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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: TP6S

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00195

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **24E152**

2.STATE VENDOR OR MEDICAID NO.
(L2) **926219900**

3. NAME AND ADDRESS OF FACILITY
(L3) **ELLIOT CARE HOME INC**
(L4) **1500 ELLIOT AVENUE SOUTH**
(L5) **MINNEAPOLIS, MN** (L6) **55404**

4. TYPE OF ACTION: **7** (L8)

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **03/26/2015** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY **10** (L7)

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

12.Total Facility Beds **15** (L18)

13.Total Certified Beds **15** (L17)

10.THE FACILITY IS CERTIFIED AS:

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

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

X B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: **A, 3, 4, 8** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
		15		
(L37)	(L38)	(L39)	(L42)	(L43)

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

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):
Facility's request for continuing waivers at tags F0353, F0354, and F0458 are approved.

17. SURVEYOR SIGNATURE Date :
Gloria Derfus, Supervisor 04/09/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Anne Kleppe, Enforcement Specialist 04/24/2015 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
04/01/1976
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal
INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
04/09/2015
(L33)

DETERMINATION APPROVAL

Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 24-E152

Electronically Delivered: April 24, 2015

Mr. Mark Jefferis, Administrator
Elliot Care Home Inc
1500 Elliot Avenue South
Minneapolis, Minnesota 55404

Dear Mr. Jefferis:

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 March 6, 2015 the above facility is certified for:

15 - Nursing Facility II Beds

Your request for waivers at tags F0353, F0354, & F0458 have been appoved based on the submitted documentation. If you are not in compliance with the above requirements at the time of your next survey, you will be required to submit a Plan of Correction for these deficiency(ies) or renew your request for waiver in order to continue your participation in the Medicaid Program.

You should advise our office of any changes in staffing, services, or organization, which might affect your certification status. If, at the time of your next survey, we find your facility to not be in substantial compliance your Medicare and Medicaid provider agreement may be subject to non-renewal or termination.

Please contact me if you have any questions about this electronic notice.

Sincerely,

Anne Kleppe

Anne Kleppe, Enforcement Specialist
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Email: anne.kleppe@state.mn.us
Telephone: (651) 201-4124 Fax: (651) 215-9697

MINNESOTA MDH DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically Delivered: March 26, 2015

Mr. Mark Jefferis, Administrator
Elliot Care Home Inc
1500 Elliot Avenue South
Minneapolis, Minnesota 55404

RE: Project Number SE152024

Dear Mr. Jefferis:

On February 26, 2015, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on February 12, 2015. 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.

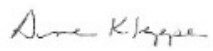
On March 26, 2015, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on March 18, 2015 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on February 12, 2015. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of March 6, 2015. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on February 12, 2015, effective March 6, 2015 and therefore remedies outlined in our letter to you dated February 26, 2015, will not be imposed.

Your request for three temporary waivers, with a dates of completion on March 24, 2016, involving the deficiencies cited under 0353, 0354, & 0458 at the time of the February 12, 2015 standard survey has been approved. Failure to come into substantial compliance with these deficiencies by the date indicated in your plan of correction may result in the imposition of enforcement remedies.

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

Please contact me if you have any questions about this electronic notice.

Sincerely,



Anne Kleppe, Enforcement Specialist
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Email: anne.kleppe@state.mn.us
Telephone: (651) 201-4124 Fax: (651) 215-9697

Department of Health and Human Services
Centers for Medicare & Medicaid Services

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
24E152	A. Building B. Wing	3/26/2015

Name of Facility	Street Address, City, State, Zip Code
ELLIOT CARE HOME INC	1500 ELLIOT AVENUE SOUTH MINNEAPOLIS, MN 55404

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).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **F0272** Reg. # **483.20(b)(1)** LSC	Correction Completed **03/06/2015**	ID Prefix **F0273** Reg. # **483.20(b)(2)(i)** LSC	Correction Completed **03/06/2015**	ID Prefix **F0279** Reg. # **483.20(d), 483.20(k)(1)** LSC	Correction Completed **03/06/2015**
ID Prefix **F0281** Reg. # **483.20(k)(3)(i)** LSC	Correction Completed **03/06/2015**	ID Prefix **F0334** Reg. # **483.25(n)** LSC	Correction Completed **03/06/2015**	ID Prefix **F0356** Reg. # **483.30(e)** LSC	Correction Completed **03/06/2015**
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	GD/AK	03/26/2015	18623	03/26/2015
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
2/12/2015			

Department of Health and Human Services
Centers for Medicare & Medicaid Services

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D.C. 20503.

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
24E152	A. Building 01 - MAIN BUILDING 01 B. Wing	3/18/2015

Name of Facility	Street Address, City, State, Zip Code
ELLIOT CARE HOME INC	1500 ELLIOT AVENUE SOUTH MINNEAPOLIS, MN 55404

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).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix Reg. # NFPA 101 LSC K0012	Correction Completed 02/26/2015	ID Prefix Reg. # NFPA 101 LSC K0033	Correction Completed 02/26/2015	ID Prefix Reg. # NFPA 101 LSC K0040	Correction Completed 02/26/2015
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By State Agency	Reviewed By PS/AK	Date: 03/26/2015	Signature of Surveyor: 28120	Date: 03/18/2015
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:
Followup to Survey Completed on: 2/17/2015		Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: TP6S

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00195

1. MEDICARE/MEDICAID PROVIDER NO. (L1) **24E152**
2. STATE VENDOR OR MEDICAID NO. (L2) **926219900**

3. NAME AND ADDRESS OF FACILITY
(L3) **ELLIOT CARE HOME INC**
(L4) **1500 ELLIOT AVENUE SOUTH**
(L5) **MINNEAPOLIS, MN** (L6) **55404**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9)

6. DATE OF SURVEY **02/12/2015** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY **10** (L7)

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

FISCAL YEAR ENDING DATE: (L35) **12/31**

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

12. Total Facility Beds **15** (L18)

13. Total Certified Beds **15** (L17)

10. THE FACILITY IS CERTIFIED AS:
A. In Compliance With Program Requirements Compliance Based On:
__ 1. Acceptable POC
X B. Not in Compliance with Program Requirements and/or Applied Waivers:

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

* Code: **B, 3, 4, 8*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
		15		
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

Annual waivers, at tags 0353, 0354, and 0458 are approved. See attached Fire Safety Evaluation System (FSES) for Life Safety Code results.

17. SURVEYOR SIGNATURE — Date : 03/23/2015 (L19)
Eva Loch, HFE NE II

18. STATE SURVEY AGENCY APPROVAL — Date: 04/07/2015 (L20)
Anne Kleppe, Enforcement Specialist

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION **04/01/1976** (L24)

23. LTC AGREEMENT BEGINNING DATE (L41)

24. LTC AGREEMENT ENDING DATE (L25)

25. LTC EXTENSION DATE: (L27)

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

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal
INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE: (L28)

29. INTERMEDIARY/CARRIER NO. (L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE 4-9-2015 (L33)

DETERMINATION APPROVAL

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: TP6S

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7. On-Site Visit **9. Other**
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **02/12/2015** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 10 (L7)

01 Hospital	**05 HHA**	**09 ESRD**	**13 PTIP**	**22 CLIA**
02 SNF/NF/Dual	**06 PRTF**	**10 NF**	**14 CORF**	
03 SNF/NF/Distinct	**07 X-Ray**	**11 ICF/IID**	**15 ASC**	
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FISCAL YEAR ENDING DATE: (L35)
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To (b) :

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Compliance Based On:
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And/Or Approved Waivers Of The Following Requirements:
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X 3. 24 Hour RN
X 4. 7-Day RN (Rural SNF)
___ 5. Life Safety Code
___ 6. Scope of Services Limit
___ 7. Medical Director
X 8. Patient Room Size
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(L37)	(L38)	(L39)	(L42)	(L43)

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1861 (e) (1) or 1861 (j) (1): (L15)

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

Annual waivers, at tags 0353, 0354, and 0458 are approved. See attached Fire Safety Evaluation System (FSES) for Life Safety Code results.

17. SURVEYOR SIGNATURE — Date :
Eva Loch, HFE NE II — 03/23/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Anne Kleppe, Enforcement Specialist — 04/07/2015 (L20)

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

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04/01/1976
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B. Rescind Suspension Date:
(L45)

26. TERMINATION ACTION: (L30)
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28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered
February 26, 2015

Mr. Mark Jefferis, Administrator
Elliot Care Home Inc
1500 Elliot Avenue South
Minneapolis, Minnesota 55404

RE: Project Number SE152024

Dear Mr. Jefferis:

On February 12, 2015, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

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

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

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

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

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

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

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

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

DEPARTMENT CONTACT

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

Gloria Derfus, Unit Supervisor
Minnesota Department of Health
P.O. Box 64900
St. Paul, Minnesota 55108-2970
gloria.derfus@state.mn.us
Telephone: (651) 201-3792
Fax: (651) 201-3790

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 March 24, 2015, 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 March 24, 2015 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 May 12, 2015 (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 August 12, 2015 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

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

Mr. Patrick Sheehan, Supervisor
Health Care Fire Inspections
State Fire Marshal Division
pat.sheehan@state.mn.us
Telephone: (651) 201-7205 Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24E152	A. BUILDING _____ B. WING _____	02/12/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELLIOT CARE HOME INC	1500 ELLIOT AVENUE SOUTH MINNEAPOLIS, MN 55404

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS THE FACILITY PLAN OF CORRECTION (POC) WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION.	F 000		
F 272 SS=D	483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions;	F 272		3/6/15

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

Electronically Signed | 03/06/2015

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

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F 272	Continued From page 1 Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to comprehensively assess 1 of 3 residents (R8) dental status. Findings include: R8 on 2/9/15, at 1:28 p.m. when R8 asked if he had tooth problems, gum problems, mouth sores, or denture problems R8 stated "You can feel the tin sticking out probably needs to be filed out. I told her a while back and she said she gets the answering message all the time" as he was pointing to his left lower jaw to the back. On 2/10/15, at 11:15 a.m. R8 was observed in the dining room (DR) seated at the table when a staff member indicated the residents were going to have a birthday activity and was going to serve cake and coffee.	F 272	F272 483.20(b)(1) COMPREHENSIVE ASSESSMENTS The Elliot Care Home understands the importance of comprehensive assessments and in particular to the dental needs of all the residents. The Elliot Care Home acknowledges a need to improve the assessment of resident dental issues when triggered in the MDS. The RN will assess and evaluate all dental concerns that are triggered and address them appropriately under either ADL or Dental on the MDS. RN will follow up with Program Director or licensed staff	

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F 272	Continued From page 2 -At 11:17 a.m. R8 was observed eating a piece of cake and coffee and no signs or symptoms of pain or sensitivity noted during the observation. -At 11:21 a.m. when asked how the treat was R8 indicated it was really good. When asked if he had any sensitivity from the sweets and warm or hot beverages, R8 denied and stated when he ate a potato chip for example the back molar would have the food stick in it and thought probably maybe needed to be grinded down. R8's diagnoses included schizophrenia, seizure history and depression obtained from the quarterly Minimum Data Set (MDS) dated 10/31/14. In addition the MDS indicated R8 had intact cognition. Activities of daily living (ADL) Care Area Assessment (CAA) dated 5/2/14, indicated R8 required supervision and set up for dressing, eating, toileting, daily grooming and showering and did not address R8 dental/oral needs. Grooming care plan dated 5/1/12, indicated R8 had his own teeth and directed staff to observe for brushing teeth. Review of R8's record revealed the following: -Annual MDS dated 5/16/14, had indicated R8 had obvious or likely cavity or broken natural teeth and had mouth or facial pain, discomfort or difficulty with chewing. -Quarterly MDS's dated 8/10/14, and 10/31/14, both were left blank for dental assessment. - Referral sheet dated 9/15/14, indicated R8 had an extraction done for lower right tooth. On 2/10/15, at 11:43 a.m. licensed practical nurse (LPN)-A was interviewed and indicated she was aware of the tooth problem with the inner molar sticking out and stated R8 had been seen twice in the past year for it. She further remarked R8 had	F 272	regarding appointments needed, and/or increased assistance with ADL's. The licensed staff have discussed and reviewed the MDS process & need to evaluate all comprehensive assessments. Elliot Care Home has successfully trained 2 additional licensed staff to complete MDS,s but more importantly have trained them in all comprehensive assessments. The additional staff have hands-on with our residents on a daily basis. They will meet with the RN who is completing the MDS to discuss and address the comprehensive assessments. R-8 appointments have been scheduled for the dentist and refused. An additional appointment has been scheduled for March 17, 2015 and was made when the previous scheduled appointment was refused. The additional training and staff will ensure all assessments are completed correctly, timely, and most importantly provide the optimum care for the residents. ********* 3-20-2015 The following text provides additional information and a revision to the above plan of correction. ********* Therefore, Monitoring is intended to show that our audits are used by design and frequency	

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F 272	Continued From page 3 refused to go in for two scheduled appointments and she was going to follow up on it and had not. On 2/11/15, at 11:45 a.m. the director of nursing (DON) was interviewed. She indicated she did all the facility MDSs. The DON indicated she completed the ADL CAA dated 5/2/14, and did not develop a dental CAA which addressed comprehensively the needs for R8 in spite of all the dental concerns and services he had received. -When asked if that was sufficient enough to address the dental/oral status needs for R8 DON stated "with the population we have we do not do a lot for them and all that is just addressed in the ADL CAA and not on a separate dental one even though it triggered." Care Planning Policy and Procedure dated 11/2002, directed on the procedure for new residents: "1. MDS will be started on new residents 7 days after the resident is admitted and completed by day 11th. All disciplines will complete their assigned sections and initial. 2. The RN will compile the Resident Assessment Protocol [RAP] before the 13th day to determine which triggered need to be considered for care planning. 3. By the 13th day, triggered RAP will have assessments written on them to determine whether or not to proceed with the RAP to the care plan. 4. The care plan needs to be completed by the 21st day. The care plan should be developed from what was decided to proceed on and other pertinent information."	F 272	and acted upon by Elliot Care Home nursing staff. The monitoring of audits and schedules will be checked and followed up on Monday through Friday by the Program Director. Further, the monitoring of the audits will be done weekly by the RN/DON during scheduled hours. And, additional monitoring of the audits will be done by 2 licensed staff at a minimum of every 90 days to further provide relevant information about the needs of the resident to be included in the MDS. The RN/DON and Program Director will monitor ongoing compliance. Date of completion March 6, 2015	
F 273	483.20(b)(2)(i) COMPREHENSIVE	F 273		3/6/15

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F 273 SS=D	Continued From page 4 ASSESSMENT 14 DAYS AFTER ADMIT A facility must conduct a comprehensive assessment of a resident within 14 calendar days after admission, excluding readmissions in which there is no significant change in the resident's physical or mental condition. (For purposes of this section, "readmission" means a return to the facility following a temporary absence for hospitalization or for therapeutic leave.) This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to comprehensively assess resident's needs within the required timeframe for 1 of 1 resident (R15) who was newly admitted to the facility. Findings include: R15 on 2/9/15, at 4:30 p.m. was observed seated at the DR table drinking coffee from a mug R15 appeared to be breathing heavily and was short of breath. During the observation, R15 indicated he was having some pain in his tail bone and that was because of the arthritis. He confirmed he did take the pain medication at his request which helped ease the discomfort. R15 also indicated he was able to verbalize pain to the staff. He revealed he would stand up and walk and that help provide comfort. R15 was admitted on 1/23/15, to the facility with diagnoses of arthritis, chronic obstructive pulmonary, morbid obesity obtained from the admission MDS dated 2/11/15.	F 273	F273 483.20(b)(2)(i) COMPREHENSIVE ASSESSMENT 14 DAYS AFTER ADMIT MDS's need to be done within the set time requirements. This has been reviewed with RN/DON tasked to do the MDS's. The MDS, RAPS & Care plan has been completed as well as all comprehensive assessments including a pain assessment for R-15.. The results of the assessments reflecting R-15's problems/needs have been incorporated in existing methods to provide monitoring for interventions, progress, and evaluation. To ensure compliance and sustain required practices, the following items have been implemented: The admission check list has been updated to include the time limits for completion for MDS, RAPS, Care	

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F 273	Continued From page 5 Pain Assessment dated 1/30/15, indicated R15 had indicated he had pain or hurting in the last five days, pain was frequently, had rated the pain six out of ten on a scale of 0 to 10, reported he had shortness of breath with activity and lying flat but none at rest. Also, the cognitive Patterns Assessment dated 1/30/15, indicated R15 had intact cognition. In addition to pain, psychotropic medication use and dental had not been comprehensively assessed. During document review it was noted the admission Minimum Data Set (MDS) had not been completed and was six days past the required time frame. On 2/11/15, at approximately 1:13 p.m. DON indicated she had not done R15's MDS and acknowledged she was out of compliance. Care Planning Policy and Procedure dated 11/2002, directed on the procedure for new residents: "1. MDS will be started on new residents 7 days after the resident is admitted and completed by day 11th. All disciplines will complete their assigned sections and initial. 2. The RN will compile the Resident Assessment Protocol [RAP] before the 13th day to determine which triggered need to be considered for care planning. 3. By the 13th day, triggered RAP will have assessments written on them to determine whether or not to proceed with the RAP to the care plan. 4. The care plan needs to be completed by the 21st day. The care plan should be developed from what was decided to proceed on and other pertinent information."	F 273	Planning and comprehensive assessments. Two additional licensed nurses have been successfully trained to complete MDS, and assessments. A schedule with required due dates is posted at the nurses desk to ensure completion per regulation. In order to better manage this work load and scheduling on the part of the Elliot Care Home Director of Nursing, who is tasked with doing MDS's, two additional licensed nursing staff have been trained to submit timely MDS's. This will be monitored by the 2 licensed staff and will be incorporated into the existing monitoring that is currently in place to monitor charting required for MDS. This is a successful ongoing practice that is completed daily. RN and LPN will monitor for over all and on going compliance to RN/DON and administrator Date of completion March 6, 2015	

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F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based observation, interview and document review, the facility failed to develop a care plan to include potential risk for bleeding/side effects for 1 of 1 resident (R13) reviewed for anticoagulant medication use. Findings include: R13's quarterly Minimum Data Set (MDS) dated 10/24/14, indicated R13 received anticoagulant seven days a week. R13 diagnoses included bilateral subdural	F 279	F279 483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS The Elliot Care Home affirms the importance of a comprehensive care plan. R-13's care plan has been updated to reflect the anticoagulant prescribed. Additionally, the Elliot Care Home policies and procedures have been updated to include anticoagulants that need to be	3/6/15

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F 279	Continued From page 7 hematoma, recurrent deep vein thrombosis (DVT) and hypertension (HTN) obtained from the Physician Orders dated 12/15/14. R13's Physicians Orders dated 12/15/14, indicated R13 received: -Warfarin sodium 5 milligrams (mg) 1 tablet at bedtime on Sunday, Tuesday, Wednesday, Thursday & Saturday international normalized ratio (INR) 2/2/15, was 2.1 continue with same dose recheck INR 3/2/15, -Warfarin sodium 7.5 mg 1 tablet orally at bedtime on Monday and Friday R13's falls Care Area Assessment (CAA) dated 1/23/15, indicated R13 was at risk for falls and related to use of an anti-depressant and had diagnosis of hypertension. The care directed staff to monitor for presences of side effects and indicated R13 had scheduled anticoagulation medication and was at risk for bleeding. The CAA directed staff to supervise when showering. R13 lacked a care plan which addressed his needs and cares with the use of Coumadin and what staff was monitoring. On 2/10/15, at 12:00 p.m. to 12:20 p.m. R13 was observed seated at the dining room table eating his lunch dressed up in a long sleeved green shirt with jeans then stood up.and went back to his room after. On 2/10/15, at 2:10 p.m. R13 was observed in his room lying in bed covered with a blanket upon entering the room R13 indicated he was taking a nap and resting. On 2/11/15, at 7:23 p.m. to 7:42 a.m. R13 was observed seated at the DR table eating his	F 279	monitored for safety and timely management. All nursing staff have reviewed the policy and procedures and understands the need & importance to always include the use of anticoagulants on the care plan. The following items are in place to ensure safety for all residents & avoid recurrence. The licensed staff will continue to review care plans every 90 days (minimum) & will sign the review sheet in each residents chart to ensure this has been completed. The Elliot Care Home admission check list has been updated to include anticoagulant orders. This will ensure anticoagulants are addressed on the care plan,MDS,CAA, as well as the MAR & treatment sheets to monitor for side effects & provide safety & preventative measures. The on-going performance monitoring will be done by the Pharmacist consultant every month. In addition, the licensed nursing staff involved with scheduling appointments, labs, and anticoagulant orders will monitor for compliance and on-going performance. DON and Program Director and Pharmacist Consultant will implement and monitor for compliance. Date of completion 3-6-2015	

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F 279	Continued From page 8 breakfast when finished R13 walked over to the nursing station pumped some hand sanitizer to his hands and rubbed his hands together went back upstairs. No visible bleeding was noted throughout all observations. On 2/11/15, at 11:49 a.m. the director of nursing (DON) stated when a resident was on an anticoagulant such as Coumadin she would indicate in the care plan monitoring for signs of bruising and bleeding, administer medications as ordered and do labs. -At 11:53 a.m. both DON and licensed practical nurse (LPN) verified the risk for bleeding, bruising and other side effects had not been addressed in the care plan. LPN-A indicated there was no separate problem area that had been developed. In addition the DON indicated other than being charted weekly that staff was monitoring for bruising there was no care plan. On 2/12/15, at 9:45 a.m. when asked if he knew medications he was taking R13 indicated some. When asked about Coumadin he indicated he knew about the the bruising and thought the staff were monitoring for all the other side effects which he did not know them all. On 2/12/15, at 2:00 p.m. the policy was requested and LPN-A indicated there was no specific policy for anticoagulant use, monitoring and care planning for side effects.	F 279		
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality.	F 281		3/6/15

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F 281	Continued From page 9 This REQUIREMENT is not met as evidenced by: Based on observations, interview and document review, the facility failed to develop an initial care plan with interventions based on the resident's health needs at the time of admission for 1 of 1 resident (R8) reviewed for pain. Findings include: On 2/9/15, at 4:30 p.m. R15 was observed seated at the DR table drinking coffee from a mug. R15 appeared to be breathing heavily and was short of breath. During observation, R15 indicated he was having some pain in his tail bone and that was because of the arthritis he had. R15 did take pain medication which helped. R15 also indicated he was able to verbalize the pain to the staff and a lot of the times when he had the pain he would stand up and walk. R15 commented that helped in relieving the discomfort. R15 was admitted on 1/23/15, to the facility with diagnoses of arthritis, chronic obstructive pulmonary, morbid obesity obtained from the admission Minimum Data Set (MDS) dated 2/11/15. R15's Problem List/Initial Care Plan dated 1/23/15, and 1/25/15, identified R15 had limited mobility, had difficulty with mobility secondary to health issues and being overweight. Care plan directed evaluating every day for safety and ability to ambulate in and out of building, continue to meet goal of walking one block every day. The care plan however did not address pain management plan and interventions.	F 281	F281 483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The Elliot Care Home acknowledges that R-15 pain assessment was incomplete and not timely. As of 2-11-15, R-15's care plan reflects pain as a Problem/Need that requires an assessment and interventions and goals. The care plan has been reviewed by all licensed staff and updated. R-15 was newly admitted. Normally, upon admission, the Program Director and the DON would quickly accomplish the pain assessment as reflected on the care plan with interventions. To prevent recurrence for new admissions, the Program Director and DON have initiated the following to facilitate pain assessments immediately upon admission that are promptly included on the care plan. Elliot nursing staff have reviewed current admission practices that emphasize the gathering of sufficient information for appropriate assessments including pain. The Elliot Care Home has been successful with prior admissions with resulting timely assessments and care planning.	

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F 281	Continued From page 10 Review of the 1/23/15, through 2/10/15, Medication Administration Records (MARs) and Treatment Administration Records (TARs) noted R15 had received Tylenol as needed on 1/31/15, and 2/1/15, for left shoulder pain. The Nursing Progress Notes, MAR and TAR was void of a pain assessment. The Pain Assessment dated 1/30/15, indicated R15 had indicated he had pain or hurting in the last five days, pain was frequently, had rated the pain six out of ten on a scale of 0 to 10, reported he had shortness of breath with activity and lying flat but none at rest. In addition the cognitive Patterns Assessment dated 1/30/15, indicated R15 had intact cognition. On 2/10/15, at 11:07 a.m. licensed practical nurse (LPN)-A indicated she was not aware of the resident having any pain but thought R15 had expressed it in the past. She said sitting too long made him have pain in his lower back but he had never expressed he had continuous pain. When asked if a pain assessment had been done for R15 LPN-A indicated she was not aware of one being done. On 2/12/15, at 1:27 p.m. LPN-A acknowledged she had completed the pain assessment on 1/30/15, but had not developed a sufficient temporary care plan to address the pain issues that had been identified from the interviewing R15 on 1/30/15. On 2/12/15, at 2:00 p.m. the policy was requested for initial care planning but was not provided.	F 281	The Elliot Care Home nursing staff will follow the facility admission policy and procedure and request H&P, doctor's orders, and history and other medical records to be received prior to admission for review. Regardless of documentation received prior to admission, the Elliot Care Home admission practices include initiating a pain assessment that is included on the care plan whether the existence of pain is or is not cited. To ensure that pain assessments are done at the point of admission for all new residents going forward, pain assessment interview worksheets are now included in the admission packet kept at the nurses station in preparation for new admissions. The pain assessment accomplished by the use of the interview worksheet is added immediately to the initial admission care plan. This is in conjunction with the MDS requirement to do a pain assessment upon admission with inclusion on the formal on going care plan. Monitoring for sustained accomplishment of pain assessments and initial care planning at the point of admission is accomplished by the use of the Elliot Care Home Admission Packet Checklist that is included in the resident's chart. Furthermore, all assessment forms completed at the point of admission have been updated to include a text alert for the nurses to review assessments with the	

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F 281	Continued From page 11	F 281	initial care plan needs. Monitoring is further facilitated by the completion of a timely admission MDS that will make use of the completed initial pain assessment worksheet and initial care plan. On going monitoring will also be done by the Program Director/RN who will confirm that the check list is completed immediately post admission and reflected in both the initial care plan and the care plan resulting from the MDS. Date of completion March 6, 2015	
F 334 SS=D	483.25(n) INFLUENZA AND PNEUMOCOCCAL IMMUNIZATIONS The facility must develop policies and procedures that ensure that -- (i) Before offering the influenza immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's legal	F 334		3/6/15

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F 334	Continued From page 12	F 334		

representative was provided education regarding the benefits and potential side effects of influenza immunization; and
(B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal.

The facility must develop policies and procedures that ensure that --
(i) Before offering the pneumococcal immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization;
(ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized;
(iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and
(iv) The resident's medical record includes documentation that indicated, at a minimum, the following:
(A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and
(B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal.
(v) As an alternative, based on an assessment and practitioner recommendation, a second pneumococcal immunization may be given after 5 years following the first pneumococcal immunization, unless medically contraindicated or

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F 334	Continued From page 13 the resident or the resident's legal representative refuses the second immunization. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure 2 of 5 residents (R13, R9) were offered and/or received pneumococcal vaccinations as recommended by Centers for Disease Control (CDC). Findings include: R13's Physician Order dated 12/15/14, indicated R13 was admitted to the facility on 3/3/08. Review of R13's Personal Immunization History dated 3/3/08, lacked documentation if a pneumococcal vaccination had been received, contraindicated or refused. R9's Physician Orders dated 12/8/14, indicated R9 was admitted to the facility on 1/1/00. Review of R9's Personal Immunization History dated 1/1/00, lacked documentation if pneumococcal vaccination had been received, contraindicated or refused. On 2/11/15, at 12:48 p.m. licensed practical nurse (LPN)-A indicated the facility had mailed the regulation after the last survey when same deficiency had been cited to several clinics that saw the residents at the facility. Because of some of the resident ' s age was less than 65 years old the clinics were not comfortable to administer the	F 334	F334 483.25(n) INFLUENZA AND PNEUMOCOCCAL IMMUNIZATIONS The Elliot Care Home immunization policy and procedures for pneumococcal vaccinations reflects the following: Prior to the resident's annual physical, the Elliot Care Home will provide the resident with education on pneumococcal vaccines. The Pneumococcal Polysaccharide Vaccine information sheet per the Center for Disease Control will be used. At this time, the resident's interest in the vaccine or refusal will be passed on to the resident's physician in preparation for their annual physical appointment. In turn, the determination of the doctor to provide the vaccine or that it is contraindicated will be received back from the doctor post physical and entered into the resident's chart Immunization Record. Documentation for the discussion and education currently for the Pneumococcal vaccine was omitted for R9 and R13. The discussion and education for R9 and R13 has been completed and documented. The pharmacist consultant will assist the Program Director to audit the	

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F 334	Continued From page 14 immunization. Both the director of nursing (DON) and program manager verified R13 and R9 had not received pneumovax immunizations. In addition program manager verified immunization had not been offered or documented as contraindicated. The program manager further indicated one of the clinics had indicated if a resident wanted the immunization the clinic would give it. Immunization Policy and Procedure directed "The goal of immunizations is to minimize or prevent disease processes by ensuring immunizations are up to date for all the residents. The components of the pneumococcal vaccine: nursing staff will meet with the residents prior to their annual physical to provide patient teaching and education regarding the PPSV. The Vaccine Information Statement" from the center for disease control will be used. 2. Documentation on the "Immunization Record" will record the steps for compliance, contraindications, and refusals..."	F 334	Immunization Record to prevent ommissions. DON and Program Director will monitor for compliance. Date of completion March 6, 2015	
F 353 SS=C	483.30(a) SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS The facility must have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care. The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans:	F 353		2/26/15

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F 353	Continued From page 15 Except when waived under paragraph (c) of this section, licensed nurses and other nursing personnel. Except when waived under paragraph (c) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to provide licensed nursing coverage as required for each shift. This had the potential to affect all 14 residents in the facility at the time of the survey. Findings include: The facility did not staff all shifts with a licensed nurse. Each resident's medical record contained a statement signed by the physician, stating the resident was not in need of 24 hour licensed nursing care. During interview with all 14 residents, no complaints were offered regarding their health needs while residing in the facility. The director of the nursing was interviewed on 2/10/15, at 2:30 p.m. via phone call, verified findings and stated the facility will apply for a waiver.	F 353	F353 483.30 (a) Sufficient 24 HR Nursing Staff Per Care Plans Waiver Requested 2-26-2015 Each resident□s primary physician has signed a statement stating that in his/her opinion, it is not necessary to require 24 hours of licensed nursing care, but minimal supervision for ADL□s due to each resident□s ambulatory status and capability of self preservation. Also, the program director, DON, administrator, and owner are all available by cell phones with pagers. This waiver request seeks to included the use of a Trained Medication Aide (TMA) on the 11:00 PM to 7:00 AM shift, the 3:00 PM top 11:00 PM shift and the 7:00 AM to 3:00 PM shift only when necessary. 3-12-2015 Please see attached letter uploaded on 3-6-2015. In addition, per telephone conversation on 3-10-2015 with	

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F 353	Continued From page 16	F 353	Gloria Derfus, Unit Supervisor, the Elliot waiver request letter was faxed to Gloria Derfus at fax number 651-215-9697 on the afternoon of 3-10-2015. 3-20-2015 Please see faxed Elliot Care Home dedicated letter to F353 stating our waiver request. This will be faxed this afternoon Friday 3-20-2015 to the attention of Gloria Derfus, Unit Supervisor, fax number 651-215-9697.	
F 354 SS=C	483.30(b) WAIVER-RN 8 HRS 7 DAYS/WK, FULL-TIME DON Except when waived under paragraph (c) or (d) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week. Except when waived under paragraph (c) or (d) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis. The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure a registered nurse (RN) was working in the facility eight hours a day, seven days a week. This had the potential to affect all 14 residents in the facility at the time of the survey.	F 354	F354 483.30 (b) Waiver-RN 8 Hrs 7 Days/Wk, Full-Time DON Waiver requested. 2-26-2015	2/26/15

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F 354	Continued From page 17 Findings include: The facility did not meet the requirement for RN coverage for eight hours daily. A review of resident records of the facility revealed statement by the physician stating residents were not in need of 24 hour licensed nursing care. A waiver was in place at the time of the survey for lack of required RN coverage eight hours a day, seven days a week. During interview with all 14 residents, no complaints were offered regarding their health needs while a residing in the facility. During interview via phone on 2/10/15, at 2:30 p.m. the director of nursing verified findings and stated the facility will apply for a waiver.	F 354	At the present time, with the residents currently residing at Elliot, the lack of an RN on the premises 8 hours per day will not jeopardize the care of the residents. All of the residents primary care physicians have indicated that the residents are capable of self-preservation with the DON monitoring their care 8 hours per week and in conjunction with some scheduled RN's. 3-12-2015 Please see attached letter uploaded on 3-6-2015. In addition, per telephone conversation on 3-10-2015 with Gloria Derfus, Unit Supervisor, the Elliot waiver request letter was faxed to Gloria Derfus at fax number 651-215-9697 on the afternoon of 3-10-2015. 3-20-2015 Please see faxed Elliot Care Home dedicated letter requesting a waiver to F354. The letter is being faxed this afternoon to Gloria Derfus, Unit Supervisor at 651-215-9697.	
F 356 SS=C	483.30(e) POSTED NURSE STAFFING INFORMATION The facility must post the following information on a daily basis: o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law).	F 356		3/6/15

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F 356	Continued From page 18 - Certified nurse aides. o Resident census. The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows: o Clear and readable format. o In a prominent place readily accessible to residents and visitors. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure the posted nurse staffing information was accurate. This practice had the potential to affect all 14 residents who resided in the facility as well as visitors. Findings include: On 2/9/15, at 1:12 p.m. the nurse staffing posting was observed stored inside a clear plastic page protector hanging on the board to left by the entrance door across to the nursing station. The nursing posting lacked the name of the facility, and the census. On 2/10/15, at 7:46 a.m. to 3:22 p.m. the nurse	F 356	F356 483.30(e) POSTED NURSE STAFFING INFORMATION The Elliot Care Home has been and will continue to prominantly post on a daily basis data sheets that display nurse staffing information including the resident census for each day. The data sheet has been updated on the facility main computer to permanently include the name of the facility. A policy & procedure has been written, reviewed & implemented to ensure compliance. This will be reviewed & approved by the Medical Director @ the	

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F 356	Continued From page 19 staffing posting lacked the name and current census. On 2/11/15, at 7:36 a.m. when surveyor was looking at the posting R7 who was seated at the corner by the phone indicated that was the schedule with all the staff scheduled hours to work. Upon looking the nurse posting still lacked the facility name and census for all the days 2/9/15, 2/10/15, and 2/11/15. On 2/11/15, at 2:46 p.m. the program manager and the director of nursing both verified the staff posting lacked the name and the census. The program manager indicated "this is the exception where I have to do a one on one, fill the census and I have been busy and just did not get to it." Program manager went on to show surveyor other sheets which had the census but lacked the name of the facility from 12/1/14, through 2/11/15. On 2/12/14, at 3:10 p.m. the nurse staffing posting policy was requested and the program manager indicated there was no policy.	F 356	next QAR meeting. The 11pm-7am and 7am-3pm staff will now record the actual hours worked by licensed & non-licensed staff as well as the resident census every 24 hours. The Program Director will be responsible for monitoring accurate information every 24 hours. The Program Director will also report any necessary changes on the form to the administrator who will update the form. The RN/DON and the Administrator will be responsible for monitoring to sustain the current plan. Corrected as of February 26, 2015	
F 458 SS=B	483.70(d)(1)(ii) BEDROOMS MEASURE AT LEAST 80 SQ FT/RESIDENT Bedrooms must measure at least 80 square feet per resident in multiple resident bedrooms, and at least 100 square feet in single resident rooms. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review ,the facility failed to provide 80 square feet of living space for each resident in three multiple occupancy bedrooms (Room 101, room 102 and	F 458	F 458 483.70 (d)(1)(ii) Bedrooms measure at least 80 sq ft / resident	2/26/15

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F 458	Continued From page 20 room 202). This had the potential to affect 8 of 8 residents residing in those rooms. Findings include: Observation on 2/11/15 revealed rooms 101, 102, and 202 each had three beds in them. Room 102 accommodated three residents (R1, R3 and R15). Room 202 accommodated three residents (R15, R13 and R6). Room 101 had three beds, with currently only two residents residing in the room (R12 and R2). The three resident rooms in the facility did not meet the space requirement. On 1/11/15 the Maintenance Director provided the measurements of the rooms: - The total square footage in room 101 measured 227.7 square feet, providing each individual with 75.8 square feet of living space, - Room 102 measured 216 square feet, providing each individual with 72 square feet of living space, - Room 202 measured 196 square feet, providing each individual with 65 square feet of living space. Residents residing in the rooms were interviewed and did not offer complaints or a desire to change rooms. A room-size waiver was in place at the time of the survey. During interview on 2/12/15, at 9:10 a.m. the licensed practical nurse (LPN)-A stated the facility was planning on admitting a new female resident in the near future as the third resident in room 101.	F 458	Waiver requested 2-26-2015 Residents involved in the indicated rooms have been interviewed by the owner. Each resident expressed no dissatisfaction with their own personal space in their rooms. Granting this waiver will not adversely affect the health and safety of the residents. 3-12-2015 Please see attached letter uploaded on 3-6-2015. In addition, per telephone conversation on 3-10-2015 with Gloria Derfus, Unit Supervisor, the Elliot waiver request letter was faxed to Gloria Derfus at fax number 651-215-9697 on the afternoon of 3-10-2015.	

ELLIOT CARE HOME, INC.
1500 ELLIOT AVE SO
MPLS, MN 55404
612-339-2291

Facsimile Transmission Cover Sheet

Date: 3/20/15 Number of Pages Including Cover Sheet 3

To: MDH

Attn: GLORIA DERFUS Fax# 651-215-9697

From: MARK JEFFERIS, ADMINISTRATOR

Memo: WAIVER REQUEST LETTERS TAG F354 + F353 FROM SURVEY DONE 2/12/2015.

*The information in this fax contains confidential information. If you receive this fax in error, please call 612-339-2291 immediately. Thank you.

Elliot Care Home, Inc.
Kimberly Louricas
1500 Elliot Ave. S.
Minneapolis, MN 55404

March 20, 2015

Gloria Derfus, Unit Supervisor
Minnesota Department of Health
1645 Energy Park Drive
St. Paul, MN 55108-2790

Dear Gloria,

The Elliot Care Home had a standard survey completed by the Minnesota Department of Health and Public Safety on 2-12-2015 and received a deficiency related to the following federal regulation for which we request a waiver.

F353 483.30 (a)(1) & (2) Nursing Services

Each resident's primary physician has signed a statement stating that in his/her opinion, it is not necessary to require 24 hours of licensed nursing care, but minimal supervision for ADL's due to each resident's ambulatory status and capability of self preservation. Also, the program director, DON, administrator, owner are all available by cell phone with pagers.

This waiver request seeks to include the use of a Trained Medication Aide (TMA) on the 11:00 PM to 7:00 AM shift, the 3:00 PM to 11:00 PM shift and the 7:00 to 3:00 PM shift only when necessary.

Sincerely,

Mark T. Jefferis
Administrator

Elliot Care Home, Inc.
Kimberly Louricas
1500 Elliot Ave. S.
Minneapolis, MN 55404

March 20, 2015

Gloria Derfus, Unit Supervisor
Minnesota Department of Health
1645 Energy Park Drive
St. Paul, MN 55108-2790

Dear Gloria,

The Elliot Care Home had a standard survey completed by the Minnesota Department of Health and Public Safety on 2-12-2015 and received a deficiency related to the following federal regulation for which we request a waiver.

F353 483.30 (a)(1) & (2) Nursing Services

Each resident's primary physician has signed a statement stating that in his/her opinion, it is not necessary to require 24 hours of licensed nursing care, but minimal supervision for ADL's due to each resident's ambulatory status and capability of self preservation. Also, the program director, DON, administrator, owner are all available by cell phone with pagers.

This waiver request seeks to include the use of a Trained Medication Aide (TMA) on the 11:00 PM to 7:00 AM shift, the 3:00 PM to 11:00 PM shift and the 7:00 to 3:00 PM shift only when necessary.

Sincerely,

Mark T. Jefferis
Administrator

Elliot Care Home, Inc.
Kimberly Louricas
1500 Elliot Ave. S.
Minneapolis, MN 55404

February 26, 2015
revised letter: March 20, 2015

Gloria Derfus, Unit Supervisor
Minnesota Department of Health
1645 Energy Park Drive
St. Paul, MN 55108-2790

RE: Revised waiver request letter specific to F354

Dear Gloria,

The Elliot Care Home had a standard survey completed by the Minnesota Department of Health and Public Safety on 2-12-2015 and received a deficiency related to the following federal regulation for which we request a waiver. This letter seeks to provide additional information over and above the request letter dated 2-26-2015 based on the initial rejection on ePOC dated 3-19-2015.

F354 483.30 (b)(1)-(3) Nursing Services

At the present time, with the residents currently residing at Elliot, the lack of an RN on the premises 8 hours per day will not jeopardize the care of the residents. All of the residents' primary care physicians have indicated that the residents are capable of self preservation with the DON monitoring their care 8 hours per week. The owner monitors the DON's hours per pay period to assure hours are no less than 8 per week. Additionally, the facility has attempted to hire an RN full time.

During this past year the Elliot Care Home has advertised for a full time RN with the following means:

1. Minnesota Department of Employment and Economic Development on going and renewed
2. Minneapolis-CSM Simplicity which is the job advertising site for metro area colleges on going and renewed
3. Minneapolis Jobs.com on going and renewed
4. Craigs List first three months
5. The Elliot Care has offered all its part time RN's full time hours.
6. Word of mouth networking with the Elliot Care Home pharmacist consultant and dietician monthlty and the medical director quarterly of available full time RN position

During this current year the Elliot Care Home will advertise for a full time RN with the following means:

1. Minnesota Department of Employment and Economic Development on going and renewed
2. Minneapolis-CSM Simplicity which is the job advertising site for metro area colleges on going and renewed
3. Minneapolis Jobs.com on going and renewed
4. Career Builders.com will be used with a frequency based on a review of cost
5. The Elliot Care has offered all its part time RN's full time hours.
6. Word of mouth networking with the Elliot Care Home pharmacist consultant and dietician monthlty and the medical director quarterly of available full time RN position

Therefore, the Elliot Care Home requests a waiver for F354.

Sincerely,

Mark T. Jefferis
Administrator

Elliot Care Home, Inc.
Kimberly Louricas
1500 Elliot Ave. S.
Minneapolis, MN 55404

February 26, 2015

Gloria Derfus, Unit Supervisor
Minnesota Department of Health
1645 Energy Park Drive
St. Paul, MN 55108-2790

Dear Gloria,

The Elliot Care Home had a standard survey completed by the Minnesota Department of Health and Public Safety on 2-12-2015 and received deficiencies related to the following federal regulations for which we request waivers. Following each tag and regulation number our reasons for requesting waivers are explained.

F353 483.30 (a)(1) & (2) Nursing Services

Each resident's primary physician has signed a statement stating that in his/her opinion, it is not necessary to require 24 hours of licensed nursing care, but minimal supervision for ADL's due to each resident's ambulatory status and capability of self preservation. Also, the program director, DON, administrator, owner are all available by cell phone with pagers.

This waiver request seeks to include the use of a Trained Medication Aide (TMA) on the 11:00 PM to 7:00 AM shift, the 3:00 PM to 11:00 PM shift and the 7:00 to 3:00 PM shift only when necessary.

F354 483.30 (b)(1)-(3) Nursing Services

At the present time, with the residents currently residing at Elliot, the lack of an RN on the premises 8 hours per day will not jeopardize the care of the residents. All of the residents' primary care physicians have indicated that the residents are capable of self preservation with the DON monitoring their care 8 hours per week. The owner monitors the DON's hours per pay period to assure hours are no less than 8 per week. Additionally, the facility has attempted to hire an RN full time. We request a waiver.

F 458 483.70 (d)(1)(ii) Physical Environment

Residents involved in the indicated rooms have been interviewed by the owner. Each resident expressed no dissatisfaction with their own personal space in their rooms. Granting this waiver will not adversely affect the health and safety of the residents.

Please do not hesitate to contact me and/or Kim Louricas, Owner and Program Director if you should need additional information.

Sincerely,

Mark T. Jefferis
Administrator

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24E152	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**02/17/2015**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELLIOT CARE HOME INC	**1500 ELLIOT AVENUE SOUTH** **MINNEAPOLIS, MN 55404**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS	K 000		

FIRE SAFETY

A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety. At the time of this survey, Elliot Care Home 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 TO:

Healthcare Fire Inspections
State Fire Marshal Division
445 Minnesota St., Suite 145
St. Paul, MN 55101-5145, OR

By email to:
Marian.Whitney@state.mn.us

EPOC

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

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

2. The actual, or proposed, completion date.

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		03/06/2015

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELLIOT CARE HOME INC	**1500 ELLIOT AVENUE SOUTH** **MINNEAPOLIS, MN 55404**

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K 000	Continued From page 1 Elliot Care Home is a 3-story building with a full basement. The building was constructed in 1906 and was determined to be of Type V(111) construction. The building is fully fire sprinkler protected. The facility has a complete fire alarm system with smoke detection in the corridors and spaces open to the corridor, that is monitored for automatic fire department notification. The facility has a licensed capacity of 15 beds and had a census of 14 at the time of the survey. The requirement at 42 CFR Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 012 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Building construction type and height meets one of the following. 19.1.6.2, 19.1.6.3, 19.1.6.4, 19.3.5.1 This STANDARD is not met as evidenced by: Based on observation and interview, this building does not meet the requirements for construction type and height. This deficient practice could affect all residents. Findings include: During a tour of the facility between 10:00 AM and 11:30 AM on 02/17/2015, observation revealed that this 1906, 3-story, fully fire sprinklered building of Type V(111) construction does not meet the minimum construction requirements of the code for type and height. This deficient practice was verified by the administrator at the time of the inspection. Note: This deficiency need not be corrected if an	K 012	K012 NFPA 101 Life Safety Code Standard Elliot Care Home has passed the FSES on 2-18-2015.	2/26/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24E152	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**02/17/2015**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELLIOT CARE HOME INC	**1500 ELLIOT AVENUE SOUTH** **MINNEAPOLIS, MN 55404**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 012	Continued From page 2 FSES can establish that the facility has an overall level of fire safety equivalent to that required by the Life Safety Code.	K 012		
K 033 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Exit components (such as stairways) are enclosed with construction having a fire resistance rating of at least one hour, are arranged to provide a continuous path of escape, and provide protection against fire or smoke from other parts of the building. 8.2.5.2, 19.3.1.1 This STANDARD is not met as evidenced by: Based on observation, the stairway enclosure of this facility does not meet the required one (1) hour fire resistive construction. This deficient practice could affect all residents. Findings include: On facility tour between 10:00 AM and 11:30 AM on 02/17/2015, observation revealed that the wall of the 2 stair enclosures are constructed of plaster on wood lath on wood studs, which does not meet minimum the requirements for this type of facility. This deficient practice was verified by maintenance at the time of the inspection. Note: This deficiency need not be corrected if an FSES can establish that the facility has an overall level of fire safety equivalent to that required by the Life Safety Code.	K 033	K033 NFPA 101 Life Safety Code Standard Elliot Care Home has passed the FSES on 2-18-2015.	2/26/15
K 040	NFPA 101 LIFE SAFETY CODE STANDARD	K 040		2/26/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24E152	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**02/17/2015**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELLIOT CARE HOME INC	**1500 ELLIOT AVENUE SOUTH** **MINNEAPOLIS, MN 55404**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 040 SS=F	Continued From page 3 Exit access doors and exit doors used by health care occupants are of the swinging type and are at least 32 inches in clear width. 19.2.3.5 This STANDARD is not met as evidenced by: Based on observation, the resident room doors on the 2nd floor do not meet the 32-inch clear width requirement. This deficient practice could affect all residents. Findings include: On facility tour between 10:00 AM and 11:30 AM on 02/17/2015, observation revealed that the doors to all five (5) resident rooms on the 2nd floor were found to be only 31 inches in clear width. This does not meet the 32-inch requirement for existing exit access doors. This deficient practice was verified by maintenance at the time of the inspection. Note: This deficiency need not be corrected if an FSES can establish that the fire has an overall level of fire safety equivalent to that required by the Life Safety Code.	K 040	K040 NFPA 101 Life Safety Code Standard Elliot Care Home has passed the FSES on 2-18-2015.	

Sheehan, Pat (DPS)

From: Sheehan, Pat (DPS)
Sent: Monday, February 23, 2015 3:00 PM
To: rochi_lsc@cms.hhs.gov
Cc: robert.rexeisen@state.mn.us; 'kimlouricas@netzero.net'; Dietrich, Shellae (MDH); 'Fiske-Downing, Kamala'; Henderson, Mary (MDH); 'Johnston, Kate'; Kleppe, Anne (MDH); Leach, Colleen (MDH); marian.whitney@state.mn.us; Meath, Mark (MDH); Zwart, Benjamin (MDH)
Subject: Elliot Care Hme (24E152) 2015 FSES - Previously Approved - No Changes

This is to inform you that I am accepting the FSES report that was conducted on 2-17-15 at the Elliot Care Home. The exit date was 2-17-15.

I am recommending that CMS approved this report.

Patrick Sheehan, Fire Safety Supervisor
Office: 651-201-7205 Cell: 651-470-4416
Health Care & Corrections Fire Inspections
Minnesota State Fire Marshal Division Est. 1905
445 Minnesota St., Suite 145, St Paul, MN 55101-5145
FAX: 651-215-0525
Web: fire.state.mn.us

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

FE152024

Form Approved
OMB No. 0938-0242

ZONE 1 OF 4 ZONES

FIRE/SMOKE ZONE* EVALUATION WORKSHEET FOR HEALTH CARE FACILITIES

2000 LIFE SAFETY CODE

FACILITY ELLIOT CARE HOME	BUILDING 01-MAIN BUILDING
ZONE(S) EVALUATED BASEMENT	
PROVIDER/VENDOR NO. 23E152	DATE OF SURVEY 02/17/2015

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

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

TABLE 1. OCCUPANCY RISK PARAMETER FACTORS

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

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

TABLE 2. OCCUPANCY RISK FACTOR CALCULATION

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

	F		R
1.0 X	☐	=	☐

TABLE 3B. (EXISTING BUILDINGS)

	F		R
0.6 X	1.60	=	1

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

SURVEYOR SIGNATURE ROBERT REXEISEN	TITLE DEPUTY STATE FIRE MARSHAL	DATE 02/17/2015
FIRE AUTHORITY SIGNATURE	TITLE FIRE SAFETY SUPERVISOR	DATE 2-23-15

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

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

TABLE 4.

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

NOTE:

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

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

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

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

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

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

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

For SI units: 1 ft = 0.3048 m

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

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

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

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

TABLE 5. INDIVIDUAL SAFETY EVALUATIONS

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

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

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

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

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

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

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

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

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

TABLE 7. ZONE FIRE SAFETY EQUIVALENCY EVALUATION									Yes	No
Containment Safety (S_1)	minus	Mandatory Containment (S_a)	≥ 0	S_1 18	−	S_a 9	=	C 9	✓	
Extinguishment Safety (S_2)	minus	Mandatory Extinguishment (S_b)	≥ 0	S_2 13	−	S_b 7	=	E 7	✓	
People Movement Safety (S_3)	minus	Mandatory People Movement (S_c)	≥ 0	S_3 5	−	S_c 2	=	P 2	✓	
General Safety (S_4)	minus	Occupancy Risk (R)	≥ 0	S_4 15	−	R 1	=	G 14	✓	

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

CONCLUSIONS

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

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

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

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

FE152024

Form Approved
OMB No. 0938-0242

ZONE 2 OF 4 ZONES

FIRE/SMOKE ZONE* EVALUATION WORKSHEET FOR HEALTH CARE FACILITIES

2000 LIFE SAFETY CODE

FACILITY	BUILDING
ELLIOT CARE HOME	01-MAIN BUILDING

ZONE(S) EVALUATED: FIRST FLOOR

PROVIDER/VENDOR NO.	DATE OF SURVEY
23E152	02/17/2015

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

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

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

TABLE 1. OCCUPANCY RISK PARAMETER FACTORS

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

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

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

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

TABLE 2. OCCUPANCY RISK FACTOR CALCULATION

	M		D		L		T		A		F
OCCUPANCY RISK	1.0	X	1.5	X	1.1	X	4.0	X	1.2	=	7.92

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

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

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

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

TABLE 3A. (NEW BUILDINGS)

	F		R
1.0 X		=	

TABLE 3B. (EXISTING BUILDINGS)

	F		R
0.6 X	7.92	=	5

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

SURVEYOR SIGNATURE ROBERT REXEISEN		TITLE DEPUTY STATE FIRE MARSHAL	DATE 02/17/2015
FIRE AUTHORITY SIGNATURE		TITLE FIRE SAFETY SUPERVISOR	DATE 2-23-15

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

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

TABLE 4.

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

NOTE:

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

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

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

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

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

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

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

For SI units: 1 ft = 0.3048 m

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

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

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

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

TABLE 5. INDIVIDUAL SAFETY EVALUATIONS

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

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

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

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

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

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

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

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

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

TABLE 7. ZONE FIRE SAFETY EQUIVALENCY EVALUATION									Yes	No
Containment Safety (S_1)	minus	Mandatory Containment (S_a)	≥ 0	S_1 10	−	S_a 5	=	C 5	✓	
Extinguishment Safety (S_2)	minus	Mandatory Extinguishment (S_b)	≥ 0	S_2 15	−	S_b 4	=	E 11	✓	
People Movement Safety (S_3)	minus	Mandatory People Movement (S_c)	≥ 0	S_3 3	−	S_c 1	=	P 2	✓	
General Safety (S_4)	minus	Occupancy Risk (R)	≥ 0	S_4 7	−	R 5	=	G 2	✓	

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

CONCLUSIONS

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

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

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

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

FE152024

Form Approved
OMB No. 0938-0242

ZONE 3 OF 4 ZONES

FIRE/SMOKE ZONE* EVALUATION WORKSHEET FOR HEALTH CARE FACILITIES

2000 LIFE SAFETY CODE

FACILITY	BUILDING
ELLIOT CARE HOME	01-MAIN BUILDING

ZONE(S) EVALUATED: SECOND FLOOR

PROVIDER/VENDOR NO.	DATE OF SURVEY
23E152	02/17/2015

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

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

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

TABLE 1. OCCUPANCY RISK PARAMETER FACTORS

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

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

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

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

TABLE 2. OCCUPANCY RISK FACTOR CALCULATION

	M		D		L		T		A		F
OCCUPANCY RISK	1.0	X	1.2	X	1.2	X	4.0	X	1.2	=	6.90

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

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

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

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

TABLE 3A. (NEW BUILDINGS)

	F		R
1.0 X		=	

TABLE 3B. (EXISTING BUILDINGS)

	F		R
0.6 X	6.90	=	4

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

SURVEYOR SIGNATURE ROBERT REXEISEN		TITLE DEPUTY STATE FIRE MARSHAL	DATE 02/17/2015
FIRE AUTHORITY SIGNATURE		TITLE FIRE SAFETY SUPERVISOR	DATE 2-23-15

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

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

TABLE 4.

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

NOTE:

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

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

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

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

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

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

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

For SI units: 1 ft = 0.3048 m

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

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

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

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

TABLE 5. INDIVIDUAL SAFETY EVALUATIONS

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

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

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

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

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

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

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

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

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

TABLE 7. ZONE FIRE SAFETY EQUIVALENCY EVALUATION								Yes	No
Containment Safety (S_1)	minus	Mandatory Containment (S_a)	≥ 0	S_1 14	−	S_a 9	= C 5	✓	
Extinguishment Safety (S_2)	minus	Mandatory Extinguishment (S_b)	≥ 0	S_2 13	−	S_b 6	= E 7	✓	
People Movement Safety (S_3)	minus	Mandatory People Movement (S_c)	≥ 0	S_3 3	−	S_c 3	= P 0	✓	
General Safety (S_4)	minus	Occupancy Risk (R)	≥ 0	S_4 11	−	R 4	= G 7	✓	

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

CONCLUSIONS

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

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

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

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

FE152024

Form Approved
OMB No. 0938-0242

ZONE 4 OF 4 ZONES

FIRE/SMOKE ZONE* EVALUATION WORKSHEET FOR HEALTH CARE FACILITIES

2000 LIFE SAFETY CODE

FACILITY	BUILDING
ELLIOT CARE HOME	01-MAIN BUILDING

ZONE(S) EVALUATED: THIRD FLOOR

PROVIDER/VENDOR NO.	DATE OF SURVEY
23E152	02/17/2015

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

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

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

TABLE 1. OCCUPANCY RISK PARAMETER FACTORS

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

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

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

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

TABLE 2. OCCUPANCY RISK FACTOR CALCULATION

	M		D		L		T		A		F
OCCUPANCY RISK	☐	X	☐	X	1.2	X	☐	X	☐	=	1.20

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

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

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

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

TABLE 3A. (NEW BUILDINGS)

	F		R
1.0 X	☐	=	☐

TABLE 3B. (EXISTING BUILDINGS)

	F		R
0.6 X	1.20	=	1

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

SURVEYOR SIGNATURE ROBERT REXEISEN		TITLE DEPUTY STATE FIRE MARSHAL	DATE 02/17/2015
FIRE AUTHORITY SIGNATURE		TITLE FIRE SAFETY SUPERVISOR	DATE 2-23-15

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

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

TABLE 4.

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

NOTE:

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

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

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

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

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

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

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

For SI units: 1 ft = 0.3048 m

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

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

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

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

TABLE 5. INDIVIDUAL SAFETY EVALUATIONS

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

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

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

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

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

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

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

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

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

TABLE 7. ZONE FIRE SAFETY EQUIVALENCY EVALUATION									Yes	No
Containment Safety (S_1)	minus	Mandatory Containment (S_a)	≥ 0	S_1 9	−	S_a 9	=	C 0	✓	
Extinguishment Safety (S_2)	minus	Mandatory Extinguishment (S_b)	≥ 0	S_2 8	−	S_b 6	=	E 2	✓	
People Movement Safety (S_3)	minus	Mandatory People Movement (S_c)	≥ 0	S_3 3	−	S_c 3	=	P 0	✓	
General Safety (S_4)	minus	Occupancy Risk (R)	≥ 0	S_4 6	−	R 1	=	G 5	✓	

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

CONCLUSIONS

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

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

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

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered
February 26, 2015

Mr. Mark Jefferis, Administrator
Elliot Care Home Inc
1500 Elliot Avenue South
Minneapolis, Minnesota 55404

Re: Enclosed State Boarding Care Home Licensing Orders - Project Number SE152024

Dear Mr. Jefferis:

The above facility survey was completed on February 12, 2015 for the purpose of assessing compliance with Minnesota Department of Health Boarding Care Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health, Compliance Monitoring 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.

The State licensing orders are delineated on the attached Minnesota Department of Health order form (attached). 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 Boarding Care Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute after the statement, "This Rule is not met as evidenced by." Following the surveyors findings is 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.

When all orders are corrected, the order form should be acknowledged electronically and submitted to this office at 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 me.

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 with any questions related to this letter.

Sincerely,

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00195	A. BUILDING: _____ B. WING _____	02/12/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELLIOT CARE HOME INC	1500 ELLIOT AVENUE SOUTH MINNEAPOLIS, MN 55404

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
3 000	INITIAL COMMENTS *****ATTENTION****** BOARDING CARE HOME LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On January 9th, 10th, 11th and 12th, surveyors of this Department's staff, visited the above provider and the following correction orders are issued. When corrections are completed, please sign and date, make a copy of these orders and return the original to the Minnesota Department of	3 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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3 000	Continued From page 1 Health, Division of Compliance Monitoring, Licensing and Certification Program; 85 East Seventh Place, Suite 220; P.O. Box 64900, St. Paul, Minnesota 55164-0900. BOARDING CARE HOME LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.	3 000		
3 601	MN St. Statute 144.56 Subp. 2c Tuberculosis Prevention And Control	3 601		3/6/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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3 601	Continued From page 2 (a) A boarding care home must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in CDC's Morbidity and Mortality Weekly Report (MMWR). This program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, residents, and volunteers. The Department of Health shall provide technical assistance regarding implementation of The guidelines. (b) Written compliance with this subdivision must be maintained by the boarding care home. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure tuberculosis (TB) screening was completed within 72 hours from admission and received a tuberculin skin test (TST) for 1 of 1 resident (R15), and failed to ensure 1of 2 employees (nursing assistant (NA)-A) had Baseline TB Screening Tool for Health Care Workers completed upon hire. In addition, the facility failed to ensure 1 of 2 employees (activities staff-A) received a 2nd TST.	3 601	Corrected as of 3-6-2015	

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3 601	Continued From page 3 Findings include: R15 was admitted to the facility on 1/23/15, and the Baseline TB Screening Tool for Nursing Home and Boarding Care Homes Residents had not been completed. The medical record revealed R15 had a chest x-ray completed on 1/27/15, which was four days after he had lived at the facility. In addition, the the chest x-ray did not indicated the reason and/or if R15 had a past history of positive TST and no medical evaluation was completed after to rule out infectious disease. Review of nursing assistant (NA)-A personnel file reviewed a hire date of 4/23/14. During further review, it was revealed NA-A had Interferon Gamma Release Assay (TB blood test) completed 4/24/14, which had a negative result but had not completed the Baseline TB Screening Tool for Health Care Workers. Review of activities staff-A personnel file revealed a hire dated of 1/7/14, on the same date a TB symptom screening had been completed and a staff had received 1st step TST which was read 1/9/14, as negative and no induration. During further review, it was revealed activity staff-A had not received the 2nd step TST. On 2/12/15, at 9:17 a.m. licensed practical nurse (LPN)-A also the program manager verified the finding for the activities staff indicated that was during the shortage of the solution and because of the facility and the employee were low risk the 2nd step TST had not been given. -9:15 a.m. LPN-A verified NA-A had no TB Screening Tool completed in the personnel file. LPN-A further indicated, "I will check to see if it got mixed up with another staff."	3 601		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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3 601	Continued From page 4 On 2/12/15, at 9:19 a.m. LPN-A verified R15 had a chest x-ray done 1/27/15, when asked the reason why the chest x-ray had been done she indicated "we opted for the x-ray because we did not have a record if he had a positive Mantoux in the past or was contraindicated.We are low risk facility." - When asked if a medical examination had been done to rule out infectious disease she verified that was never done. -At 9:23 a.m. LPN-A verified there was no TB Screening for R15 in the chart she indicated "Am not sure if it was not done I hate to really on my memory but will look in the admission checklist." On 2/12/15, at 1:06 p.m. LPN-A indicated the chest x-ray had been scheduled prior to R15 moving into the facility and was not done to for ruling out infectious disease. LPN-A acknowledged it should have been done to protect the residents and the staff at the facility. LPN-A further indicated all the residents had to be tested or receive TST prior to being admitted at the facility. Tuberculosis Preventation and Control Policies and Procedures dated May 2014, directed "Elliot Care Home conducts resident baseline ** TB screening upon admission to the Elliot Home with results placed in the resident's chart... Elliot Care Home conducts new employee baseline ** TB screening with result placed in the personnel files..." SUGGESTED METHOD FOR CORRECTION: The director of nursing could educate nursing staff on appropriate documentation of results of TST per Centers for Disease Control and Prevention (CDC) recommendations. The director	3 601		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
3 601	Continued From page 5 of nursing and/or designee could assure facility policies are current, implemented and monitored and provide direction on how to properly perform, read and document results of a TST. TIME PERIOD FOR CORRECTION: Twenty One (21) days.	3 601		
31942	MN Rule 144A.10 Subd. 8b Establish Resident and Family Councils Resident advisory council. Each nursing home or boarding care home shall establish a resident advisory council and a family council, unless fewer than three persons express an interest in participating. If one or both councils do not function, the nursing home or boarding care home shall document its attempts to establish the council or councils at least once each calendar year. This subdivision does not alter the rights of residents and families provided by section 144.651, subdivision 27. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to attempt to form a family council within the past calendar year as required. This had the potential to affect all 14 residents who resided in the facility. Findings include: On 2/10/15, at 2:07 p.m. the program director stated "We used to have a family council and some of the people have died or are not able to come to the facility." When asked when a family council was last attempted to be formed program	31942	Completed as of 3-6-2015	3/6/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00195	A. BUILDING: _____ B. WING _____	02/12/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELLIOT CARE HOME INC	1500 ELLIOT AVENUE SOUTH MINNEAPOLIS, MN 55404

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
31942	Continued From page 6 director indicated " probably two years ago there is no formal family council and no family members come here but I do talk to two family members regularly and that is it. Most of our residents are their own self and have nobody who is involved in their lives." On 2/12/15, at 3:00 p.m. the policy was requested and the program manager indicated there was a policy but was not sure where it was and would fax a copy. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) and/or designee could review or revise policies, provide education for staff regarding formulation of a Family Council.	31942		

Minnesota Department of Health
Protecting, maintaining and improving the health of all Minnesotans

MINNESOTA MDH DEPARTMENT of HEALTH

Confirmation page! Thank you for using the data entry system.
If you have comments please send to:
monica.larson@health.state.mn.us

Please print this page and give it to your state survey team. A page for both the CMS-671 and CMS-672 will be required to complete the process.	Print this Page
Would you like to go to the CMS-672 form for data entry?	Go to CMS-672
I'm finished and would like to exit the application.	Exit

Standard Survey Date Format: mm/dd/yy From F1: **02/09/15** To F2: **02/12/15**	Extended Survey Date Format: mm/dd/yy From F3: To F4:	
Name of Facility: **ELLIOT CARE HOME INC**	Provider Number: **24E152**	Fiscal Year ending:
Address: **1500 ELLIOT AVENUE SOUTH, MINNEAPOLIS, HENNEPIN, MN 55404**		
Telephone Number: F6 **612-339-2291**	State/County Code: **MN / HENNEPIN**	State/Region Code: **MN / 05**
A. F9 **02 - Nursing Facility (NF) - Medicaid** Participation B. Is this facility hospital based? F10 **No** If yes, indicate Hopsital Provider Number: F11		
Ownership: F12 **03 - For Profit - Corporation**		
Owned or leased by Multi-Facility Organization: F13 **No** Name of Multi-Facility Organization: F14		
Dedicated Special Care Units (show number of beds for all that apply)		
AIDS F15 **0** Dialysis F17 **0** Head Trama F19 **0**	Alzheimer's Disease F16 **0** Disabled Child Young Adult F18 **0** Hospice F20 **0**	

Huntington's Disease F21 **0** Ventilator/Respiratory Care F22 **0**
Other Spec Rehab. F23 **0**

Does the facility currently have an organized resident group? F24	**Yes**
Does the facility currently have an organized group of family members of residents? F25	**No**
Does the facility conduct experimental research? F26	**No**
Is the facility part of a continuing care retirement community (CCRC)? F27	**No**

If the facility currently has a staffing waiver, indicate the type(s) of waiver(s) by writing in the date(s) of the last approval. Indicate the number of hours waived for each type of waiver granted. If the facility does not have a waiver, write NA in the blanks.

Waiver of seven day RN requirement.	Date: mm/dd/yy F28 **04/14/14**	Hours waived per week: F29 **64**
Waiver of 24 hr licensed nursing requirement.	Date: mm/dd/yy F30 **04/14/14**	Hours waived per week: F31 **114**

Does the facility currently have an approved nurse aide training and competency program? F32	**No**

The following three questions are to be completed by the survey team.

1) Was this a staggered Survey?	**Surveyor to complete**
2) If staggered, day of the week starting?	**Surveyor to Complete**
3) If staggered, starting time?	**Surveyor to complete AM**

FACILITY STAFFING

		A	B	C	D
	Tag #	Services Provided 1 2 3	Full-Time Staff (hours)	Part-Time Staff (hours)	Contract (hours)
Administration	F33		**0**	**8**	**0**
Physician Services	F34	**No No Yes**			
Medical Director	F35		**0**	**0**	**0**
Other Physician	F36		**0**	**0**	**0**
Physician Extender	F37	**No No Yes**	**0**	**0**	**0**

Nursing Services	F38	Yes No Yes			
RN Director of Nursing	F39		0	16	0
Nurses with Admin Duties	F40		0	16	0
Registered Nurses	F41		0	52	0
Licensed Practical/ Vocational Nurses	F42		80	34	0
Certified Nurse Aides	F43		0	0	0
Nurse Aides in Training	F44		0	0	0
Medication	F45		80	104	0
Pharmacists	F46	Yes No No	0	0	4
Dietary Services	F47	Yes No No			
Dietitian	F48		0	0	0
Food Service Workers	F49		72	48	0
Therapeutic Services	F50				
Occupational Therapist	F51	No No No	0	0	0
Occupational Therapy Assistant	F52		0	0	0
Occupational Therapy Aides	F53		0	0	0
Physical Therapist	F54	No No No	0	0	0
Physical Therapy Assist	F55		0	0	0
Physical Therapy Aides	F56		0	0	0
Speech/Language	F57	No No No	0	0	0
Therapeutic Recreation Spec.	F58	No No No	0	0	0
Qualified Activities Prof.	F59	No No Yes	0	0	0
Other Activities Staff	F60	Yes No Yes	0	100	0
Qualified Social Workers	F61	No No Yes	0	0	0

Other Social Services Staff	F62	Yes No Yes	20	0	0
Dentists	F63	No No Yes	0	0	0
Podiatrists	F64	No No Yes	0	0	0
Mental Health Services	F65	No No Yes	0	0	0
Vocational Services	F66	No No No			
Clinical Laboratory Services	F67	Yes No Yes			
Diagnostic X-ray Services	F68	No No Yes			
Administration Storage of Blood	F69	Yes No No			
Housekeeping Services	F70	Yes No No	72	0	0
Other	F71		0	36	0
Name of Person Completing Form: **Kimberly Louricas**					Date: **02/13/15**

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See also > Compliance Monitoring Home

For questions about this page, please contact our Compliance Monitoring Division: health.fpc-web@state.mn.us

- Certificates & Records
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- Environments & Your Health
- Facilities & Professions
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- Prevention & Healthy Living
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ELLIOT CARE HOME INC				
Provider No. **24E152**	Medicare F75 **0**	Medicaid F76 **14**	Other F77 **0**	Total Residents F78 **14**

ADL	Independent	Assist of One Two Staff	Dependent
Bathing	F79 **10**	F80 **4**	F81 **0**
Dressing	F82 **11**	F83 **3**	F84 **0**
Transferring	F85 **14**	F86 **0**	F87 **0**
Toilet Use	F88 **14**	F89 **0**	F90 **0**
Eating	F91 **14**	F92 **0**	F93 **0**

A. Bowel/Bladder Status	**B. Mobility**
F94 **0** With indwelling or external catheter.	F100 **0** Bedfast all or most of time..
F95 Of total number of residents with catheters, **0** were present on admission.	F101 **0** In chair all or most of time.
	F102 **14** Independently ambulatory.

F96 **7** Occasionally or frequently incontinent of bladder.

F97 **2** Occasionally or frequently incontinent of bowel.

F98 **6** On individually written bladder training program.

F99 **0** On individually written bowel training program.

F103 **1** Ambulation with assistance or assistive device.

F104 **0** Physically restrained.

F105 Of total number of residents with restrained, **0** were admitted with orders for restraints.

F106 **0** With contractures.

F107 Of total number of residents with contractures, **0** had contractures on admission.

C. Mental Status

F108 **0** With mental retardation.

F109 **4** With documentation signs and symptoms of depression.

F110 **13** With documentation psychiatric diagnosis (excluding dementias and depression).

F111 **0** Dementia: multi-infarct, senile, Alzheimer's type, or other than Alzheimer's type.

F112 **14** With behavioral symptoms.

F113 **14** Of the total number of residents with behavioral symptoms, the total number receiving a behavior management prpgram.

F114 **0** Receiving health rehabilitative services for MI/MR.

D. Skin Integrity

F115 **0** With pressure sores (exclude stage I).

F116 **0** Of the total number of residents with pressure sores excluding stage I, how many residents had pressure sores on admission?

F117 **2** Receiving preventive skin care.

F118 **0** With rashes.

E. Special Care

F119 **0** Receiving hospice care benefit.

F120 **0** Receiving radiation therapy.

F121 **0** Receiving chemotherapy.

F127 **0** Receiving suction.

F128 **0** Receiving injections (exclude vitamin B12 injections)

F129 **0** Receiving tube feedings.

F122 **0** Receiving dialysis. F123 **0** Receiving intravenous therapy, parenteral nutrition, and/or blood transfusion. F124 **0** Receiving respiratory treatment. F125 **0** Receiving tracheostomy care. F126 **0** Receiving ostomy care.	F130 **0** Receiving mechanically altered diets including pureed and all chopped food (not only meat). F131 **0** Receiving specialized rehabilitative services (Physical therapy, speech-language therapy, occupational therapy). F132 **0** Assistive devices while eating.

F. Medication	**G. Other**
F133 **13** Receiving any psychoactive medication. F134 **11** Receiving antipsychotic medications. F135 **4** Receiving antianxiety medications. F136 **7** Receiving antidepressant medications. F137 **0** Receiving hypnotic medication. F138 **0** Receiving antibiotics. F139 **0** On pain management program.	F140 **0** With unplanned significant weight loss/gain. F141 **0** Who do not communicate in the dominant language of the facility (includes those who use sign language). F142 **0** Who use non-oral communicationdevices. F143 **0** With advance directives. F144 **12** Received influenza immunization. F145 **5** Received pneumococcal vaccine.

I certify that this Information is accurate to the best of my knowledge.		
Name of Person Completing	Title	Date
Kimberly Louricas	**Program Director**	**02/13/2015**

To be completed by MDH survey team.
F146 Was ombudsman office notified prior to survey? **Yes**
F147 Was ombudsman present during any portion of the survey? **No**
F148 Medication error rate **0%**

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See also > Compliance Monitoring Home

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINSTRATION

FORM APPROVED
OMB No. 0938-0391

SURVEY TEAM COMPOSITION AND WORKLOAD REPORT

Provider/Supplier Number	Provider/Supplier Name
24E152	ELLIOT CARE HOME INC

Type of Survey (select all that apply):

I	K				

A Complaint Investigation
B Dumping Investigation
C Federal Monitoring
D Follow-up Visit
E Initial Certification
F Inspection of Care
G Validation
H Life safety Code
I Recertification
J Sanction/Hearing
K State License
L Chow

Extent of Survey (Select all that apply):

A					

A Routine/Standard (all providers/suppliers)
B Extended Survey (HHA or long term care facility)
C Partial Extended Survey (HHA)
D Other Survey

SURVEY TEAM AND WORKLOAD DATA

Please enter the workload information for each surveyor. Use the surveyor's information number.

Surveyor Id Number (A)	First Date Arrived (B)	Last Date Departed (C)	Pre-Survey Preparation Hours (D)	On-Site Hours 12am-8am (E)	On-Site Hours 8am-6pm (F)	On-Site Hours 6pm-12am (G)	Travel Hours (H)	Off-Site Report Preparation Hours (I)
1. Team Leader 30182	02-09-2015	02-12-2015	1.00	1.00	32.00	1.00	0.00	4.00
2. 32982	02-09-2015	02-12-2015	0.00	1.00	23.25	1.75	0.00	4.00
3.								
4.								
5.								
6.								
7.								
8.								
9.								
10.								

Total Supervisory Review Hours 2.75

Total Clerical/Data Entry Hours..... 3.25

Was Statement of Deficiencies given to the provider on-site at completion of the survey? ..... Y

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINSTRATION

FORM APPROVED
OMB No. 0938-0391

SURVEY TEAM COMPOSITION AND WORKLOAD REPORT

Provider/Supplier Number	Provider/Supplier Name
24E152	ELLIOT CARE HOME INC

Type of Survey (select all that apply):

H	K	I			

A Complaint Investigation
B Dumping Investigation
C Federal Monitoring
D Follow-up Visit
E Initial Certification
F Inspection of Care
G Validation
H Life safety Code
I Recertification
J Sanction/Hearing
K State License
L Chow

Extent of Survey (Select all that apply):

A					

A Routine/Standard (all providers/suppliers)
B Extended Survey (HHA or long term care facility)
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1. Team Leader 28120	02-17-2015	02-17-2015	0.50	0.00	1.50	0.00	2.00	2.00
2.								
3.								
4.								
5.								
6.								
7.								
8.								
9.								
10.								

Total Supervisory Review Hours 0.75

Total Clerical/Data Entry Hours.. 0.25

Was Statement of Deficiencies given to the provider on-site at completion of the survey? .....

FORM HCFA-670 (12-91)

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

PROVIDER NUMBER	FACILITY NAME	SURVEY DATE
K1 24-E152	Elliot Care Home, Inc	* K4 02/17/2015

K6 DATE OF PLAN APPROVAL

K3 MULTIPLE CONSTRUCTION

TOTAL NUMBER OF BUILDINGS 1

NUMBER OF THIS BUILDING _____

[A]

A BUILDING
B WING
C FLOOR
D APARTMENT UNIT

LSC FORM INDICATOR

Health Care Form		
12	2786R	2000 EXISTING
13	2786R	2000 NEW

ASC Form		
14	2786U	2000 EXISTING
15	2786U	2000 NEW

ICF/MR Form		
16	2786V, W, X	2000 EXISTING
17	2786V, W, X	2000 NEW

* K7 [12] SELECT NUMBER OF FORM USED FROM ABOVE

COMPLETE IF ICF/MR IS SURVEYED UNDER CHAPTER 21

SMALL (16 BEDS OR LESS)

K8: [ ] 1 PROMPT 2 SLOW 3 IMPRACTICAL

LARGE

K8: [ ] 4 PROMPT 5 SLOW 6 IMPRACTICAL

APARTMENT HOUSE

K8: [ ] 7 PROMPT 8 SLOW 9 IMPRACTICAL

(Check if K29 or K56 are marked as not applicable in the 2786 M, R, T, U, V, W, X and Y.)

K29: [ ] K56: [ ]

ENTER E – SCORE HERE

K5: [ ] e.g. 2.5

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

A1. [ ]	A2. [X]	A3. [ ]	A4. [X]	A5. [ ]
(COMP. WITH ALL PROVISIONS)	(ACCEPTABLE POC)	(WAIVERS)	(FSES)	(PERFORMANCE BASED DESIGN)

FACILITY DOES NOT MEET LSC

B. [ ]

K0180

A. [X]	B. [ ]	C. [ ]
FULLY SPRINKLERED (All required areas are sprinklered)	PARTIALLY SPRINKLERED (Not all required areas are sprinklered)	NONE (No sprinkler system)

* MANDATORY

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

FE152024

2000 CODE

Form Approved
OMB Exempt

FIRE SAFETY SURVEY REPORT 2000 CODE - HEALTH CARE
Medicare – Medicaid

1. (A) PROVIDER NUMBER	1. (B) MEDICAID I.D. NO.
K1 24E152	K2

PART I — Life Safety Code, New and Existing
PART IV — Waiver Recommendation Form

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

2. NAME OF FACILITY	2. (A) MULTIPLE CONSTRUCTION (BLDGS)	2. (B) ADDRESS OF FACILITY (STREET, CITY, STATE, ZIP CODE)	
ELLIOT CARE HOME, INC	A. BUILDING 1 B. WING C. FLOOR K3	1500 ELLIOT AVENUE SOUTH MINNEAPOLIS, MN 55404	A. (•) Fully Sprinklered (All required areas are sprinklered) B. ( ) Partially Sprinklered (Not all required areas are sprinklered) C. ( ) None (No sprinkler system) K0180

3. SURVEY FOR	4. DATE OF SURVEY	DATE OF PLAN APPROVAL	SURVEY UNDER
[✓] MEDICARE [✓] MEDICAID	K4 02/17/2015	K6	5. [✓] 2000 EXISTING 6. [ ] 2000 NEW K7

5. SURVEY FOR CERTIFICATION OF

1. ( ) HOSPITAL 2. (•) SKILLED/NURSING FACILITY 4. ( ) ICF/MR UNDER HEALTH CARE 5. ( ) HOSPICE

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

1. (•) ENTIRE FACILITY 2. ( ) DISTINCT PART OF (SPECIFY)_____

3. [ ] IF DISTINCT PART OF HOSPITAL, IS HOSPITAL ACCREDITED?
a. ( ) YES b. (•) NO

6. BED COMPOSITION				
a. TOTAL NO. OF BEDS IN THE FACILITY 15	b. NUMBER OF HOSPITAL BEDS CERTIFIED FOR MEDICARE ___	c. NUMBER OF SKILLED BEDS CERTIFIED FOR MEDICARE 15	d. NUMBER OF SKILLED BEDS CERTIFIED FOR MEDICAID 15	e. NUMBER OF NF or ICF/MR BEDS CERTIFIED FOR MEDICAID ___

7. A. (•) THE FACILITY MEETS, BASED UPON (CHECK ALL APPROPRIATE BOXES)

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

B. ( ) THE FACILITY DOES NOT MEET THE STANDARD
K9

SURVEYOR *(Signature)*	TITLE	OFFICE	DATE
ROBERT REXEISEN SURVEYOR ID 28120 K10	DEPUTY STATE FIRE MARSHAL	STATE FIRE MARSHAL	02/17/2015
FIRE AUTHORITY OFFICIAL *(Signature)*	**TITLE**	**OFFICE**	**DATE**
	FIRE SAFETY SUPERVISOR	STATE FIRE MARSHAL	2-23-15

ID PREFIX		MET	NOT MET	N/A	REMARKS
	PART I - LSC REQUIREMENTS - Items in italics relate to the FSES				K12- 3-story building with a full basement. The building was constructed in 1906 and was determined to be of Type V (111) construction. The building is fully fire sprinkler protected. The facility has a complete fire alarm system with smoke detection in the corridors and spaces open to the corridor, that is monitored for automatic fire department notification.
	BUILDING CONSTRUCTION				
K11	If the building has a common wall with a nonconforming building, the common wall is a fire barrier having at least a two hour fire resistance rating constructed of materials as required for the addition. Communicating openings occur only in corridors and shall be protected by approved self-closing fire doors with at least 1½ hour fire resistance rating 18.1.1.4.1, 18.1.1.4.2, 18.2.3.2, 19.1.1.4.1, 19.1.1.4.2	○	○	●	
K12	2000 EXISTING Building construction type and height meets one of the following: 19.1.6.2, 19.1.6.3, 19.1.6.4, 19.3.5.1	○	●	○	
	1 ○ I (443), I (332), II (222) — Any Height				
	2 ○ II (111) — One story only (non-sprinklered).				
	3 ○ II (111) — Not over three stories with complete automatic sprinkler system.				
	4 ○ III (211) — Not over two stories with complete automatic sprinkler system.				
	5 ● V (111) — Not over two stories with complete automatic sprinkler system.				
	6 ○ IV (2HH) — Not over two stories with complete automatic sprinkler system.				
	7 ○ II (000) — Not over two stories with complete automatic sprinkler system.				
	8 ○ III (200) — Not over one story with complete automatic sprinkler system.				
	9 ○ V (000) — Not over one story with complete automatic sprinkler system.				
	☐ Building contains fire treated wood. *Give a brief description, in REMARKS, of the construction, the number of stories, including basements, floors on which patients are located, location of smoke or fire barriers and dates of approval. Complete sketch or attach small floor plan of the building as appropriate.*				

ID PREFIX					MET	NOT MET	N/A	REMARKS
K12	2000 NEW Building construction type and height meets one of the following: 18.1.6.2, 18.1.6.3, 18.3.5.1.							
	1		I (443), I (332), II (222)	Any height with complete automatic sprinkler system				
	2		II (111)	Not over three stories with complete automatic sprinkler system				
	3		III (211)	Not over one story with complete automatic sprinkler system.				
	4		V (111)					
	5		IV (2HH)					
	6		II (000)					
	7		III (200)	Not Permitted				
	8		V (000)					
	☐ Building contains fire treated wood. *Give a brief description, in REMARKS, of the construction, the number of stories, including basements, floors on which patients are located, location of smoke or fire barriers and dates of approval. Complete sketch or attach small floor plan of the building as appropriate.*							
K103	Interior walls and partitions in buildings of Type I or Type II construction shall be noncombustible or limited-combustible materials. 18.1.6.3, 19.1.6.3 (Indicate N/A for existing buildings using listed fire retardant treated wood studs within non-load bearing one-hour rated partitions.)				○	○	◉	

ID PREFIX		MET	NOT MET	N/A	REMARKS
	INTERIOR FINISH				
K14	2000 EXISTING Interior finish for means of egress, including exposed interior surfaces of buildings such as fixed or movable walls, partitions, columns, and ceilings has a flame spread rating of Class A or Class B. Interior finishes existing before December 17, 2010 that are applied directly to wall and ceilings with a thickness of less than 1/28 inch shall be permitted to remain in use without flame spread rating documentation. 10.2, 19.3.3.1, 19.3.3.2, NFPA TIA 00-2 *Indicate flame spread rating/s* A	◉	○		
	2000 NEW Interior finish for means of egress, including exposed interior surfaces of buildings such as fixed or movable walls, partitions, columns, and ceilings has a flame spread rating of Class A or Class B. Lower half of corridor walls, not exceeding 4ft in height, may have a Class C flame spread rating. 10.2, 18.3.3.1, 18.3.3.2, NFPA TIA 00-2 *Indicate flame spread rating/s*_____				
K15	2000 EXISTING Interior finish for rooms and spaces not used for corridors or exitways, including exposed interior surfaces of buildings such as fixed or movable walls, partitions, columns, and ceilings has a flame spread rating of Class A or Class B. (In fully-sprinklered buildings, flame spread rating of Class C may be continued in use within rooms separated in accordance with 19.3.6 from the exit access corridors.) 19.3.3.1, 19.3.3.2 *Indicate flame spread rating/s* A	◉	○		
	2000 NEW Interior finish for rooms and spaces not used for corridors or exitways, including exposed interior surfaces of buildings such as fixed or movable walls, partitions, columns, and ceilings has a flame spread rating of Class A or Class B. (Rooms not over 4 persons in capacity may have a flame spread rating of Class A, Class B, or Class C). 18.3.3.1, 18.3.3.2. *Indicate flame spread rating/s*_____				

ID PREFIX		MET	NOT MET	N/A	REMARKS
K16	2000 EXISTING Newly installed interior floor finish complying with 10.2.7 shall be permitted in corridors and exits if Class I. 19.3.3.3 In smoke compartments protected throughout by an approved, supervised automatic sprinkler system in accordance with 19.3.5.2, no interior floor finish requirements shall apply.	◉	○	○	
	CORRIDOR WALLS AND DOORS				
K17	2000 EXISTING Corridors are separated from use areas by walls constructed with at least ½ hour fire resistance rating. In fully sprinklered smoke compartments, partitions are only required to resist the passage of smoke. In non-sprinklered buildings, walls extend to the underside of the floor or roof deck above the ceiling. (Corridor walls may terminate at the underside of ceilings where specifically permitted by Code. Charting and clerical stations, waiting areas, dining rooms, and activity spaces may be open to corridor under certain conditions specified in the Code. Gift shops may be separated from corridors by non-fire rated walls if the gift shop is fully sprinklered.) 19.3.6.1, 19.3.6.2, 19.3.6.4, 19.3.6.5 *If the walls have a fire resistance rating, give rating _____ if the walls terminate at the underside of a ceiling, give a brief description in REMARKS, of the ceiling, describing the ceiling throughout the floor area.*	◉	○		
	2000 NEW Corridor walls shall form a barrier to limit the transfer of smoke. Such walls shall be permitted to terminate at the ceiling where the ceiling is constructed to limit the transfer of smoke. No fire resistance rating is required for the corridor walls. 18.3.6.1, 18.3.6.2, 18.3.6.4, 18.3.6.5				

ID PREFIX		MET	NOT MET	N/A	REMARKS
K18	2000 EXISTING Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas shall be substantial doors, such as those constructed of 1¾ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Clearance between bottom of door and floor covering is not exceeding 1 inch. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Doors shall be provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.2.3.2.1. Roller latches are prohibited by CMS regulations in all health care facilities. 19.3.6.3	◉	○		
	Show in REMARKS, details of doors, such as fire protection ratings, automatic closing devices, etc.				
	2000 NEW Doors protecting corridor openings shall be constructed to resist the passage of smoke. Clearance between bottom of door and floor covering is not exceeding 1 inch. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Doors shall be provided with positive latching hardware. Dutch doors meeting 18.3.6.3.6 are permitted. Roller latches shall be prohibited. 18.3.6.3				
	Show in REMARKS, details of doors, such as fire protection ratings, automatic closing devices, etc.				
K19	Vision panels in corridor walls or doors shall be fixed window assemblies in approved frames. (In fully sprinklered smoke compartments, there are no restrictions in the area and fire resistance of glass and frames.) In other than smoke compartments containing patient bedrooms, miscellaneous opening are permitted in vision panels or doors provided the aggregate area of the opening per room does not exceed 20 in.^{2} and the opening is installed in bottom half of the wall (80 in.^{2} in fully sprinklered buildings). 18.3.6.5, 19.3.6.2.3, 19.3.6.3.8, 19.3.6.5	◉	○	○	

ID PREFIX		MET	NOT MET	N/A	REMARKS
	VERTICAL OPENINGS				
K20	2000 EXISTING Stairways, elevator shafts, light and ventilation shafts, chutes, and other vertical openings between floors are enclosed with construction having a fire resistance rating of at least one hour. An atrium may be used in accordance with 8.2.5, 8.2.5.6, 19.3.1.1 *If all vertical openings are properly enclosed with construction providing at least a two hour fire resistance rating, also check this box.* ☐	◉	○	○	
	If enclosures are less than required, give a brief description and specific location in REMARKS.				
	2000 NEW Stairways, elevator shafts, light and ventilation shafts, chutes, and other vertical openings between floors are enclosed with construction having a fire resistance rating of at least two hours connecting four stories or more. (One hour for single story building and buildings up to three stories in height.) An atrium may be used in accordance with 8.2.5.6, 8.2.5, 18.3.1.1.				
	If enclosures are less than required, give a brief description and specific location in REMARKS.				
K21	Doors in an exit passageway, stairway enclosure, horizontal exit, smoke barrier or hazardous area enclosure are self-closing and kept in the closed position, unless held open by as release device complying with 7.2.1.8.2 that automatically closes all such doors throughout the smoke compartment or entire facility upon activation of: ☐ (a) The required manual fire alarm system and ☐ (b) Local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system and ☐ (c) The automatic sprinkler system, if installed 18.2.2.2.6, 18.3.1.2, 19.2.2.2.6, 19.3.1.2, 7.2.1.8.2 Door assemblies in vertical openings are of an approved type with appropriate fire protection rating. 8.2.3.2.3.1 Boiler rooms, heater rooms, and mechanical equipment rooms doors are kept closed.	◉	○	○	

ID PREFIX		MET	NOT MET	N/A	REMARKS
	Describe method used in REMARKS				
	SMOKE COMPARTMENTATION AND CONTROL				
K23	2000 EXISTING Smoke barriers shall be provided to form at least two smoke compartments on every sleeping room floor for more than 30 patients. 19.3.7.1, 19.3.7.2	◉	○	○	
	2000 NEW Smoke barriers shall be provided to form at least two smoke compartments on every floor used by inpatients for sleeping or treatment, and on every floor with an occupant load of 50 or more persons, regardless of use. Smoke barriers shall also be provided on floors that are usable, but unoccupied. 18.3.7.1, 18.3.7.2				
K24	The smoke compartments shall not exceed 22,500 square feet and the travel distance to and from any point to reach a door in the required smoke barrier shall not exceed 200 feet. 18.3.7.1, 19.3.7.1	◉	○	○	
	Detail in REMARKS zone dimensions including length of zones and dead end corridors.				
K25	2000 EXISTING Smoke barriers shall be constructed to provide at least a one half hour fire resistance rating and constructed in accordance with 8.3. Smoke barriers shall be permitted to terminate at an atrium wall. Windows shall be protected by fire-rated glazing or by wired glass panels and steel frames. 8.3, 19.3.7.3, 19.3.7.5	◉	○	○	
	2000 NEW Smoke barriers shall be constructed to provide at least a one hour fire resistance rating and constructed in accordance with 8.3. Smoke barriers shall be permitted to terminate at an atrium wall. Windows shall be protected by fire-rated glazing or by wired glass panels in approved frames. 8.3, 18.3.7.3, 18.3.7.5				
K26	Space shall be provided on each side of smoke barriers to adequately accommodate the total number of occupants in adjoining compartments. 18.3.7.4, 19.3.7.4	◉	○	○	

ID PREFIX		MET	NOT MET	N/A	REMARKS
K27	2000 EXISTING Doors in smoke barriers have at least a 20 minute fire protection rating or are at least 1¾ inch thick solid bonded core wood. Non-rated protective plates that do not exceed 48 inches from the bottom of the door are permitted. Horizontal sliding doors comply with 7.2.1.14. Doors shall be self-closing or automatic-closing in accordance with 19.2.2.2.6. Swinging doors are not required to swing with egress and positive latching is not required. 19.3.7.5, 19.3.7.6, 19.3.7.7	◉	○	○	
	2000 NEW Doors in smoke barriers have at least a 20 minute fire protection rating or are at least 1¾ inch thick solid bonded core wood. Non-rated protective plates that do not exceed 48 inches from the bottom of the door are permitted. Horizontal sliding doors comply with 7.2.1.14. Swinging doors shall be arranged so that each door swings in an opposite direction. Doors shall be self-closing and rabbets, bevels or astragals are required at the meeting edges. Positive latching is not required. 18.3.7.5, 18.3.7.6, 18.3.7.8				
K28	2000 EXISTING Door openings in smoke barriers shall provide a minimum clear width of 32 inches (81 cm) for swinging or horizontal doors. 19.3.7.7	◉	○	○	
	2000 NEW Door openings in smoke barriers are installed as swinging or horizontal doors shall provide a minimum clear width as follows: Provider Type / Swinging Doors / Horizontal Sliding Doors Hospitals and Nursing Facilities: 41.5 inches (105 cm) / 83 inches (211 cm) Psychiatric Hospitals and Limited Care Facilities: 32 inches (81 cm) / 64 inches (163 cm) 18.3.7.7				

ID PREFIX		MET	NOT MET	N/A	REMARKS
K104	Penetrations of smoke barriers by ducts are protected in accordance with 8.3.5. Dampers are not required in duct penetrations of smoke barriers in fully ducted HVAC systems where a sprinkler system in accordance with 18/19.3.5 is provided for adjacent smoke compartments. 18.3.7.3, 19.3.7.3. Hospitals may apply a 6-year damper testing interval conforming to NFPA 80 & NFPA 105. All other health care facilities must maintain a 4-year damper maintenance interval. 8.3.5	◉	○	○	
	Describe any mechanical smoke control system in REMARKS.				
	HAZARDOUS AREAS				
K29	2000 EXISTING One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors. Doors shall be self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1	◉	○	○	

Area	Automatic Sprinkler	Separation	N/A
a. Boiler and Fuel-Fired Heater Rooms	✔	✔	
c. Laundries (greater than 100 sq feet)	✔	✔	
d. Repair Shops and Paint Shops			✔
e. Laboratories (if classified a Severe Hazard - see K31)			✔
f. Combustible Storage Rooms/Spaces (over 50 sq feet)	✔	✔	
g. Trash Collection Rooms			✔
i. Soiled Linen Rooms	✔	✔	

Describe the floor and zone locations of hazardous areas that are deficient in REMARKS.

ID PREFIX		MET	NOT MET	N/A	REMARKS
	2000 NEW Hazardous areas are protected in accordance with 8.4. The areas shall be enclosed with a one hour fire-rated barrier, with a ¾ hour fire-rated door, without windows (in accordance with 8.4). Doors shall be self-closing or automatic closing in accordance with 7.2.1.8. Hazardous areas are protected by a sprinkler system in accordance with 9.7, 18.3.2.1, 18.3.5.1.				

Area	Automatic Sprinkler	Separation	N/A
a. Boiler and Fuel-Fired Heater Rooms			
c. Laundries (greater than 100 sq feet)			
d. Repair, Maintenance and Paint Shops			
e. Laboratories (if classified a Severe Hazard - see K31)			
f. Combustible Storage Rooms/Spaces (over 50 and less than 100 sq feet)			
g. Trash Collection Rooms			
i. Soiled Linen Rooms			
m. Combustible Storage Rooms/Spaces (over 100 sq feet)			

Describe the floor and zone locations of hazardous areas that are deficient in REMARKS.

K30	Gift shops shall be protected as hazardous areas when used for storage or display of combustibles in quantities considered hazardous. Non-rated walls may separate gift shops that are not considered hazardous, have separate protected storage and that are completely sprinkled. Gift shops may be open to the corridor if they are not considered hazardous, have separate protected storage, are completely sprinklered and do not exceed 500 square feet. 18.3.2.5, 19.3.2.5	○	○	◉	

Area	Automatic Sprinkler	Separation	N/A
L. Gift Shop storing hazardous quantities of combustibles	☐	☐	☐

ID PREFIX		MET	NOT MET	N/A	REMARKS
K211	Where Alcohol Based Hand Rub (ABHR) dispensers are installed: ☐ The corridor is at least 6 feet wide ☐ The maximum individual fluid dispenser capacity shall be 1.2 liters (2 liters in suites of rooms) ☐ The dispensers shall have a minimum spacing of 4 ft from each other ☐ Not more than 10 gallons are used in a single smoke compartment outside a storage cabinet. ☐ Dispensers are not installed over or adjacent to an ignition source. ☐ If the floor is carpeted, the building is fully sprinklered. 18.3.2.7, CFR 403.744, 418.110, 460.72, 482.41, 483.70, 485.623	◉	○	○	K33 Observation revealed that the wall of the 2 stair enclosures are constructed of plaster on wood lath on wood studs, which does not meet minimum the requirements for this type of facility.
	EXITS AND EGRESS				
K22	Access to exits shall be marked by approved, readily visible signs in all cases where the exit or way to reach exit is not readily apparent to the occupants. Doors, passages or stairways that are not a way of exit that are likely to be mistaken for an exit have a sign designating “No Exit”. 7.10, 18.2.10.1, 19.2.10.1	◉	○	○	
K32	Not less than two exits, remote from each other, are provided for each floor or fire section of the building. Not less than one exit from each floor or fire section shall be a door leading outside, stair, smoke-proof enclosure, ramp, or exit passageway. Only one of these two exits may be a horizontal exit. Egress shall not return through the zone of fire origin. 18.2.4.1, 18.2.4.2, 19.2.4.1, 19.2.4.2	◉	○		
K33	2000 EXISTING Exit enclosures (such as stairways) are enclosed with construction having a fire resistance rating of at least one hour, are arranged to provide a continuous path of escape, and provide protection against fire or smoke from other parts of the building. 7.1.3.2, 8.2.5.2, 8.2.5.4, 19.3.1.1 *If all vertical openings are properly enclosed with construction providing at least a two hour fire resistance rating, also check this box.* ☐	○	◉	○	
	If enclosures are less than required, give a brief description and specific location in REMARKS.				

ID PREFIX		MET	NOT MET	N/A	REMARKS
	2000 NEW Exit enclosures (such as stairways) in buildings four stories or more are enclosed with construction having a fire resistance rating of at least two hours, are arranged to provide a continuous path of escape, and provide a protection against fire and smoke from other parts of the building. In all buildings less than four stories, the enclosure is at least one hour. 7.1.3.2, 8.2.5.2, 8.2.5.4, 18.3.1.1, 18.2.2.3				
	If enclosures are less than required, give a brief description and specific location in REMARKS.				
K34	Stairways and smokeproof enclosures used as exits are in accordance with 7.2. 18.2.2.3, 18.2.2.4, 19.2.2.3, 19.2.2.4	◉	○	○	
K35	The capacity of required mean of egress is based on its width, in accordance with 7.3.	◉	○		
K36	Travel distance (exit access) to exits are measured in accordance with 7.6. • Room door to exit ≤ 100 ft (≤ 150 ft sprinklered) • Point in room or suite to exit ≤ 150 ft (≤ 200 ft sprinklered) • Point in room to room door ≤ 50 ft • Point in suite to suite door ≤ 100 ft 18.2.6, 19.2.6	◉	○		
K37	2000 EXISTING Existing dead-end corridors shall be permitted to be continued to be used if it is impractical and unfeasible to alter them so that exists are accessible in not less than two different directions from all points in aisles, passageways, and corridors. 19.2.5.10	◉	○	○	
	2000 NEW Every exit and exit access shall be arranged so that no corridor, aisle or passageway has a pocket or dead-end exceeding 30 feet. 18.2.5.10				
K38	Exit access is so arranged that exits are readily accessible at all times in accordance with 7.1. 18.2.1, 19.2.1	◉	○		
K39	2000 EXISTING Width of aisles or corridors (clear and unobstructed) serving as exit access shall be at least 4 feet. 19.2.3.3	◉	○		

ID PREFIX		MET	NOT MET	N/A	REMARKS
	2000 NEW Width of aisles or corridors (clear and unobstructed) serving as exit access in hospitals and nursing homes shall be at least 8 feet. In limited care facility and psychiatric hospitals, width of aisles or corridors shall be at least 6 feet. 18.2.3.3, 18.2.3.4				K40 Observation revealed that the doors to all five (5) resident rooms on the 2nd floor were found to be only 31 inches in clear width. This does not meet the 32-inch requirement for existing exit access doors.
K40	2000 EXISTING Exit access doors and exit doors used by health care occupants are of the swinging type and are at least 32 inches in clear width. An exception is provided for existing 34-inch doors in existing occupancies. 19.2.3.5	○	◉		
	2000 NEW Exit access doors and exit doors used by health care occupants are of the swinging type and are at least 41.5 inches in clear width. Doors in exit stairway enclosures shall be no less than 32 inches in clear width. In psychiatric hospitals or limited care facilities (e.g.,ICF/MD providing medical treatment) doors are at least 32 inches wide. 18.2.3.5				
K41	All sleeping rooms have a door leading to a corridor providing access to an exit or have a door leading directly to grade. One room may intervene in accordance with 18.2.5.1, 19.2.5.1 *If doors lead directly to grade from each room, check this box.* ☐	◉	○		
K42	Any patient sleeping room or suite of rooms of more than 1,000 sq. ft. has at least 2 exit access doors remote from each other. 18.2.5.2, 19.2.5.2	◉	○		
K43	Patient room doors are arranged such that the patients can open the door from inside without using a key. Special door locking arrangements are permitted in facilities. 18.2.2.2.4, 18.2.2.2.5, 19.2.2.2.4, 19.2.2.2.5	◉	○	○	
	If door locking arrangement without delay egress is used indicate in REMARKS 18.2.2.2.2, 19.2.2.2.2	○	○	◉	
K44	Horizontal exits, if used, are in accordance with 7.2.4. 18.2.2.5, 19.2.2.5	○	○	◉	
K47	Exit and directional signs are displayed in accordance with 7.10 with continuous illumination also served by the emergency lighting system. 18.2.10.1, 19.2.10.1 (Indicate N/A in one story existing occupancies with less than 30 occupants where the line of exit travel is obvious.)	◉	○	○	

ID PREFIX		MET	NOT MET	N/A	REMARKS
K72	Means of egress shall be continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. No furnishings, decorations, or other objects shall obstruct exits, access thereto, egress there from, or visibility thereof shall be in accordance with 7.1.10. 18.2.1, 19.2.1	◉	○		
	ILLUMINATION				
K45	Illumination of means of egress, including exit discharge, is arranged so that failure of any single lighting fixture will not leave the area in darkness. Lighting system shall be either continuously in operation or capable of automatic operation without manual intervention. 18.2.8, 19.2.8, 7.8	◉	○		
K46	Emergency lighting of at least 1½ hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1.	◉	○		
K105	2000 NEW (INDICATE N/A FOR EXISTING) Buildings equipped with or requiring the use of life support systems (electro-mechanical or inhalation anesthetics) have illumination of means of egress, emergency lighting equipment, exit, and directional signs supplied by the Life Safety Branch of the electrical system described in NFPA 99. 18.2.9.2., 18.2.10.2 (Indicate N/A if life support equipment is for emergency purposes only).			☑	
	EMERGENCY PLAN AND FIRE DRILLS				
K48	There is a written plan for the protection of all patients and for their evacuation in the event of an emergency. 18.7.1.1, 19.7.1.1	◉	○	○	
K50	Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9:00 PM and 6:00 AM a coded announcement may be used instead of audible alarms. 18.7.1.2, 19.7.1.2	◉	○	○	

ID PREFIX		MET	NOT MET	N/A	REMARKS
	FIRE ALARM SYSTEMS				
K51	A fire alarm system is installed with systems and components approved for the purpose in accordance with NFPA 70, National Electric Code and NFPA 72, National Fire Alarm Code to provide effective warning of fire in any part of the building. Fire alarm system wiring or other transmission paths are monitored for integrity. Initiation of the fire alarm system is by manual means and by any required sprinkler system alarm, detection device, or detection system. Manual alarm boxes are provided in the path of egress near each required exit. Manual alarm boxes in patient sleeping areas shall not be required at exits if manual alarm boxes are located at all nurse's stations. Occupant notification is provided by audible and visual signals. In critical care areas, visual alarms are sufficient. The fire alarm system transmits the alarm automatically to notify emergency forces in the event of fire. The fire alarm automatically activates required control functions. System records are maintained and readily available. 18.3.4, 19.3.4, 9.6	◉	○		
K52	A fire alarm system required for life safety shall be, tested, and maintained in accordance with NFPA 70 National Electric Code and NFPA 72 National Fire Alarm Code and records kept readily available. The system shall have an approved maintenance and testing program complying with applicable requirement of NFPA 70 and 72. 9.6.1.4, 9.6.1.7,	◉	○		
K155	Where a required fire alarm system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction shall be notified, and the building shall be evacuated or an approved fire watch shall be provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service. 9.6.1.8	◉	○	○	
K53	2000 EXISTING (INDICATE N/A FOR HOSPITAL AND FULLY SPRINKLERED NURSING HOMES) In an existing nursing home, not fully sprinklered, the resident sleeping rooms and public areas (dining rooms, activity rooms, resident meeting rooms, etc) are to be equipped with single station battery-operated smoke detectors. There will be a testing, maintenance and battery replacement program to ensure proper operation. CFR 483.70	○	○	◉	

ID PREFIX		MET	NOT MET	N/A	REMARKS
	2000 NEW (NURSING HOME AND EXISTING LIMITED CARE FACILITIES) An automatic smoke detection system is installed in all corridors. (As an alternative to the corridor smoke detection system on patient sleeping room floors, smoke detectors may be installed in each patient sleeping room and at smoke barrier or horizontal exit doors in the corridor.) Such detectors are electrically interconnected to the fire alarm system. 18.3.4.5.3				
K109	2000 EXISTING LIMITED CARE FACILITIES (INDICATE N/A FOR HOSPITALS OR NURSING HOMES) An automatic smoke detection system is installed in all corridors with detector spacing no further apart than 30 ft on center in accordance with NFPA 72. (As an alternative to the corridor smoke detection system on patient sleeping room floors, smoke detectors may be installed in each patient sleeping room and at smoke barrier or horizontal exit doors in the corridors.) Such detectors are electrically interconnected to the fire alarm system. 19.3.4.5.1 Smoke Detection System ☐ Corridors ☐ Rooms ☐ Bath	○	○	◉	
K54	All required smoke detectors, including those activating door hold-open devices, are approved, maintained, inspected and tested in accordance with the manufacturer's specifications. 9.6.1.3	◉	○		
	Give a brief description, in REMARKS of any smoke detection system which may be installed.				
K55	2000 EXISTING Every patient sleeping room shall have an outside window or outside door. Except for newborn nurseries and rooms intended for occupancy for less than 24 hours. 19.3.8	◉	○		
	2000 NEW Every patient sleeping room shall have an outside window or outside door. The allowable sill height shall not exceed 36 inches (91 cm) above the floor. Windows are not required for recovery rooms, newborn nurseries, emergency rooms, and similar rooms				

ID PREFIX		MET	NOT MET	N/A	REMARKS
	intended for occupancy for less than 24 hours. Window sill height for limited care facilities shall not exceed 44 inches (112 cm) above the floor. 18.3.8				
K60	Initiation of the required fire alarm systems shall be by manual fire alarm initiation, automatic detection, or extinguishing system operation. 18.3.4.2, 19.3.4.2, 9.6.2.1	◉	○		
	AUTOMATIC SPRINKLER SYSTEMS				
K56	2000 EXISTING Where required by section 19.1.6, Health care facilities shall be protected throughout by an approved, supervised automatic sprinkler system in accordance with section 9.7. Required sprinkler systems are equipped with water flow and tamper switches which are electrically interconnected to the building fire alarm. In Type I and II construction, alternative protection measures shall be permitted to be substituted for sprinkler protection in specific areas where State or local regulations prohibit sprinklers. 19.3.5, 19.3.5.1, NPFA 13	◉	○	○	
	2000 NEW There is an automatic sprinkler system installed in accordance with NFPA13, Standard for the Installation of Sprinkler Systems, with approved components, device and equipment, to provide complete coverage of all portions of the facility. Systems are equipped with waterflow and tamper switches, which are connected to the fire alarm system. In Type I and II construction, alternative protection measures shall be permitted to be substituted for sprinkler protection in specific areas where State or local regulations prohibit sprinklers. 18.3.5, 18.3.5.1.				
K154	Where a required automatic sprinkler system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction shall be notified, and the building shall be evacuated or an approved fire watch system be provided for all parties left unprotected by the shutdown until the sprinkler system has been returned to service. 9.7.6.1.	◉	○	○	
	A. Date sprinkler system last checked and necessary maintenance provided. 11/26/2014				

ID PREFIX		MET	NOT MET	N/A	REMARKS
	B. Show who provided the service. SIMPLEX				
	C. Note the source of water supply for the automatic sprinkler system. CITY WATER				
	(Provide, in REMARKS, information on coverage for any non-required or partial automatic sprinkler system.)				
K61	Automatic sprinkler system supervisory attachments are installed and monitored for integrity in accordance with NFPA 72, and provide a signal that sounds and is displayed at a continuously attended location or approved remote facility when sprinkler operation is impaired. 9.7.2.1, NFPA 72	◉	○	○	
K62	Automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 18.7.6, 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5	◉	○	○	
K63	Required automatic sprinkler systems have an adequate and reliable water supply which provides continuous and automatic pressure. 9.7.1.1, NFPA 13	◉	○	○	
K64	Portable fire extinguishers shall be installed, inspected, and maintained in all health care occupancies in accordance with 9.7.4.1, NFPA 10. 18.3.5.6, 19.3.5.6	◉	○		
	SMOKING REGULATIONS				
K66	Smoking regulations shall be adopted and shall include not less than the following provisions: 18.7.4, 19.7.4, 8-6.4.2 (NFPA 99) (1) Smoking shall be prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area shall be posted with signs that read NO SMOKING or shall be posted with the international symbol for no smoking. Exception: In facilities where smoking is prohibited and signs are prominently placed at all major entrances, secondary signs that prohibit smoking in use areas are not required. (Note: This exception is not applicable to medical gas storage areas.) 8-3.1.11.3 (NFPA 99)	◉	○	○	

ID PREFIX		MET	NOT MET	N/A	REMARKS
	(2) Smoking by patients classified as not responsible shall be prohibited, except when under direct supervision. (3) Ashtrays of noncombustible material and safe design shall be provided in all areas where smoking is permitted. (4) Metal containers with self-closing cover devices into which ashtrays can be emptied shall be readily available to all areas where smoking is permitted.	○	○	○	
	BUILDING SERVICE EQUIPMENT				
K67	Heating, ventilating, and air conditioning shall comply with 9.2 and shall be installed in accordance with the manufacturer's specifications. 18.5.2.1, 19.5.2.1, 9.2, NFPA 90A, 18.5.2.2, 19.5.2.2	◉	○	○	
K68	Combustion and ventilation air for boiler, incinerator and heater rooms is taken from and discharged to the outside air. 18.5.2.2, 19.5.2.2.	◉	○	○	
K69	Cooking facilities shall be protected in accordance with 9.2.3. 18.3.2.6, 19.3.2.6, NFPA 96	◉	○	○	
K70	Portable space heating devices shall be prohibited in all health care occupancies. Except it shall be permitted to be used in non-sleeping staff and employee areas where the heating elements of such devices do not exceed 212°F (100°C). 18.7.8, 19.7.8	◉	○	○	
K71	Rubbish Chutes, Incinerators and Laundry Chutes. 18.5.4, 19.5.4, 9.5, 8.4, NFPA 82 (1) Any existing linen and trash chute, including pneumatic rubbish and linen systems, that opens directly onto any corridor shall be sealed by fire resistive construction to prevent further use or shall be provided with a fire door assembly having a fire protection rating of 1 hour. All new chutes shall comply with 9.5. (2) Any rubbish chute or linen chute, including pneumatic rubbish and linen systems, shall be provided with automatic extinguishing protection in accordance with 9.7. (3) Any trash chute shall discharge into a trash collection room used for no other purpose and protected in accordance with 8.4.	○	○	◉	

ID PREFIX		MET	NOT MET	N/A	REMARKS
	(4) Existing flue-fed incinerators shall be sealed by fire resistive construction to prevent further use.	○	○	◉	
K160	2000 EXISTING Elevators comply with the provision of 9.4. Elevators are inspected and tested as specified in A17.1, Safety Code for Elevators and Escalators. Fire Fighter's Service is operated monthly with a written record. Existing elevators conform to ASME/ANSI A17.3, *Safety Code for Existing Elevators & Escalators*. All existing elevators, having a travel distance of 25 ft or more above or below the level that best serves the needs of emergency personnel for fire fighting purposes, conform with Firefighter's Service Requirements of ASME/ANSI A17.3. 9.4.2, 9.4.3, 19.5.3 (Includes firefighters service **phase I** key recall and smoke detector automatic recall, firefighters service **phase II** emergency in-car key operation, machine room smoke detectors, and elevator lobby smoke detectors.)	○	○	◉	
	2000 NEW Elevators comply with the provision of 9.4. Elevators are inspected and tested as specified in A17.1, Safety Code for Elevators and Escalators. Fire Fighter's Service is operated monthly with a written record. New elevators conform to ASME/ANSI A17.1, Safety Code for Elevators and Escalators, including Fire Fighter's Service Requirements. 9.4.2, 9.4.3, 18.5.3 (Includes firefighters service **phase I** key recall and smoke detector automatic recall, firefighters service **phase II** emergency in-car key operation, machine room smoke detectors, and elevator lobby smoke detectors.)				
K161	2000 EXISTING Escalators, dumbwaiters, and moving walks comply with the provisions of 9.4. All existing escalators, dumbwaiters, and moving walks conform to the requirements of ASME/ANSI A17.3, *Safety Code for Existing Elevators and Escalators.* 19.5.3, 9.4.2.2	○	○	◉	

ID PREFIX		MET	NOT MET	N/A	REMARKS
	(Includes escalator emergency stop buttons and automatic skirt obstruction stop. For power dumbwaiters includes hoistway door locking to keep doors closed except for floor where car is being loaded or unloaded.)	○	○	●	
	2000 NEW Escalators, dumbwaiters, and moving walks comply with the provisions of 9.4. All escalators and conveyors comply with ASME/ANSI A17.1, *Safety Code for Elevators and Escalators.* 18.5.3, 9.4.2.1				
	FURNISHINGS AND DECORATIONS				
K73	Combustible decorations shall be prohibited unless they are flame-retardant or in such limited quantity that hazard of fire development or spread is not present. 18.7.5.4, 19.7.5.4	●	○	○	
K74	Draperies, curtains, including cubicle curtains, and other loosely hanging fabrics and films serving as furnishings or decorations are flame resistant in accordance with NFPA 701 except for shower curtains. Sprinklers in areas where cubical curtains are installed shall be in accordance with NFPA 13 to avoid obstruction of the sprinkler. 10.3.1, 18.3.5.5, 19.3.5.5, 18.7.5.1, 19.7.5.1, NFPA 13 ☐ Newly introduced upholstered furniture shall meet the char length and heat release criteria specified when tested in accordance with the methods cited in 10.3.2 (2) and 10.3.3, 18.7.5.2, 19.7.5.2. ☐ Newly introduced mattresses shall meet the char length and heat release criteria specified when tested in accordance with the method cited in 10.3.2 (3) and 10.3.4. 18.7.5.3, 19.7.5.3 ☐ Newly introduced upholstered furniture and mattresses means purchased since March, 2003.	●	○	○	
K75	Soiled linen or trash collection receptacles shall not exceed 32 gal (121 L) in capacity. The average density of container capacity in a room or space shall not exceed .5 gal/ft^2 (20.4 L/m^2). A	●	○	○	

ID PREFIX		MET	NOT MET	N/A	REMARKS
	capacity of 32 gal (121 L) shall not be exceeded within any 64-ft^2 (5.9-m^2) area. Mobile soiled linen or trash collection receptacles with capacities greater than 32 gal (121 L) shall be located in a room protected as a hazardous area when not attended. 18.7.5.5, 19.7.5.5	◉	○	○	
	LABORATORIES				
K31	Laboratories employing quantities of flammable, combustible, or hazardous materials that are considered a severe hazard shall be protected in accordance with NFPA 99. (Laboratories that are not considered to be severe hazard shall meet the provision of K29.) 18.3.2.2, 19.3.2.2, Chapter 10 (NFPA 99)	○	○	◉	
K136	Procedures for laboratory emergencies shall be developed. Such procedures shall include alarm actuation, evacuation, and equipment shutdown procedures, and provisions for control of emergencies that could occur in the laboratory, including specific detailed plans for control operations by an emergency control group within the organization or a public fire department in accordance with 10-2.1.3.1 (NFPA 99), 18.3.2.2., 19.3.2.1	○	○	◉	
K131	Emergency procedures shall be established for controlling chemical spills in accordance with 10-2.1.3.2 (NFPA 99)	○	○	◉	
K132	Continuing safety education and supervision shall be provided, incidents shall be reviewed monthly, and procedures reviewed annually shall be in accordance with 10-2.1.4.2 (NFPA 99).	○	○	◉	
K133	Fume hoods shall be in accordance with 5-4.3, 5-6.2 (NFPA 99).	○	○	◉	
K134	Where the eyes or body of any person can be exposed to injurious corrosive materials, suitable fixed facilities for quick drenching or flushing of the eyes and body shall be provided within the work area for immediate emergency use. Fixed eye baths designed and installed to avoid injurious water pressure shall be in accordance with 10-6 (NFPA 99).	○	○	◉	
K135	Flammable and combustible liquids shall be used from and stored in approved containers in accordance with NFPA 30, Flammable and Combustible Liquids Code, and NFPA 45, Standard on Fire Protection for Laboratories Using Chemicals.	○	○	◉	

ID PREFIX		MET	NOT MET	N/A	REMARKS
	Storage cabinets for flammable and combustible liquids shall be constructed in accordance with NFPA 30, Flammable and Combustible liquids Code, 4-3 (NFPA 99), 10-7.2.1 (NFPA 99)	○	○	◉	
	MEDICAL GASES AND ANESTHETIZING AREAS				
K76	Medical gas storage and administration areas shall be protected in accordance with NFPA 99, Standard for Health Care Facilities. (a) Oxygen storage locations of greater than 3,000 cu.ft. are enclosed by a one-hour separation. (b) Locations for supply systems of greater than 3,000 cu.ft. are vented to the outside. 4-3.1.1.2 (NFPA 99), 8-3.1.11.1 (NFPA 99), 18.3.2.4, 19.3.2.4	○	○	◉	
K77	Piped in medical gas, vacuum and waste anesthetic gas disposal systems comply with NFPA 99, Chapter 4.	○	○	◉	
K78	Anesthetizing locations shall be protected in accordance with NFPA 99, Standard for Health Care Facilities. (a) Shutoff valves are located outside each anesthetizing location and arranged so that shutting off one room or location will not affect others. (b) Relative humidity is maintained equal to or great than 35% 4-3.1.2.3(n) and 5-4.1.1 (NFPA 99), 18.3.2.3, 19.3.2.3	○	○	◉	
K140	Medical gas warning systems shall be in accordance with NFPA 99, Standard for Health Care Facilities. (a) Master alarm panels are in two separate locations and have audible and visible signals. (b) There are high/low alarms for +/- 20% operating pressure. This section shall be in accordance with NFPA 99, 4-3.1.2.2 (c) Where a level 2 gas system is used, one alarm panel that complies with 4-3.1.2.2(b)3a,b,c,d and with 4-3.1.2.2(c)2,5 shall be permitted. 4-4.1 (NFPA 99) exception No. 4. 4-3.1.2.2 (NFPA 99)	○	○	◉	
K141	Medical gas storage areas shall have a precautionary sign, readable from a distance of 5 ft, that is conspicuously displayed on each door or gate of the storage room or enclosure. The sign shall include the following wording as a minimum: CAUSION, OXIDIZING GAS(ES) STORED WITHIN, NO SMOKING. 18.3.2.4, 19.3.2.4, 8-3.1.11.3 (NFPA 99)	○	○	◉	

ID PREFIX		MET	NOT MET	N/A	REMARKS
K142	All occupancies containing hyperbaric facilities shall comply with NFPA 99, Standard for Health Care Facilities, Chapter 19.	○	○	◉	
K143	Transferring of liquid oxygen from one container to another shall be accomplished at a location specifically designated for the transferring that is as follows:: (a) separated from any portion of a facility wherein patients are housed, examined, or treated by a separation of a fire barrier of 1-hour fire-resistive construction; and (b) the area that is mechanically ventilated, sprinklered, and has ceramic or concrete flooring; and (c) in an area that is posted with signs indicating that transferring is occurring, and that smoking in the immediate area is not permitted in accordance with NFPA 99 and Compressed Gas Association. 8-6.2.5.2 (NFPA 99)	○	○	◉	
	ELECTRICAL AND EMERGENCY POWER				
K106	Hospitals and inpatient hospices with life support equipment have an Type I Essential Electric System, and nursing homes have a Type II ESS that are powered by a generator with a transfer switch and separate power supply in accordance with NFPA 99. 12-3.3.2, 13-3.3.2.1, 16-3.3.2 (NFPA 99)	○	○	◉	
K107	Required alarm and detection systems are provided with an alternative power supply in accordance with NFPA 72. 9.6.1.4, 18.3.4.1, 19.3.4.1	◉	○		
K108	2000 NEW (INDICATE N/A FOR EXISTING) Power for Alarms, emergency communication systems, and illumination of generator set locations are in accordance with essential electrical system of NFPA 99. 18.5.1.2			☑	
K144	Generators inspected weekly and exercised under load for 30 minutes per month and shall be in accordance with NFPA 99 and NFPA 110. 3-4.4.1 and 8-4.2 (NFPA 99), Chapter 6 (NFPA 110)	○	○	◉	
K145	The Type I EES is divided into the critical branch, life safety branch and the emergency system and Type II EES is divided into the emergency and critical systems in accordance with 3-4.2.2.2, 3-5.2.2 (NFPA 99)	○	○	◉	

ID PREFIX		MET	NOT MET	N/A	REMARKS
K146	The nursing home/hospice with no life support equipment shall have an alternate source of power separate and independent from the normal source that will be effective for minimum of 1½ hour after loss of the normal source 3-6. (NFPA 99)	◉	○	○	
K147	Electrical wiring and equipment shall be in accordance with National Electrical Code. 9-1.2 (NFPA 99) 18.9.1, 19.9.1	◉	○		
K130	Miscellaneous List in the REMARKS sections, any items that are not listed previously, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567.	○	○	○	

PART IV RECOMMENDATION FOR WAIVER OF SPECIFIC LIFE SAFETY CODE PROVISIONS

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

PROVISION NUMBER(S)	JUSTIFICATION
K84	

Surveyor *(Signature)*	Title	Office	Date
Fire Authority Official *(Signature)*	Title	Office	Date

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

PROVIDER NUMBER	FACILITY NAME	SURVEY DATE
K1		* K4

K6 DATE OF PLAN APPROVAL

K3 MULTIPLE CONSTRUCTION

TOTAL NUMBER OF BUILDINGS _____

NUMBER OF THIS BUILDING _____

☐

A BUILDING
B WING
C FLOOR
D APARTMENT UNIT

LSC FORM INDICATOR

Health Care Form		
12	2786R	2000 EXISTING
13	2786R	2000 NEW

ASC Form		
14	2786U	2000 EXISTING
15	2786U	2000 NEW

ICF/MR Form		
16	2786V, W, X	2000 EXISTING
17	2786V, W, X	2000 NEW

* K7 ☐ SELECT NUMBER OF FORM USED FROM ABOVE

COMPLETE IF ICF/MR IS SURVEYED UNDER CHAPTER 21

SMALL (16 BEDS OR LESS)

K8: ☐ 1 PROMPT 2 SLOW 3 IMPRACTICAL

LARGE

K8: ☐ 4 PROMPT 5 SLOW 6 IMPRACTICAL

APARTMENT HOUSE

K8: ☐ 7 PROMPT 8 SLOW 9 IMPRACTICAL

(Check if K29 or K56 are marked as not applicable in the 2786 M, R, T, U, V, W, X and Y.)

K29: ☐ K56: ☐

ENTER E – SCORE HERE

K5: ☐ e.g. 2.5

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

A1. ☐ (COMP. WITH ALL PROVISIONS)

A2. ☐ (ACCEPTABLE POC)

A3. ☐ (WAIVERS)

A4. ☐ (FSES)

A5. ☐ (PERFORMANCE BASED DESIGN)

FACILITY DOES NOT MEET LSC

B. ☐

K0180

A. ☐ FULLY SPRINKLERED (All required areas are sprinklered)

B. ☐ PARTIALLY SPRINKLERED (Not all required areas are sprinklered)

C. ☐ NONE (No sprinkler system)

* MANDATORY

PROJECT NUMBER:	PROVIDER NAME	SURVEY DATE
FE152024	ELLIOT CARE HOME	02/17/2015

Administrator: RANDY HED | Phone Number: 612/339-2291

Email address: KIMLOURICAS@NETZERO.NET

State Fire Inspector: BOB REXEISEN, ROBERT.REXEISEN@STATE.MN.US, 612/386-4657

These are preliminary findings only. A complete and final Statement of Deficiencies 2567 report will be provided by US Mail.

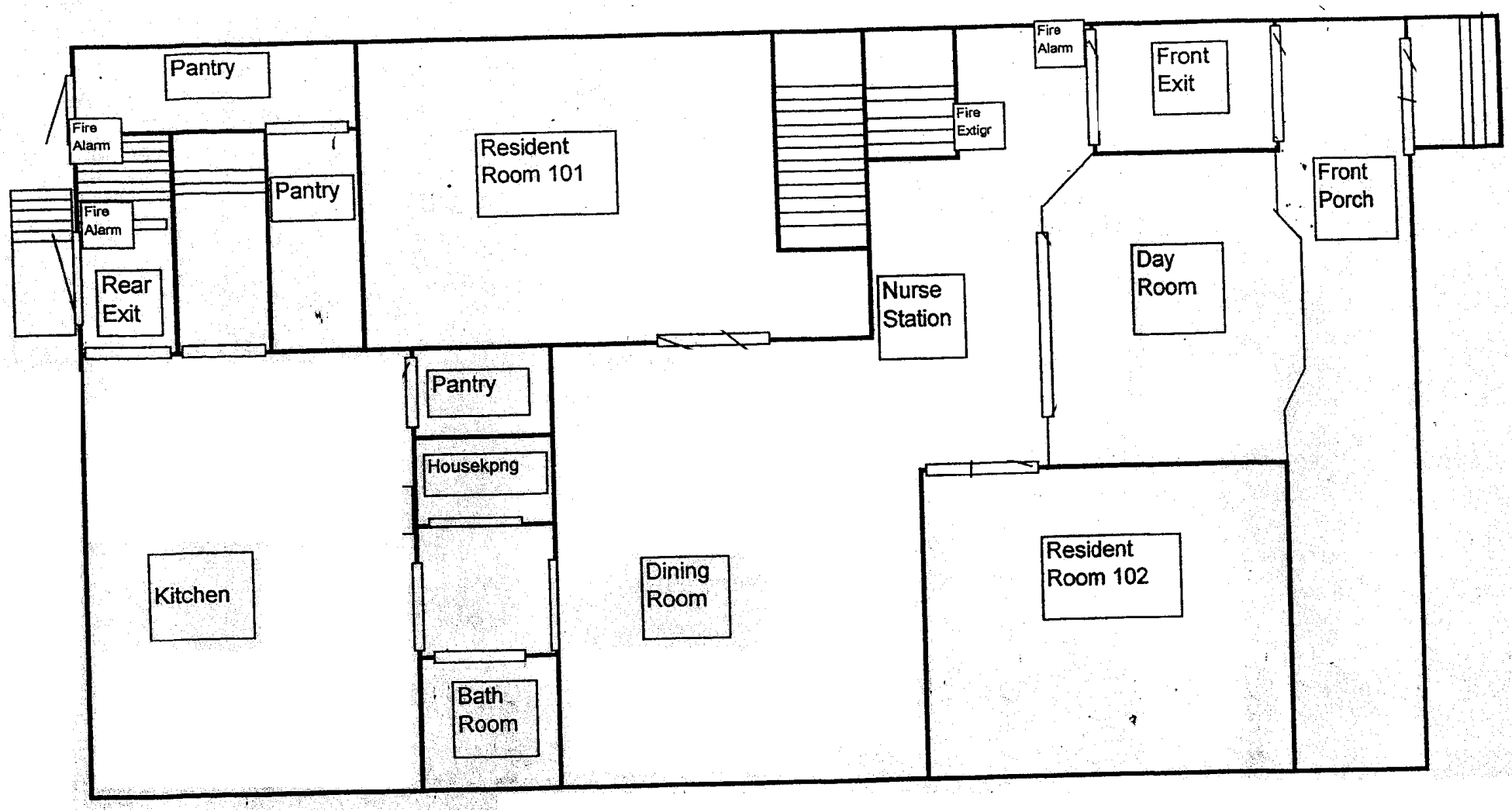
☑ **At the time of this inspection, this facility was found to comply with the requirements of the 2000 Life Safety Code applicable to: ☑ SNF/NF ☐ Hospital ☐ ICF/IID ☐ ASC Facilities participating in the Medicare/Medicaid programs.**

☑ **The following fire/life safety deficiencies were found during this inspection:**

K TAG S& S	☑ Draft Summary of Deficiency(ies) ☐ Revisit ☐ Clearance
	FACILITY PASSES BASED ON FSES REPORT
K12 S/S=F	Construction type-FSES
K33 S/S=F	Stair construction-FSES
K40 S/S=F	Resident room stair width-FSES

All Life Safety Code Plans of Correction shall be submitted to the State Fire Marshal Healthcare Supervisor within 10 days of receipt of the CMS-2567, Statement of Deficiencies
-All deficiencies shall be completed within 40 days of the MDH Surveyors exit, regardless of when the State Fire Marshal exits
-Any deficiencies exceeding 40 days -BUT- less than 60 days require verbal approval of the State Fire Marshal Healthcare Supervisor
-Any deficiencies exceeding 60 days but less than 365 days require a K-84, Temporary Waiver Request submitted to the State Fire Marshal Healthcare Supervisor

HC140317



FIRST FLOOR

FSES ZONE 2

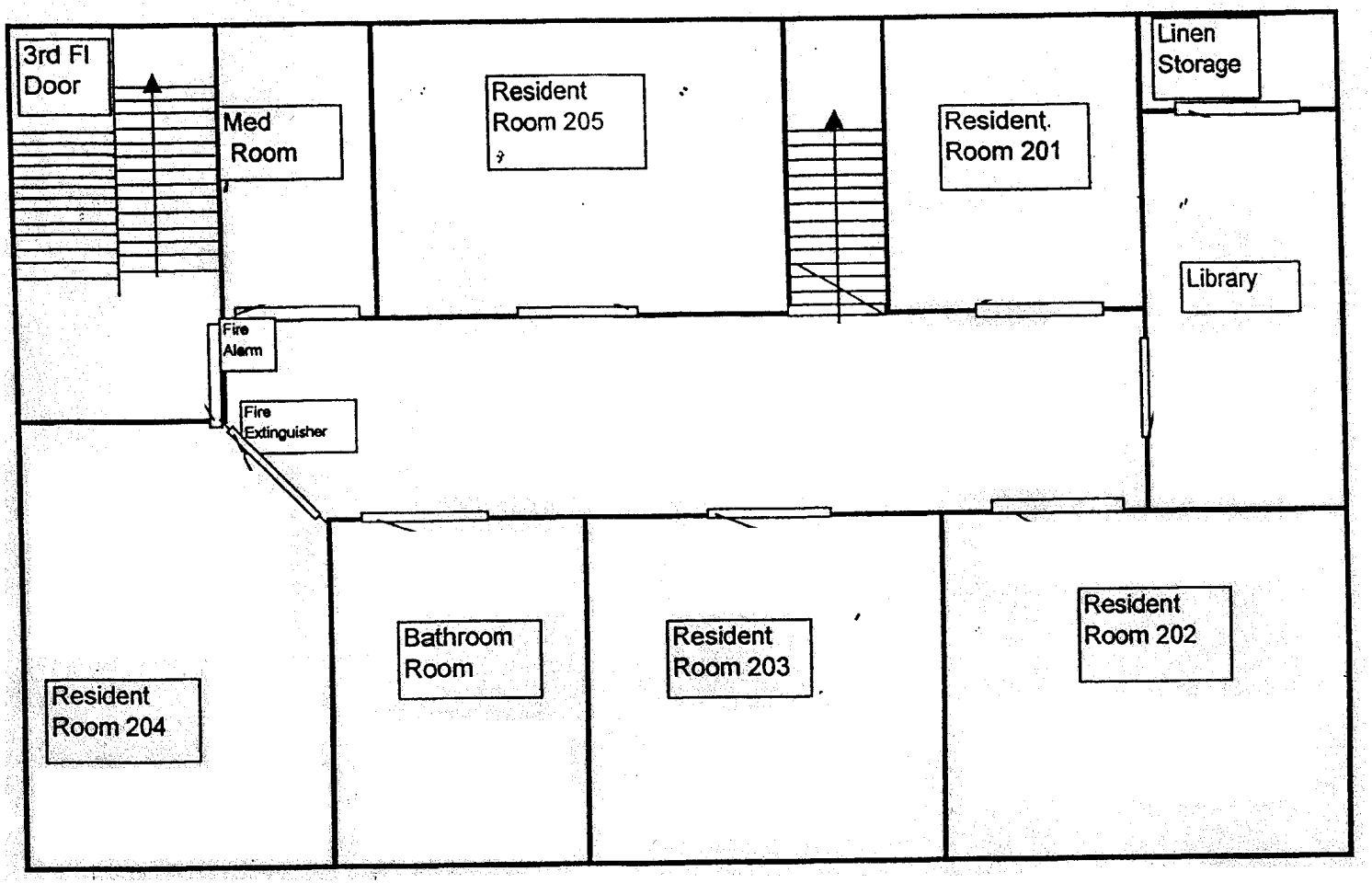
1/9/12 BR

ORIGINAL

For Fire Marshal Division File

ELLIOT CARE HOME, INC

HC140317



SECOND FLOOR

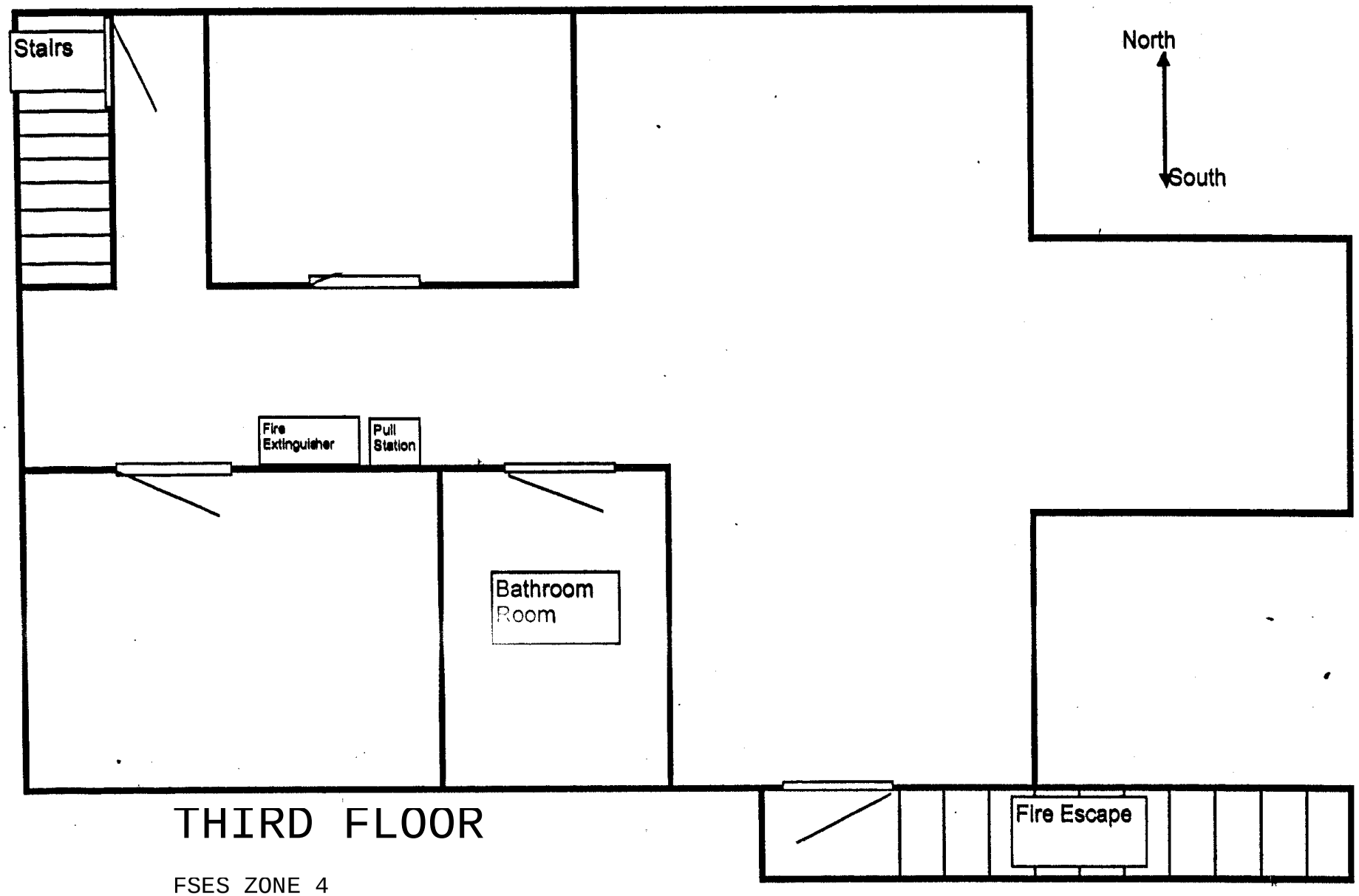
FSES ZONE 3

1/9/12 BR

ORIGINAL

For Fire Marshal Division File

ELLIOT CARE HOME, INC



THIRD FLOOR

FSES ZONE 4

HC140317

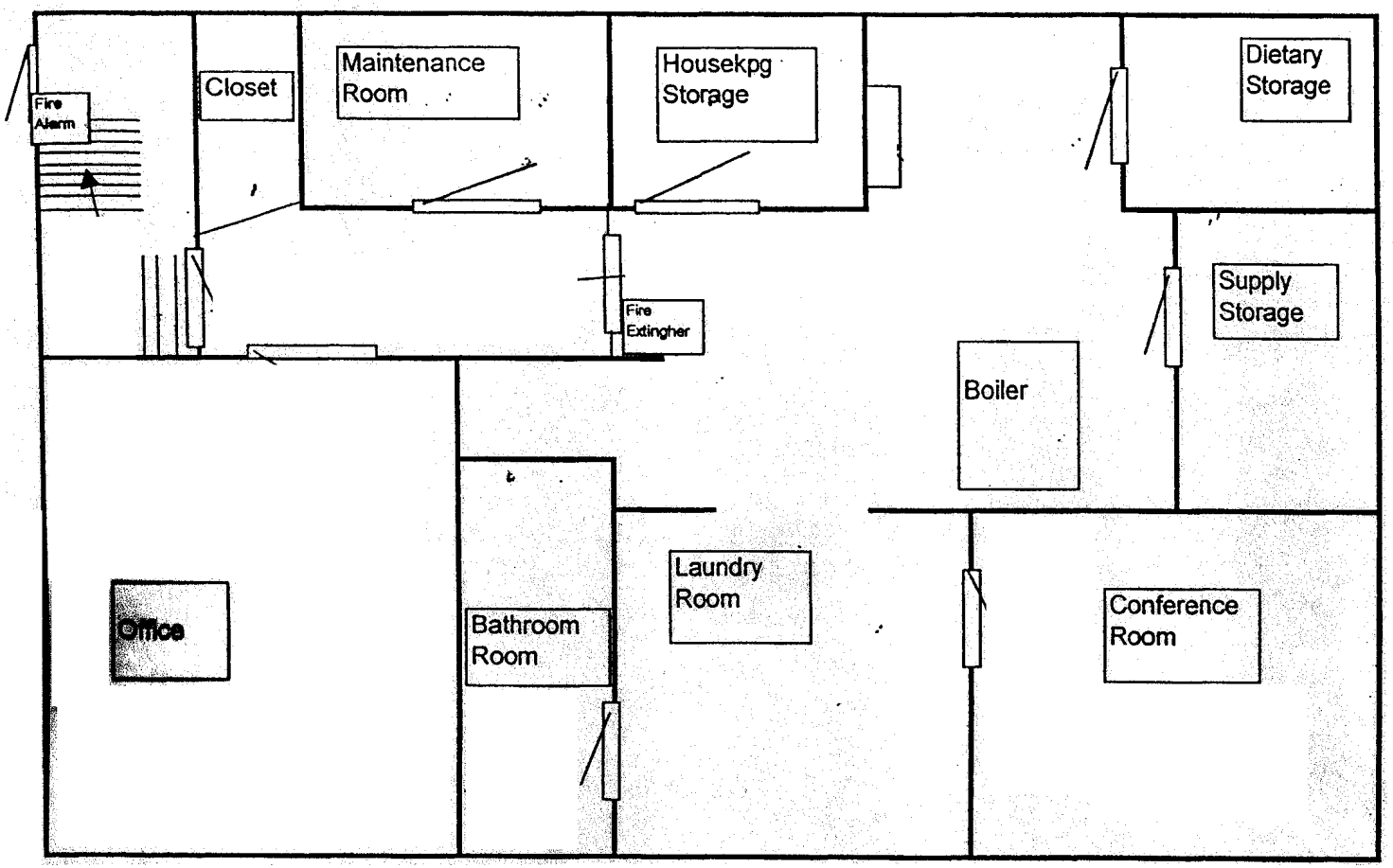
1/9/12 BR

ORIGINAL

For Fire Marshal Division File

ELLIOT CARE HOME, INC

HC140317



BASEMENT

FSES ZONE 1

ORIGINAL

For Fire Marshal Division File

1/9/12 BR

ELLIOT CARE HOME, INC

SE152024

MINNESOTA DEPARTMENT OF HEALTH
Division of Health Policy, Information and Compliance Monitoring
85 East Seventh Place, Suite 300, P.O. Box 64900
St. Paul, Minnesota 55164-0900

Email for ADMINISTRATOR: elliotcare@usbwireless.com

National Provider Identifier (NPI) Number: 1891821658

One facility may have multiple NPI Numbers. Please verify the NPI number associated with the provider type for this survey, i.e. for a nursing home survey, the NPI Number will be associated with the Nursing Home.

OWNERSHIP INFORMATION AT THE TIME OF SURVEY

Name of Facility: ELLIOT CARE HOME INC City: MINNEAPOLIS

Name of Legal Entity Operating Provider: ELLIOT CARE HOME, INC.

Name and Address of Governing Board President:

Name: KIMBERLY LOURICAS

Address: 3528 EMERSON AVE S

City/State/Zip: MINNEAPOLIS, MN 55408

If legal entity or president of the governing board is different than what is noted above, please provide the information below.

Name of Facility: _____ City: _____

Name of Legal Entity Operating Provider: _____

Name and Address of Governing Board President:

Name: _____

Address: _____

City/State/Zip: _____

SIGNATURE

Completed by: Kimberly Lourican

Title: LPN/ Program Director

Date: 2/9/15