff will pick up water mugs and send to the kitchen 2. Kitchen staff will sanitize and refill with fresh ice water then cover with a clean cloth. 3. At the beginning of the PM shift, nursing will dispense fresh mugs to residents. 4. All staff to make sure to sanitize hands between water passes if pass was interrupted. 5. When completed, return to kitchen for sanitizing. SUGGESTED METHOD OF CORRECTION: The Director of Nursing could develop and implement polices and procedures related to sanitary water distribution to residents and educate staff. A designated staff member could monitor the system to ensure infection control measures are being implemented. The Quality Assurance Committee could randomly audit for compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21375		
21620	MN Rule 4658.1345 Labeling of Drugs	21620		2/15/16

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21620	Continued From page 17 Drugs used in the nursing home must be labeled in accordance with part 6800.6300. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure eye drop medications were properly labeled with prescription medication labels for 1 of 3 (R3) residents who received eye drop medications on the Edgewood wing. Findings include: On 01/07/2016, at 9:02 a.m. the Edgewood medication cart storage review was conducted with licensed practical nurse (LPN)-A. During the review, a bottle of Alphagan brimonidine 1%, and a bottle of Lumigan 0.01% eye drops were observed in the medication cart drawer without a prescription label nor a date when opened identified. LPN-A verified the medications were prescribed for R3. LPN-A confirmed the bottles did not have an appropriate prescription medication label attached, and both eye drop bottles were not dated when opened. LPN-A further verified the prescription eye drop medication boxes also failed to have a prescription label. LPN-A stated all eye drop medications should be labeled with a prescription medication label and a date when the bottle was opened. LPN-A stated she had training on administering medications safely and confirmed medication labels were to be verified with the medication administration record for accuracy of medication administration. LPN-A stated she would call pharmacy immediately to obtain	21620	Corrected	

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	00578N	A. BUILDING: _____ B. WING _____	01/07/2016

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21620	Continued From page 18 prescription labels for the eye drops. On 1/07/2016, at 9:18 a.m. the director of nursing (DON) verified all medications including eye drops should have prescription medication labels on them and eye drops should be dated indicating when they were opened. The DON verified it was her expectation staff ensure medications were properly labeled and dated before administering the medications, including eye drops. The facility Medication Administration policy revised 7/13, directed staff to ascertain that the package was completely and properly labeled and to review the medication label for resident name, medication name, strength, dosage, expiration date, physician name and direction for administering and to administer medication from labeled containers. A SUGGESTED METHOD FOR CORRECTION: The director of nursing or designee could review and revise the policies and procedures related the dating and labeling of medications. The DON or designee could provide education to all involved staff. The facility could develop a monitoring system to ensure ongoing compliance and report the findings to the Qualify Assurance Committee. TIME PERIOD FOR CORRECTION: Twenty one (21) days.	21620		