### DEPARTMENT OF HEALTH AND HUMAN SERVICES

### CENTERS FOR MEDICARE & MEDICAID SERVICES

ID: QSNS

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL
PART 1 - TO BE COMPLETED BY THE STATE SURVEY AGENCY

| PART   | I - TO BE COMPLETED BY TH  | IE STATE SURVEY AGENCY  | Facility ID: 00578N  |  |  |
|--|--|---|--|--|--|
| MEDICARE/MEDICAID PROVIDER NO.     (L1) 245616  2.STATE VENDOR OR MEDICAID NO.     (L2) 850026600                  | 3. NAME AND ADDRESS OF FACIL<br>(L3) <b>LIFECARE GREENBUSH N</b><br>(L4) <b>19120 200TH STREET</b><br>(L5) <b>GREENBUSH, MN</b>  |   | 4. TYPE OF ACTION: 7 (L8)  1. Initial 2. Recertification 3. Termination 4. CHOW 5. Validation 6. Complaint   |  |  |
| 5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9)   | 7. PROVIDER/SUPPLIER CATEGOI 01 Hospital 05 HHA 0  | RY <u>03</u> (L7)<br>09 ESRD 13 PTIP 22 CLIA  | 7. On-Site Visit 9. Other  8. Full Survey After Complaint  |  |  |
| 6. DATE OF SURVEY <b>02/29/2016</b> (L34) 8. ACCREDITATION STATUS: (L10) 0 Unaccredited                            | 03 SNF/NF/Distinct 07 X-Ray  | 10 NF 14 CORF<br>11 ICF/IID 15 ASC<br>12 RHC 16 HOSPICE   | FISCAL YEAR ENDING DATE: (L35)  09/30  |  |  |
| 11. LTC PERIOD OF CERTIFICATION From (a): To (b):  12. Total Facility Beds 13. Total Certified Beds 40 (L18)       | 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 Wai | And/Or Approved Waivers Of  2. Technical Personnel  3. 24 Hour RN  4. 7-Day RN (Rural SN  5. Life Safety Code | 7. Medical Director  |  |  |
| 14. LTC CERTIFIED BED BREAKDOWN  18 SNF 18/19 SNF 19 SN  20 20  (L37) (L38) (L39)                                  |  | 15. FACILITY MEETS 1861 (e) (1) or 1861 (j) (1):  | (L15)  |  |  |
| 16. STATE SURVEY AGENCY REMARKS (IF APPLI<br>17. SURVEYOR SIGNATURE  | CABLE SHOW LTC CANCELLATION DA  Date :   | (TE):  18. STATE SURVEY AGENCY  | / APPROVAL Date:   |  |  |
| Lyla Burkman, Unit Supervisor  | 03/02/2016   | Enforcement   | seath  |  |  |
| PART II - TO B   | E COMPLETED BY HCFA REG  | GIONAL OFFICE OR SINGLE S   |  |  |  |
| DETERMINATION OF ELIGIBILITY      _X 1. Facility is Eligible to Participate     2. Facility is not Eligible  (L21) | 20. COMPLIANCE WITH C<br>RIGHTS ACT:   | <ol><li>Ownership/Contr</li></ol>   | <ul> <li>21. 1. Statement of Financial Solvency (HCFA-2572)</li> <li>2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)</li> <li>3. Both of the Above :</li> </ul>  |  |  |
| 22. ORIGINAL DATE 23. LTC AGRI OF PARTICIPATION BEGINNI 04/13/2009 (L24) (L41)                                     | NG DATE ENDING DATE (L25)  |   | INVOLUNTARY  05-Fail to Meet Health/Safety  one of the state of the st |  |  |
| A. Suspen  | TIVE SANCTIONS ion of Admissions: (L44) Suspension Date: (L45)   | 04-Other Reason for Withdrawal  | OTHER 07-Provider Status Change 00-Active  |  |  |
| 28. TERMINATION DATE: (L28)  | 29. INTERMEDIARY/CARRIER NO. 03001   | 30. REMARKS (L31)   |  |  |  |
| 31. RO RECEIPT OF CMS-1539 (L32)   | 32. DETERMINATION OF APPROVAL D 02/22/2016   | (L33) DETERMINATION APP   | ROVAL  |  |  |

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES

#### CENTERS FOR MEDICARE & MEDICAID SERVICES

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00578N

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

CCN: 24 5616

STATE AGENCY REMARKS

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



### 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



### 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 Meeth

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

### POST-CERTIFICATION REVISIT REPORT

|                                    | R / SUPPLIER / CLIA /  | MULTIPLE CONS          |           | II ICATIO    | IN KEVIOII KI       | LFORT         |           | DATE O  | F REVISIT        |  |  |
|------------------------------------|--|------------------------|-----------|--------------|---------------------|---------------|-----------|---------|------------------|--|--|
| 1DENTIFIC<br>245616                | CATION NUMBER Y1   | A. Building<br>B. Wing |           |              |                     |               | Y2        | 2/29/20 | 16 <sub>Y3</sub> |  |  |
| NAME OF                            | FACILITY   | l                      |           |              | STREET ADDRESS, CIT | Y. STATE. ZIF | CODE      |         |                  |  |  |
|                                    | RE GREENBUSH MANO  | R                      |           |              | 19120 200TH STREET  | ,             |           |         |                  |  |  |
|                                    |  |                        |           |              | GREENBUSH, MN 5672  | 6             |           |         |                  |  |  |
| program,<br>corrected<br>provision | 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). |                        |           |              |                     |               |           |         |                  |  |  |
| ITE                                | М  | DATE                   | ITEM      |              | DATE                | ITEM          |           |         | DATE             |  |  |
| Y4                                 |  | Y5                     | Y4        |              | Y5                  | Y4            |           |         | 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           |           |         |                  |  |  |
|                                    |  |                        | T         |              |                     | 1             |           |         |                  |  |  |

| REVIEWED BY<br>STATE AGENCY     |  | REVIEWED BY  | DATE       | SIGNATURE OF SURVEYOR |     | DATE       |
|---------------------------------|--|--|------------|-----------------------|-----|------------|
|                                 |  | (INITIALS)<br>LB/mm                                      | 03/02/2016 | 28                    | 035 | 02/29/2016 |
| REVIEWED BY<br>CMS RO           |  | REVIEWED BY (INITIALS)                                   | DATE       | TITLE                 |     | DATE       |
| FOLLOWUP TO SURVEY COMPLETED ON |  | CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF |            |                       |     |            |

ID Prefix

Reg. #

LSC

Correction

Completed

Form CMS - 2567B (09/92) EF (11/06)

ID Prefix

Reg. #

1/7/2016

LSC

ID Prefix

Reg.#

LSC

Correction

Completed

UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?

YES NO

Correction

Completed

### POST-CERTIFICATION REVISIT REPORT

|                                    | R / SUPPLIER / C                |   | STRUCTION<br>- GREENBUSH MA           | NOR   |   | DATE OF                        | F REVISIT        |
|------------------------------------|---------------------------------|---|---------------------------------------|---|---|--------------------------------|------------------|
| 245616                             |                                 | Y1 B. Wing  | CICEINDOOTTWA                         | NOTC  |   | Y2 2/19/20                     | 16 <sub>Y3</sub> |
| NAME OF<br>LIFECAR                 | FACILITY<br>E GREENBUSH         | H MANOR   |                                       | STREET ADDRESS, CIT<br>19120 200TH STREET<br>GREENBUSH, MN 5672   |   |                                |                  |
| program,<br>corrected<br>provision | to show those dand the date su  | leficiencies previously repo<br>uch corrective action was a | orted on the CMS-2 accomplished. Each | , Medicaid and/or Clinical Laborato<br>567, Statement of Deficiencies and<br>n deficiency should be fully identifie<br>n the CMS-2567 (prefix codes sho | d Plan of Correction, the dusing either the reg | that have been gulation or LSC |                  |
| ITEI                               | M                               | DATE  | ITEM                                  | DATE  | ITEM  |                                | DATE             |
| Y4                                 |                                 | Y5  | Y4                                    | Y5  | Y4  |                                | Y5               |
| ID Prefix                          |                                 | Correction  | ID Prefix                             | Correction  | ID Prefix                                       |                                | Correction       |
| Reg. #                             | NFPA 101                        | Completed   | Reg. #                                | Completed   | Reg. #  |                                | Completed        |
| LSC                                | K0025                           | 01/22/2016  | LSC                                   |   | LSC   |                                |                  |
| ID Prefix                          |                                 | Correction  | ID Prefix                             | Correction  | ID Prefix                                       |                                | Correction       |
| Reg. #                             |                                 | Completed   | Reg. #                                | Completed   | Reg. #  |                                | Completed        |
| LSC                                |                                 |   | LSC                                   |   | LSC   |                                | Completed        |
| 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   |                                |                  |
| REVIEWE<br>STATE AG                |                                 | REVIEWED BY (INITIALS) TL/mm                                | DATE 03/02/2016                       | SIGNATURE OF SURVEYOR   | ;   | DATE 02/19                     | 9/2016           |
| REVIEWE<br>CMS RO                  | D BY                            | REVIEWED BY<br>(INITIALS)                                   | DATE                                  | TITLE   |   | DATE                           |                  |
| FOLLOWU                            | FOLLOWUP TO SURVEY COMPLETED ON |   |                                       | ANY UNCORRECTED DEFICIENCIES<br>TED DEFICIENCIES (CMS-2567) SEN   |   |                                | :                |

1/5/2016

YES NO

### DEPARTMENT OF HEALTH AND HUMAN SERVICES

### CENTERS FOR MEDICARE & MEDICAID SERVICES

ID: QSNS

## MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

|   | PART I -                      | TO BE COMPI   | LETED BY T                       | HE STAT                       | TE SURVEY A   | AGENCY  |  | Fa  | acility ID: 00578N                               |
|---|-------------------------------|---|----------------------------------|-------------------------------|---|---|--|---|--|
| 1. MEDICARE/MEDICAID PROVII<br>(L1) 245616<br>2.STATE VENDOR OR MEDICAID<br>(L2) 850026600      |                               | 3. NAME AND AE (L3) LIFECARE (L4) 19120 200TI (L5) GREENBUS | GREENBUSH<br>H STREET            |                               | (L6) <b>:</b>   | 56726   | 4. TYPE (  1. Initial  3. Termin  5. Valida  7. On-Sit | nation<br>tion  | 2. Recertification 4. CHOW 6. Complaint 9. Other |
| 5. EFFECTIVE DATE CHANGE OI<br>(L9)   | OWNERSHIP                     | 7. PROVIDER/SU<br>01 Hospital                               | JPPLIER CATEG<br>05 HHA          | ORY<br>09 ESRD                | 03 (L7)<br>13 PTIP  | 22 CLIA   |  | urvey After (   |  |
| 6. DATE OF SURVEY  8. ACCREDITATION STATUS:  0 Unaccredited 1 TJC 2 AOA 3 Other                 | <b>07/2016</b> (L34)<br>(L10) | 02 SNF/NF/Dual<br>03 SNF/NF/Distinct<br>04 SNF              | 06 PRTF<br>07 X-Ray<br>08 OPT/SP | 10 NF<br>11 ICF/IID<br>12 RHC | 14 CORF<br>15 ASC<br>16 HOSPICE                           |   | FISCAL YE.   | AR ENDIN<br>9/30  | G DATE: (L35)                                    |
| 11LTC PERIOD OF CERTIFICATION From (a): To (b):  12.Total Facility Beds 13.Total Certified Beds | 40 (L18)<br>40 (L17)          | Compliance1. A  X B. Not in Con                             | equirements e Based On:          | gram                          | 2. Tech<br>3. 24 H<br>4. 7-Da<br>5. Life s                | y RN (Rural SN  | 6. So<br>7. M<br>8. Po                                 | Requirement<br>cope of Ser<br>Medical Direct<br>atient Room<br>eds/Room | vices Limit<br>ector                             |
| 14. LTC CERTIFIED BED BREAKD  18 SNF 18/19 SNF  20  (L37) (L38)                                 |                               | ICF<br>(L42)  | IID<br>(L43)                     |                               | 15. FACILITY N<br>1861 (e) (1) or                         |   | (1   | L15)  |  |
| 16. STATE SURVEY AGENCY REI See Attached Remarks 17. SURVEYOR SIGNATURE                         | MARKS (IF APPLICA             | BLE SHOW LTC CA   | ANCELLATION I                    | DATE):                        | 18. STATE SUR   | VEY AGENCY  | APPROVAL   |   | Date:  |
| Debra Vincent, HFE  | NEII                          | 0   | 01/25/2016                       | (L19)                         | Mark.   | Meath   | , Enforcem   | ent Spec  | ialist <sub>02/21/2016</sub> (L20                |
| PA  | RT II - TO BE                 | COMPLETED I   | BY HCFA RE                       | GIONAL                        | OFFICE OR   | SINGLE S  | TATE AGE   | NCY   |  |
| DETERMINATION OF ELIGIB     1. Facility is Eligible to     2. Facility is not Eligible          | Participate                   |   | IPLIANCE WITH<br>HTS ACT:        | I CIVIL                       | 2. O  | tatement of Finant<br>wnership/Contro<br>oth of the Above | l Interest Disclo                                      |   | *  |
| 22. ORIGINAL DATE  OF PARTICIPATION  04/13/2009   | 23. LTC AGREEN<br>BEGINNING   |   | 4. LTC AGREEN<br>ENDING DAT      |                               | 26. TERMINAT<br>VOLUNTARY<br>01-Merger, Close             |   | -  | INVOLUN<br>05-Fail to M   | leet Health/Safety                               |
| (L24) 25. LTC EXTENSION DATE:  (L27)  |                               | VE SANCTIONS n of Admissions:                               | (L25)<br>(L44)<br>(L45)          |                               | 02-Dissatisfactio<br>03-Risk of Involu<br>04-Other Reason | ntary Termination   | n<br><u>!</u>  | <u>OTHER</u>  | eet Agreement  Status Change                     |
| 28. TERMINATION DATE:   | 29                            | . INTERMEDIARY/   | /CARRIER NO.                     |                               | 30. REMARKS   |   |  |   |  |
|   | (L28)                         | 00001   |                                  | (L31)                         |   |   |  |   |  |
| 31. RO RECEIPT OF CMS-1539  | 32                            | . DETERMINATION   | OF APPROVAL                      | DATE                          |   |   |  |   |  |

(L33)

DETERMINATION APPROVAL

(L32)

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

## MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00578N

**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).



#### 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:

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

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

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

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

<u>Informal Dispute Resolution</u> - 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.

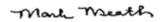
Questions regarding all documents submitted as a response to the Life Safety Code deficiencies (those preceded by a "K" tag), i.e., the plan of correction, request for waivers, should be directed to:

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

Fax: (651) 215-9697

PRINTED: 01/26/2016 FORM APPROVED OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: |  | (X2) MULTIPLE CONSTRUCTION  A. BUILDING  |                     |   | (X3) DATE SURVEY<br>COMPLETED  |                            |
|--|--|--|---------------------|---|--|----------------------------|
|  |  | 245616   | B. WING             |   | 01/07  | 7/2016                     |
|  | PROVIDER OR SUPPLIER   | IOR  |                     | STREET ADDRESS, CITY, STATE, ZIP CODE<br>19120 200TH STREET<br>GREENBUSH, MN 56726  | ·  |                            |
| (X4) ID<br>PREFIX<br>TAG   | (EACH DEFICIENCY   | TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORREC<br>(EACH CORRECTIVE ACTION SHO<br>CROSS-REFERENCED TO THE APPR<br>DEFICIENCY)   | ULD BE   | (X5)<br>COMPLETION<br>DATE |
| F 000  | INITIAL COMMENT  | rs   | F 0                 | 00  |  |                            |
|  | as your allegation of<br>Department's accepenrolled in ePOC, y<br>at the bottom of the<br>form. Your electror<br>be used as verificate<br>Upon receipt of an | of correction (POC) will serve of compliance upon the otance. Because you are rour signature is not required of first page of the CMS-2567 nic submission of the POC will cion of compliance.  Cacceptable electronic POC, an our facility may be conducted to |                     |   |  |                            |
| F 282<br>SS=D  | validate that substa<br>regulations has bee<br>your verification.  | ntial compliance with the en attained in accordance with   | F 2                 | 32  | 2  | 2/15/16                    |
|  | must be provided b   | led or arranged by the facility<br>y qualified persons in<br>ch resident's written plan of   |                     |   |  |                            |
|  | by: Based on observative review, the facility for walker exercise proplan for 1 of 1 resident rehabilitation and factorial assistance for 1 of 1.            | ion, interview and document ailed to provide a platform agram as directed by the care ent (R44) reviewed for ailed to provide toileting 3 residents (R14) who tance to toilet as directed by   |                     | For all residents, staff were eduresident care plan policy and insthe importance of following care Reviewed care plan policy, its usto access it and its importance ameeting on 01-20-16. For staff attend the meeting, notes from timeeting regarding this was post staff to read and sign off before 5, 2016.  R44's elimination plan has been and updated on 1/8/16 and post | structed on plans. se, where at staff not able to the sed for February |                            |
| ABORATOR)  | / DIRECTOR'S OR PROVID   | DER/SUPPLIER REPRESENTATIVE'S SIGN   | NATURE              | TITLE   | (X   | (6) DATE                   |

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

**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.

|                          | OF DEFICIENCIES<br>OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  | ` '                 |    | E CONSTRUCTION  |   | E SURVEY<br>PLETED         |
|--------------------------|---|---|---------------------|----|---|---|----------------------------|
|                          |   | 245616  | B. WING             |    |   | 01/(  | 07/2016                    |
|                          | PROVIDER OR SUPPLIER  |   |                     | 19 | REET ADDRESS, CITY, STATE, ZIP CODE<br>1120 200TH STREET<br>REENBUSH, MN 56726  |   |                            |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC   | ATEMENT OF DEFICIENCIES<br>BY MUST BE PRECEDED BY FULL<br>LSC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | x  | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD<br>CROSS-REFERENCED TO THE APPROP<br>DEFICIENCY)  | BE  | (X5)<br>COMPLETION<br>DATE |
| F 282                    | arm platform walk directed by the car R44's current mobindicated R44 had related to chronic hemiparesis (weal of the body) and refor all activities of directed staff to comotion to left upper right upper extrem week and standing walker with assist a goal of 5-10 min On 1/7/16, at 9:52 stated R44 had no platform walker sin rehabilitation prog NA-C stated since added to the prograthe platform walker R44 had not been The Nursing Assis Recreational Prog ROM 3-5 x's week bicycle 2-3 x's week | e the recommended elevated or (EVA) standing program as re plan.  whility care plan dated 11/17/15, impaired physical mobility pain, diabetic complications, left complications, left complications, left complications, left complete extensive assistance daily living. The care plan emplete passive range of extremities 3-5 times a week, ity use yellow band 3-5 x's grogram with EVA platform of two staff 3-5 x's per week for utes.  a.m. nursing assistant (NA)-C to been using the standing note NA-C had taken over the ram the first of December. The recumbent stepper was ram on 10/16/15, she thought or was discontinued therefore | F 2                 | 82 | daily care book. Bowel and Bladde assessments for all residents will be completed quarterly, annually or wisignificant change the next 3 month. Care plans and the daily care assigned sheets will be updated as indicated assessment.  For R14, the rehab aid to-do list was corrected on 1/8/16 to reflect what care plan states. The current care being followed.  DON or designee will do random observation audits 3x weekly x4 we ensure policy is being followed. Rewill be reported to the performance improvement committee. | e th a ns. gnment l per as her plan is eeks to esults |                            |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: |  | (X2) MUL<br>A. BUILD  |                    | (X3) DATE SURVEY<br>COMPLETED |   |     |                            |
|--|--|---|--------------------|-------------------------------|---|-----|----------------------------|
|  |  | 245616  | B. WING            |                               |   | 01/ | 07/2016                    |
|  | PROVIDER OR SUPPLIER RE GREENBUSH MAN  | IOR   |                    | 191                           | REET ADDRESS, CITY, STATE, ZIP CODE<br>120 200TH STREET<br>REENBUSH, MN 56726                           |     |                            |
| (X4) ID<br>PREFIX<br>TAG   | (EACH DEFICIENCY   | TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)  | ID<br>PREFI<br>TAG | ×                             | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY) | BE  | (X5)<br>COMPLETION<br>DATE |
| F 282  | no feeling in the left assisted to a standing on 1/7/16, at 10:58 stand on the elevate previous facility but here. R44 stated it had been taken to the walker. R44 stated exercise for longer platform walker beautiform walker beau | t leg and leaned forward when ing position.  a.m. R44 stated she used to ed walker when she was at a had only done it a few times had been months since she the standing platform (EVA) I she would like to be able to periods and use the standing cause it would help keep her  1:11 a.m. the physical therapist bectation was for R44 to be VA platform walker as directed.  1:40 a.m. the director of fied R44 had not received the ise as directed by the care | F2                 | 282                           |   |     |                            |

# DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES (X1) PROVIDER/SUPPLIED/CLIA

| AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: |  |  | RIPLE CONSTRUCTION  NG |   | (X3) DATE SURVEY<br>COMPLETED |                            |
|--|--|--|------------------------|---|-------------------------------|----------------------------|
|  |  | 245616   | B. WING                |   | 01                            | /07/2016                   |
|  | PROVIDER OR SUPPLIER   | IOR  |                        | STREET ADDRESS, CITY, STATE, ZIP C<br>19120 200TH STREET<br>GREENBUSH, MN 56726             |                               |                            |
| (X4) ID<br>PREFIX<br>TAG   | (EACH DEFICIENC)   | TEMENT OF DEFICIENCIES<br>/ MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG    | PROVIDER'S PLAN OF COF<br>(EACH CORRECTIVE ACTION<br>CROSS-REFERENCED TO THE<br>DEFICIENCY) | SHOULD BE                     | (X5)<br>COMPLETION<br>DATE |
| F 282  | and consumed her -At 8:16 a.m. R14 wheading towards ov -At 8:21 a.m. R14 eproceeded to look thousekeeper was of the glassesAt 8:37 a.m. NA-B assisted R14 to be prompted to use thincontinent brief chochanged. R14 was until 11:34 a.m. wheentered the room to -At 11:34 a.m. the pout of bed and procambulate in the hal -At 11:40 a.m. the threeded to use the might have to. R14 room and into the R14's brief was we The therapist verified had a strong urine she was assisted on NA-B stated R14 wheeded to go to the assisted to bed the she needed to use | this time, R14 had received breakfast meal. Wheeled out of the dining room wn room. Entered own room and for eye glasses. A observed to assist in finding entered R14's room and d. R14 was not offered or e toilet nor was R14's ecked for incontinence or observed to remain in bed en the physical therapist ocomplete an evaluation. Ohysical therapist assisted R14 to lway. Herapist asked R14 if she pathroom. R14 stated she was wheeled back to the oathroom. R14 did void and and had a strong urine smell. The end of the toilet before going to be the toilet before going to be the toilet before she was refore R14 was not asked if | F 2                    | 82  |                               |                            |
|  | before and after me  | eals and R14 should be asked<br>he needed to use the toilet.   |                        |   |                               |                            |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: |   | . ,   |                     | (X3) DATE SURVEY<br>COMPLETED   |                            |
|--|---|---|---------------------|---|----------------------------|
|  |   | 245616  | B. WING             |   | 1/07/2016                  |
|  | PROVIDER OR SUPPLIER  | IOR   | 1                   | TREET ADDRESS, CITY, STATE, ZIP CODE<br>9120 200TH STREET<br>GREENBUSH, MN 56726  |                            |
| (X4) ID<br>PREFIX<br>TAG   | (EACH DEFICIENCY  | TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)   | (X5)<br>COMPLETION<br>DATE |
| F 282  | The DON verified F followed.  | 114's care plan was not   | F 282               |   |                            |
| F 311<br>SS=D  | for following the car   | a.m. the DON stated a policy<br>re plan could not be found.<br>TMENT/SERVICES TO<br>IN ADLS   | F 311               |   | 2/15/16                    |
|  | services to maintain  | the appropriate treatment and n or improve his or her abilities aph (a)(1) of this section.   |                     |   |                            |
|  | by: Based on observate review, the facility farm platform standinaintain or minimizers.   | NT is not met as evidenced cion, interview and document ailed to provide an elevated ing program in order to be the loss of lower extremity esident (R44) in the sample litation services.  |                     | 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                          |
|  | 11/29/15, indicated impairment, was dia (severe weakness of diabetes, had limite of the upper and low staff assistance with ambulate. The Acti Assessment (CAA) had left sided hemily ability to care for her | imum Data Set (MDS) dated R44 had no cognitive agnosed with hemiplegia on one side of body) and drange of motion on one side wer body and required total hall mobility and did not vities of Daily Living Care Area dated 9/6/15, indicated R44 paresis which impacted her erself. The CAA indicated R44 take own decision and had left |                     | 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. | ,                          |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: |   |  | ` '                 | PLE CONSTRUCTION  G   |  | E SURVEY<br>IPLETED        |
|---|---|--|---------------------|---|--|----------------------------|
|   |   | 245616   | B. WING _           |   | 01/  | 07/2016                    |
|   | PROVIDER OR SUPPLIER  | IOR  |                     | STREET ADDRESS, CITY, STATE, ZIP COE<br>19120 200TH STREET<br>GREENBUSH, MN 56726   |  |                            |
| (X4) ID<br>PREFIX<br>TAG  | (EACH DEFICIENCY  | TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORR<br>(EACH CORRECTIVE ACTION SI<br>CROSS-REFERENCED TO THE AP<br>DEFICIENCY)  | HOULD BE   | (X5)<br>COMPLETION<br>DATE |
| F 311   | accident (stroke).  A Rehabilitation Se and signed by the p 8/25/15, indicated F establish a rehabilit recommendation in extremity strengthe week, active range and active assisted and ankles, 3 sets all transfers with as recommended R44 program with eleva (all brakes locked) 8-10 minutes 3-5x's  A Rehabilitation Se 10/16/15, and signe was being screene. The recommendati stepper 3x's a week 5-10 minutes with be R44's current mobi indicated R44 had related to chronic p and left hemiparesi assistance of staff. The care plan direct exercise program was week, right upper x's week and stand walker with assist of a goal of 5-10 minutes. | e to a cerebral vascular  rvices Screening form dated obysical therapist (PT), on R44's mobility was screened to ration program. The cluded bilateral lower ning exercises 3-5 days per of motion (ROM) on right side on left side for hips, knees, of 10-15 repetitions. Perform resist of two. The PT also participate in standing ted arm (EVA) platform walker with assist of two with goal of sweek.  rvices Screening form dated ded by the PT, indicated R44 d for a recumbent stepper. On was to use the recumbent with nursing staff with goal of both legs only.  It care plan dated 11/17/15, impaired physical mobility ain, diabetic complications and required extensive for all activities of daily living. Steed staff to complete the which consisted of passive left upper extremities 3-5 times extremity use yellow band 3-5 ing program with EVA platform of two staff 3-5 x's per week for | F 31                | The Interdisciplinary team will rehab nursing program quarte annually, and with significant of The rehab team will refer to the indicated.  DON or designee will do randobservation audits 3x weekly ensure policy is being followed will be reported to the perform improvement committee. | erly,<br>change.<br>nerapy when<br>om<br>x4 weeks to<br>d. Results |                            |

# DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES (X1) PROVIDER/SUPPLIED/CLIA

|                          | FOF DEFICIENCIES<br>DF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:   |                     | IPLE CONSTRUCTION IG  |         | TE SURVEY<br>MPLETED       |
|--------------------------|--|--|---------------------|---|---------|----------------------------|
|                          |  | 245616   | B. WING _           |   | 01      | /07/2016                   |
|                          | PROVIDER OR SUPPLIER   | IOR  |                     | STREET ADDRESS, CITY, STATE, ZIP CODE<br>19120 200TH STREET<br>GREENBUSH, MN 56726                    |         |                            |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY   | TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRE<br>(EACH CORRECTIVE ACTION SHI<br>CROSS-REFERENCED TO THE APF<br>DEFICIENCY) | OULD BE | (X5)<br>COMPLETION<br>DATE |
| F 311                    | been using the star NA-C had taken ov the first of Decemb recumbent stepper 10/16/15, she though discontinued thereform. The Nursing Assist Recreational Programom 3-5 x's week, the bicycle 2-3 x's week. The Dicycle 2-3 x's week. The Programment of EVA week.  R44's rehab programed EVA week.  R44's rehab programed EVA week.  R44's rehab programed exercises12/10/15 indicated exercises12/10/15, indicated exercises12/15/15, indicated the stepper12/31/15, written be completed and part the stepper15/16, written by participated in exermore. R44 had pair thought it was becaused and up lift staff us further indicated R4 said it benefited he  On 1/06/16, at 10:1 who was also a nur | (NA)-C stated R44 had not ading platform walker since er the rehabilitation program er. NA-C stated since the was added to the program on ght the platform walker was ore R44 had not been doing it.  ant Daily Cares Record and am Forms indicated R44's Thera bands exercises and week. The form lacked the a platform walker 3-5x's a  ss notes were reviewed and ng:  R44 participated well with  R44 used the stepper for 10 pated well with exercises. If R44 exercised 10 minutes on any NA-C indicated R44 icipated in exercises, etches. Was on the stepper for NA-C indicated R44 cises and usually asked for an in left shoulder and R44 cises and usually asked for an in left shoulder and R44 cises of the mechanical sed to transfer her. The note late enjoyed the stepper and | F 31                |   |         |                            |

|                          | OF DEFICIENCIES OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  | ` '                 | PLE CONSTRUCTION  IG   |             | E SURVEY<br>IPLETED        |
|--------------------------|---|--|---------------------|--|-------------|----------------------------|
|                          |   | 245616   | B. WING _           |  | 01/         | 07/2016                    |
|                          | PROVIDER OR SUPPLIER RE GREENBUSH MAN   | IOR  |                     | STREET ADDRESS, CITY, STATE, ZIP CODE<br>19120 200TH STREET<br>GREENBUSH, MN 56726                           | , , , , , , |                            |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)  | TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTI<br>(EACH CORRECTIVE ACTION SHOUL<br>CROSS-REFERENCED TO THE APPRO<br>DEFICIENCY) | _D BE       | (X5)<br>COMPLETION<br>DATE |
| F 311                    | At 10:16 a.m. AA-A and bear weight with no feeling in the left assisted to a standing of the left assisted the elevate previous facility but here. R44 stated it had been taken to a stated the girl that a was really good at it duty so often that a spend in therapy so therapy. R44 stated exercise for longer platform walker beastronger.  On 1/07/2016, at 1.7 (PT) stated her expansist R44 with the recommendation. The left and the progress and where the left and the progress and where the left and | heel R44 to the activity room. Is stated R44 could stand up the the mechanical lift but had a leg so leaned forward when any position.  a.m. R44 stated she used to sed walker when she was at a had only done it a few times had been months since she the EVA platform walker. R44 used to provide rehab nursing the but was called to kitchen the did not have the time to a she did not always get a she would like to be able to periods and use the standing cause it would help keep her the PT stated R44 was not a to have weight bearing ded R44 was not happy with anted to be able to get better.  I:40 a.m. the director of sed they were in the process of shabilitation program. The DS nurse was the person the with questions but currently son designated to oversee the ed DON stated the MDS nurse did was doing whatever time she did to the process of t | F 31                |  |             |                            |

| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION |  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:   | (X2) MULTIPLE CONSTRUCTION A. BUILDING |  | (X3) DATE SURVEY<br>COMPLETED |                            |
|---|--|--|--|--|-------------------------------|----------------------------|
|   |  | 245616   | B. WING                                | ····   | 01/0                          | 07/2016                    |
|   | PROVIDER OR SUPPLIER   |  | -                                      | STREET ADDRESS, CITY, STATE, ZIP CODE<br>19120 200TH STREET<br>GREENBUSH, MN 56726   |                               |                            |
| (X4) ID<br>PREFIX<br>TAG                            | (EACH DEFICIENC  | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>LSC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG                    | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)   | BE                            | (X5)<br>COMPLETION<br>DATE |
| F 311<br>F 315<br>SS=D                              | and Procedure ind placed on a Restorindicated, to achieve physical, mental are The procedure indicassess each resided. The Case Manage for each specific pieces Restorative Nursin care given. The Case and make recommed 483.25(d) NO CAT RESTORE BLADE. Based on the resident who enter indwelling catheter resident's clinical ocatheterization was who is incontinent treatment and servinfections and to refunction as possible. This REQUIREME by: | prative Nursing Program Policy icated the residents would be rative Nursing Program, when we and maintain optimal and psychosocial functioning. Icated PT would evaluate and ents' need for therapy service. It would complete flow sheets rogram for care plan and grassistant would document ase Manager would evaluate east quarterly, and meet with and therapy to review programs lendations.  HETER, PREVENT UTI, DER  Jent's comprehensive acility must ensure that a set the facility without an is not catheterized unless the condition demonstrates that a services to prevent urinary tract estore as much normal bladder e. | F 311                                  |  | and on                        | 2/15/16                    |
|   | review the facility facility facility facility facility facility   | tion, interview and document ailed to provide timely toileting ng to the assessed need for 1 l) reviewed for toileting.  |  | For all residents, staff were educat resident care plans and instructed a importance of following care plans. Reviewed care plan policy, its use, to access it and its importance at staff meeting on 01-20-16. For staff not attend the meeting, notes from the | on the<br>where<br>taff       |                            |

|                          | OF DEFICIENCIES OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  | , ,                 | IPLE CONSTRUCTION NG  | ` '   | E SURVEY<br>IPLETED        |
|--------------------------|---|--|---------------------|---|---|----------------------------|
|                          |   | 245616   | B. WING _           |   | 01/   | 07/2016                    |
|                          | PROVIDER OR SUPPLIER  | IOR  |                     | STREET ADDRESS, CITY, STATE, ZIP<br>19120 200TH STREET<br>GREENBUSH, MN 56726   |   |                            |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY  | TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF C<br>(EACH CORRECTIVE ACTIC<br>CROSS-REFERENCED TO TH<br>DEFICIENCY  | ON SHOULD BE<br>IE APPROPRIATE  | (X5)<br>COMPLETION<br>DATE |
| F 315                    | R14's quarterly Min 11/2/15, indicated F dementia. The MDS cognitively impaired one staff for transfe hygiene and was from R14's Urinary Income Assessment (CAA) had occasional streeprompt voiding befor every 2-3 hours. R14's cognition, R1 between toileting timincontinence if not passisted.  R14's Bowel and B dated 10/29/15, indurinary incontinence assist with transfers. The assessment in the toilet, had periodincontinent pads/brompt R14 to void activities and at nig indicated R14 requione staff for toiletin bladder daily, but won the toilet. The capull up incontinent is panties. | imum Data Set (MDS) dated<br>R14 was diagnosed with<br>S indicated R14 was<br>d, required extensive assist of<br>erring, toileting, personal<br>equently incontinent of urine. | F 31                | meeting regarding this wastaff to read and sign off be 5, 2016.  Goal is to prevent urinary and restore as much norm function as possible. R44's plan has been reviewed at 1/8/16 and posted in the described by the complete annually or with a signification next 3 months. Care plan care assignment sheets was indicated per assessment. DON or designee will do resolve to the perfer improvement committee. | tract infections hal bladder selimination and updated on laily care book.  Sments for all d quarterly, ant change the s and the daily will be updated ent.  andom kly x4 weeks to bwed. Results |                            |

| -                        | OF DEFICIENCIES OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  | ` '                 | PLE CONSTRUCTION  G  |         | TE SURVEY<br>MPLETED       |
|--------------------------|--|--|---------------------|--|---------|----------------------------|
|                          |  | 245616   | B. WING _           |  | 01      | /07/2016                   |
|                          | PROVIDER OR SUPPLIER RE GREENBUSH MAN  | IOR  |                     | STREET ADDRESS, CITY, STATE, ZIP CODE 19120 200TH STREET GREENBUSH, MN 56726                           |         |                            |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)   | TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORREC<br>(EACH CORRECTIVE ACTION SHO<br>CROSS-REFERENCED TO THE APP<br>DEFICIENCY) | OULD BE | (X5)<br>COMPLETION<br>DATE |
| F 315                    | room table. During and consumed her -At 8:16 a.m. R14 wheading towards ov -At 8:21 a.m. R14 eproceeded to look fhousekeeper was of the glassesAt 8:37 a.m. nursing R14's room and as not offered or prome R14's incontinent boor changed. R14 wheat which is not offered or prome R14's incontinent boor changed. R14 wheat which is not offered or prome R14's incontinent boor changed. R14 wheat is needed to use the from the first income and into the first income and a strong of 1/6/16, at 1:12: not offered or taken bed and had not be she was assisted on NA-B confirmed R1 assistance from 7:1 hours and 25 minut would have told the bathroom before she | this time, R14 had received breakfast meal. wheeled out of the dining room wn room. entered own room and or eye glasses. A observed to assist in finding assistant (NA)-B entered sisted R14 to bed. R14 was pted to use the toilet nor was rief checked for incontinence as observed to remain in bed en the physical therapist o complete an evaluation. Ohysical therapist assisted R14 to lway. herapist asked R14 if she pathroom. R14 stated she was wheeled back to the pathroom. R14 did void and a with urine and had a strong erapist verified R14's brief was | F 31                | 5  |         |                            |

|                          | STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING  |   |                     | (X3) DATE SURVEY<br>COMPLETED   |      |                            |
|--------------------------|---|---|---------------------|---|------|----------------------------|
|                          |   | 245616  | B. WING             | ····  | 01/  | 07/2016                    |
|                          | PROVIDER OR SUPPLIER  | IOR   |                     | STREET ADDRESS, CITY, STATE, ZIP CODE 19120 200TH STREET GREENBUSH, MN 56726                                |      |                            |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY  | TEMENT OF DEFICIENCIES<br>MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIED DEFICIENCY) | D BE | (X5)<br>COMPLETION<br>DATE |
| F 315                    | (DON) confirmed R assist R14 to the to and should have be hours. The DON ve followed.   | ge 11 o.m. the director of nursing 14's care plan directed staff to ilet before and after meals een asked to toilet every 2-3 rified R14's care plan was not a.m. the DON stated a policy   | F 3                 | 15  |      |                            |
| F 431<br>SS=D            | for toileting could not 483.60(b), (d), (e) E LABEL/STORE DR  The facility must en a licensed pharmac of records of receip controlled drugs in accurate reconciliat records are in order controlled drugs is reconciled.  Drugs and biological labeled in accordant | or be found. DRUG RECORDS, UGS & BIOLOGICALS  Inploy or obtain the services of sist who establishes a system t and disposition of all sufficient detail to enable antion; and determines that drug r and that an account of all maintained and periodically  als used in the facility must be see with currently accepted | F 4                 | 31  |      | 2/15/16                    |
|                          | professional princip appropriate access instructions, and the applicable.  In accordance with facility must store a locked compartmer controls, and perminave access to the  The facility must propermanently affixed controlled drugs list                         | les, and include the ory and cautionary e expiration date when  State and Federal laws, the II drugs and biologicals in onts under proper temperature to only authorized personnel to   |                     |   |      |                            |

|                          | OF DEFICIENCIES OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:   | , ,                 | E CONSTRUCTION  | (X3) DATE S<br>COMPL             |                            |
|--------------------------|---|--|---------------------|---|----------------------------------|----------------------------|
|                          |   | 245616   | B. WING             |   | 01/07                            | 7/2016                     |
|                          | PROVIDER OR SUPPLIER RE GREENBUSH MAN   | IOR  | 1                   | TREET ADDRESS, CITY, STATE, ZIP CODE<br>9120 200TH STREET<br>GREENBUSH, MN 56726  |                                  |                            |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)  | ATEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD<br>CROSS-REFERENCED TO THE APPROPF<br>DEFICIENCY)   | BE                               | (X5)<br>COMPLETION<br>DATE |
| F 431                    | abuse, except whe package drug distri   | and other drugs subject to<br>n the facility uses single unit<br>bution systems in which the<br>ninimal and a missing dose can   | F 431               |   |                                  |                            |
|                          | by: Based on observareview, the facility formedications were prescription medications.  | NT is not met as evidenced tion, interview and document ailed to ensure eye drop properly labeled with ation labels for 1 of 3 (R3) ived eye drop medications on g.  |                     | The Medication Administration policistates, "the label of each patient's individual medications container shaclearly indicate the patient's full nan physician's name, prescription num name of drug, strength and quantity drug, date of original issue, or in carefill, the most recent date thereof, expiration as applicable". R3 eye dwere subsequently labeled and date | all ne, ber, of se of a and rops |                            |
|                          | medication cart sto with licensed practi review, a bottle of A a bottle of A a bottle of Lumigan observed in the me prescription label n identified. LPN-A was prescribed for R3. I did not have an appredication label at bottles were not da further verified the medication boxes a prescription label. I medications should medication label ar | 9:02 a.m. the Edgewood rage review was conducted cal nurse (LPN)-A. During the Alphagan brimonidine 1%, and 0.01% eye drops were edication cart drawer without a or a date when opened erified the medications were LPN-A confirmed the bottles propriate prescription tached, and both eye drop ted when opened. LPN-A prescription eye drop also failed to have a LPN-A stated all eye drop to be labeled with a prescription and a date when the bottle was ted she had training on |                     | 1/7/16.  All nursing staff directed to read and review the Medication Administratio policy posted in each medication ro Due by February 5, 2016.  DON or designee will do random observation audits 3x weekly x4 we ensure policy is being followed. Re will be reported to the performance improvement committee.  | d<br>n<br>om.                    |                            |

# DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA

| OF DEFICIENCIES<br>OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:   | ` '  |  |   | E SURVEY<br>IPLETED   |
|---|--|--|--|---|---|
|   | 245616   | B. WING _  | ·····  | 01/   | 07/2016   |
|   | IOR  |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br>19120 200TH STREET<br>GREENBUSH, MN 56726   | •   |   |
| (EACH DEFICIENCY  | / MUST BE PRECEDED BY FULL   | ID<br>PREFIX<br>TAG  | (EACH CORRECTIVE ACTION SHOU   | LD BE   | (X5)<br>COMPLETION<br>DATE  |
| administering medi-<br>medication labels w<br>medication adminis<br>medication adminis<br>would call pharmac  | cations safely and confirmed vere to be verified with the stration record for accuracy of stration. LPN-A stated she by immediately to obtain  | F 43   | :1   |   |   |
| nursing (DON) verifieye drops should he labels on them and indicating when the verified it was her emedications were p                                | fied all medications including ave prescription medication eye drops should be dated by were opened. The DON expectation staff ensure properly labeled and dated   |  |  |   |   |
| revised 7/13, direct package was comp and to review the mame, medication rexpiration date, phy administering and tabeled containers. 483.65 INFECTION | ed staff to ascertain that the bletely and properly labeled nedication label for resident name, strength, dosage, vsician name and direction for o administer medication from  | F 44   | .1   |   | 2/15/16   |
| Infection Control Pr<br>safe, sanitary and of<br>to help prevent the<br>of disease and infe-  | rogram designed to provide a comfortable environment and development and transmission ction.   |  |  |   |   |
|   | PROVIDER OR SUPPLIER  RE GREENBUSH MAN  SUMMARY STA (EACH DEFICIENCY REGULATORY OR L  Continued From pa administering medi medication labels w medication adminis would call pharmac prescription labels for a general supplier of the continued revised of the containers.  The facility Medicat revised of the containers and to review the m name, medication review t | PROVIDER OR SUPPLIER  RE GREENBUSH MANOR  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  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.  483.65 INFECTION CONTROL, PREVENT | PROVIDER OR SUPPLIER  RE GREENBUSH MANOR  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  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.  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(a) Infection Control Program | PROVIDER OR SUPPLIER  REGREENBUSH MANOR  SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSO IDENTIFYING INFORMATION)  Continued From page 13  Administering medications safely and confirmed medication labels were to be verified with the 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 and have prescription medication when man 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.  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(a) Infection Control Program | PROVIDER OR SUPPLIER  19120 2007H STREET, STATE, ZIP CODE  19120 2007H STREET, GREENBUSH, MN 56726  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  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 medication label for resident name, medication habel for resident name, medication habel for resident name, medication mame, strength, dosage, expiration date, physician name and direction for administering and to administer medication from labeled containers.  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 |

| -                        | OF DEFICIENCIES<br>OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  | ` '                |     | E CONSTRUCTION   | (X3) DATE<br>COMI             | E SURVEY<br>PLETED         |
|--------------------------|--|---|--------------------|-----|--|-------------------------------|----------------------------|
|                          |  | 245616  | B. WING            |     |  | 01/0                          | 07/2016                    |
|                          | PROVIDER OR SUPPLIER   |   |                    | 19  | TREET ADDRESS, CITY, STATE, ZIP CODE<br>9120 200TH STREET<br>GREENBUSH, MN 56726   |                               |                            |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC  | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)  | ID<br>PREFI<br>TAG |     | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)   | BE                            | (X5)<br>COMPLETION<br>DATE |
| F 441                    | in the facility; (2) Decides what p should be applied to (3) Maintains a rec actions related to in (b) Preventing Spro (1) When the Infect determines that a r prevent the spread isolate the resident (2) The facility mus communicable disc from direct contact direct contact will t (3) The facility mus hands after each d hand washing is in professional practic (c) Linens Personnel must ha | ich it - ontrols, and prevents infections procedures, such as isolation, to an individual resident; and ord of incidents and corrective infections.  Bead of Infection tion Control Program resident needs isolation to it of infection, the facility must it. It prohibit employees with a bease or infected skin lesions is with residents or their food, if ransmit the disease. It require staff to wash their irect resident contact for which dicated by accepted | F 4                | 141 |  |                               |                            |
|                          | by: Based on observa review the facility factorial was maintained du on one of two units   | NT is not met as evidenced ation, interview and document ailed to ensure infection control aring the fresh water distribution (Rosewood) with the potential dents residing on Rosewood.   |                    |     | Ice/Fresh Water Policy and proced was updated on 01-20-16 to ensure infection control practices are main during the fresh water pass. Revie changes to the water pass at staff meeting on 01-20-16. For staff not attend the meeting, notes from the meeting regarding the fresh water pass at staff not attend the meeting the fresh water pass at staff not attend the meeting, notes from the meeting regarding the fresh water pass at staff not attend the meeting the fresh water pass at staff not attend the meeting the fresh water pass at staff not attend the meeting the fresh water pass at staff not attend the meeting the fresh water pass at staff not attend the meeting the fresh water pass at staff not attend the meeting the fresh water pass at staff not attend the meeting the fresh water pass at staff not attend the meeting the fresh water pass at staff not attend the meeting the fresh water pass at staff not attend the meeting the fresh water pass at staff not attend the meeting the fresh water pass at staff not attend the meeting the fresh water pass at staff not attend the meeting the fresh water pass at staff not attend the meeting the fresh water pass at staff not attend the meeting the fresh water pass at staff not attend the meeting the fresh water pass at staff not attend the meeting the fresh water pass at staff not attend the meeting the fresh water pass at staff not attend the fresh water pass at staff not | e<br>tained<br>wed<br>able to |                            |

|                          | OF DEFICIENCIES<br>OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   | (X2) MUL<br>A. BUILD |    | E CONSTRUCTION  |         | E SURVEY<br>PLETED         |
|--------------------------|--|---|----------------------|----|---|---------|----------------------------|
|                          |  | 245616  | B. WING              |    |   | 01/0    | 07/2016                    |
|                          | PROVIDER OR SUPPLIER RE GREENBUSH MAN  | IOR   |                      | 19 | REET ADDRESS, CITY, STATE, ZIP CODE<br>0120 200TH STREET<br>REENBUSH, MN 56726  | , 0.27  |                            |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY   | TEMENT OF DEFICIENCIES<br>MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG  | X  | PROVIDER'S PLAN OF CORRECTIO<br>(EACH CORRECTIVE ACTION SHOULE<br>CROSS-REFERENCED TO THE APPROP<br>DEFICIENCY)   | ) BE    | (X5)<br>COMPLETION<br>DATE |
| F 441                    | was observed to obmugs (with handles with ice and water, insert a straw into the clean mugs were placent. NA-A was observed to water mith a dirty water mith a dirty water mith a dirty mug, of the cart next to the dirty mug on the the clean mugs. With the clean mugs. With the clean mugs and carring room. NA-A proceed remained mingled in dirty straws were placed was no separation of the water mained mingled in dirty straws were placed was no separation of the water mained mingled in dirty straws were placed was not observed to was an itizer throughout the clean and did not keep the c | a.m. nursing assistant (NA)-A stain a cart with clean water b) from the kitchen, fill them put a lid on the mugs and he hole of each lid. All the laced on the top shelf of the lerved to enter R44's room mug and come out of the room ug. NA-A removed the straw placed the used straw on top he clean water mugs and set to shelf of the cart next to the same hand NA-A used straw, NA-A picked up a fied it into the next resident ded in this manner for the later pass. The dirty mugs in with clean mugs and the laced on top of the cart. There of dirty and clean. NA-A was sh hands or utilize had | F 4                  | 41 | was posted for staff to read and sign before February 5, 2016. Updated Water/Ice Pass policy and procedul implemented on January 21, 2016. DON or designee will do random observation audits 3x weekly x4 weensure policy is being followed. Rewill be reported to the performance improvement committee. | eeks to |                            |

|                          | OF DEFICIENCIES DF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  | ` '                | FIPLE CONSTRUCTION  NG  |  |      | SURVEY<br>PLETED           |
|--------------------------|---|---|--------------------|---|--|------|----------------------------|
|                          |   | 245616  | B. WING            |   |  | 01/0 | 7/2016                     |
|                          | PROVIDER OR SUPPLIER  | IOR   |                    | STREET ADDRESS, CITY, S<br>19120 200TH STREET<br>GREENBUSH, MN 56 |  |      |                            |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY  | TEMENT OF DEFICIENCIES<br>MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREFI<br>TAG | (EACH CORRECTION CROSS-REFERENCE                                  | PLAN OF CORRECTION<br>TIVE ACTION SHOULD<br>CED TO THE APPROPF<br>EFICIENCY) | BE   | (X5)<br>COMPLETION<br>DATE |
| F 441                    | the observed fresh the best practice.  On 1/07/2016 at 11 interview, the infect (RN)-C stated durin was a breach in infet there was a potentiathe facility's policy where the facility Policy a Control: Water/Ice In the facility Policy a Control water here are water mugs and se 2. Kitchen staff will water then cover with 3. At the beginning dispense fresh mug 4. All staff to make between water pass | the rooms. The DON stated water pass was probably not  :52 a.m. during a telephone ion control registered nurse in the above water pass, there extion control. RN-C confirmed all for cross contamination and was not followed.  and Procedure for Infection Pass dated 2/09, noted: shift, nursing staff will pick up and to the kitchen sanitize and refill with fresh ice the a clean cloth. of the PM shift, nursing will |                    | 41  |  |      |                            |

PRINTED: 01/28/2016

DEPARTMENT OF HEALTH AND HUMAN SERVICES F5616009 FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A: BUILDING 02 - GREENBUSH MANOR 245616 B. WING 01/05/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 19120 200TH STREET LIFECARE GREENBUSH MANOR GREENBUSH, MN 56726 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION ID (X5) COMPLETION PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) DATE TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) 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



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

Electronically Signed

TITLE

(X6) DATE

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.

FORM CMS-2567 (02-99) Previous Versions Obsolete

Event ID: QSNS21

Facility ID: 00578N

| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION |  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  | (X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - GREENBUSH MANOR |  | (X3) DATE SURVEY<br>COMPLETED |                            |
|---|--|--|---|--|-------------------------------|----------------------------|
|   |  | 245616   | B. WING_  |  | 01/                           | 05/2016                    |
|   | PROVIDER OR SUPPLIER   | IOR  |   | STREET ADDRESS, CITY, STATE, ZIP CODE<br>19120 200TH STREET<br>GREENBUSH, MN 56726                     | 1 011                         | 00/2010                    |
| (X4) ID<br>PREFIX<br>TAG                            | (EACH DEFICIENC)   | TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG   | PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY) | BE                            | (X5)<br>COMPLETION<br>DATE |
| K 000   | Continued From pa  | ge 1   | K 00  | 00   |                               |                            |
|   | By e-mail to:<br>Marian.Whitney@s  | tate.mn.us   |   |  |                               |                            |
|   | or   |  |   |  |                               |                            |
|   | Angela.Kappenmar   | n@state.mn.us  |   |  |                               |                            |
|   |  | RRECTION FOR EACH<br>T INCLUDE ALL OF THE<br>DRMATION:   |   |  |                               |                            |
|   | 1. A description of voto correct the defici  | what has been, or will be, done<br>ency.   |   |  |                               |                            |
|   | 2. The actual, or pro  | oposed, completion date.   |   |  |                               |                            |
|   |  | r title of the person ection and monitoring to ence of the deficiency.   |   |  |                               |                            |
|   | 1-story building with determined to be Ty clinic and an assiste and separated with   | h Manor was built in 2010, is a<br>nout a basement and was<br>ype V(111) construction, A<br>ed living building are attached<br>2-hour fire barriers between<br>clinic, and the Manor and the<br>ing.   |   |  |                               |                            |
|   | with 1-hour and 2-h fully protected with a installed in accorda Standard for the Ins 1999 edition. The fa which includes corrithroughout and in a accordance with NF | d into 4 smoke compartments our fire barriers. The facility is an automatic sprinkler system nee with NFPA 13 The stallation of Sprinkler Systems icility has a fire alarm system idor smoke detection Il common areas, installed in FPA 72 "The National Fire edition. All sleeping rooms |   |  |                               |                            |

|                          | OF DEFICIENCIES OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   |                     | IPLE CONSTRUCTION<br>IG <b>02 - GREENBUSH MANOR</b>   |     | TE SURVEY<br>MPLETED       |
|--------------------------|---|---|---------------------|---|-----|----------------------------|
|                          |   | 245616  | B. WING_            |   | 01/ | /05/2016                   |
| l _                      | PROVIDER OR SUPPLIER RE GREENBUSH MAN   | IOR   |                     | STREET ADDRESS, CITY, STATE, ZIP CODE<br>19120 200TH STREET<br>GREENBUSH, MN 56726  |     |                            |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)  | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTIO<br>(EACH CORRECTIVE ACTION SHOULD<br>CROSS-REFERENCED TO THE APPROP<br>DEFICIENCY)   | BE  | (X5)<br>COMPLETION<br>DATE |
| K 000                    | Continued From pa   | ige 2   | K 00                | 00  |     | 8                          |
|                          | have smoke detect<br>automatic fire detect<br>Minnesota State Fir<br>alarm system is modepartment notifica<br>The facility has a ca   | ion and hazardous areas have ction in accordance with the re Code 2007 edition. The fire onitored for automatic fire tion.  apacity of 40 beds and had a  |                     |   |     |                            |
|                          | census of 36 at the The facility was sur  | time of the survey. veyed as one building.  |                     |   |     |                            |
| K 025<br>SS=F            | NOT MET as evide<br>NFPA 101 LIFE SA<br>Smoke barriers are<br>least a one-hour fir<br>accordance with 8.3<br>terminate at an atrii<br>protected by fire-rai<br>panels in approved<br>separate compartm<br>floor. Dampers are<br>penetrations of smo | e constructed to provide at e resistance rating in 3. Smoke barriers may um wall. Windows are ted glazing or by wired glass frames. A minimum of two nents are provided on each not required in duct oke barriers in fully ducted and air conditioning systems. | K 02                | 25  |     | 1/22/16                    |
|                          | Based on observat<br>determined that the<br>smoke barrier walls<br>101-2000 edition, S<br>18.3.7.3, 8.3.2, and  | s not met as evidenced by:<br>ions and staff interview, it was<br>facility failed to maintain<br>in accordance with NFPA<br>ections 18.3.7, 18.3.7.1,<br>8.3.6. This deficient practice<br>ducts of combustion spread   |                     | LifeCare Greenbush Manor had a passing score after a Fire Safety Evaluation System (FSES) survey conducted by Fire Safety Resource Brett Dallager, Maintenance Superv |     |                            |

| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION    |  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  |                     | (X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - GREENBUSH MANOR   |                    | (X3) DATE SURVEY<br>COMPLETED |  |
|--|--|--|---------------------|---|--------------------|-------------------------------|--|
|  |  | 245616   | B. WING             | <del></del>   | 01/                | 05/2016                       |  |
| NAME OF PROVIDER OR SUPPLIER  LIFECARE GREENBUSH MANOR |  |  |                     | STREET ADDRESS, CITY, STATE, ZIP CODE  19120 200TH STREET  GREENBUSH, MN 56726  |                    |                               |  |
| (X4) ID<br>PREFIX<br>TAG                               | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION) |  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTIO<br>(EACH CORRECTIVE ACTION SHOULD<br>CROSS-REFERENCED TO THE APPROP<br>DEFICIENCY)                   | OULD BE COMPLÉTION |                               |  |
| K 025  | O25 Continued From page 3 throughout the facility in the event of a fire which   |  | K 02                | K 025  will be responsible for maintaining the ongoing compliance with the conditions necessary to maintain a passing FSES score. |                    |                               |  |
|  | could affect all 40 residents, staff and visitors.  Findings include:  |  |                     |   |                    |                               |  |
|  | 1/5/2016, it was obwalls do not extend the ceiling. This co NFPA 101 (00) 8-3.   | veen 11:00am to 2:00pm on eserved that the smoke barrier thought the attic space above ndition is not covered by the 2 exceptions and does not ent for a smoke barrier wall. |                     |   |                    |                               |  |
|  | This deficient practice was confirmed by the Maintenance Supervisor (BD).  |  |                     | 5   |                    |                               |  |
|  |  |  |                     |   |                    |                               |  |
|  |  |  |                     |   |                    | K                             |  |
|  |  |  |                     |   | -                  |                               |  |
|  |  |  |                     |   |                    |                               |  |
|  |  |  |                     |   |                    |                               |  |
|  |  |  |                     |   |                    |                               |  |
|  |  |  |                     |   |                    |                               |  |
|  |  |  |                     |   |                    | -                             |  |

## REPORT OF CONSULTANT FSES FINDINGS

LifeCare Greenbush Manor 19120 - 200<sup>th</sup> Street Greenbush, MN 56726

Provider No. 245616

Date of Survey: January 20 & 22, 2016

Prepared by: Robert L. Imholte, President Fire Safety Resources, LLC 16768 County Road 160 Cold Spring, MN 56320 320-685-8559 RimholteFiresafe@aol.com



16768 County Road 160 Cold Spring, MN 56320 (320) 685-8559

E-mail: RImholteFiresafe@aol.com

January 22, 2016

Ms. Susan Lisell Administrator LifeCare Greenbush Manor 19120 – 200<sup>th</sup> 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 – 200<sup>th</sup> 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:

- o 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 dayl

Robert S. Indult

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:

- o 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.

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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.
- o 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).

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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.
- o No incinerator or space heaters were found.
- o The facility's evacuation plan and fire drill records were reviewed and appeared to be in order.
- o The facility's smoking regulations were reviewed and appeared to be in order. LifeCare Greenbush Manor is a smoke-free campus.
- o Documentation review showed all draperies, cubicle curtains, upholstered furniture, mattresses and decorations to be in accordance with NFPA 101(00), Sec. 18.7.5.
- o 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.

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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 1%-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.

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### 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 1%-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.

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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.

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### 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 "\ge 1/2" 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 1%-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.

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### 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 (7) [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 "\ge 1/2 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 1%-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.

Page 9 of 9

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]:

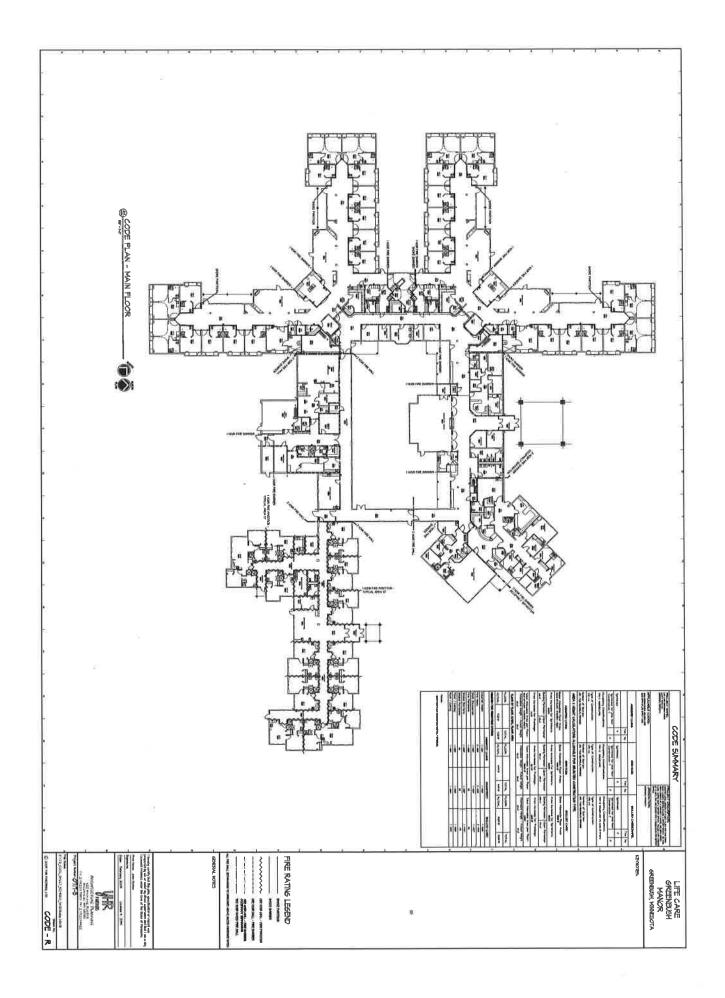
System-connected smoke detectors were found in the egress corridor, spaces open to the corridor and in all habitable spaces.

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*.



| N | E   | 1         | <br>OF | 4    | <br>ZONES |
|---|-----|-----------|--------|------|-----------|
|   | 0.4 | <b>DE</b> | 211    | TIFO |           |

|  | ZONE 1 OF 4 ZONE   |
|--|--|
| FIRE/SMOKE ZONE* EVALUATION  | N WORKSHEET FOR HEALTH CARE FACILITIES                     |
|  | 2000 LIFE SAFETY CODE                                      |
| FACILITY LIFECARE GREENBUSH MANOR  | BUILDING 02-GREENBUSH MANOR                                |
| ZONE(S) EVALUATED ROSEVICOD  |  |
| PROVIDER/VENDOR NO. 245616   | DATE OF SURVEY 01/22/2016                                  |
| COMPLETE THIS WORKSHEET FOR EACH ZON ONE WORKSHEET CAN BE USED FOR THOSE | NE. WHERE CONDITIONS ARE THE SAME IN SEVERAL ZONES, ZONES. |
| Step 1: Determine Occupancy Risk Parameter F                             | 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. OCCUPANC     | Y RISK PARAMI                      | ETER FA                                  | CTOR            | S                         |                     |  |
|-------------------------|------------------------------|-----------------|------------------------------------|--|-----------------|---------------------------|---------------------|--|
| Risk Parameters         |                              | Risk I          | actors Values                      |  |                 |                           |                     |  |
| 1. Patient              | Mobility Status              | Mobile          | Limited M                          | Limited Mobility                         |                 | ot Mobile                 | Not Movable         |  |
| Mobility (M)            | Risk Factor                  | 1.0             | 1.6                                |  | (3.2)           |                           | 4.5                 |  |
| 2. Patient Density (D)  | No. of Patients              | 1–5             | 6-10                               | 6–10                                     |                 | 1130                      | >30                 |  |
| Density (D)             | Risk Factor                  | 1.0             | 1.2                                |  | 1.5             |                           | 2.0                 |  |
| 3. Zone                 | Floor                        | 1/1             | 2 <sup>nd</sup> or 3 <sup>rd</sup> | 4º to                                    | 6 <sup>th</sup> | 7 <sup>th</sup> and Above | Basements           |  |
| Location (L)            | Risk Factor                  | (1.1)           | 1,2                                | 1.4                                      |                 | 1.6                       | 1.6                 |  |
| 4. Ratio of Patients to | <u>Patients</u><br>Attendant | <u>1–2</u><br>1 | <u>3–5</u><br>1                    | 6-10<br>1                                |                 | <u>≥10</u><br>1           | One or More<br>None |  |
| Attendants (T)          | Risk Factor                  | 1.0             | 1.1                                | 1.2                                      |                 | 1.5                       | 4.0                 |  |
| 5. Patient              | Age                          | Under 65 Ye     | ars and Over 1 year                | ear 65 Years and Over 1 Year and Younger |                 |                           |                     |  |
| Average<br>Age (A)      | 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. OC    | CUPAN | CY RISK | FACTO | R CALCU | LATION |      |  |
|----------------|-------|---------|-------|---------|--------|------|--|
| OCCUPANCY RISK | M     | D       | L     | T       | A      | F    |  |
| OCCUPANCY RISK | 2.2   | (1.5) X | 1.1   | ().L    | [],[]  | 1.60 |  |

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

| TABLE 3A. (NEW BUILDINGS) | TABLE 3B. (EXISTING BUILDINGS) |  |  |
|---------------------------|--------------------------------|--|--|
| 1.0 x 7.6 = 7.6 = 0       | 0.6 x = R                      |  |  |

| * FIRE/SMOKE ZONE is a space separated from all other spaces b | y floors, horizontal exits, or smoke bar | riers.          |
|--|--|-----------------|
| SURVEYOR SIGNATURE FIRE SAFEKI RESOURCES, LI                   | LC TITLE PRESIDENT                       | DATE 01/22/2016 |
| Thomas Linhoff 12424   | TITLE Supervisor                         | DATE 02-18-2016 |
| Form CMS-2786T (02/2013)                                       |  | Page 1          |

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   | Param                             | eters Va         | lues              |                              |                         |  |  |
| 1. Construction                           |                               | Combustible<br>Types III, IV, and V |          |                                   |                  |                   |                              | ble<br>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                            | . <del>-</del> 7                    | -9       | -7                                |                  | -7                | 2                            | 4                       |  |  |
| 4th and Above                             | -13                           | -7                                  | -13      | -7                                |                  | -9                | -7                           | 4                       |  |  |
| Interior Finish     (Corridors and Exits) | Class C<br>-5(0) <sup>r</sup> | Class B<br>0(3) <sup>f</sup>        |          | Clas                              |                  |                   |                              |                         |  |  |
| 3. Interior Finish                        | Class C                       | Class B                             |          | Clas                              | s A              | 1                 |                              |                         |  |  |
| (Rooms)                                   | -3(1) <sup>f</sup>            | 1(3)                                |          |                                   | 3                |                   |                              |                         |  |  |
| 4. Corridor<br>Partitions/Walls           | None or Incomplet             | e <1/2 haur                         |          | ≥¹/₂ to <                         |                  |                   | ≥1 hour<br>2(0) <sup>a</sup> |                         |  |  |
| 5. Doors to Corridor                      | No Door                       | <20 mln Fl                          | PR       | ≥20 min FPR                       |                  |                   | min FPR and<br>Auto Clos.    |                         |  |  |
|   | -10                           | 0                                   |          | (100)°                            |                  | 2(0) <sup>d</sup> |                              | - 19                    |  |  |
| 6. Zone Dimensions                        | Dead End                      |                                     |          | 0                                 | L                | No Dea            | d Ends >30 ft and Z          | one Length Is           |  |  |
|   | >100 ft                       | >50 ft to 100 ft                    | 30 ft to | 50 ft                             | >15              | ) ft              | 100 ft to 150 ft             | <100 ft                 |  |  |
|   | -6(0) <sup>6</sup>            | -4(0) <sup>b</sup>                  | -2(0)    | ) <sup>b</sup>                    | -2(0             | ))°               | (0)                          | 1                       |  |  |
| 7. Vertical Openings                      | Open 4 or More                | Open 2 or                           | r 3      |                                   | End              | closed wit        | h Indicated Fire Res         | lst.                    |  |  |
|   | Floors                        | Floors                              |          | <1 hr                             |                  | ≥                 | 1 hr to <2 hr                | ≥2 hr                   |  |  |
|   | -14                           | -10                                 |          | C                                 |                  |                   | 2(0)*)                       | 3(0)*                   |  |  |
| 8. Hazardous Areas                        | Double Deficiency             |                                     |          |                                   | Single           | Deficienc         | у                            | No Deficiencies         |  |  |
|   | In Zone                       | Outside Zo                          | one      | In Zone                           |                  | In A              | Adjacent Zone                |                         |  |  |
|   | -11                           | -5                                  |          | -6                                |                  |                   | -2                           | (0)                     |  |  |
| 9. Smoke Control                          | No Control                    | Smoke Bar<br>Serves Zo              |          | Mech. Assisted Systems<br>by Zone |                  | tems              |                              |                         |  |  |
|   | (-5\0)°                       | 0                                   |          | 3                                 |                  |                   |                              |                         |  |  |
| 10. Emergency                             | <2 Routes                     |                                     | Multiple |                                   |                  |                   | le Routes                    |                         |  |  |
| Movement<br>Routes                        |                               | Deficier                            | nt       | W/O Horizontal<br>Exit(s)         |                  |                   | Horizontal<br>Exlt(s) Di     |                         |  |  |
|   | -8                            | -2                                  |          | (                                 | 0)               |                   | 1                            | 5                       |  |  |
| 11. Manual Fire Alarm                     | No Man                        | ual Fire Alarm                      |          |                                   | Manua            | al Fire Ala       | rm                           |                         |  |  |
|   |                               |                                     |          | W/O F.                            | D. Conn.         | ,                 | N/F.D. Conn                  |                         |  |  |
|   |                               | -4                                  |          |                                   | 1                |                   | (2)                          |                         |  |  |
| 12 Smoke Detection and Alarm              | None                          | Corridor C                          | Only     | Rooms Only                        |                  |                   | orridor and<br>ablt. Spaces  | Total Spaces<br>In Zone |  |  |
|   | 0(3) <sup>g</sup>             | 2(3) <sup>g</sup>                   |          | 3                                 | (3) <sup>g</sup> |                   | (4)                          | 5                       |  |  |
| 13, Automatic<br>Sprinklers               | None                          | Corridor a<br>Habit, Spa            |          |                                   | ntire<br>ilding  |                   |                              |                         |  |  |
|   | 0                             | 8                                   |          | 1                                 | 10)              |                   |                              |                         |  |  |

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

For SI units: 1 ft = 0.3048 m

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

<sup>&</sup>lt;sup>c</sup> 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")

<sup>&</sup>lt;sup>f</sup> 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.

<sup>&</sup>lt;sup>9</sup> 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<sub>1</sub>, S<sub>2</sub>, S<sub>3</sub>, S<sub>6</sub> to blocks labeled S<sub>1</sub>, S<sub>2</sub>, S<sub>3</sub>, S<sub>6</sub> in Table 7 on page 4 of this sheet.

| TABLE 5. INDIVIDUAL SAFETY EVALUATIONS |   |  |   |                                     |  |  |  |  |  |
|--|---|--|---|-------------------------------------|--|--|--|--|--|
| Safety Parameters                      | Containment<br>Safety (S <sub>1</sub> ) | Extinguishment<br>Safety (S <sub>2</sub> ) | People Movement<br>Safety (S <sub>3</sub> ) | General<br>Safety (S <sub>4</sub> ) |  |  |  |  |  |
| 1. Construction                        | 0                                       | 0  |   | 0                                   |  |  |  |  |  |
| Interior Finish     (Corr. and Exit)   | 3                                       |  | 3   | 3                                   |  |  |  |  |  |
| 3. Interior Finish (Rooms)             | 3                                       |  |   | 3                                   |  |  |  |  |  |
| 4. Corridor Partitions/Walls           |   |  |   | \$                                  |  |  |  |  |  |
| 5. Doors to Corridor                   |   |  | ĝ   | 1                                   |  |  |  |  |  |
| 6. Zone Dimensions                     |   |  | 0   | 0                                   |  |  |  |  |  |
| 7. Vertical Openings                   | 0                                       |  | 0   | 0                                   |  |  |  |  |  |
| 8. Hazardous Areas                     | Ó                                       | 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  | L   | 4                                   |  |  |  |  |  |
| 13. Automatic Sprinklers               | 10                                      | 10   | 10 ÷2=5                                     | 10                                  |  |  |  |  |  |
| Total Value                            | S1= \B                                  | S2=  | S= 8  | S4= 19                              |  |  |  |  |  |

| MANDATORY S                    | AFETY REQUII |               | LE 6.<br>PR USE IN HOSI | PITALS OR NI | JRSING HOME                          | S)     |
|--------------------------------|--------------|---------------|-------------------------|--------------|--------------------------------------|--------|
|                                |              | Inment<br>S₃) | Extingui<br>(S          |              | People Movement<br>(S <sub>0</sub> ) |        |
| Zone Location                  | New          | Exist.        | New                     | Exist.       | New                                  | Exist. |
| * story                        | (11)         | 5             | (15)12)ª                | 4            | (8(5)°                               | 1      |
| 2nd or 3rd story <sup>b</sup>  | 15           | 9             | 17(14) <sup>a</sup>     | 6            | 10(7)ª                               | 3      |
| I <sup>™</sup> story or higher | 18           | 9             | 19(16)ª                 | 6            | 11(8) <sup>a</sup>                   | 3      |

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

b. For a 2<sup>rd</sup> 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: Sa=7, Sb=10, and Sc=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 Sa, Sb, and So 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 EC | UIVALENCY EVALUATION   | Yes | No |
|---|-------|--|-----------|--|-----|----|
| Containment<br>Safety (S <sub>1</sub> )     | minus | Mandatory<br>Containment (S₄)                  | ≥ 0       | $\begin{bmatrix} s_1 \\ l \theta \end{bmatrix} - \begin{bmatrix} s_n \\ l l \end{bmatrix} = \begin{bmatrix} c \\ -7 \end{bmatrix}$ | 1   |    |
| Extinguishment<br>Safety (S₂)               | minus | Mandatory<br>Extingulshment (S <sub>6</sub> )  | ≥ 0       | S <sub>2</sub> S <sub>6</sub> E  | /   |    |
| People Movement<br>Safety (S <sub>3</sub> ) | minus | Mandatory People<br>Movement (S <sub>2</sub> ) | ≥ 0       | S <sub>3</sub> - S <sub>c</sub> = P  | 1   |    |
| General<br>Safety (S₄)                      | minus | Occupancy<br>Risk (R)                          | ≥ 0       | $\begin{array}{c ccccccccccccccccccccccccccccccccccc$  | \_/ |    |

| Co<br>Fo | mplete one copy of this worksheet for each facility. reach consideration, select and mark the appropriate column.   | Met | Not<br>Met | Not<br>Applic |
|----------|---|-----|------------|---------------|
| A.       | Building utilities conform to the requirements of Section 9.1.  | V   | 0          | 12/20         |
| 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.  | 1   |            |               |
| 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. | 1   |            |               |
| D.       | Fuel-burning space heaters and portable electrical space heaters are not used.  | 1   |            |               |
| E.       | There are no flue-fed incinerators.   | J   |            |               |
| 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.  | 1   |            |               |
| G.       | Smoking regulations have been adopted and implemented in accordance with 18.7.4 and 19.7.4.   | 1   |            | Fig. 16       |
| H,       | Draperies, upholstered furniture, mattresses, furnishings, and decoration combustibility is limited in accordance with 18.7.5 and 19.7.5.   | 1   |            |               |
| 1.       | Fire extinguishers are provided in accordance with the requirements of 18.3.5.4 and 19.3.5.6.   | J   |            | WEST IN       |
| 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.   | 1   |            |               |
| L,       | Standpipes are provided in all new high rise buildings as required by 18.4.2.   |     |            |               |

## CONCLUSIONS

- 1. All of the checks in Table 7 are in the "Yes" column, The level of fire safety is at least equivalent to that prescribed by the *Life Safety Code*.\*
- 2. One of more of the checks in Table 7 are in the "No" column. The level of fire safety is not shown by this system to be equivalent to that prescribed by the *Life Safety Code*.\*

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

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

|    |   |      | ,  | NAID EVELLIA |
|----|---|------|----|--------------|
| 1E | 2 | OF _ | 4. | ZONES        |

|                  |                   |                  | 2014              | <u> </u> |              |       | 20 |
|------------------|-------------------|------------------|-------------------|----------|--------------|-------|----|
| FIRE/SMOKE ZONE* | <b>EVALUATION</b> | <b>WORKSHEET</b> | <b>FOR HEALTH</b> | CARE     | <b>FACIL</b> | ITIES |    |

|           |                          | 2000 LIFE SAFETY COD        | ıΕ |
|-----------|--------------------------|-----------------------------|----|
| FACILITY  | LIFECARE GREENBUSH MANOR | BUILDING 02-GREENBUSH MANOR |    |
| ZONE(S) E |                          |                             |    |
| PROVIDER  | RIVENDOR 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. OCCUPANC     | Y RISK PARAM                        | ETER FA          | CTOR                                 | S                         |                     |  |
|---------------------------|------------------------------|-----------------|-------------------------------------|------------------|--------------------------------------|---------------------------|---------------------|--|
| Risk Parameters           | Risk Factors Values          |                 |                                     |                  |                                      |                           |                     |  |
| 1. Patient                | Mobility Status              | Mobile          | Limited M                           | lobility         | N                                    | ot Mobile                 | Not Movable         |  |
| Mobility (M)              | Risk Factor                  | 1.0             | 1.6                                 | 1.6              |                                      | 3.2                       | 4.5                 |  |
| 2. Patient<br>Density (D) | No. of Patients              | 1–5             | 6–10                                | 6–10             |                                      | 11–30                     | >30                 |  |
| Definity (D)              | Risk Factor                  | 1.0             | 1.2                                 |                  | 1.5                                  |                           | 2.0                 |  |
| 3. Zone                   | Floor                        | 1 11            | 2 <sup>114</sup> or 3 <sup>14</sup> | 4th to           | 6 <sup>th</sup>                      | 7 <sup>th</sup> and Above | Basements           |  |
| Location (L)              | Risk Factor                  | (1,1)           | 1.2                                 | 1.4              |                                      | 1.6                       | 1.6                 |  |
| 4. Ratio of Patients to   | <u>Patients</u><br>Attendant | <u>1–2</u><br>1 | <u>3–5</u><br>1                     | <u>6–10</u><br>1 |                                      | <u>≥10</u><br>1           | One or More<br>None |  |
| Attendants (T)            | Risk Factor                  | 1.0             | 1.1                                 | (1.2)            |                                      | 1.5                       | 4.0                 |  |
| 5. Patient                | Age                          | Under 65 Ye     | ars and Over 1 year                 |                  | 65 Years and Over 1 Year and Younger |                           |                     |  |
| Average<br>Age (A)        | 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. OCC   | CUPANC | Y RISK | FACTO | R CALCU | LATION |     |
|----------------|--------|--------|-------|---------|--------|-----|
|                | M      | D      | L     | T       | Α      | F   |
| OCCUPANCY RISK | 3,2 X  | 1.5 X  | 3,1   | x 1,2 x | 1.2 =  | 7.6 |

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

| TABLE 3A. (NEW BUILDINGS)                  | TABLE 3B. (EXISTING BUILDINGS) |
|--|--------------------------------|
| $1.0 \times \boxed{7.6} = \boxed{7.6} = 8$ | 0.6 x = R                      |

| * FIRE/SMOKE ZONE is a space separated from all other spaces by fig | oors, horizontal exits, or smoke barrier | 3.              |
|---|--|-----------------|
| SURVEYOR SIGNATURE ROBERT RESOURCES LLC                             | TITLE PRESIDENT                          | DATE 01/22/2016 |
| Thomas Linhoff 12424  | TITLE Supervisor                         | DATE 02-18-2016 |
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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         | l.                        |                   |                                  |                             |                         |  |
|---|-------------------------------|----------------------------------|-----------------|---------------------------|-------------------|----------------------------------|-----------------------------|-------------------------|--|
| Safety Parameters                         |                               |                                  | Safety          | Param                     | eters Va          | lues                             |                             |                         |  |
| 1. Construction                           |                               | Combustible<br>es III, IV, and V |                 |                           |                   | NonCombustible<br>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                               | <del>-</del> 13 | -7                        |                   | -9                               | -7                          | 4                       |  |
| Interior Finish     (Corridors and Exits) | Class C<br>-5(0) <sup>f</sup> | Class B<br>0(3) <sup>f</sup>     |                 | Clas                      | The second second |                                  |                             |                         |  |
|   |                               |                                  |                 |                           | /                 | 1                                |                             |                         |  |
| 3. Interior Finish<br>(Rooms)             | Class C<br>-3(1) <sup>r</sup> | Class B                          |                 | Clas                      | s A               | +                                | 1                           |                         |  |
| 4. Corridor                               | None or Incomplete            |                                  |                 | ≥¹/₂ to <                 |                   | -                                | ≥1 hour                     |                         |  |
| Partitions/Walls                          | -10(0) <sup>a</sup>           | 0                                |                 | (10                       |                   | ļ                                | 2(0) <sup>a</sup>           |                         |  |
| 5. Doors to Corridor                      | No Door                       | <20 mln Fi                       | PR              | <u>&gt;</u> 20 ml         |                   | ≥20 mln FPR and<br>Auto Clos.    |                             |                         |  |
|   | -10 0                         |                                  |                 | (1)                       | D) <sup>d</sup>   | 2(0) <sup>d</sup>                |                             |                         |  |
| 6. Zone Dimensions                        | Dead End                      |                                  |                 |                           |                   | No Dea                           | d Ends >30 ft and 2         | Zone Length Is          |  |
|   | >100 ft                       | >50 ft to 100 ft                 | 30 ft to        | 50 ft                     | >150              |                                  | 100 ft to 150 ft            | <100 ft                 |  |
|   | -6(0) <sup>t</sup>            | -4(0) <sup>b</sup>               | -2(             | 0) <sup>b</sup>           | -2(0              | )°                               | (0)                         | 1                       |  |
| 7. Vertical Openings                      | Open 4 or More                | oors Floors                      |                 | <1 hr                     |                   |                                  | h Indicated Fire Res        |                         |  |
|   | Floors                        |                                  |                 |                           |                   | >                                | 1 hr to <2 hr               | ≥2 hr                   |  |
|   | -14 -10                       |                                  |                 | C                         | )                 | 1                                | 2(0)")                      | 3(0)°                   |  |
| 8. Hazardous Areas                        | Double Deficiency             |                                  |                 |                           |                   | Deficienc                        |                             | No Deficiencies         |  |
|   | In Zone                       | Outside Zo                       | one             | In Zone                   |                   | In A                             | Adjacent Zone               |                         |  |
|   | -11                           | -5                               |                 | -6                        |                   |                                  | -2                          | (0)                     |  |
| 9. Smoke Control                          | No Control                    | Smoke Bar<br>Serves Zo           |                 | Mech. Assiste<br>by Zo    |                   | isted S <u>y</u> s<br>Zone       | tems                        |                         |  |
|   | (-5)0)°                       | 0                                |                 | 3                         |                   |                                  |                             |                         |  |
| 10. Emergency                             | <2 Routes                     |                                  |                 | Multiple Routes           |                   |                                  |                             |                         |  |
| Movement<br>Routes                        |                               | Deficien                         | ıt              | W/O Horizontal<br>Exit(s) |                   | Horizontal<br>Exit(s) Dir        |                             | Direct Exit(s)          |  |
|   | -8                            | -2                               |                 |                           | 0)                |                                  | 1                           | 5                       |  |
| 11. Manual Fire Alarm                     | No Man                        | ual Fire Alarm                   |                 |                           | Manua             | I Fire Ala                       | rm                          |                         |  |
|   |                               |                                  |                 | W/O F                     | .D. Conn.         | 1                                | W/F.D. Conn                 |                         |  |
|   | -4                            |                                  |                 |                           | 1                 |                                  | (2)                         |                         |  |
| 12 Smoke Detection and Alarm              | None                          | Corridor C                       | Only            | Roon                      | ns Only           |                                  | orridor and<br>abit. Spaces | Total Spaces<br>In Zone |  |
|   | 0(3) <sup>g</sup>             | 2(3) <sup>9</sup>                |                 | 3                         | (3) <sup>g</sup>  |                                  | (4)                         | 5                       |  |
| 13. Automatic<br>Sprinklers               | None                          | Corridor a                       |                 |                           | ntire<br>iilding  |                                  |                             |                         |  |
|   | 0                             | 8                                |                 | 7                         | 10)               |                                  |                             |                         |  |

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

For SI units: 1 ft = 0.3048 m

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

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

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

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.

<sup>&</sup>lt;sup>9</sup> 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<sub>1</sub>, S<sub>2</sub>, S<sub>3</sub>, S<sub>6</sub> to blocks labeled S<sub>1</sub>, S<sub>2</sub>, S<sub>3</sub>, S<sub>6</sub> in Table 7 on page 4 of this sheet.

| TAI                                  | BLE 5. INDIVIDUAL                       | SAFETY EVALUAT                             | IONS  |                        |
|--------------------------------------|---|--|---|------------------------|
| Safety Parameters                    | Containment<br>Safety (S <sub>1</sub> ) | Extinguishment<br>Safety (S <sub>2</sub> ) | People Movement<br>Safety (S <sub>3</sub> ) | General<br>Safety (S4) |
| 1. Construction                      | 0                                       | 0  |   | 0                      |
| Interior Finish     (Corr. and Exit) | 3                                       |  | 3   | 3                      |
| 3. Interior Finish (Rooms)           | 3                                       |  |   | 3                      |
| 4. Corridor Partitions/Walls         | 1                                       |  |   | 8                      |
| 5. Doors to Corridor                 | *                                       |  |   | J                      |
| 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                          | S1= 18                                  | S2= 16                                     | S₃= Q                                       | S4= 19                 |

| MANDATORY S                              | AFETY REQUI      | - " - " | LE 6.<br>R USE IN HOSI | PITALS OR NU | RSING HOME                           | S)     |
|--|------------------|---------|------------------------|--------------|--------------------------------------|--------|
|  | Containment (Sa) |         | Extingui<br>(S         |              | People Movement<br>(S <sub>0</sub> ) |        |
| Zone Location                            | New              | Exist.  | New                    | Exist.       | New                                  | Exist. |
| 1 <sup>®</sup> story                     | (11)             | 5       | (15)(12)ª              | 4            | (8)(5)*                              | 1      |
| 2 <sup>™</sup> or 3rd story <sup>b</sup> | 15               | 9       | 17(14) <sup>a</sup>    | 6            | 10(7) <sup>a</sup>                   | 3      |
| 4th story or higher                      | 18               | 9       | 19(16)ª                | 6            | 11(8) <sup>a</sup>                   | 3      |

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

b. For a 2<sup>nd</sup> 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: S₀=7, S₀=10, and S₀=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 Sa, Sb, and Sc 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 EQU | IVALENCY EVALUATION   | Yes | No |
|---|-------|--|------------|---|-----|----|
| Containment<br>Safety (S <sub>1</sub> )     | minus | Mandatory<br>Containment (S <sub>*</sub> ) | ≥ 0        | $\begin{array}{c c} S_1 & S_2 & C \\ \hline 18 & - 11 & - 7 \end{array}$                      | 1   |    |
| Extinguishment<br>Safety (S <sub>2</sub> )  | minus | Mandatory<br>Extinguishment (S₀)           | ≥ 0        | S <sub>2</sub> S <sub>6</sub> E [ ]   | 1   |    |
| People Movement<br>Safety (S <sub>3</sub> ) | minus | Mandatory People<br>Movement (S₃)          | ≥ 0        | S <sub>3</sub> S <sub>c</sub> P<br>8 - 8 = 0  | 1   |    |
| General<br>Safety (S <sub>4</sub> )         | minus | Occupancy<br>Risk (R)                      | ≥ 0        | $\begin{bmatrix} S_4 & R & G \\ Jq & - & g \end{bmatrix} = \begin{bmatrix} J_1 \end{bmatrix}$ | 1   |    |

|    | TABLE 8. FACILITY FIRE SAFETY REQUIREMENTS WORKSHEET  | •   |            |                |
|----|---|-----|------------|----------------|
|    | mplete one copy of this worksheet for each facility.<br>r each consideration, select and mark the appropriate column.   | Met | Not<br>Met | Not<br>Applic. |
| A. | Building utilities conform to the requirements of Section 9.1.  | 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.  | 1   |            |                |
| 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. | 1   |            |                |
| D. | Fuel-burning space heaters and portable electrical space heaters are not used.  | J   |            |                |
| E. | There are no flue-fed incinerators.   | 1   |            |                |
| Ę, | 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.  | 1   |            |                |
| G. | Smoking regulations have been adopted and implemented in accordance with 18.7.4 and 19.7.4.   | J   |            | 1000           |
| Н, | Draperies, upholstered furniture, mattresses, furnishings, and decoration combustibility is limited in accordance with 18.7.5 and 19.7.5.   | 1   |            |                |
| L. | Fire extinguishers are provided in accordance with the requirements of 18.3.5.4 and 19.3.5.6.   | J,  |            |                |
| J. | Exit signs are provided in accordance with the requirements of 18.2.10.1 and 19.2.10.   | 1   |            |                |
| K. | Emergency lighting is provided in accordance with 18.2.9.1 or 19.2.9.   | V   |            | 1              |
| L. | Standpipes are provided in all new high rise buildings as required by 18.4.2.   |     |            | 1              |

# CONCLUSIONS 1. All of the checks in Table 7 are in the "Yes" column. The level of fire safety is at least equivalent to that prescribed by the Life Safety Code.\* 2. One of more of the checks in Table 7 are in the "No" column. The level of fire safety is not shown by this system to be equivalent to that prescribed by the Life Safety Code.\* \*The equivalency covered by this worksheet includes the majority of considerations covered by the Life Safety Code. There are a few considerations that are not evaluated by this method. These must be considered separately. These additional considerations are covered in Table 8, the "Facility Fire Safety Requirements Worksheet." One copy of this separate worksheet is to be completed for each facility.

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

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|    |     |         |      | OMB Exempt |
|----|-----|---------|------|------------|
| E_ | 3   | OF      | 4    | ZONES      |
| CA | \RE | FACILIT | TIES |            |

| FIRE/SMC                     | KE ZONE* EVA  | _UATION WO                            | RKSHEET F                             | OR HE              |   |                     |  |
|------------------------------|---|---------------------------------------|---------------------------------------|--------------------|---|---------------------|--|
| LITY LIFE CAS                | E GREENBUSH N   | MANOR                                 | BUILDING                              | 02-GR              | CEEHBUSH MAH  | 2000 LIFE SAFETY    |  |
| E/C) EVALUATED               | ADMINISTRATIVE!   |                                       |                                       | J                  | 10001111111   |                     |  |
| VIDER/VENDOR NO.             | 245616  | COMMONIA                              | DATE OF SURV                          | ÆΥ .               | 01/22/2016  |                     |  |
|                              | VORKSHEET FOR E<br>CAN BE USED FOR  |                                       |                                       | ONS ARE            | THE SAME IN S   | EVERAL ZONES,       |  |
| A. For each                  | e Occupancy Risk Pa<br>Risk Parameter in Ta<br>nly one for each of th                             | ble 1, select and                     | circle the appro                      | opriate ris        | sk factor value.  |                     |  |
| 2.00000000                   | TABLE 1   | . OCCUPANCY                           | RISK PARAME                           | TER FA             | CTORS   |                     |  |
| Risk Parameters              |   | Risk Fa                               | ctors Values                          |                    |   |                     |  |
| 1. Patient                   | Mobility Status   | Mobile                                | Limited Mo                            | oblifty            | Not Mobile  | Not Movable         |  |
| Mobility (M)                 | Risk Factor   | 1.0                                   | 1.6                                   |                    | 3.2   | 4.5                 |  |
| 2. Patient<br>Density (D)    | No. of Patients   | 1~5                                   | 6–10                                  |                    | 11–30   | >30                 |  |
| Bellially (B)                | Risk Factor   | 1.0                                   | 1.2                                   |                    | 1.5   | 2.0                 |  |
| 3. Zone                      | Floor   | 1ម                                    | 2 <sup>ad</sup> or 3 <sup>ad</sup>    | 4 <sup>th</sup> to | 6 <sup>th</sup> 7 <sup>th</sup> and Abo                                       | ve Basements        |  |
| Location (L)                 | Risk Factor   | 1.1                                   | 1.2                                   | 1.4                | 1.6   | 1.6                 |  |
| Ratio of     Patients to     | <u>Patients</u><br>Attendant  | <u>12</u><br>1                        | <u>3–5</u><br>1                       | <u>6–1</u> 1       | Q <u>≥10</u><br>1   | One or More<br>None |  |
| Attendants (T)               | Risk Factor   | 1,0                                   | 1.1                                   | (1.2               | 1.5   | 4,0                 |  |
| 5. Patient<br>Average        | Age   | Under 65 Year                         | s and Over 1 year                     |                    | 65 Years and Over 1 Year and Younger  |                     |  |
| Age (A)                      | Risk Factor   |                                       | 1.0                                   |                    | (1.2  |                     |  |
| A. Transfer t                | Occupancy Risk Factor<br>he circled risk factor<br>F by multiplying the                           | values from Tabl                      | e 1 to the corre                      |                    |   | ×                   |  |
|                              | TABLE 2   | 2. OCCUPANCY                          | RISK FACTOR                           | CALCU              | LATION  |                     |  |
|                              | OCCUPANCY I   |                                       | D L<br>2,0 x 1.j x                    |                    | $\begin{bmatrix} A \\ 1.2 \end{bmatrix} = \begin{bmatrix} 10.1 \end{bmatrix}$ |                     |  |
| A. If building B. Transfer t | Adjusted Building St<br>is classified as "NEV<br>the value of F from Ta<br>R to the block labeled | V" use Table 3A.<br>able 2 to Table 3 | If building is cla<br>A or Table 3B a | s approp           | riate. Calculate R.   | ole 3B.             |  |
| TABL                         | E 3A. (NEW BUILDI   | NGS)                                  |                                       | TABLE              | 3B. (EXISTING BU  | JILDINGS)           |  |
|                              | $1.0 \times \frac{F}{ 0.1 } = \frac{R}{ 0.1 }$  | =                                     |                                       |                    | 0.6 x = F   | 3                   |  |
| RE/SMOKE ZONE Is a s         | pace separated from all   | other spaces by flo                   | ors, horizontal exi                   | lts, or smo        | ke barriers.  |                     |  |
| RVEYOR SIGNATURE             |   |                                       | TITLE ,                               |                    | DATE  | (4)                 |  |

Supervisor

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  | 4.                                     |                  |                   |                              |                         |
|---|-------------------------------------|------------------------------|----------|--|------------------|-------------------|------------------------------|-------------------------|
| Safety Parameters                           |                                     |                              | Safety   | / Param                                | eters Va         | lues              |                              |                         |
| 1. Construction                             | Combustible<br>Types III, IV, and V |                              |          |  |                  |                   | NonCombus<br>Types I and     |                         |
| Floor or Zone                               | 000                                 | 111                          | 200      | 211 +                                  | 2HH              | 000               | 111                          | 222, 332, 4             |
| 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<br>(Corridors and Exits) | Class C<br>-5(0) <sup>f</sup>       | Class B<br>0(3) <sup>f</sup> |          | Clas                                   |                  |                   |                              |                         |
| 3. Interior Finish<br>(Rooms)               | Class C<br>-3(1) <sup>f</sup>       | Class B                      |          | Clas                                   | s A              |                   |                              |                         |
| 4. Corridor<br>Partitions/Walls             | None or Incomplet                   | e <1/2 hour                  |          | ≥¹/₂ to <                              | 1 hour           |                   | ≥1 hour<br>2(0) <sup>a</sup> |                         |
| 5. Doors to Corridor                        | No Door                             | <20 min Ff                   | PR       | ≥20 mln FPR                            |                  |                   | min FPR and<br>Auto Clos.    |                         |
|   | -10                                 | 0                            |          | (1(0) <sup>d</sup>                     |                  | 2(0) <sup>d</sup> |                              |                         |
| 6. Zone Dimensions                          |                                     | Dead End                     |          |  |                  | No Dea            | d Ends >30 ft and a          | Zone Lenath Is          |
|   | >100 ft                             | >50 ft to 100 ft             | 30 ft to | ft to 50 ft >150                       |                  |                   | 100 ft to 150 ft             | <100 ft                 |
|   | -6(0) <sup>b</sup>                  | -4(0) <sup>b</sup>           | -2(      | ·2(0) <sup>b</sup> (-2)0) <sup>c</sup> |                  | )°                | 0                            | 1                       |
| 7. Vertical Openings                        | Open 4 or More                      | Open 2 or                    | 3        |  | Enc              | losed wit         | h Indicated Fire Re          | sist.                   |
|   | Floors Floors                       |                              |          | <1 hr                                  |                  |                   | 1 hr to <2 hr                | ≥2 hr                   |
|   | -14                                 | -10                          |          | 0                                      |                  |                   | 2(0)9                        | 3(0)°                   |
| 8. Hazardous Areas                          | Double                              | Deficiency                   |          |  | Single D         | Deficienc         | y                            | No Deficiencies         |
|   | In Zone                             | Outside Zo                   | ne       | In Zone                                |                  | In A              | Adjacent Zone                |                         |
|   | -11                                 | -5                           |          | -6                                     |                  |                   | -2                           | (0)                     |
| 9. Smoke Control                            | No Control                          | Smoke Bar<br>Serves Zo       |          | Mech. Assisted Systems<br>by Zone      |                  | tems              |                              |                         |
|   | (-5)0)°                             | 0                            |          | 3                                      |                  |                   |                              |                         |
| 10. Emergency                               | <2 Routes                           |                              |          | Multiple Routes                        |                  |                   |                              |                         |
| Movement<br>Routes                          |                                     | Deficien                     | t        | W/O Horizontal<br>Exlt(s)              |                  |                   | Horizontal<br>Exit(s)        | Direct Exit(s)          |
|   | -8                                  | -2                           |          | (0)                                    |                  |                   | 1                            | 5                       |
| 11. Manual Fire Alarm                       | No Man                              | ual Fire Alarm               |          |  | Manual           | Fire Ala          | rm                           |                         |
|   |                                     |                              |          |  | D. Conn.         | 1                 | N/F.D. Conn                  |                         |
|   |                                     | -4                           |          |  | 1                |                   | (2)                          |                         |
| 12. Smoke Detection and Alarm               | None                                | Corridor O                   | nly      | Room                                   | is Only          |                   | orridor and<br>bit. Spaces   | Total Spaces<br>In Zone |
|   | 0(3) <sup>g</sup>                   | 2(3)0)                       |          | 3(                                     | (3) <sup>9</sup> |                   | 4                            | 5                       |
| 13. Automatic<br>Sprinklers                 | None                                | Corridor a<br>Habit, Spa     |          |  | itire<br>Iding   |                   |                              |                         |
|   | 0                                   | 8                            |          | 1                                      | 10)              |                   |                              |                         |

NOTE: <sup>a</sup> Use (0) where parameter 5 is -10.

For SI units: 1 ft = 0.3048 m

<sup>&</sup>lt;sup>b</sup> Use (0) where parameter 10 is -8.

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

<sup>&</sup>lt;sup>d</sup> Use (0) where parameter 4 is -10.

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

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.

<sup>&</sup>lt;sup>9</sup> 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<sub>1</sub>, S<sub>2</sub>, S<sub>3</sub>, S<sub>6</sub> to blocks labeled S<sub>1</sub>, S<sub>2</sub>, S<sub>3</sub>, S<sub>6</sub> in Table 7 on page 4 of this sheet.

| TABLE 5. INDIVIDUAL SAFETY EVALUATIONS |   |  |   |                        |  |  |  |
|--|---|--|---|------------------------|--|--|--|
| Safety Parameters                      | Containment<br>Safety (S <sub>1</sub> ) | Extinguishment<br>Safety (S <sub>2</sub> ) | People Movement<br>Safety (S <sub>3</sub> ) | General<br>Safety (S₄) |  |  |  |
| 1. Construction                        | 0                                       | O  |   | 0                      |  |  |  |
| Interior Finish     (Corr. and Exit)   | 3                                       |  | 3   | 3                      |  |  |  |
| 3. Interior Finish (Rooms)             | 3                                       |  |   | 3                      |  |  |  |
| 4. Corridor Partitions/Walls           | 1                                       |  |   | -                      |  |  |  |
| 5. Doors to Corridor                   | 1                                       |  | 1   | J                      |  |  |  |
| 6. Zone Dimensions                     |   |  | -2  | -2                     |  |  |  |
| 7. Vertical Openings                   | 0                                       |  | 0   | 0                      |  |  |  |
| 8. Hazardous Areas                     | O                                       | 0  |   | 0                      |  |  |  |
| 9. Smoke Control                       |   |  | -5  | -5                     |  |  |  |
| 10. Emergency Movement Routes          |   |  | 0   | $\circ$                |  |  |  |
| 11. Manual Fire Alarm                  |   | 2  |   | 2                      |  |  |  |
| 12. Smoke Detection and Alarm          |   | 3  | 3   | 3                      |  |  |  |
| 13. Automatic Sprinklers               | lo                                      | 10   | 10 ÷2=5                                     | 10                     |  |  |  |
| Total Value                            | S1= 18                                  | S2=15                                      | S <sub>3=</sub> 5                           | S4= 16                 |  |  |  |

| MANDATORY S                            | AFETY REQUIF |        | LE 6.<br>R USE IN HOSF | PITALS OR NU | RSING HOMES            | S)     |
|--|--------------|--------|------------------------|--------------|------------------------|--------|
| Containment (Sa)                       |              |        | Extinguis<br>(St       |              | People Movemen<br>(Sc) |        |
| Zone Location                          | New          | Exist. | New                    | Exist.       | New                    | Exist. |
| ਬ story                                | (11)         | 5      | 15(12)a)               | 4            | 8(5) <sup>a</sup> )    | 1      |
| <sup>™</sup> or 3rd story <sup>b</sup> | 15           | 9      | 17(14) <sup>a</sup>    | 6            | 10(7)ª                 | 3      |
| th 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 2<sup>nd</sup> 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: Sa=7, Sb=10, and Sc=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 Sa, Sb, and Sc 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 EQL | JIVALENCY EVALUATION   | Yes | No |
|--|-------|--|------------|--|-----|----|
| Containment<br>Safety (S <sub>1</sub> )    | minus | Mandatory<br>Containment (S <sub>4</sub> ) | ≥ 0        | $\begin{array}{c c} S_1 & S_8 & C \\ \hline 18 & -11 & = 7 \end{array}$                  | 1   |    |
| Extinguishment<br>Safety (S <sub>2</sub> ) | minus | Mandatory<br>Extinguishment (S₀)           | ≥ 0        | $\begin{array}{c ccccccccccccccccccccccccccccccccccc$                                    | 1   |    |
| People Movement<br>Safety (S₃)             | minus | Mandatory People<br>Movement (S₊)          | ≥ 0        | S <sub>3</sub> S <sub>6</sub> P S <sub>7</sub> = O                                       | 1   |    |
| General<br>Safety (S <sub>4</sub> )        | minus | Occupancy<br>Risk (R)                      | ≥ 0        | $\begin{array}{c c} S_4 & R & G \\ \hline J_b & - \boxed{J_1} & = \boxed{5} \end{array}$ | 1   |    |

|          | TABLE 8. FACILITY FIRE SAFETY REQUIREMENTS WORKSHEET  | Γ   |            |                |
|----------|---|-----|------------|----------------|
| Co<br>Fo | mplete one copy of this worksheet for each facility. r each consideration, select and mark the appropriate column.  | Met | Not<br>Met | Not<br>Applic. |
| A.       | Building utilities conform to the requirements of Section 9.1.  | 1   |            | Joseph Company |
| 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.  | 1   |            |                |
| 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. | 1   |            |                |
| D.       | Fuel-burning space heaters and portable electrical space heaters are not used.  | J   |            | To the first   |
| E.       | There are no flue-fed incinerators.   | 1   |            |                |
| 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.  | 1   | - 7        |                |
| G.       | Smoking regulations have been adopted and implemented in accordance with 18.7.4 and 19.7.4.   | 1   |            |                |
| H.       | Draperies, upholstered furniture, mattresses, furnishings, and decoration combustibility is limited in accordance with 18.7.5 and 19.7.5.   | 1   |            | 1000           |
| I.       | Fire extinguishers are provided in accordance with the requirements of 18.3.5.4 and 19.3.5.6.   | J   |            | V              |
| J.       | Exit signs are provided in accordance with the requirements of 18.2.10.1 and 19.2.10.   | 7   |            |                |
| K.       | Emergency lighting is provided in accordance with 18.2.9.1 or 19.2.9.   | 1   |            |                |
| L.       | Standpipes are provided in all new high rise buildings as required by 18.4.2.   |     |            | 1              |

# CONCLUSIONS 1. All of the checks in Table 7 are in the "Yes" column. The level of fire safety is at least equivalent to that prescribed by the Life Safety Code.\* 2. One of more of the checks in Table 7 are in the "No" column. The level of fire safety is not shown by this system to be equivalent to that prescribed by the Life Safety Code.\* \*The equivalency covered by this worksheet includes the majority of considerations covered by the Life Safety Code. There are a few considerations that are not evaluated by this method. These must be considered separately. These additional considerations are covered in Table 8, the "Facility Fire Safety Requirements Worksheet." One copy of this separate worksheet is to be completed for each facility.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0838-0242. The time required to complete this information collection is estimated to average 5 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, Attn: PRA Reports Clearance Officer, 7500 Security Bouleverd, Baltimore, Maryland 21244-1850.

|      |   |    |   | OMB Exempt |
|------|---|----|---|------------|
| ZONE | L | OF | 4 | ZONES      |

|              |                 |                      | The second secon |            |
|--------------|-----------------|----------------------|--|------------|
| FIRE/SMOKE Z | ONE* EVALUATION | <b>WORKSHEET FOR</b> | R HEALTH CARE  | FACILITIES |

|   | 2000 LIFE SAFETY CODE                              |
|---|--|
| FACILITY LIFECARE GREENBUSH MAHOR   | BUILDING OZ-GREENBUSH MANOR                        |
| ZONE(S) EVALUATED SUPPORT SERVICES WING                                     |  |
| PROVIDER/VENDOR NO. 245616  | DATE OF SURVEY O1/22/2016                          |
| COMPLETE THIS WORKSHEET FOR EACH ZONE. WORKSHEET CAN BE USED FOR THOSE ZONI | HERE CONDITIONS ARE THE SAME IN SEVERAL ZONES, ES. |

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    | Y RISK PARAMI       | ETER FACTO                         | ORS                                  |                     |  |
|---------------------------|------------------------------|-----------------|---------------------|------------------------------------|--------------------------------------|---------------------|--|
| Risk Parameters           |                              | Risk F          | actors Values       |                                    |                                      |                     |  |
| 1. Patient                | Mobility Status              | Mobile          | Limited M           | obility                            | Not Mobile                           | Not Movable         |  |
| Mobility (M)              | Risk Factor                  | 1.0             | 1.6                 | 1.6                                |                                      | 4.5                 |  |
| 2. Patient                | No. of Patients              | 1–5             | 6–10                | )                                  | 1130                                 | >30                 |  |
| Density (D)               | Risk Factor                  | 1.0             | (1.2                | )                                  | 1.5                                  | 2.0                 |  |
| 3. Zone                   | Floor                        | 14              | 2º or 3º            | 4 <sup>th</sup> to 6 <sup>th</sup> | 7 <sup>th</sup> and Above            | Basements           |  |
| Location (L.)             | Risk Factor                  | (1.1)           | 1.2                 | 1.4                                | 1.6                                  | 1.6                 |  |
| 4. Ratio of Patients to   | <u>Patients</u><br>Attendant | <u>1-2</u><br>1 | <u>3–5</u><br>1     | <u>6–10</u><br>1                   | <u>&gt;10</u><br>1                   | One or More<br>None |  |
| Attendants (T)            | Risk Factor                  | 1.0             | 1.1                 | (1.2)                              | 1.5                                  | 4.0                 |  |
| 5. Patient                | Age                          | Under 65 Ye     | ars and Over 1 year | 65                                 | 65 Years and Over 1 Year and Younger |                     |  |
| Average<br>Age <i>(A)</i> | 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. OCC   | UPANC      | Y RISK     | FACTOR | CALCU      | LATION    |     |
|----------------|------------|------------|--------|------------|-----------|-----|
| OCCUPANCY RISK | M<br>3,2 × | D<br>1.2 x | (.) x  | T<br>1.2 x | A [1.2] = | 6.1 |

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

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

B. Transfer the value of F from Table 2 to Table 3A or Table 3B as appropriate. Calculate R.C. Transfer R to the block labeled R in Table 7 on page 4 of the work sheet.

| TABLE 3A. (NEW BUILDINGS)   | TABLE 3B. (EXISTING BUILDINGS) |
|---|--------------------------------|
| 1.0 x $\begin{bmatrix} 6.1 \\ 6.1 \end{bmatrix} = \begin{bmatrix} 6.1 \\ 6.1 \end{bmatrix} = 7$ | 0.6 x = =                      |

| * FIRE/SMOKE ZONE is a space separated from all other spaces by floors, norizontal exits, or smoke partiers. |                 |            |  |  |  |  |  |  |
|--|-----------------|------------|--|--|--|--|--|--|
| SURVEYOR SIGNATURE ROBERT RESOURCES, LLC   | TITLE PRESIDENT | O1/22/2016 |  |  |  |  |  |  |
| Thomas Linhoff 12424   | Supervisor      | 02-18-2016 |  |  |  |  |  |  |

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

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.

|   |                               |  | TAI                   | BLE 4.         |                                   |                            |                               |                         |  |  |
|---|-------------------------------|--|-----------------------|----------------|-----------------------------------|----------------------------|-------------------------------|-------------------------|--|--|
| Safety Parameters                         |                               |  | S                     | Safety Paran   | neters V                          | alues                      |                               |                         |  |  |
| 1. Construction                           | Тур                           | Combustible<br>Types III, IV, and V  |                       |                |                                   |                            | NonCombustible Types i and II |                         |  |  |
| Floor or Zone                             | 000                           | 111  | 200                   | ) 211 +        | 2HH                               | 000                        | 111                           | 222, 332, 43            |  |  |
| First                                     | -2                            | 0  | -2                    | C              |                                   | 0                          | 2                             | 2                       |  |  |
| Second                                    | -7                            | -2   | -4                    | -2             | 2                                 | -2                         | 2                             | 4                       |  |  |
| Third                                     | -9                            | -7   | -9                    | -7             |                                   | -7                         | 2                             | 4                       |  |  |
| 4th and Above                             | -13                           | :+7  | -13                   | -              | 7                                 | -9                         | -7                            | 4                       |  |  |
| Interior Finish     (Corridors and Exits) | Class C<br>-5(0) <sup>†</sup> | Class<br>0(3   |                       | Clas           | ss A                              |                            |                               |                         |  |  |
| 3, Interior Finish                        | Class C                       | Class  | , B                   |                | ss A                              | -                          |                               |                         |  |  |
| (Rooms)                                   | -3(1) <sup>r</sup>            | 1(3  |                       |                | 3)                                |                            |                               |                         |  |  |
| 4. Corridor Partitions/Walls              | None or Incomplete            | <1/2 he  |                       |                | <1 hour                           |                            | ≥1 hour<br>2(0)ª              | WIII                    |  |  |
| 5. Doors to Corridor                      | No Door                       | <20 mln  | FPR                   | ≥20 mi         | in FPR                            | ≥20 min FPR and Auto Clos. |                               |                         |  |  |
|   | -10                           | 0  |                       | 1              | ) <sup>d</sup>                    |                            | 2(0) <sup>d</sup>             |                         |  |  |
| 6. Zone Dimensions                        |                               | Dead End   |                       |                |                                   |                            | d Ends >30 ft and             | Zone Length Is          |  |  |
|   | >100 ft                       | The second secon |                       | 30 ft to 50 ft |                                   | 50 ft                      | 100 ft to 150 ft              | <100 ft                 |  |  |
|   | -6(0) <sup>b</sup>            | -4(0)b   |                       | -2(0)b         | (-2)                              | (0)°                       | 0                             | 1                       |  |  |
| 7. Vertical Openings                      | Open 4 or More                |  | Open 2 or 3<br>Floors |                |                                   |                            | h Indicated Fire Re           |                         |  |  |
|   | Floors                        |  |                       |                | hr                                | ≥:                         | 1 hr to <2 hr                 | ≥2 hr                   |  |  |
|   | -14                           | -10  | )                     |                | 0                                 |                            | 2(0)3)                        | 3(0)°                   |  |  |
| 8. Hazardous Areas                        |                               | Deficiency   |                       |                |                                   | Deficiency                 |                               | No Deficiencies         |  |  |
|   | In Zone                       | Outside  |                       |                | In Zone                           |                            | Adjacent Zone                 |                         |  |  |
|   | -11                           | -5   |                       |                | -6                                |                            | -2                            | (0)                     |  |  |
| 9. Smoke Control                          | No Control                    | Smoke 6<br>Serves  |                       | ×              | Mech. Assisted Systems<br>by Zone |                            | tems                          |                         |  |  |
|   | (-5(0)°                       | 0  |                       | 1              |                                   | 3                          |                               |                         |  |  |
| 10. Emergency                             | <2 Routes                     | -  |                       |                | Multi                             | ple Routes                 |                               |                         |  |  |
| Movement<br>Routes                        |                               | Defici   | ent                   |                | iorizontal<br>kit(s)              |                            | Horizontal<br>Exit(s)         | Direct Exit(s)          |  |  |
|   | -8                            | -2   |                       |                | 0)                                |                            | . 1                           | 5                       |  |  |
| 11. Manual Fire Alarm                     | No Man                        | ıal Fire Alarm   |                       |                | Manu                              | al Fire Alai               | rm                            |                         |  |  |
|   |                               |  |                       | W/O F.         | D. Conn.                          | V                          | WF.D. Conn                    |                         |  |  |
|   |                               | -4   |                       |                | 1                                 |                            | (2)                           |                         |  |  |
| 12. Smoke Detection and Alarm             | None                          | Corridor   | Only                  | Roon           | ıs Only                           |                            | orridor and<br>bit. Spaces    | Total Spaces<br>In Zone |  |  |
|   | 0(3) <sup>9</sup>             | 2(3)   | ) <sup>g</sup>        | 3              | (3) <sup>g</sup>                  |                            | (4)                           | 5                       |  |  |
| 13. Automatic<br>Sprinklers               | None                          | Corrido<br>Habit, S  |                       |                | ntire<br>Iding                    |                            |                               |                         |  |  |
|   | 0                             | 8  |                       | (              | 10)                               |                            |                               |                         |  |  |

For Si units: 1 ft = 0,3048 m

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

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

<sup>&</sup>lt;sup>c</sup> Use (0) on floor with fewer than 31 patients (existing buildings only)

<sup>&</sup>lt;sup>d</sup> Use (0) where parameter 4 is -10.

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.

 $<sup>^{\</sup>mathbf{q}}$  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<sub>1</sub>, S<sub>2</sub>, S<sub>3</sub>, S<sub>6</sub> to blocks labeled S<sub>1</sub>, S<sub>2</sub>, S<sub>3</sub>, S<sub>6</sub> in Table 7 on page 4 of this sheet.

| TABLE 5. INDIVIDUAL SAFETY EVALUATIONS |   |  |   |                        |  |  |  |  |  |
|--|---|--|---|------------------------|--|--|--|--|--|
| Safety Parameters                      | Containment<br>Safety (S <sub>1</sub> ) | Extinguishment<br>Safety (S <sub>2</sub> ) | People Movement<br>Safety (S <sub>3</sub> ) | General<br>Safety (S4) |  |  |  |  |  |
| 1. Construction                        | 0                                       | 0  |   | 0                      |  |  |  |  |  |
| Interior Finish     (Corr. and Exit)   | 3                                       |  | 3   | 3                      |  |  |  |  |  |
| 3. Interior Finish (Rooms)             | 3                                       |  | 7000  | 3                      |  |  |  |  |  |
| 4. Corridor Partitions/Walls           | I                                       |  |   | 1                      |  |  |  |  |  |
| 5. Doors to Corridor                   | 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   | l <sub>t</sub> .       |  |  |  |  |  |
| 13. Automatic Sprinklers               | 10                                      | 10   | 10 ÷2=5                                     | 10                     |  |  |  |  |  |
| Total Value                            | S1= 18                                  | S2= 1(o                                    | S3= ( <sub>0</sub>                          | S4= \ ]                |  |  |  |  |  |

| MANDATORY S                               | AFETY REQUI |               | LE 6.<br>R USE IN HOSE | PITALS OR N | JRSING HOMES                         | 3)     |
|---|-------------|---------------|------------------------|-------------|--------------------------------------|--------|
|   |             | inment<br>Sa) | Extingui<br>(S         |             | People Movement<br>(S <sub>c</sub> ) |        |
| Zone Location                             | New         | Exist.        | New                    | Exist.      | New                                  | Exist. |
| 1 <sup>st</sup> story                     | (1)         | 5             | 15(12) <sup>a</sup> )  | 4           | 8(5) <sup>8</sup> )                  | 1      |
| 2 <sup>rd</sup> or 3rd story <sup>b</sup> | 15          | 9             | 17(14)ª                | 6           | 10(7)ª                               | 3      |
| 4 <sup>th</sup> story or higher           | 18          | 9             | 19(16)ª                | 6           | 11(8) <sup>a</sup>                   | 3      |

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

b. For a 2<sup>nd</sup> 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<sub>d</sub>=7, S<sub>D</sub>=10, and S<sub>D</sub>=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 Sa, Sb, and Sc 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 EQU | JIVALENCY EVALUATION  | Yes | No |
|---|-------|-----------------------------------|------------|---|-----|----|
| Containment<br>Safety (S <sub>1</sub> )     | minus | Mandatory<br>Containment (S₄)     | ≥ 0        | $\begin{bmatrix} S_1 & S_a \\ IQ & - II \end{bmatrix} = \begin{bmatrix} C \\ 7 \end{bmatrix}$                                       | 1   |    |
| Extinguishment<br>Safety (S <sub>2</sub> )  | minus | Mandatory<br>Extinguishment (S₀)  | ≥ 0        | $\begin{bmatrix} S_2 \\ I_{10} \end{bmatrix} - \begin{bmatrix} S_b \\ I_{2} \end{bmatrix} = \begin{bmatrix} E \\ L_1 \end{bmatrix}$ | 1   |    |
| People Movement<br>Safety (S <sub>3</sub> ) | minus | Mandatory People<br>Movement (S₀) | ≥ 0        | $\begin{bmatrix} S_3 & S_c \\ S & - S_c \end{bmatrix} = \begin{bmatrix} P \\ S \end{bmatrix}$                                       | 1   |    |
| General<br>Safety (S <sub>4</sub> )         | minus | Occupancy<br>Risk (R)             | ≥ 0        | $\begin{bmatrix} S_4 \\ I \end{bmatrix} - \begin{bmatrix} R \\ I \end{bmatrix} = \begin{bmatrix} G \\ I \end{bmatrix}$              | 1   |    |

|          | TABLE 8. FACILITY FIRE SAFETY REQUIREMENTS WORKSHEET  | Г   |            |               |
|----------|---|-----|------------|---------------|
| Co<br>Fo | mplete one copy of this worksheet for each facility. reach consideration, select and mark the appropriate column.   | Met | Not<br>Met | Not<br>Applic |
| A.       | Building utilities conform to the requirements of Section 9.1.  | J   |            | DOWN THE      |
| 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.  | 1   |            |               |
| 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. | 1   |            |               |
| D.       | Fuel-burning space heaters and portable electrical space heaters are not used.  | 1   |            | 100 Paris     |
| E.       | There are no flue-fed incinerators.   | J   |            |               |
| 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.  | 1   |            |               |
| G.       | Smoking regulations have been adopted and implemented in accordance with 18.7.4 and 19.7.4.   | J   |            |               |
| H.       | Draperies, upholstered furniture, mattresses, furnishings, and decoration combustibility is limited in accordance with 18.7.5 and 19.7.5.   | 1   |            |               |
| _l,      | Fire extinguishers are provided in accordance with the requirements of 18.3.5.4 and 19.3.5.6.   | 1   |            | Maria Maria   |
| J,       | Exit signs are provided in accordance with the requirements of 18.2,10.1 and 19.2,10.   | 1   |            |               |
| 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.   |     |            |               |

## 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.

CONCLUSIONS

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



### 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 <u>only a suggestion</u> 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 <a href="http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm">http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm</a>. 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

Lifecare Greenbush Manor January 15, 2016 Page 2

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

PRINTED: 02/23/2016 FORM APPROVED

(X6) DATE

Minnesota Department of Health

|                          | IT OF DEFICIENCIES<br>OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  | (X2) MULTIPLE CONSTRUCTION  A. BUILDING: |  |       | (X3) DATE SURVEY<br>COMPLETED |  |
|--------------------------|--|---|--|--|-------|-------------------------------|--|
|                          |  |   | A. BOILDING.                             |  |       |                               |  |
|                          |  | 00578N  | B. WING                                  |  | 01/0  | 7/2016                        |  |
| NAME OF                  | PROVIDER OR SUPPLIER   |   | , ,                                      | STATE, ZIP CODE  |       |                               |  |
| LIFECAF                  | RE GREENBUSH MAN   | IOR   | )TH STREET<br>JSH, MN 56                 |  |       |                               |  |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY   | TEMENT OF DEFICIENCIES<br>/ MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG                      | PROVIDER'S PLAN OF CORRECTI<br>(EACH CORRECTIVE ACTION SHOUI<br>CROSS-REFERENCED TO THE APPRO<br>DEFICIENCY) | _D BE | (X5)<br>COMPLETE<br>DATE      |  |
| 2 000 Initial Comments   |  |   | 2 000                                    |  |       |                               |  |
|                          | ****ATTE   | NTION*****  |  |  |       |                               |  |
|                          | NH LICENSING   | CORRECTION ORDER  |  |  |       |                               |  |
|                          | 144A.10, this correpursuant to a surve found that the deficiency found that the deficiency form of corrected shall with a schedule of the Minnesota Deposition of the Minnesota Deposition of the Minnesota MN Rumber and MN Rumber and MN Rumber and MN Rumber and MN Rumber arule contain comply with any of lack of compliance. re-inspection with a result in the assess | hether a violation has been   |  |  |       |                               |  |
|                          | that may result fron<br>orders provided tha<br>the Department wit  | hearing on any assessments<br>n non-compliance with these<br>at a written request is made to<br>hin 15 days of receipt of a<br>ent for non-compliance.                      |  |  |       |                               |  |
|                          | receipt of State lice<br>the Minnesota Dep<br>Informational Bullet<br>http://www.health.s  | participate in the electronic<br>nsure orders consistent with<br>artment of Health<br>tin 14-01, available at<br>tate.mn.us/divs/fpc/profinfo/inf<br>e licensing orders are |  |  |       |                               |  |

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

01/25/16 **Electronically Signed** 

TITLE

STATE FORM 6899 If continuation sheet 1 of 19 QSNS11

| STATEMEN      | NT OF DEFICIENCIES<br>OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:   |               |   |      | SURVEY<br>LETED  |
|---------------|---|--|---------------|---|------|------------------|
|               |   | 00578N   | B. WING       |   | 01/0 | 7/2016           |
| NAME OF       | PROVIDER OR SUPPLIER  | STREET ADI   |               | STATE, ZIP CODE   |      |                  |
| LIFECAF       | RE GREENBUSH MAN  | IOR  | TH STREET     |   |      |                  |
| (X4) ID       | SUMMARY STA   | TEMENT OF DEFICIENCIES   | JSH, MN 56    | PROVIDER'S PLAN OF CORRECTION   | ON.  | (X5)             |
| PREFIX<br>TAG | (EACH DEFICIENCY  | MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)   | PREFIX<br>TAG | (EACH CORRECTIVE ACTION SHOUL<br>CROSS-REFERENCED TO THE APPRO<br>DEFICIENCY) | D BE | COMPLETE<br>DATE |
| 2 000         | Continued From pa   | ge 1   | 2 000         |   |      |                  |
|               | you electronically. is necessary for State enter the word "context. You must then State licensure procompletion date, the corrected prior to e Minnesota Department's provider and the folissued. Please indicorrection that you and identify the date. Minnesota Department's the State Licensing federal software. Ta | n, 6th, and 7th 2016, surveyors is staff, visited the above lowing correction orders are locate in your electronic plan of have reviewed these orders, is when they will be completed. The ent of Health is documenting Correction Orders using ag numbers have been |               |   |      |                  |
|               | Nursing Homes.  The assigned tag n column entitled "ID"   | umber appears in the far left<br>Prefix Tag." The state<br>ompliance is listed in the  |               |   |      |                  |
|               | "Summary Stateme<br>and replaces the "T<br>correction order. The<br>findings which are in<br>after the statement,<br>evidence by." Follow   | ent of Deficiencies" column o Comply" portion of the nis column also includes the n violation of the state statute , "This Rule is not met as wing the surveyors findings Method of Correction and   |               |   |      |                  |
|               | FOURTH COLUMN<br>"PROVIDER'S PLA<br>APPLIES TO FEDE   | RD THE HEADING OF THE<br>N WHICH STATES,<br>N OF CORRECTION." THIS<br>ERAL DEFICIENCIES ONLY.<br>R ON EACH PAGE.   |               |   |      |                  |

6899

Minnesota Department of Health STATE FORM

QSNS11 If continuation sheet 2 of 19

|                          | TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  |  |   | E CONSTRUCTION   | (X3) DATE<br>COMF | SURVEY<br>PLETED         |
|--------------------------|--|--|---|--|-------------------|--------------------------|
|                          |  | 00578N   | B. WING                                   |  | 01/0              | 7/2016                   |
|                          | PROVIDER OR SUPPLIER   | 19120 200  | DRESS, CITY, S<br>TH STREET<br>JSH, MN 56 |  |                   |                          |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY   | TEMENT OF DEFICIENCIES<br>' MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG                       | PROVIDER'S PLAN OF CORRECTI<br>(EACH CORRECTIVE ACTION SHOUL<br>CROSS-REFERENCED TO THE APPRO<br>DEFICIENCY) | D BE              | (X5)<br>COMPLETE<br>DATE |
| 2 000                    | Continued From pa  | ge 2   | 2 000                                     |  |                   |                          |
|                          | PLAN OF CORREC   | QUIREMENT TO SUBMIT A<br>CTION FOR VIOLATIONS OF<br>E STATUTES/RULES.  |   |  |                   |                          |
| 2 565                    | MN Rule 4658.0405<br>Plan of Care; Use   | 5 Subp. 3 Comprehensive  | 2 565                                     |  |                   | 2/15/16                  |
|                          |  | omprehensive plan of care personnel involved in the .  |   |  |                   |                          |
|                          | by: Based on observati review, the facility fa walker exercise pro plan for 1 of 1 resid rehabilitation and fa assistance for 1 of 3 | ent is not met as evidenced on, interview and document ailed to provide a platform gram as directed by the care ent (R44) reviewed for ailed to provide toileting 3 residents (R14) who tance to toilet as directed by |   | Corrected  |                   |                          |
|                          | Findings include:  |  |   |  |                   |                          |
|                          |  | the recommended elevated r (EVA) standing program as e plan.   |   |  |                   |                          |
|                          | indicated R44 had i<br>related to chronic p<br>hemiparesis (weaki  | ity care plan dated 11/17/15,<br>mpaired physical mobility<br>ain, diabetic complications, left<br>ness or paralysis on one side   |   |  |                   |                          |

Minnesota Department of Health

STATE FORM G899 QSNS11 If continuation sheet 3 of 19

| STATEME                  | NT OF DEFICIENCIES<br>I OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:   | ` '                                       | E CONSTRUCTION | (X3) DATE SURVEY<br>COMPLETED |  |      |                          |
|--------------------------|---|--|---|----------------|-------------------------------|--|------|--------------------------|
|                          |   | 00578N   | B. WING                                   |                | 01/0                          | 7/2016   |      |                          |
|                          | PROVIDER OR SUPPLIER  | 19120 200  | ORESS, CITY, S<br>TH STREET<br>JSH, MN 56 |                |                               |  |      |                          |
| (X4) ID<br>PREFIX<br>TAG | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)  |  | (EACH DEFICIENCY MUST BE PRECEDED BY FULL |                | ID<br>PREFIX<br>TAG           | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIED TO THE | D BE | (X5)<br>COMPLETE<br>DATE |
| 2 565                    | for all activities of directed staff to cormotion to left upper right upper extremit week and standing walker with assist of a goal of 5-10 minut.  On 1/7/16, at 9:52 a stated R44 had not platform walker since habilitation progra NA-C stated since added to the prograthe platform walker R44 had not been of the Nursing Assist Recreational Programom 3-5 x's week, bicycle 2-3 x's week, bicycle 2-3 x's week the recommended week.  On 1/06/16, at 10:1 who was also a nur to wheel a mechan room, return and wand bear weight with no feeling in the left assisted to a standing on 1/7/16, at 10:58 stand on the elevat previous facility but here. R44 stated it had been taken to the standing of the left assisted to a standing of | aily living. The care plan implete passive range of extremities 3-5 times a week, by use yellow band 3-5 x's program with EVA platform if two staff 3-5 x's per week for tes.  a.m. nursing assistant (NA)-C been using the standing be NA-C had taken over the am the first of December. The recumbent stepper was am on 10/16/15, she thought was discontinued therefore doing it.  ant Daily Cares Record and am Forms included R44's Thera band exercises and the kanner band exercises and the ka | 2 565                                     |                |                               |  |      |                          |

Minnesota Department of Health

STATE FORM G899 QSNS11 If continuation sheet 4 of 19

| -                        | STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:   |   | (X2) MULTIPLE CONSTRUCTION  A. BUILDING:   |  |       | (X3) DATE SURVEY<br>COMPLETED |  |
|--------------------------|--|---|--|--|-------|-------------------------------|--|
|                          |  | 00578N  | B. WING                                    |  | 01/0  | 7/2016                        |  |
|                          | PROVIDER OR SUPPLIER   | 19120 200   | DRESS, CITY, S<br>OTH STREET<br>JSH, MN 56 |  |       |                               |  |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY   | TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG                        | PROVIDER'S PLAN OF CORRECTI<br>(EACH CORRECTIVE ACTION SHOUL<br>CROSS-REFERENCED TO THE APPRO<br>DEFICIENCY) | LD BE | (X5)<br>COMPLETE<br>DATE      |  |
| 2 565                    | platform walker bed stronger.  On 1/07/2016, at 11 (PT) stated her expassisted with the EV On 1/07/2016, at 11 nursing (DON) verificated by platform exerciplan.  R14 was not provided directed by the care minutes on the more minutes on the more staff for toileting indicated R14 required one staff for toileting bladder daily, but we plan directed staff to fregular panties.  On 1/6/16, from 7:1 was observed seater oom table. During and consumed her -At 8:16 a.m. R14 we heading towards ov -At 8:21 a.m. R14 or proceeded to look from the glasses. | cause it would help keep her  2:11 a.m. the physical therapist ectation was for R44 to be VA platform walker as directed.  2:40 a.m. the director of fied R44 had not received the ise as directed by the care  ed assistance with toileting as e plan for four hours and 25 ming of 1/6/16.  red 10/28/15, directed staff to oiding before and after meals, ht. In addition, the care plan red extensive assistance of g and was incontinent of ill void in toilet also. The care o utilize pull up briefs in place  5 a.m. until 8:16 a.m. R14 ed in a wheelchair at the dining this time, R14 had received breakfast meal. wheeled out of the dining room wn room. | 2 565                                      |  |       |                               |  |
|                          |  | d. R14 was not offered or e toilet nor was R14's  |  |  |       |                               |  |

Minnesota Department of Health

STATE FORM G899 QSNS11 If continuation sheet 5 of 19

|  | STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  |  | ` '   | E CONSTRUCTION | (X3) DATE SURVEY<br>COMPLETED                                  |       |                          |
|--|--|--|---|----------------|--|-------|--------------------------|
| L CONTRACTOR L S WING  |  |  |   |                |  |       |                          |
| UU5/8N B. WING 01/07/201   |  |  | 00578N  | B. WING        |  | 01/0  | 7/2016                   |
| NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE   | AME OF PROVID  | ROVIDER OR SUPPLIEF  |   | , ,            | ,  |       |                          |
| LIFECARE GREENBUSH MANOR  19120 200TH STREET  GREENBUSH, MN 56726  | IFECARE GR   | GREENBUSH MA   | ANOR  |                |  |       |                          |
| PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COM  | PRÉFIX   | (EACH DEFICIENC  | CY MUST BE PRECEDED BY FULL   | PREFIX         | (EACH CORRECTIVE ACTION SHOUL<br>CROSS-REFERENCED TO THE APPRO | LD BE | (X5)<br>COMPLETE<br>DATE |
| 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 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 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 | incorchant until enter-At 1 out of ambordant committee and ambordant committee | incontinent brief changed. R14 was until 11:34 a.m. whentered the room-At 11:34 a.m. the out of bed and proambulate in the hard and the might have to. R1-room and into the R14's brief was word that a strong urine On 1/6/16, at 1:12 not offered or take bed and had not be she was assisted NA-B stated R14 where plan directed before and after meded to use On 1/6/16, at 3:00 care plan directed before and after mevery 2-3 hours if The DON verified followed.  On 1/7/16, at 11:4 for following the case of the Director of National Suggested NA-B stated R14 where plan directed before and after mevery 2-3 hours if The DON verified followed.  On 1/7/16, at 11:4 for following the case of the Director of National R14 was until 11:4 for following the case of the Director of National R15 was until 11:4 for following the case of the Director of National R15 was until 11:4 for following the case of the Director of National R15 was until 11:4 for following the case of the Director of National R15 was until 11:4 for following the case of the Director of National R15 was until 11:4 for following the case of the Director of National R15 was until 11:4 for following the case of the Director of National R15 was until 11:4 for following the case of the Director of National R15 was until 11:4 for following the case of the Director of National R15 was until 11:4 for following the C15 w | checked for incontinence or s observed to remain in bed hen the physical therapist to complete an evaluation. It is physical therapist assisted R14 oceeded to assist R14 to allway. It therapist asked R14 if she is bathroom. R14 stated she is bathroom. R14 did void and ret and had a strong urine smell. If it is is incertain the toilet before going to be to the toilet before going to be taken to the toilet since out of bed over four hours prior. It is would have told the NA if she he bathroom before she was be the toilet.  In p.m. the DON confirmed R14's it is the toilet.  In p.m. the DON confirmed R14's it is the toilet.  In p.m. the DON confirmed R14's it is the toilet.  In p.m. the DON confirmed R14's it is the toilet.  In p.m. the DON stated a policy are plan could not be found. | 2 565          |  |       |                          |

Minnesota Department of Health

STATE FORM G899 QSNS11 If continuation sheet 6 of 19

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                                    |  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:   | (X2) MULTIPLE CONSTRUCTION A. BUILDING: |  | (X3) DATE SURVEY<br>COMPLETED           |         |
|--|--|--|---|--|---|---------|
|  |  |  |   |  |   |         |
| 00578N   |  | B. WING  |   | 01/0   | 01/07/2016                              |         |
| NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE  19120 200TH STREET |  |  |   |  |   |         |
| LIFECARE GREENBUSH MANOR  GREENBUSH, MN 56726  |  |  |   |  |   |         |
| (X4) ID<br>PREFIX<br>TAG   | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)   |  | ID<br>PREFIX<br>TAG                     | PROVIDER'S PLAN OF CORRECTI<br>(EACH CORRECTIVE ACTION SHOUL<br>CROSS-REFERENCED TO THE APPRO<br>DEFICIENCY) | E ACTION SHOULD BE O TO THE APPROPRIATE |         |
| 2 565  | Continued From page 6  |  | 2 565                                   |  |   |         |
|  | 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.  |  |   |  |   |         |
| 2 910  | MN Rule 4658.0525 Subp. 5 A.B Rehab - Incontinence   |  | 2 910                                   |  |   | 2/15/16 |
|  | have a continuous management to recunnecessary use or comprehensive reshome must ensure  A. a resident without an indwellinunless the resident that catheterization  B. a resident with receives appropriate prevent urinary trace   | nce. A nursing home must program of bowel and bladder duce incontinence and the f catheters. Based on the ident assessment, a nursing that: ho enters a nursing home in a catheter is not catheterized is clinical condition indicates was necessary; and into is incontinent of bladder the treatment and services to it infections and to restore as the function as possible. |   |  |   |         |
|  | by: Based on observative review the facility factorial assistance according to the control of th | ent is not met as evidenced ion, interview and document ailed to provide timely toileting ng to the assessed need for 1 ) reviewed for toileting.  |   | Corrected  |   |         |
|  | Findings include:  |  |   |  |   |         |

6899

Minnesota Department of Health STATE FORM

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: |   | (X2) MULTIPL<br>A. BUILDING:   | E CONSTRUCTION                            | (X3) DATE SURVEY<br>COMPLETED  |        |                          |
|--|---|--|---|--|--------|--------------------------|
|  |   | 00578N   | B. WING                                   |  | 01/0   | 7/2016                   |
|  | PROVIDER OR SUPPLIER RE GREENBUSH MAN   | 19120 200  | ORESS, CITY, S<br>TH STREET<br>JSH, MN 56 |  |        |                          |
| (X4) ID<br>PREFIX<br>TAG   | (EACH DEFICIENCY  | TEMENT OF DEFICIENCIES<br>'MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG                       | PROVIDER'S PLAN OF CORRECT<br>(EACH CORRECTIVE ACTION SHOU<br>CROSS-REFERENCED TO THE APPRO<br>DEFICIENCY) | ILD BE | (X5)<br>COMPLETE<br>DATE |
| 2 910  | R14's quarterly Min 11/2/15, indicated F dementia. The MDS cognitively impaired one staff for transfer hygiene and was from R14's Urinary Incorn Assessment (CAA) had occasional streprompt voiding befor every 2-3 hours. R14's cognition, R1 between toileting tirincontinence if not passisted.  R14's Bowel and Bid dated 10/29/15, indurinary incontinence assist with transfers. The assessment into the toilet, had periodincontinent pads/brindicated there would plan.  R14's care plan dat prompt R14 to void activities and at nig indicated R14 requione staff for toileting bladder daily, but won the toilet. The capull up incontinent be panties.  On 1/6/16, from 7:1 was observed seated. | imum Data Set (MDS) dated<br>R14 was diagnosed with<br>S indicated R14 was<br>I, required extensive assist of<br>erring, toileting, personal<br>equently incontinent of urine. | 2 910                                     |  |        |                          |

Minnesota Department of Health

STATE FORM G899 QSNS11 If continuation sheet 8 of 19

| STATEMEN                 | NT OF DEFICIENCIES<br>OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  |                     |   | (X3) DATE<br>COMP | SURVEY<br>LETED          |
|--------------------------|--|--|---------------------|---|-------------------|--------------------------|
|                          |  | 00578N   | B. WING             |   | 01/0              | 7/2016                   |
| NAME OF I                | PROVIDER OR SUPPLIER   |  |                     | STATE, ZIP CODE   | 1 01/0            | 172010                   |
| LIFECAF                  | RE GREENBUSH MAN   | IOR  | TH STREET           |   |                   |                          |
|                          | T  |  | JSH, MN 56          |   |                   |                          |
| (X4) ID<br>PREFIX<br>TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)   |  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) |                   | (X5)<br>COMPLETE<br>DATE |
| 2 910                    | Continued From pa  | ge 8   | 2 910               |   |                   |                          |
|                          | heading towards ov-At 8:21 a.m. R14 eproceeded to look fhousekeeper was of the glassesAt 8:37 a.m. nursing R14's room and as not offered or prome R14's incontinent bor changed. R14 wountil 11:34 a.m. who entered the room to-At 11:34 a.m. the pout of bed and procambulate in the hall-At 11:40 a.m. the timeeded to use the kinght have to. R14 room and into the best R14's brief was well | wheeled out of the dining room wn room. Intered own room and or eye glasses. A observed to assist in finding ag assistant (NA)-B entered sisted R14 to bed. R14 was pted to use the toilet nor was rief checked for incontinence as observed to remain in bed en the physical therapist ocomplete an evaluation. Obysical therapist assisted R14 to lway. Interest asked R14 if she oathroom. R14 stated she was wheeled back to the eathroom. R14 did void and a with urine and had a strong erapist verified R14's brief was |                     |   |                   |                          |
|                          | not offered or taker<br>bed and had not be<br>she was assisted o<br>NA-B confirmed R1<br>assistance from 7:1<br>hours and 25 minut<br>would have told the<br>bathroom before sh  | p.m. NA-B verified R14 was a to the toilet before going to be taken to the toilet since out of bed over four hours prior. 4 was not provided toileting 5 a.m. until 11:40 a.m. (four tes). NA-B also stated R14 NA if she needed to go to the ne was assisted to bed, not asked if she needed to   |                     |   |                   |                          |
|                          | (DON) confirmed R  | o.m. the director of nursing<br>114's care plan directed staff to<br>ilet before and after meals   |                     |   |                   |                          |

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Minnesota Department of Health
STATEMENT OF DEFICIENCIES (X1)

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: |   |   |                         |  | SURVEY    |                          |
|---|---|---|-------------------------|--|-----------|--------------------------|
| ANDILAN   | OF CONTILCTION  | IDENTIFICATION NOMBER.  | A. BUILDING:            |  | COMPLETED |                          |
|   |   | 00578N B. WING 01/07/   |                         | 07/2016  |           |                          |
| NAME OF I   | PROVIDER OR SUPPLIER  | STREET AD   | DRESS, CITY, S          | STATE, ZIP CODE  |           |                          |
| LIFECAF   | RE GREENBUSH MAN  | IOR   | TH STREET<br>JSH, MN 56 |  |           |                          |
| (X4) ID<br>PREFIX<br>TAG  | (EACH DEFICIENC)  | NTEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG     | PROVIDER'S PLAN OF CORRECTI<br>(EACH CORRECTIVE ACTION SHOUI<br>CROSS-REFERENCED TO THE APPRO<br>DEFICIENCY) | _D BE     | (X5)<br>COMPLETE<br>DATE |
| 2 910   | Continued From pa   | ige 9   | 2 910                   |  |           |                          |
|   |   | een asked to toilet every 2-3<br>erified R14's care plan was not  |                         |  |           |                          |
|   | 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 FOI<br>(21) days.   | R CORRECTION: Twenty-one  |                         |  |           |                          |
| 2 915   | Subp. 6. Activities comprehensive reshome must ensure A. a resident is treatments and ser abilities in activities deterioration is a not the resident's cond part, activities of daresident's ability to:  (1) bathe, dres (2) transfer and (3) use the toi (4) eat; and (5) use speece   | given the appropriate vices to maintain or improve of daily living unless ormal or characteristic part of ition. For purposes of this aily living includes the ss, and groom; and ambulate; | 2 915                   |  |           | 2/15/16                  |

Minnesota Department of Health

|                          | STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  |  |                         |  |      | SURVEY<br>LETED          |
|--------------------------|---|--|-------------------------|--|------|--------------------------|
|                          |   | 00578N   | B. WING                 |  | 01/0 | 7/2016                   |
| NAME OF                  | PROVIDER OR SUPPLIER  | STREET ADI   | DRESS, CITY, S          | STATE, ZIP CODE  | •    |                          |
| LIFECAF                  | RE GREENBUSH MAN  | IOR  | TH STREET<br>JSH, MN 56 |  |      |                          |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY  | TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG     | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIED TO THE | D BE | (X5)<br>COMPLETE<br>DATE |
| 2 915                    | Continued From page 10  |  | 2 915                   |  |      |                          |
|                          | by: Based on observati review, the facility farm platform stand maintain or minimiz strength for 1 of 1 r reviewed for rehabi   | ent is not met as evidenced on, interview and document ailed to provide an elevateding program in order to the loss of lower extremity esident (R44) in the sample litation services.      |                         | Corrected  |      |                          |
|                          | 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). |  |                         |  |      |                          |
|                          | and signed by the p<br>8/25/15, indicated F<br>establish a rehabilit<br>recommendation in<br>extremity strengthe  | rvices Screening form dated obysical therapist (PT), on R44's mobility was screened to ation program. The cluded bilateral lower ning exercises 3-5 days per of motion (ROM) on right side |                         |  |      |                          |

Minnesota Department of Health

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:   |  | (X2) MULTIPLE<br>A. BUILDING:            | E CONSTRUCTION   |                                | (X3) DATE SURVEY<br>COMPLETED |  |
|--|--|--|--|--------------------------------|-------------------------------|--|
|  | 00578N   | B. WING                                  |  | 01/                            | 07/2016                       |  |
| LIFECARE GREENBUSH MANOR 19120 200   |  | DDRESS, CITY, S'DOTH STREET BUSH, MN 567 |  |                                |                               |  |
| PREFIX (EACH DEFICI  | STATEMENT OF DEFICIENCIES<br>NCY MUST BE PRECEDED BY FULL<br>OR LSC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG                      | PROVIDER'S PLAN OF C<br>(EACH CORRECTIVE ACTION<br>CROSS-REFERENCED TO THE<br>DEFICIENCY | ON SHOULD BE<br>IE APPROPRIATE | (X5)<br>COMPLETE<br>DATE      |  |
| and ankles, 3 s all transfers with recommended program with el (all brakes lock) 8-10 minutes 3-10 minutes 3-10 minutes was being screet. The recommenstepper 3x's a was 5-10 minutes with related to chroround left hemipal assistance of sith the care plan of exercise programinge of motion a week, right up x's week and st walker with assistance as a goal of 5-10 minutes with assistance of sith the care plan of exercise programinge of motion a week, right up x's week and st walker with assistance of 5-10 minutes with assistance of sith the care plan of exercise programinge of motion a week, right up x's week and st walker with assistance of 5-10 minutes with assistance of sith the care plan of exercise programinge of motion a week, right up x's week and st walker with assistance of sith the care plan of exercise programment as a goal of 5-10 minutes with assistance of sith the care plan of exercise programment as a goal of 5-10 minutes with assistance of sith the care plan of exercise programment as a goal of 5-10 minutes with assistance of sith the care plan of exercise programment as a goal of 5-10 minutes with assistance of sith the care plan of exercise programment as a goal of 5-10 minutes with assistance of sith the care plan of exercise programment as a goal of 5-10 minutes with assistance of sith the care plan of exercise programment as a goal of 5-10 minutes with a goal of 5 | sted on left side for hips, knees, ets of 10-15 repetitions. Perform assist of two. The PT also R44 participate in standing evated arm (EVA) platform walkered) with assist of two with goal of 5x's week.  Services Screening form dated igned by the PT, indicated R44 ened for a recumbent stepper. Idation was to use the recumbent week with nursing staff with goal of the both legs only.  obility care plan dated 11/17/15, ad impaired physical mobility in pain, diabetic complications resis and required extensive aff for all activities of daily living. Irrected staff to complete the m which consisted of passive to left upper extremities 3-5 time per extremity use yellow band 3-5 anding program with EVA platform st of two staff 3-5 x's per week fo | f<br>S<br>S<br>S<br>O<br>T               |  |                                |                               |  |

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| STATEMEN      | IT OF DEFICIENCIES<br>OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   | (X2) MULTIPLE CONSTRUCTION A. BUILDING: |   | (X3) DATE SURVEY<br>COMPLETED |                  |
|---------------|--|---|---|---|-------------------------------|------------------|
|               |  | 00578N  | B. WING                                 |   | 01/0                          | 7/2016           |
| NAME OF I     | PROVIDER OR SUPPLIER   | STREET ADI  | DRESS, CITY, S                          | STATE, ZIP CODE   | · · ·                         |                  |
| LIFECAF       | RE GREENBUSH MAN   | IOR   | TH STREET<br>JSH, MN 56                 |   |                               |                  |
| (X4) ID       | SUMMARY STA  | TEMENT OF DEFICIENCIES  | ID ID                                   | PROVIDER'S PLAN OF CORRECTION   | ON                            | (X5)             |
| PREFIX<br>TAG | (EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)  |   | PREFIX<br>TAG                           | (EACH CORRECTIVE ACTION SHOUL<br>CROSS-REFERENCED TO THE APPRO<br>DEFICIENCY) | D BE                          | COMPLETE<br>DATE |
| 2 915         | Continued From pa  | ge 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 progre revealed the followi  | ss notes were reviewed and ng:  |   |   |                               |                  |
|               | -12/1/15, indicated R44 participated well with exercises12/10/15 indicated R44 used the stepper for 10 minutes and participated well with exercises12/15/15, indicated R44 exercised 10 minutes on the stepper.  |   |   |   |                               |                  |
|               | the stepper12/31/15, written by NA-C indicated R44 completed and participated in exercises, Theraband and stretches. Was on the stepper for 15 minutes1/5/16, 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.  |   |   |   |                               |                  |
|               | stand on the elevat<br>previous facility but<br>here. R44 stated it<br>had been taken to t   | a.m. R44 stated she used to<br>ed walker when she was at a<br>had only done it a few times<br>had been months since she<br>he EVA platform walker. R44<br>used to provide rehab nursing |   |   |                               |                  |

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|                          | STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  |   |                     | E CONSTRUCTION  | (X3) DATE SURVEY<br>COMPLETED |                          |
|--------------------------|---|---|---------------------|---|-------------------------------|--------------------------|
|                          |   | 00578N  | B. WING             |   | 01/07/2016                    |                          |
|                          | NAME OF PROVIDER OR SUPPLIER  LIFECARE GREENBUSH MANOR  19120 20 GREENB   |   |                     |   |                               |                          |
| (X4) ID<br>PREFIX<br>TAG | X (EACH DEFICIENCY MUST BE PRECEDED BY FULL   |   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) |                               | (X5)<br>COMPLETE<br>DATE |
| 2 915                    | was really good at iduty so often that sepend in therapy so therapy. R44 stated exercise for longer platform walker bed stronger.  On 1/07/2016, at 17 (PT) stated her expassist R44 with the recommendation. The progress and which walking and needed activity. The PT and the progress and which was not a per rehab aide went to there was not a per rehab program. The had stepped up and had to supervise the | t, but was called to kitchen he did not have the time to a she did not always get a she would like to be able to periods and use the standing cause it would help keep her al:11 a.m. the physical therapist fectation was for rehab staff to EVA platform walker per her the PT stated R44 was not do to have weight bearing ded R44 was not happy with anted to be able to get better.  I:40 a.m. the director of sed they were in the process of shabilitation program. The DS nurse was the person the with questions but currently son designated to oversee the ed DON stated the MDS nurse downs doing whatever time she | 2 915               |   |                               |                          |
|                          | and Procedure indiplaced on a Restor indicated, to achiev physical, mental an The procedure indicassess each reside The Case Manager for each specific pr Restorative Nursing care given. The Ca each program at least  | cated the residents would be ative Nursing Program, when he and maintain optimal dipsychosocial functioning. Cated PT would evaluate and ents' need for therapy service. It would complete flow sheets ogram for care plan and go Assistant would document se Manager would evaluate ast quarterly, and meet with and therapy to review programs.   |                     |   |                               |                          |

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Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

|                          | T OF DEFICIENCIES OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  |                         | E CONSTRUCTION   | (X3) DATE SURVEY<br>COMPLETED |                          |
|--------------------------|--|---|-------------------------|--|-------------------------------|--------------------------|
|                          |  |   |                         |  |                               |                          |
|                          |  | 00578N  | B. WING                 |  | 01/0                          | 7/2016                   |
| NAME OF F                | PROVIDER OR SUPPLIER   |   |                         | STATE, ZIP CODE  |                               |                          |
| LIFECAR                  | E GREENBUSH MAN  | IOR   | TH STREET<br>JSH, MN 56 |  |                               |                          |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)   | TEMENT OF DEFICIENCIES<br>( MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG     | PROVIDER'S PLAN OF CORRECTI<br>(EACH CORRECTIVE ACTION SHOUI<br>CROSS-REFERENCED TO THE APPRO<br>DEFICIENCY) | _D BE                         | (X5)<br>COMPLETE<br>DATE |
| 2 915                    | 5 Continued From page 14   |   | 2 915                   |  |                               |                          |
|                          | and make recomm  | endations.  |                         |  |                               |                          |
|                          | 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 (21) days.   | R CORRECTION: Twenty-one  |                         |  |                               |                          |
| 21375                    | MN Rule 4658.0800<br>Program   | 0 Subp. 1 Infection Control;  | 21375                   |  |                               | 2/15/16                  |
|                          | home must establis   | on control program. A nursing sh and maintain an infection signed to provide a safe and nt.   |                         |  |                               |                          |
|                          | by: Based on observative review the facility fawas maintained during on one of two units   | ent is not met as evidenced ion, interview and document ailed to ensure infection control ring the fresh water distribution (Rosewood) with the potential dents residing on Rosewood. |                         | Corrected  |                               |                          |
|                          | Findings include:  |   |                         |  |                               |                          |
|                          |  | a.m. nursing assistant (NA)-A stain a cart with clean water   |                         |  |                               |                          |

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Minnesota Department of Health STATE FORM

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: |  |  | ` '                     | E CONSTRUCTION  | (X3) DATE SURVEY<br>COMPLETED |                          |
|---|--|--|-------------------------|---|-------------------------------|--------------------------|
|   |  |  |                         |   |                               |                          |
|   |  | 00578N   | B. WING                 |   | 01/0                          | 7/2016                   |
| NAME OF PRO   | OVIDER OR SUPPLIER   | STREET ADD   | DRESS, CITY, S          | STATE, ZIP CODE   |                               |                          |
| LIFECARE  | GREENBUSH MAN  | OR   | TH STREET<br>JSH, MN 56 |   |                               |                          |
| (X4) ID<br>PREFIX<br>TAG  | (EACH DEFICIENCY   | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG     | PROVIDER'S PLAN OF CORRECTIC<br>(EACH CORRECTIVE ACTION SHOUL)<br>CROSS-REFERENCED TO THE APPROF<br>DEFICIENCY) | D BE                          | (X5)<br>COMPLETE<br>DATE |
| m w in cl ca w w fro of the to cl ro re red di w no sa cl st cl st di cl th                         | with ice and water, pasert a straw into the lean mugs were plaart. NA-A was observith a clean water more the dirty water more the dirty mug, of the cart next to the dirty mug on the lean mug and carried the clean mug and carried the water of the water and the lean mug and carried the lean and separation of the water and lean and did not know the lean and | of from the kitchen, fill them but a lid on the mugs and he hole of each lid. All the aced on the top shelf of the erved to enter R44's rooming and come out of the rooming. NA-A removed the straw placed the used straw on top he clean water mugs and set top shelf of the cart next to the same hand NA-A used straw, NA-A picked up a hied it into the next resident ded in this manner for the later pass. The dirty mugs in with clean mugs and the faced on top of the cart. There of dirty and clean. NA-A was she hands or utilize had | 21375                   |   |                               |                          |

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Minnesota Department of Health STATE FORM

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

|                          | STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  |   | (X2) MULTIPLE CONSTRUCTION A. BUILDING: |   |      | (X3) DATE SURVEY<br>COMPLETED |  |
|--------------------------|---|---|---|---|------|-------------------------------|--|
|                          |   |   | 7t. Boilebiiva.                         |   |      |                               |  |
|                          |   | 00578N  | B. WING                                 |   | 01/0 | 7/2016                        |  |
| NAME OF F                | PROVIDER OR SUPPLIER  |   | , ,                                     | STATE, ZIP CODE   |      |                               |  |
| LIFECAR                  | E GREENBUSH MAN   | IOR   | )TH STREET<br>JSH, MN 56                |   |      |                               |  |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY  | TEMENT OF DEFICIENCIES<br>( MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG                     | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) |      | (X5)<br>COMPLETE<br>DATE      |  |
| 21375                    | Continued From page 16  |   | 21375                                   |   |      |                               |  |
|                          | interview, the infect<br>(RN)-C stated durin<br>was a breach in infe  | :52 a.m. during a telephone ion control registered nurse ing the above water pass, there ection control. RN-C confirmed al for cross contamination and 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. |   |   |   |      |                               |  |
|                          | The Director of Nur implement polices a sanitary water distri educate staff. A de monitor the system measures are being   | Sing could develop and and procedures related to abution to residents and signated staff member could to ensure infection control g implemented. The Quality tee could randomly audit for |   |   |      |                               |  |
|                          | TIME PERIOD FOR (21) days.  | R CORRECTION: Twenty-one  |   |   |      |                               |  |
| 21620                    | MN Rule 4658.134  | 5 Labeling of Drugs   | 21620                                   |   |      | 2/15/16                       |  |

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Minnesota Department of Health STATE FORM

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: |  |  | E CONSTRUCTION          | (X3) DATE SURVEY<br>COMPLETED  |            |                          |
|---|--|--|-------------------------|--|------------|--------------------------|
| 71110 1 27111   | or connection  | BENTH TO A TOTAL TO MIBELLE  | A. BUILDING:            | <del></del>  |            |                          |
|   |  | 00578N   | B. WING                 |  | 01/07/2016 |                          |
| NAME OF I   | PROVIDER OR SUPPLIER   | STREET ADI   | DRESS, CITY, S          | STATE, ZIP CODE  |            |                          |
| LIFECAF   | RE GREENBUSH MAN   | IOR  | TH STREET<br>JSH, MN 56 |  |            |                          |
| (X4) ID<br>PREFIX<br>TAG  | (EACH DEFICIENCY   | TEMENT OF DEFICIENCIES<br>MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG     | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOUL<br>CROSS-REFERENCED TO THE APPRO<br>DEFICIENCY) | D BE       | (X5)<br>COMPLETE<br>DATE |
| 21620   | in accordance with  This MN Requirements: Based on observation review, the facility formedications were purescription medicates who recent the Edgewood wings  Findings include:  On 01/07/2016, at medication cart sto with licensed praction review, a bottle of A a bottle of Lumigan observed in the medication care.  | part 6800.6300.  ent is not met as evidenced on, interview and document ailed to ensure eye drop properly labeled with ation labels for 1 of 3 (R3) eved eye drop medications on J.  9:02 a.m. the Edgewood rage review was conducted cal nurse (LPN)-A. During the alphagan brimonidine 1%, and 0.01% eye drops were dication cart drawer without a   | 21620                   | Corrected  |            |                          |
|   | identified. LPN-A verified for R3. It did not have an appropriate medication label attraction boxes apprescription label. Limedication boxes apprescription label and opened. LPN-A state administering medication labels with medication labels with medication administration admi | or a date when opened erified the medications were LPN-A confirmed the bottles propriate prescription eached, and both eye drop ted when opened. LPN-A prescription eye drop also failed to have a LPN-A stated all eye drop be labeled with a prescription of a date when the bottle was ted she had training on cations safely and confirmed were to be verified with the tration record for accuracy of tration. LPN-A stated she y immediately to obtain |                         |  |            |                          |

Minnesota Department of Health

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: |   | ` '  | E CONSTRUCTION      | (X3) DATE SURVEY<br>COMPLETED  |      |                          |
|--|---|--|---------------------|--|------|--------------------------|
|  |   | 00578N   | B. WING             | <del></del>  | 01/0 | 7/2016                   |
| NAME OF  | PROVIDER OR SUPPLIER  |  | DRESS, CITY, S      | STATE, ZIP CODE  | -    |                          |
| LIFECAF  | RE GREENBUSH MAN  | IOR The state of t | USH, MN 56          |  |      |                          |
| (X4) ID<br>PREFIX<br>TAG   | (EACH DEFICIENCY  | TEMENT OF DEFICIENCIES<br>MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTI<br>(EACH CORRECTIVE ACTION SHOUI<br>CROSS-REFERENCED TO THE APPRO<br>DEFICIENCY) | D BE | (X5)<br>COMPLETE<br>DATE |
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|  | prescription labels f   | or the eye drops.  |                     |  |      |                          |
|  | nursing (DON) verifieye drops should ha labels on them and indicating when the verified it was her emedications were p  | :18 a.m. the director of fied all medications including ave prescription medication eye drops should be dated y were opened. The DON xpectation staff ensure properly labeled and dated g the medications, including   |                     |  |      |                          |
|  | 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 ME  | ETHOD FOR CORRECTION:  |                     |  |      |                          |
|  | and revise the polic<br>the dating and labe<br>or designee could p<br>involved staff. The<br>monitoring system to   | sing or designee could review ies and procedures related ling of medications. The DON provide education to all facility could develop a to ensure ongoing compliance ngs to the Qualify Assurance  |                     |  |      |                          |
|  | TIME PERIOD FOR (21) days.  | R CORRECTION: Twenty one   |                     |  |      |                          |

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