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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: WFUL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00578N

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245616**
2.STATE VENDOR OR MEDICAID NO.
(L2) **850026600**

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **08/25/2015** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 03 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

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

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

10.THE FACILITY IS CERTIFIED AS:
X A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC

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

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

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Rebecca Haberle, HFE NEII 08/28/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath, Enforcement Specialist 08/28/2015 (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
04/13/2009
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS
Posted 08/19/2015 Co.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
05/20/2015
(L33)

DETERMINATION APPROVAL

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

CCN: 24 5616

On August 25, 2015 a health Post Certification Revisit (PCR) was completed to verify the facility had achieved and maintained compliance with Federal certification requirements pursuant to a PCR completed July 1, 2015. Based on our PCR we have determined the deficiencies issued pursuant to the July 1, 2015 PCR have been corrected, effective August 3, 2015. As a result of the August 25, 2015 PCR, this Department discontinued the Category 1 remedy of State monitoring, effective August 3, 2015.

In addition, we recommended the following actions related to the remedies outlined in the CMS Region V letter of May 19, 2015:

- Per instance civil money penalty of $1,800.00 for the deficiency cited at F325, for a total penalty of $1,800.00, will remain in effect. (42 CFR 488.430 through 488.444)

- Mandatory denial of payment for new Medicare and Medicaid admissions (DPNA) effective July 16, 2015, remain in effect. (42 CFR 488.417 (b))

Since DPNA went into effect, the facility would be subject to a two year loss of NATCEP, beginning July 16, 2015. Refer to the CMS 2567b for the results of the August 25, 2015 revisit.

Effective August 3, 2015, the facility is certified for 20 skilled nursing facility beds.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 245616

August 28, 2015

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

Dear Ms. Lisell:

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 August 3, 2015 the above facility is certified for:

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

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

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

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

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

Sincerely,

Mark Meath

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

MINNESOTA MDH DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered
August 28, 2015

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

RE: Project Number S5616007, S5616008

Dear Ms. Lisell:

On May 19, 2015, the Centers for Medicare and Medicaid Services (CMS) informed you that the following enforcement remedies were being imposed:

- Per instance civil money penalty of $1,800.00 for the deficiency cited at F325. (42 CFR 488.430 through 488.444)

- Mandatory denial of payment for new Medicare and Medicaid admissions effective July 16, 2015. (42 CFR 488.417 (b))

Also, the CMS Region V Office notified you in their letter of May 19, 2015, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from July 16, 2015.

This was based on deficiencies cited by this Department for a standard survey completed on April 16, 2015 and a Health Comparative Federal Monitoring Survey (FMS), completed on May 8, 2015. The most serious deficiencies were found to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G), where by corrections were required.

On July 1, 2015, the Minnesota Department of Health completed a Post Certification Revisit (PCR) and on June 1, 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 April 16, 2015 and an FMS completed on May 8, 2015. Based on our visit, we had determined that your facility had corrected deficiencies issued pursuant to the FMS completed on May 8, 2015. However, two deficiencies issued pursuant to the standard survey completed on April 16, 2015 had not been corrected. The most serious deficiencies were be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D).

As a result the facility continues to not be in substantial compliance, this Department imposed the following Category 1 remedy:

- State Monitoring effective July 11, 2015. (42 CFR 488.422)

In addition, this Department recommended to the CMS Region V Office the following actions related to the imposed remedies in their letter of May 19, 2015:

- Per instance civil money penalty of $1,800.00 for the deficiency cited at F325, remain in effect. (42 CFR 488.430 through 488.444)

- Mandatory denial of payment for new Medicare and Medicaid admissions effective July 16, 2015, remain in effect. (42 CFR 488.417 (b))

Furthermore, the CMS Region V Office notified you in their letter of May 19, 2015, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from July 16, 2015.

On August 25, 2015, the Minnesota Department of Health completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a PCR, completed on July 1, 2015. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of August 3, 2015. Based on our visit, we have determined that your facility has corrected the deficiencies issued pursuant to our PCR, completed on July 1, 2015, as of August 3, 2015. As a result of the revisit findings, the Department is discontinuing the Category 1 remedy of State monitoring effective August 3, 2015.

In addition, this Department recommended to the CMS Region V Office the following actions related to the remedies outlined in their letter of May 19, 2015:

- Per instance civil money penalty of $1,800.00 for the deficiency cited at F325, remain in effect. (42 CFR 488.430 through 488.444)

- Mandatory denial of payment for new Medicare and Medicaid admissions, effective July 16, 2015, be discontinued, effective August 3, 2015. (42 CFR 488.417 (b))

Further, Federal law, as specified in the Act at Sections 1819(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to a denial of payment. Therefore, Lifecare Greenbush Manor is prohibited from offering or conducting a Nurse Assistant Training/Competency Evaluation Programs or Competency Evaluation Programs for two years effective July 16, 2015. If this prohibition is not rescinded, under Public Law 105-15 (H.R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

The CMS Region V Office will notify you of their determination regarding the imposed remedies, Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) prohibition.

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

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

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Email: mark.meath@state.mn.us

Telephone: (651) 201-4118
Fax: (651) 215-9697

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245616	A. Building B. Wing	8/25/2015

Name of Facility	Street Address, City, State, Zip Code
LIFECARE GREENBUSH MANOR	19120 200TH STREET GREENBUSH, MN 56726

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

(Y4) Item	(Y5) Date Correction Completed
ID Prefix **F0282** Reg. # **483.20(k)(3)(ii)** LSC	**08/03/2015**
ID Prefix **F0311** Reg. # **483.25(a)(2)** LSC	**08/03/2015**
ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC	

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	LB/mm	08/28/2015	18618	08/25/2015
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
4/16/2015			

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: WFUL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00578N

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245616**
2.STATE VENDOR OR MEDICAID NO.
(L2) **850026600**

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **07/01/2015** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY **03** (L7)

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

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

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

10.THE FACILITY IS CERTIFIED AS:

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Rebecca Haberle, HFE NEII 07/22/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath, Enforcement Specialist 07/28/2015 (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
04/13/2009
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
05/20/2015
(L33)

Posted 08/19/2015 Co.

DETERMINATION APPROVAL

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

CCN: 24 5616

On July 1, 2015 and June 1, 2015 a health and life safety code Post Certification Revisit were completed to verify the facility had achieved and maintained compliance with Federal certification requirements pursuant to a standard survey completed on April 16, 2015 and a health comparative Federal monitoring survey (FMS) completed on May 8, 2015. Based on our revisit we have determined the life safety code deficiencies issued pursuant to the standard survey completed on April 16, 2015 and the FMS completed on May 8, 2015. However, health deficiencies issued pursuant to the standard survey completed on April 16, 2015 identified the following deficiency not corrected:

- F0311 -- S/S: D -- 483.25(a)(2) -- Treatment/services To Improve/maintain Adls

In addition, at the time of the revisit, we identified the following deficiency:

- F0282 -- S/S: D -- 483.20(k)(3)(ii) -- Services By Qualified Persons/per Care Plan

The most serious deficiency was cited at a scope and severity of D.

As a result of the revisit findings, this Department imposed the following Category 1 remedy:

• State Monitoring effective July 11, 2015. (42 CFR 488.422)

In addition, this Department recommended to the CMS Region V Office, the following actions related to the imposed remedies in their letter of May 19, 2015:

• Per instance civil money penalty of $1,800.00 for the deficiency cited at F325, for a total penalty of $1,800.00, will remain in effect. (42 CFR 488.430 through 488.444)

• Mandatory denial of payment for new Medicare and Medicaid admissions (DPNA) effective July 16, 2015, remain in effect. (42 CFR 488.417 (b))

If DPNA goes into effect the facility would be subject to a two year loss of NATCEP, beginning July 16, 2015.

Refer to the CMS 2567b (for health, Life safety code and FMS), and CMS 2567 (for the health deficiencies pursuant to the standard survey completed on April 16, 2015) along with the facilitys plan of correction. Post Certification Revisit to follow.

MINNESOTA MDH DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered
July 6, 2015

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

RE: Project Number S5616007, S5616008

Dear Ms. Lisell:

On April 28, 2015, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on April 16, 2015. 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), where by corrections were required.

On May 8, 2015, a surveyor representing the Region V Office of the Centers for Medicare and Medicaid Services (CMS), completed a Federal Monitoring Survey (FMS) of your facility. As the surveyor informed you during the exit conference, the FMS revealed that your facility continued to not be in substantial compliance. The most serious deficiencies at the time of the FMS were found to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G) , where corrections were required.

On May 19, 2015, CMS forwarded the results of the FMS and notified you that your facility was not in substantial compliance with the Federal requirements for nursing homes participation in the Medicare and Medicaid programs and that they were imposing the following enforcement remedy:

On May 19, 2015, the Centers for Medicare and Medicaid Services (CMS) informed you that the following enforcement remedies were being imposed:

- Per instance civil money penalty of $1,800.00 for the deficiency cited at F325, for a total penalty of $1,800.00. (42 CFR 488.430 through 488.444)

- Mandatory denial of payment for new Medicare and Medicaid admissions effective July 16, 2015. (42 CFR 488.417 (b))

Also, the CMS Region V Office notified you in their letter of May 19, 2015, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from July 16, 2015.

On July 1, 2015, the Minnesota Department of Health 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 April 16, 2015 and a Health Comparative Federal Monitoring Survey (FMS), completed on May 8, 2015. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of June 4, 2015. Based on our visit, we have determined that your facility has not obtained substantial compliance with the health deficiencies issued pursuant to our standard survey completed on April 16, 2015. The deficiency not corrected is as follows:

F0311 -- S/S: D -- 483.25(a)(2) -- Treatment/services To Improve/maintain Adls

In addition, at the time of this revisit, we identified the following deficiency:

F0282 -- S/S: D -- 483.20(k)(3)(ii) -- Services By Qualified Persons/per Care Plan

The most serious deficiencies in your facility were found to be isolated deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level D), as evidenced by the attached CMS-2567, whereby corrections are required.

As a result of the revisit findings that your facility is not in substantial compliance, this Department is imposing the following category 1 remedy:

- State Monitoring effective July 11, 2015. (42 CFR 488.422)

In addition, this Department recommended to the CMS Region V Office the following actions related to the imposed remedies in their letter of May 19, 2015:

- Per instance civil money penalty of $1,800.00 for the deficiency cited at F325, for a total penalty of $1,800.00, will remain in effect. (42 CFR 488.430 through 488.444)

- Mandatory denial of payment for new Medicare and Medicaid admissions effective July 16, 2015, remain in effect. (42 CFR 488.417 (b))

As the CMS Region V Office notified you in their letter of May 19, 2015, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from July 16, 2015.

The CMS Region V Office will notify you of their determination regarding the imposed remedies, Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) prohibition, and appeal rights.

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

DEPARTMENT CONTACT

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

Lyla Burkman, Unit Supervisor
Bemidji Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Email: Lyla.burkman@state.mn.us

Phone: (218) 308-2104
Fax: (218) 308-2122

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..

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

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

- 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. 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 their respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC and CMS Region V Office approval, a revisit of your facility may be conducted to verify that substantial compliance with the regulations has been attained. The revisit would 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 we will recommend that the remedies imposed be discontinued effective the date of the on-site verification. Compliance is certified as of the date of the third revisit.

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

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by July 16, 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 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.

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

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Email: mark.meath@state.mn.us

Telephone: (651) 201-4118
Fax: (651) 215-9697

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245616	A. BUILDING _____ B. WING _____	R 07/01/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 000}	INITIAL COMMENTS An onsite resurvey was conducted by surveyors of this department on 6/29/15, 6/30/15, and 7/1/15. to determine compliance with Federal deficiencies issued during a recertification survey exited on 4/16/15. During this visit the following regulations were determined to be not corrected.	{F 000}		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide ambulation assistance according to the care plan for 1 of 3 residents (R1) who required staff assistance. Findings include: R1's care plan 6/5/15, directed the staff to ambulate R1 30 feet with R1 daily using hand rails and a gait belt. On 6/30/15, at 1:05 p.m. nursing assistant (NA)-A was observed to wheel R1 to a 15 foot section of hand railing on the Edgewood living unit. NA-A applied a transfer belt to R1, assisted him to stand and walked with R1 as he held the hand rail and walked the 15 foot length of the railing. R1	F 282	F (000): Preparation, submission and implementation of this Plan of Correction (POC) does not constitute an admission of or agreement with the facts and conclusions set forth on the survey report. Our POC is prepared and executed as a means to continuously improve the quality of care and to comply with all applicable state and federal regulations. F 282: 483.20 (k) (3) (ii): Be provided by qualified persons in accordance with each resident¿s written plan of care 1. Documentation of rehabilitative nursing for resident (1) is on the resident¿s flow sheet. Assisting resident in the technique of ambulation will be included in the Care Plan. Ambulation of resident is signed off by nursing staff or rehabilitative staff. If resident refusal or resident is out-of-facility, there is	8/3/15

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

Electronically Signed

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245616	A. BUILDING _____ B. WING _____	R 07/01/2015

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F 282	Continued From page 1 then turned around and walked back 15 feet to his wheelchair. R1's gait was unsteady but was maintained with the assistance of NA-A. Review of R1's Exercise and Activity restorative documentation from 5/20/15- 6/30/15, revealed of the 41 days reviewed R1 had ambulated 19 times, refused to ambulate five times and on 14 occasions "NR" was documented and four days were left blank. On 6/30/15, at 1:10 p.m. NA-A stated the days marked as "NR" indicated "no rehab" staff was available to provide R1 services. She explained the restorative nursing staff would be reassigned from providing restorative nursing to providing direct care for the residents. She confirmed the facility did not provide R1 daily restorative services due to the staff being pulled from rehab to provide direct care. On 6/30/15, at 2:00 p.m. registered nurse (RN)-A confirmed R1 had not consistently received the restorative nursing as directed by the care plan because of short staffing issues. . On 7/1/15, at 9:00 a.m. occupational therapist (OT)-A confirmed the facility had been reassigning the restorative nursing staff to provide direct care instead of restorative care. She confirmed R1 had not received ambulation services according to his care plan. The Care Planning policy dated 11/2014, directed	F 282	documentation for non-completion. 2. Any resident on Restorative Nursing Measures will have ambulation on his/her flow sheet and care plan. Ambulation will be signed off by nursing staff or rehabilitative staff. If resident refusal or resident is out-of-facility, there will documentation for non-completion. To sustain compliance, care plan audits will be completed daily on each shift by Charge Nurse and/or MDS Nurse for one month(started third week of July). 3. Daily Staff Report meetings will address Restorative Nursing Measures. The scheduled MDS assessments will evaluate ambulation and be used as assessment opportunities to determine progress, stability and need for re-evaluation. 4. All-Staff training (started on July 6, 2015)in individual and group settings to train staff on Restorative Nursing Measures (describe the care, services, and expected outcomes of the care they provide; have a general knowledge of the care and services being provided by other therapists; have understanding of the expected outcomes of this care, and understand the relationship of these expected outcomes to the care they provide.) Report was shared with the Safety Committee July 9, 2015 and will be shared with Performance Improvement (PI) Committee at the next meeting. A report of the daily audits (started third week of July) of resident plan of care will be reviewed at the next PI Committee meeting. Surveillance will be on-going or as PI Committee deems necessary.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 282	Continued From page 2 the staff to provide services according to the care plan.	F 282	5. Director of Nursing Services or designee is responsible. 6. Completion date: August 3, 2015	
{F 311} SS=D	483.25(a)(2) TREATMENT/SERVICES TO IMPROVE/MAINTAIN ADLS A resident is given the appropriate treatment and services to maintain or improve his or her abilities specified in paragraph (a)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide assistance with ambulation services for 1 of 3 residents (R1) who required staff assistance. Findings include: R1's quarterly Minimum Data Set (MDS) indicated R1 was diagnosed with cerebral palsy, hemiplegia (weakness on one side of the body) and anxiety disorder. The MDS also indicated R1 had cognitive impairment, required extensive assistance with transfers and was able to ambulate in the hallway with extensive assistance of two staff. The MDS assessment also indicated R1 had limited mobility on one side of the body which affected both the upper and lower extremities. The Plan of Treatment for Outpatient Rehabilitation dated 10/24/13, directed staff to ambulate with R1 daily.	{F 311}	F (000): Preparation, submission and implementation of this Plan of Correction (POC) does not constitute an admission of or agreement with the facts and conclusions set forth on the survey report. Our POC is prepared and executed as a means to continuously improve the quality of care and to comply with all applicable state and federal regulations. F 311: 483.25 (a) (2): A resident is given the appropriate treatment and services to maintain or improve his or her abilities specified in paragraph (a) (1) of this section¿.483.25 (a) (1) (ii) 1. Nursing staff and/or therapy staff will assist resident (1) in the technique of ambulation using recommendations provided from evaluation. Ambulation of resident is signed off by nursing staff or rehabilitative staff. If resident refusal or resident is out-of-facility, there is documentation for non-completion. 2. Any resident assisted by staff and/or therapy staff in the technique of	8/3/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245616	A. BUILDING _____ B. WING _____	R 07/01/2015

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

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{F 311}	Continued From page 3 R1's care plan dated 6/5/15, directed staff to ambulate R1 30 feet with using hand rails and a gait belt, daily. On 6/30/15, at 1:05 p.m. nursing assistant (NA)-A was observed to wheel R1 to a 15 foot section of hand railing on the Edgewood living unit. NA-A applied a transfer belt to R1, assisted him to stand and walked with R1 as he held the hand rail and walked the 15 length of the railing. R1 then turned around and walked back 15 feet to his wheelchair. R1's gait was unsteady but was maintained with the assistance of NA-A. Review of R1's Exercise and Activity restorative documentation from 5/20/15- 6/30/15, revealed of the 41 days reviewed R1 had ambulated 19 times, refused to ambulate five times and on 14 occasions "NR" was documented and four days were left blank. On 6/30/15, at 1:10 p.m. NA-A stated the days marked as "NR" indicated "no rehab" staff was available to provide R1 services. She explained the restorative nursing staff would be reassigned from providing restorative nursing services to providing direct care for the residents. She confirmed the facility had not provided R1 daily restorative services due to the staff being pulled from rehab to provide direct care. On 6/30/15, at 2:00 p.m. registered nurse (RN)-A confirmed R1 had the ability to walk 30 feet	{F 311}	ambulation will utilize recommendations provided from evaluation. Ambulation of resident is signed off by nursing staff or rehabilitative staff. If resident refusal or resident is out-of-facility, there is documentation for non-completion. To sustain compliance, on daily basis each shift, Charge Nurse and/or MDS Nurse will observe ambulation of resident(s) and review that documentation is complete for four weeks(started third week of July). 3. Daily Staff Report meetings will address ambulation. The scheduled MDS assessments will evaluate ambulation and be used as assessment opportunities to determine progress, stability and need for re-evaluation. 4. All-Staff training (started July 6,2015)in individual and group settings to train staff on ambulation. ¿Ambulation¿ means how a resident moves between locations in his/her room and adjacent corridor on same floor. If in wheelchair; self-sufficiency once in chair. A. Weight-bearing support provided 3 or more times; B. Full staff performance of activity during part (but not all) of last 7 days. Report was shared at the Safety Committee on July 9, 2015 and will be shared with the Performance Improvement (PI) Committee at the next meeting. A report of the daily audits of observation and documentation of ambulation (started third week of July)will be presented to the PI Committee at the next meeting. Surveillance will be on-going or as PI Committee deems necessary.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245616	A. BUILDING _____ B. WING _____	R 07/01/2015

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

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{F 311}	Continued From page 4 however; he was not consistently receiving the restorative nursing as directed by the care plan because of short staffing issues. She stated the facility staff attempted to provide the restorative nursing as directed but sometimes they had to be pulled to the floor to assist with personal cares. She stated the facility had identified the problem with the restorative program, but a solution had not been implemented at this time. On 7/1/15, at 9:00 a.m. occupational therapist (OT)-A stated she reviewed the monthly restorative nursing documentation. She confirmed the facility had been reassigning the restorative nursing staff to provide direct care instead of restorative care. She confirmed R1 had not received ambulation services according to his care plan. The Restorative Nursing Measure policy dated 6/2009, indicated the nursing personnel were taught restorative nursing measures and practiced them in their daily care of the residents.	{F 311}	5. Director of Nursing or designee is responsible. 6. Completion Date: August 3, 2015	

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
245616	A. Building B. Wing	7/1/2015

Name of Facility	Street Address, City, State, Zip Code
LIFECARE GREENBUSH MANOR	19120 200TH STREET GREENBUSH, MN 56726

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

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix **F0278** Reg. # **483.20(g) - (j)** LSC	**07/01/2015**	ID Prefix **F0279** Reg. # **483.20(d), 483.20(k)(1)** LSC	**07/01/2015**	ID Prefix **F0325** Reg. # **483.25(i)** LSC	**07/01/2015**
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	LB/mm	07/06/2015	18618	07/01/2015
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
4/16/2015			

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

Form Approved LSC
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 A. Building B. Wing	(Y3) Date of Revisit
245616	02 - GREENBUSH MANOR	6/1/2015

Name of Facility	Street Address, City, State, Zip Code
LIFECARE GREENBUSH MANOR	19120 200TH STREET GREENBUSH, MN 56726

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

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix Reg. # NFPA 101 LSC K0025	Correction Completed 04/16/2015	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	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By State Agency	Reviewed By PS/mm	Date: 07/06/2015	Signature of Surveyor: 27200	Date: 06/01/2015
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:
Followup to Survey Completed on: 4/16/2015		Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245616	A. Building B. Wing	7/1/2015

Name of Facility	Street Address, City, State, Zip Code
LIFECARE GREENBUSH MANOR	19120 200TH STREET GREENBUSH, MN 56726

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

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **F0242** Reg. # **483.15(b)** LSC	Correction Completed **07/01/2015**	ID Prefix **F0280** Reg. # **483.20(d)(3), 483.10(k)(2)** LSC	Correction Completed **07/01/2015**	ID Prefix **F0325** Reg. # **483.25(i)** LSC	Correction Completed **07/01/2015**
ID Prefix **F0361** Reg. # **483.35(a)** LSC	Correction Completed **07/01/2015**	ID Prefix **F0363** Reg. # **483.35(c)** LSC	Correction Completed **07/01/2015**	ID Prefix **F0371** Reg. # **483.35(i)** LSC	Correction Completed **07/01/2015**
ID Prefix **F0441** Reg. # **483.65** LSC	Correction Completed **07/01/2015**	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

Reviewed By _____ **State Agency**	**Reviewed By** LB/mm	**Date:** 07/06/2015	**Signature of Surveyor:** 18618	**Date:** 07/01/2015
Reviewed By _____ **CMS RO**	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on: 5/8/2015

Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? **YES** **NO**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245616	A. BUILDING _____ B. WING _____	R 07/01/2015

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{F 000}	INITIAL COMMENTS An onsite resurvey was conducted by surveyors of this department on 6/29/15, 6/30/15, and 7/1/15. to determine compliance with Federal deficiencies issued during a recertification survey exited on 4/16/15. During this visit the following regulations were determined to be not corrected.	{F 000}		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide ambulation assistance according to the care plan for 1 of 3 residents (R1) who required staff assistance. Findings include: R1's care plan 6/5/15, directed the staff to ambulate R1 30 feet with R1 daily using hand rails and a gait belt. On 6/30/15, at 1:05 p.m. nursing assistant (NA)-A was observed to wheel R1 to a 15 foot section of hand railing on the Edgewood living unit. NA-A applied a transfer belt to R1, assisted him to stand and walked with R1 as he held the hand rail and walked the 15 foot length of the railing. R1	F 282		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 282	Continued From page 1	F 282		

then turned around and walked back 15 feet to his wheelchair. R1's gait was unsteady but was maintained with the assistance of NA-A.

Review of R1's Exercise and Activity restorative documentation from 5/20/15- 6/30/15, revealed of the 41 days reviewed R1 had ambulated 19 times, refused to ambulate five times and on 14 occasions "NR" was documented and four days were left blank.

On 6/30/15, at 1:10 p.m. NA-A stated the days marked as "NR" indicated "no rehab" staff was available to provide R1 services. She explained the restorative nursing staff would be reassigned from providing restorative nursing to providing direct care for the residents. She confirmed the facility did not provide R1 daily restorative services due to the staff being pulled from rehab to provide direct care.

On 6/30/15, at 2:00 p.m. registered nurse (RN)-A confirmed R1 had not consistently received the restorative nursing as directed by the care plan because of short staffing issues. .

On 7/1/15, at 9:00 a.m. occupational therapist (OT)-A confirmed the facility had been reassigning the restorative nursing staff to provide direct care instead of restorative care. She confirmed R1 had not received ambulation services according to his care plan.

The Care Planning policy dated 11/2014, directed

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F 282	Continued From page 2 the staff to provide services according to the care plan.	F 282		
{F 311} SS=D	483.25(a)(2) TREATMENT/SERVICES TO IMPROVE/MAINTAIN ADLS A resident is given the appropriate treatment and services to maintain or improve his or her abilities specified in paragraph (a)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide assistance with ambulation services for 1 of 3 residents (R1) who required staff assistance. Findings include: R1's quarterly Minimum Data Set (MDS) indicated R1 was diagnosed with cerebral palsy, hemiplegia (weakness on one side of the body) and anxiety disorder. The MDS also indicated R1 had cognitive impairment, required extensive assistance with transfers and was able to ambulate in the hallway with extensive assistance of two staff. The MDS assessment also indicated R1 had limited mobility on one side of the body which affected both the upper and lower extremities. The Plan of Treatment for Outpatient Rehabilitation dated 10/24/13, directed staff to ambulate with R1 daily.	{F 311}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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LIFECARE GREENBUSH MANOR	**19120 200TH STREET GREENBUSH, MN 56726**

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{F 311}	Continued From page 3 R1's care plan dated 6/5/15, directed staff to ambulate R1 30 feet with using hand rails and a gait belt, daily. On 6/30/15, at 1:05 p.m. nursing assistant (NA)-A was observed to wheel R1 to a 15 foot section of hand railing on the Edgewood living unit. NA-A applied a transfer belt to R1, assisted him to stand and walked with R1 as he held the hand rail and walked the 15 length of the railing. R1 then turned around and walked back 15 feet to his wheelchair. R1's gait was unsteady but was maintained with the assistance of NA-A. Review of R1's Exercise and Activity restorative documentation from 5/20/15- 6/30/15, revealed of the 41 days reviewed R1 had ambulated 19 times, refused to ambulate five times and on 14 occasions "NR" was documented and four days were left blank. On 6/30/15, at 1:10 p.m. NA-A stated the days marked as "NR" indicated "no rehab" staff was available to provide R1 services. She explained the restorative nursing staff would be reassigned from providing restorative nursing services to providing direct care for the residents. She confirmed the facility had not provided R1 daily restorative services due to the staff being pulled from rehab to provide direct care. On 6/30/15, at 2:00 p.m. registered nurse (RN)-A confirmed R1 had the ability to walk 30 feet however; he was not consistently receiving the	{F 311}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245616	A. BUILDING _____ B. WING _____	R 07/01/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 311}	Continued From page 4 restorative nursing as directed by the care plan because of short staffing issues. She stated the facility staff attempted to provide the restorative nursing as directed but sometimes they had to be pulled to the floor to assist with personal cares. She stated the facility had identified the problem with the restorative program, but a solution had not been implemented at this time. On 7/1/15, at 9:00 a.m. occupational therapist (OT)-A stated she reviewed the monthly restorative nursing documentation. She confirmed the facility had been reassigning the restorative nursing staff to provide direct care instead of restorative care. She confirmed R1 had not received ambulation services according to his care plan. The Restorative Nursing Measure policy dated 6/2009, indicated the nursing personnel were taught restorative nursing measures and practiced them in their daily care of the residents.	{F 311}		

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
245616	LIFECARE GREENBUSH MANOR

Type of Survey (select all that apply):

D					

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):

D					

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 18618	06-29-2015	07-01-2015	1.00	1.00	10.50	2.00	5.00	1.50
2.								
3.								
4.								
5.								
6.								
7.								
8.								
9.								
10.								

Total Supervisory Review Hours 0.75

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

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

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
245616	LIFECARE GREENBUSH MANOR

Type of Survey (select all that apply):

D					

A Complaint Investigation
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E Initial Certification
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H Life safety Code
I Recertification
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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 27200	06/01/15	06/01/15	0.25	0.00	0.00	0.00	0.00	0.25
2.								
3.								
4.								
5.								
6.								
7.								
8.								
9.								
10.								

Total Supervisory Review Hours 0.00

Total Clerical/Data Entry Hours.....

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

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
245616	LIFECARE GREENBUSH MANOR

Type of Survey (select all that apply):

D					

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

Extent of Survey (Select all that apply):

D					

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 18618	07-01-2015	07-01-2015	0.00	0.00	0.75	0.00	1.50	0.75
2.								
3.								
4.								
5.								
6.								
7.								
8.								
9.								
10.								

Total Supervisory Review Hours 0.00

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

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

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: WFUL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00578N

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

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

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **04/16/2015** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 03 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

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

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

10.THE FACILITY IS CERTIFIED AS:
A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC

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

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

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Yvonne Switajewski, HFE NEII 05/13/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath
Enforcement Specialist 05/19/2015 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30)

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

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

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

Posted 05/20/2015 Co.

DETERMINATION APPROVAL

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

CCN: 24 5616

A standard survey was completed at this facility on April 16, 2015. Deficiencies were found. The facility has been given an opportunity to correct before remedies woudl be imposed. Post Certification Revisit to follow.

Refer to the CMS 2567 for both health and life safety code along with the facility's plan of correction.

An FSES was conducted at the facility to determine subtantial compliance of life safety code deficiency cited at K25. Refer to the CMS 2786 T for details of the FSES.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered
April 28, 2015

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

RE: Project Number S5616007

Dear Ms. Lisell:

On April 16, 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

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

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

DEPARTMENT CONTACT

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

Lyla Burkman, Unit Supervisor
Bemidji Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
705 5th Street Northwest, Suite A
Bemidji, Minnesota 56601-2933
Email: Lyla.burkman@state.mn.us

Phone: (218) 308-2104
Fax: (218) 308-2122

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by May 26, 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 May 26, 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 July 16, 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 October 16, 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 related to this eNotice

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
85 East Seventh Place, Suite 220
P.O. Box 64900
St. Paul, Minnesota 55164-0900
Email: mark.meath@state.mn.us

Telephone: (651) 201-4118
Fax: (651) 215-9697

Enclosure

cc: Licensing and Certification File 5616s15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245616	A. BUILDING _____ B. WING _____	04/16/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual	F 278		5/20/15

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

Electronically Signed | 05/08/2015

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
	245616	A. BUILDING _____ B. WING _____	04/16/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 278	Continued From page 1 to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure the Minimum Data Set (MDS) accurately reflected the current dental status for 1 of 1 resident (R36) reviewed for dental concerns and accurately reflected the nutritional status for 1 of 3 residents (R39) reviewed for nutrition and weight loss. Findings include: R36's admission MDS dated 6/4/14, indicated R36 had no dental issues. R36's quarterly MDS dated 2/11/15, indicated R36 was diagnosed with hemiplegia (total or partial paralysis of one side of the body). The MDS also indicated R36 was cognitively intact and required extensive assistance with all activities of daily living. Dental status was not assessed. R36's care plan date 4/16/15, identified an oral hygiene focus dated 2/10/15. The oral hygiene focus identified R36 had a few of his own teeth.	F 278	Resident # 36 - MDS and Care Plan have been reviewed and revised to include dental issues/needs. Resident #39's MDS and care plan have reviewed and revised to accurately reflect weight loss issues, cognitive impairment, and physician prescribed weight loss. For all residents - the MDS's have been reviewed and/or updated as needed to include weight loss issues, cognitive issues, and physician prescribed weight loss (if ordered). MDS's have been reviewed for accurate coding. Education will be provided (mandatory attendance May 20, 2015)to all members of the Interdisciplinary Team, MDS staff and nursing on how to appropriately identify and document resident's needs / or dependencies. Staff who complete any portion of the MDS have been provided with RAI manual instructons, the policy for care planning ahas been revised, and staff will be provided education at mandatory meeting on updated policy. Upon completion of full comprehensive	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245616	A. BUILDING _____ B. WING _____	04/16/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 278	Continued From page 2 On 4/13/15, at 5:17 p.m. R36 stated he was missing most of his teeth. It was observed that R36 was missing two bottom front teeth and the upper front teeth were broken off and jagged. The remaining parts of the teeth were dark in color. The remaining upper teeth were missing. On 4/16/15, at 8:55 p.m. registered nurse (RN)-A confirmed the resident did have broken natural teeth and the MDS assessment was incorrect. On 04/16/2015, at 9:25 a.m. nursing assistant (NA)-B stated R36 had never complained of tooth pain but has commented that his teeth were bad. On 04/16/2015, at 11:53 a.m. the director of nursing (DON) confirmed R36's MDS should have identified his dental issues. urveyor: Debra Vincent R39's quarterly MDS was coded inaccurately regarding weight loss. R39's current Physician Orders indicated regular diet, mechanical soft meats and pureed fruits. R39's current physician orders lacked an order for a weight loss regimen or an order for diuretic use for weight loss. R39's quarterly nutrition assessment dated 3/3/2015, indicated R39 weights were as follows: -9/10/14: 121.4#	F 278	assessments, the Interdisciplinary Team will meet with families and resident to review completed assessments to ensure resident needs and depencencies are being addressed. DON or a designee will randomly audit MDS's, assessments, and care plans for appropriate documentation, and to ensure care plans are developed using accurately coded MDS's, with newly admitted residents or significant change three (3) times weely times four (4) weeks for appropriateness, and findings will be brought to QA/PI for recommendation and review.	

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	245616	A. BUILDING _____ B. WING _____	04/16/2015

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F 278	Continued From page 3 -12/1/14: 120.4# -2/1/15: 112.4# -3/1/15: 108.2# the assessment further indicated R39 had a significant weight loss of 12. 2% in 180 days with a goal written to prevent weight loss as long as possible. The assessment further indicated weight loss was anticipated in the future due to diagnoses of end stage cardiac disease and anxiety. R39's quarterly MDS dated 3/8/2015, indicated R39 had diagnoses that included heart failure, anxiety and dementia. The MDS also indicated R39 was cognitively impaired and was on a physician prescribed weight loss regimen. According to the Long Term Care Facility Resident Assessment Instrument User's Manual version 3.0 dated October 2013, if the resident has experienced a weight loss of 5% or more in past 30 days or 10% or more in the last 180 days, and the weight loss was planned and pursuant to a physician's order, or if the weight loss was due to a loss of fluid with physician orders for diuretics, then the MDS should be coded 1. Code 2 for weight loss-not on physician-prescribed weight loss regimen. On 4/16/2015, at 9:05 a.m. registered nurse (RN)-A confirmed R39 was not on a physician prescribed weight loss regimen and the MDS was coded inaccurately. On 4/16/2015, at 12:13 p.m. the DON confirmed	F 278		

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F 278	Continued From page 4 R39's MDS was not coded correctly and it was her expectation for the MDS to be coded accurately. A policy regarding the accurate completion of the MDS was requested but none was provided.	F 278		
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 on observation, interview and document review, the facility failed to develop a care plan to address nutritional goals and interventions related to identified nutritional supplement needs for 1 of 1 resident (R39) reviewed for nutrition and weight	F 279	Resident # 39 - Care Plan has been reviewed and interventions put into place to include nutritional goals and interventions to ensure nutritional needs are addressed.	5/20/15

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F 279	Continued From page 5 loss. Findings include: R39's quarterly Minimum Data Set (MDS) dated 3/8/2015, indicated R39 had diagnoses that included heart failure, anxiety and dementia. The MDS also indicated R39 was cognitively impaired and had weight loss of 10% or more in last 6 months. R39's quarterly Nutrition Assessment dated 12/9/14, indicated staff was to provide Ensure Clear with meals instead of juice. The assessment also indicated these requests were noted on the dietary roster, food services was notified and R39 had refused meals at least 4X in the past 7 days with other meal intakes ranging from 10-80%. R39's quarterly nutrition assessment dated 3/3/2015, indicated R39 received Ensure Clear with meals instead of juice to increase caloric intake. Goal was to prevent weight loss as long as possible. R39's undated care plan identified a nutrition/feeding focus, however, the care plan lacked interventions regarding the use of a nutritional supplement. On 4/16/15, at 8:34 a.m. nursing assistant (NA)-E verified R39 received a nutritional supplement.	F 279	All residents with identified nutritional needs have had their care plans reviewed and updated as needed. The diet sheets and meal books have been reviewed and updated. The Comprehensive Care Plan Policy has been reviewed and updated, and the Nutritional Risk Policy has been reviewed and updated to ensure between meal nourishments will be correctly provided and documented. MDS staff and all nurses will be provided education at a mandatory staff meeting May 20, 2015 on proper care plan development and importance of accuracy in recording supplements and how and where to docuemnt. DON or designee will audit resident diet sheets, and meal books three (3) times weekly times four (4) weeks to ensure proper accuracy and documentation of nutritional supplements are addressed and care plans include measurable objectives and timetables to meet resident needs are addressed. Results of audits will be brought to QA/PI for further recommendation and review.	

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F 279	Continued From page 6 NA-E verified the Rosewood dietary forms, updated 4/9/15, and the Rosewood Eat Sheets lacked information indicating a supplement was to be offered or the amount provided. NA-E stated, "we are suppose to give her the supplement for her juice. NA-E provided a Dietary Communication form dated 2/6/15, that was taped to the kitchenette cabinet, which indicated if resident ate below 50% of the meal, staff were to offer her ensure. NA-E confirmed, there was no place to document or keep track of R39's supplement consumption. NA-E stated, " she really needs the supplements, she does not eat well." On 4/16/2015, at 9:05 a.m. registered nurse (RN)-A confirmed R39 was receiving a nutritional supplement and R39's care plan did not address her nutritional supplement needs. On 4/16/2015, at 12:13 p.m. The dietician confirmed her expectation was for the RN to have nutritional supplements identified and put into place. On 4/16/2015, at 12:13 p.m. the DON confirmed it was her expectation for staff to be ensuring the care plan accurately reflected the residents needs and interventions. The facility care plan policy revised 6/09, indicated the comprehensive care plan shall incorporate goals and objectives so that all disciplines have access to such information. The policy also indicated care plan would be developed and maintained on each resident at the time of admission and kept current with each change of resident condition.	F 279		

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F 311 SS=D	483.25(a)(2) TREATMENT/SERVICES TO IMPROVE/MAINTAIN ADLS A resident is given the appropriate treatment and services to maintain or improve his or her abilities specified in paragraph (a)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to provide ambulation assistance / re-evaluation in order to maintain the resident's abilities to ambulate for 1 of 1 (R14) resident reviewed for ambulation. In addition, the facility failed to provide eating assistance during 3 of 3 meal observations in the Whitetail Trail dining room for 1 of 1 resident (R14) who required staff assistance. Findings include: R14's quarterly Minimum Data Set (MDS) dated 2/16/15, indicated R14 was diagnosed with dementia, anxiety, macular degeneration, congestive heart failure, lung disease and osteoarthritis. The MDS also indicated R14 had impaired cognition, was totally dependent on staff for transfers and mobility, did not ambulate in the hallway or the bedroom and limited assistance for eating. R14's quarterly care conference note dated 2/24/15, indicated R14's weight bearing status was being maintained and R14 was being ambulated up to 20 feet daily. A change of status MDS was in the process of being completed	F 311	Resident # 14 - The MDS and care plan have been reviewed and revised to ensure resident is receiving appropriate services and treatment in order to maintain eating and ambulation abilities. For all residents, MDS's and care plans have been reviewed and revised to ensure residents are receiving appropriate treatments and services to maintain eating and ambulation skills as appropriate, in order to maintain or improve eating and ambulation skills. The Nutrition Risk Monitoring Policy and the Restorative Nursing Program Policy have been reviewed and revised as needed. Education will be provided at a mandatory staff meeting May 20, 2015, on the revised/updated policies, along with the importance of proper monitoring and documentation of ambulation and eating. The facility book entitled "Your Rights" will be reviewed at this meeting as well. DON or a designee will conduct random observation of resident eating skills and ambulation along with documentation to ensure residents are provided with eating assistance and ambulation assistance	5/20/15

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F 311	Continued From page 8 during the survey. R14's last physical therapy (PT) progress note dated 7/24/14, indicated R14 was able to walk 100 feet with a four wheeled walker (4WW) and the physical therapist recommended R14 to continue with a rehabilitation program which included ambulation with a 4WW for distances as tolerated. The therapist also recommended R14 participate in group exercises to all joints/all motions and passive range of motion to upper extremities daily. R14's nurses Progress Notes dated 4/9/15, indicated a significant change MDS assessment was in the process of being completed due to R14's overall decline. The note also indicated R14 required more assistance with activities of daily living, had a decline in cognition, was more confused and had increased weakness. R14's care plan updated 4/14/15, indicated R14 no longer ambulated due to progressive dementia and overall decline. The Exercises and Activity sheet indicated R14 was ambulating 50 to 100 feet in January 2015. In February 2015, R14 ambulated only four times for a distance of 40-60 feet. The rest of the Exercises and Activity sheets since February 6, 2015, and all of March and April indicated R14 was unable to ambulate at all. On 4/15/15, at 8:16 a.m. R14 was observed to be wheeled into the dining room by nursing staff.	F 311	required to maintain or improve skills.	

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F 311	Continued From page 9 On 4/16/15, at 9:30 a.m. nursing assistant (NA)-F was observed to transfer R14 from the toilet to the wheelchair with a stand up mechanical lift with no concerns noted. On 4/15/15, at 12:32 p.m. licensed practical nurse (LPN)-A stated R14 has had a decline and that she would send a referral for a physical therapy and occupational therapy evaluation. On 4/16/15, at 11:10 a.m. the rehabilitation aide/nursing assistant (NA)-C stated R14 was transferred with a stand up lift and had been unable to ambulate for a long time due to increased weakness. NA-C stated normally if a resident did not ambulate as indicated by the care plan, she would report it after a month or so of repeated change in ambulation ability to the RN. After looking at the Exercise and Activity care sheets NA-C verified R14 had not ambulated for almost 2 months and it should have been reported to the nurses. On 4/16/15, at 12:10 p.m. registered nurse (RN)-B stated she was not aware R14 was not ambulating in the rehabilitation program. RN-B stated if a resident was unable to ambulate or refused ambulation, the staff were supposed to report it to the nursing staff. RN-B stated R14 was seen by occupational therapy in February 2015, for lymphedema in the arm but had not been evaluated or screened for ambulation ability in order to determine if a new treatment plan should be considered to prevent further loss. On 4/16/15, at 12:28 p.m. the director of nursing (DON) stated if R14 was not being ambulated according to the physical therapist's	F 311		

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F 311	Continued From page 10	F 311		

recommendation she should have been screened again to determine if a different program would be more effective. The DON stated they had identified a problem with the rehabilitation program and were in the process of making some changes. The DON stated the rehabilitation aid should have reported to the nurses if R14 was not ambulating.

The facility's undated Restorative Nursing Program policy indicated residents who refused to participate in the program for at least two weeks would have a referral sent to OT/PT for re-evaluation.

Eating:

On 4/13/15, at 6:06 p.m. R14 was observed seated in a wheelchair at the dining room table attempting to eat the meal. R14 was observed to bring a spoon with a carrot piece to her mouth and the carrot fell off the spoon and onto the floor. R14 then attempted to bring a spoonful of potatoes to her mouth and dropped those on her clothing protector, picked the potatoes up with her fingers and put them into her mouth. R14 took a drink of milk, picked up an empty fork and brought it to her mouth. There was no staff present in the dining room to assist R14.
-R14's attempts to independently feed herself continued until 6:23 p.m. when a licensed practical nurse (LPN) came with medications. The LPN was observed to pick up R14's fork, stab a carrot and handed the fork to R14. R14 ate the carrot. The LPN exited the room. R14 was observed to drop the fork on the floor and a tablemate seated next to R14 attempted three times to pick the fork up and could not reach it. R14 was observed to pick up a glass of milk, set

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F 311	Continued From page 11 it in her plate, pick up a coffee cup, took a drink and then set the coffee cup in her plate. -At 6:34 p.m. R14 was observed to pick up a bowl of applesauce and independently take a few small bites. - At 6:41 p.m. R14 stated she was done and attempted to push herself away from the table but could not move the wheelchair. R14's tablemate unlocked her wheelchair brakes, removed R14's clothing protector and helped R14 wheel out of the dining room. On 4/14/15, at 8:51 a.m. R14 was observed in the dining room. LPN-A was observed seated next to R14 administering her medication. LPN-A was also observed to physically assist R14 take a few bites of cereal. Following this observation, LPN-A left the dining room and R14 was observed to attempt to get her spoon to her mouth. The spoon was either empty or she was too shaky to get the spoon up to her mouth. After three attempts to feed herself, R14 quit trying. R14 was wheeled to her room without eating anything but a few bites of cereal. There was no staff in the dining assisting with the meal nor staff attempting to assist R14 with eating. On 04/15/2015, at 8:24 a.m. R14 was observed seated in the dining room independently taking small bites of her toast. - At 8:28 a.m. R14 was observed to attempt to eat cereal however, when R14 got the spoon to her mouth, the spoon was either empty or the cereal had fallen onto her clothing protector. - At 8:33 a.m. the activity staff/nursing assistant was observed standing next to R14 and physically assist her to eat.	F 311		

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F 311	Continued From page 12 -At 8:37 a.m. the activity staff was observed to assist R14 put a jacket on, verbally remind R14 to pick up and eat her toast and then exited the dining room. -At 8:38 a.m. the homemaker/nursing assistant (NA-E) stopped and told R14 she was doing really good and then cut up her toast gave R14 a bite. NA-E then left the room. -At 8:51 a.m. NA-E came to the to the table and asked R14 if she was done eating. R14 answered yes and NA-E removed R14's meal dishes from the table and proceeded to wash the table off while R14 remained seated at the table. 04/15/2015, at 12:22 p.m. LPN-A stated the facility was in the process of completing a significant change of status for R14 because she had declined. LPN-A stated R14 required more assistance with eating but was not always receptive to assistance. On 4/15/15, at 12:30 p.m. registered nurse, RN-B stated R14 had just recently declined and appeared to have trouble getting her hands up to her mouth and even holding onto her spoon. RN-A verified R14 was not provided assistance as needed. On 4/14/2015, at 9:52 p.m. a family interview was completed with R14's family member (F-2). F2 stated they wished the facility had more staff so R14 could receive more help at meal time and then her clothes maybe would not be soiled. On 4/16/15, at 12:28 p.m. the director of nursing	F 311		

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F 311	Continued From page 13 (DON) verified R14's dining experience was not dignified and added that was "not the way we work." The DON agree, R14 was not provided the eating assistance she required. The facility book entitled "Your Rights" was provided. The book section indicated for dignity, the facility must with courtesy promote and care for the resident in a manner and environment that maintained or enhanced dignity and respect in full recognition of your individuality.	F 311		
F 325 SS=D	483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to comprehensively assess weight loss and implement appropriate interventions for 2 of 3 residents (R16, R39) in the sample who were reviewed for nutrition. Findings include:	F 325	Resident # 16 and resident # 39 - the MDS's, care plans and nutritional risk assessments have been reviewed and updated as needed. For all residents the nutritional supplement list has been updated to include all residents at nutritional risk.	5/20/15

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F 325	Continued From page 14 R16 was at nutritional risk and had a weight (loss) and the nutritional supplement use was not monitored nor reviewed for most effective supplementation. R16's quarterly Minimum Data Set (MDS) dated 4/7/2014, indicated R16 was diagnosed with dementia, anxiety and congestive heart failure (CHF). The MDS also indicated R16 had severe cognitive impairment, weighed 114 pounds (lbs.) with no nutritional problems and required staff assistance for meal set up. R16's quarterly MDS completed 1/13/15, indicated R16 weighed 121 pounds, had no nutritional problem identified and required assistance of 1 person for meal tray set-up. R16's Dietary Care Area Assessment (CAA) dated 10/16/14, indicated R16 weighed 123 lbs. and weight loss was anticipated in the future due to progression of diagnosis and advanced age. The CAA indicated the dietitian started R16 on a before bed time (HS) snack which consisted of a magic cup (high calorie ice cream supplement) started on 10/21/14, due to significant weight loss. Review of R16's weights from 4/4/14, through 4/2/15, revealed the following: - On 4/4/14, weighed 140 lbs. - On 6/1/14, weighed 130 lbs. - On 12/1/14, weighed 122 lbs. - On 2/27/15, weighed 120 lbs. - On 3/1/15, weighed 118 lbs. (a loss of 22 pounds from 4/4/14) - On 4/2/15, weighed 114 lbs. The 1/5/2015, physician note indicated R16 had a	F 325	The diet sheets and meal books have been updated to include the type of supplement offered and amount taken. The Nutritional Risk Monitoring Policy has been reviewed and updated as needed. All residents will be weighed on admission and two (2) days later, and subsequently monthly. The Food and Nutrition Policy has been reviewed and revised as needed. A list of appropriate nutritional supplements has been posted in meal books. MDS nurses and dietary supervisor will complete a dietary risk assessment on admission and with any noted changes. A summary of the assessment will be included with the dietary progress note. Dietitian will e-mail dietary supervisor, DON and case managers, with recommendations. Dietary supervisor will review all residents for weight change of three (3) pounds or 5% loss in 30 days or 10% loss in 180 days. The Interdisciplinary Team will discuss nutritional risk and weight loss at care conferences and weekly as needed if loss occurs, to attempt to identify causes and interventions needed. The staff, dietary supervisor and Interdisciplinary Team will receive education at a mandatory staff meeting May 20, 2015, regarding policy and procedures, updates/changes to maintain resident's nutritional status, along with acceptable substitutions for supplements, and the need to report to case manager or dietitian refusal or reduced intake daily.	

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	245616	A. BUILDING _____ B. WING _____	04/16/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 325	Continued From page 15 slow weight loss. R16's quarterly Nutrition Assessment dated 1/5/15, and completed by the registered dietitian (RD) indicated R16 weighed 121 lbs. on 1/1/15, 122 lbs. on 12/1/14, 123.2 lbs. on 10/1/14, 129.8 lbs. on 7/9/14, and 141 lbs. on 1/2014. The assessment also indicated R16 had a 6.8% weight loss in the last 180 days which was not significant and a BMI of 22.1 which was within normal limits. The assessment indicated R16's diet order was a mechanical soft with thin liquids and to utilize a divided plate due to vision loss. In addition, the assessment indicated R16 had upper dentures and own lower natural teeth with no chewing or swallowing problems, intakes varied between 0-100% most often between 30-70% and R16 was to be provided a magic cup every HS due to gradual weight loss. The RD assessment note indicated weight loss was anticipated in the future due to progression of diagnoses with a goal to maintain weight as long as possible with monitoring of R16's weights, intakes and nursing notes. The 1/5/15, R.D. Consultation Report indicated R16's had a 6.6% weight loss and directed staff to continue with providing R16 the HS snack of magic cup due to the gradual weight loss. The 2/10/15, and 2/15/14, Consultation Report completed by the dietetic college intern indicated R16 had a 9.4% wt. loss in the last 30 days and requested staff to rewiegh R16 and to continue to provide the HS magic cup snack and plan to monitor for further weight loss and implement interventions as appropriate. The 3/2/15, physician note indicated R16 had	F 325	DON or a designee will perform random observations, audits and monitoring for proper documentation three (3) times weekly times four (4) weeks to ensure residents are receiving appropriate nutritional supplements and staff are documenting correctly. Results of audits will be brought to QA/PI meetings for further recommendations and review.	

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F 325	Continued From page 16	F 325		

slow persistent weight loss and had lost more weight in the past 6 months.

The 3/31/5, Consultation Report completed by the dietetic college intern indiated an anticpated future weight loss due to poor appetite and progression in diagnoses. No new recommendations were noted.

R16's nutrition care plan dated last revised on 4/1/15, indicated R16 was to recieve a regular, mechanical soft diet, small portions, ground meat with extra gravy or sauce. The plan directed staff to assist R16 with meal set up only, supervise R16 for eating, provide encouragement to eat, weigh R16 one time a month and provide magic cup daily which was started on 10/21/2014. The plan indicated R16's goal weight was 115-120 pounds and was currently 114 pounds.

R16's Quarterly Nutrition Assessment note dated 4/2/2015, written by the dietetic college intern indciated R126's wt was 114.2 lbs. on 4/2/15, 118.4 lbs on 3/1/15, 121 lbs. on 1/1/15, 123.2 lbs. on 10/1/14, and 139.6 lbs. on 4/1/14, which indicated a 6% wt. loss in 90 days and 7.9% wt. loss in 180 days which was not significant, a nomral BMI of 20.9, a mechanical soft diet with thin liquids and to utilize a divided plate due to vision loss. The note also indicated R16's intake varied between 0-100% and most often between 30-70% and R16 had an order for magic cup snack every HS due to gradual wt loss. The note indicated future wt loss was anticipated due to the progression of R16's diagnoses. The nutritional goal was to maintain weight as long as possible and dietary would monitor R16's weights, intakes and nursing notes. No new dietary interventions were noted.

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F 325	Continued From page 17	F 325		

The 4/2/15, RD progress note indicated approval of nutritional assessment that had been completed by a dietetic intern who visited the facility.

The 4/16/15, registered nurse (RN) progress note indicated R16's weight was 114 lbs., recieved a magic cup every HS for extra calories, ate snacks in between meals and indicated staff were to offer R16 alternatives if she did not like what she was served.

Review of the Treatment Sheet documentation indicated R16 was to recieve a magic cup per the physician's order dated 11/21/14, at 6:00 p.m. every day. The documentation further revealed the following:

-3/1/15, to 3/31/15, R16 had received the magic cup 25 out of 31 days however, the amount consumed was not documented on the treatment sheet.
- 4/1/15, to 4/14/15, R16 received the magic cup 11 of 14 days however, the amount consumed was not documented on the treatment sheet.

On 4/15/15, at 7:30 a.m. nursing assistant (NA)-G was observed to wheel R16 out of room and into the dining room.
-At 7:35 a.m. cook-A was observed to serve R16 biscuits and gravy and cream of wheat. R16 was observed to eat a couple spoonfullss of the cream of wheat.
-At 8:00 a.m. R16 was heard to tell the director of nursing (DON) that she was not a breakfast eater. R16 was osberved to eat 25% of the biscuit then wheel herself away from the table. Shortly there-after R16 was osberved sleeping in her

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F 325	Continued From page 18 wheelchair. On 4/15/15, at 11:15 a.m. R16 stated she was hungry and was observed to wheel herself into the dining room. Cook-A stated lunch was at 12:00 p.m. -At 12:15 p.m. R16 was observed to remain in the dining room, in the wheelchair, sleeping. -At 12:16 p.m. R16 was observed to wait in the dining room since 11:15 a.m. without any offer of additional nutrition / snack until this time when NA-B served R16 her lunch which consisted of meatloaf, scalloped potatoes and cauliflower. R16 was observed to eat the scalloped potatoes and then tell NA-B she did not feel good and wanted to lay down. On 4/15/15, at 3:05 p.m. evening shift NA-A verified R16 received a magic cup at 6:00 p.m. everyday and stated she did not think that was a very good time for R16 to recieve because R16 was eating supper at that time. NA-A stated R16 would consume 50% of the supplement at most times but at times would not eat it because she did not like the hard consistency of the magic cup. NA-A stated she did not think the magic cup was a real good supplement for R16 because R16 liked other things, especially anything that was sweet because R16 had a sweet tooth. On 4/16/15, at 9:00 a.m. the food service supervisor stated she had not been trained on reviewing supplements / amount consumed and was not aware the amount of the magic cup R16 consumed had not been documented. In addition, The food service supervisor stated she was aware R16 had recieved the nutritional supplement with her supper meal and that other high calorie snack supplements could be offered	F 325		

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F 325	Continued From page 19 to R16. On 4/16/15, at 11:05 a.m. the director of nursing (DON.) verified the amount of a supplement should be documented for review and was not. The DON stated R16 could benefit from additional nutritional supplement interventions. At 11:45 a.m. RN-A stated they used to have a nutritional risk/high risk list for residents with weight loss however, no longer had one. On 4/16/15, at 12:00 p.m. the RD was interviewed via telephone. The RD verified the amount of the magic cup consumed was not being documented and was also not aware R16's nutritional supplement was given with her supper meal. The RD stated the timing of the magic cup could be changed and that R16 may benefit from trying different nutritional supplements. R39 was at nutritional risk and the nutritional supplement use was not monitored nor reviewed for most effective supplementation. R39's quarterly MDS dated 3/8/2015, indicated R39 had diagnoses that included heart failure, anxiety and dementia. The MDS also indicated R39 was cognitively impaired and had weight loss of 10% or more in last 6 months. R39's quarterly Nutrition Assessment dated 12/9/14, indicated staff was to provide Ensure Clear with meals instead of juice. The assessment indicated these requests were noted on dietary roster and that food services was	F 325		

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F 325	Continued From page 20	F 325		

notified. The note further indicated R39 had refused meals at least 4X in the past 7 days with other meal intakes ranging from 10-80%.

R39's quarterly Nutrition Assessment dated 3/3/2015, indicated R39 weights were as follows: 108.2 lbs. on 3/1/15, 112.4 lbs. on 2/1/15, 120.4 lbs. on 12/1/2014, and 121.4 lbs. on 9/10/2014, which indicated a significant weight loss of 12. 2% in 180 days. The assessment indicated R39 received Ensure Clear with meals instead of juice to increase caloric intake and R39's goal was to prevent weight loss as long as possible.

R39's current Physician Orders indicated regular diet, mechanical soft meats and pureed fruits. R39's current physician orders lacked an order a nutritional supplement.

On 4/16/15, at 8:34 a.m. NA-E verified R39 received a nutritional supplement. NA-E verified the Rosewood dietary forms, updated 4/9/15, and the Rosewood Eat Sheets lacked information indicating a supplement was to be offered or the amount provided. NA-E stated, "we are suppose to give her the supplement for her juice, and the family wants us to give it as well." NA-E provided Rosewood Eat sheets from 3/28/15, to 4/16/15, which indicated the amount consumed per meal and fluid intake. NA-E verified R39 had poor intake for meals on those days, and some days did not eat the meal at all. NA-E confirmed the forms lacked any documentation regarding a nutritional supplement provided with the exception of 4/16/15, which indicated 150 cubic centimenters (cc) of breeze supplement was

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F 325	Continued From page 21	F 325		

provided. NA-E provided a Dietary Communication form dated 2/6/15, that was taped to the kitchenette cabinet, which indicated if resident ate below 50% of meal, to please offer her ensure. NA-E confirmed, there was no place to document or keep track of R39's supplements provided or amount consumed. NA-E stated R39 really needed the supplements as she did not eat very well.

On 4/16/2015, at 12:13 p.m. The dietician confirmed her expectations was for the RN to have nutritional supplements identified and put into place and would expect staff to keep track of the amount consumed and how often it was provided. The dietician stated it was recommended that a process be put into place on tracking supplements as it seemed to have gotton lost. The dietician verified R39 was to receive the ensure clear.

On 4/16/2015, at 9:05 a.m. RN-A confirmed the facility was not monitoring or documenting R39's supplement use / consumption.

On 4/16/2015, at 12:13 p.m. the DON confirmed it was her expectation for staff to monitor and document supplement use.

The 1/2009, Nutrition Risk Monitoring policy, indicated the RD would chart monthly on the nutritional progress of all residents who were on the risk list. The policy indicated the RD would add or change any of the problems goals, and interventions as deemed necessary.

The 2009, Food & Nutrition Services policy,

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F 325	Continued From page 22 indicated the facility identified nutritionally at risk patients/residents and provided for their increased nutritional needs. Patients/residents would be offered additional between meal nourishments if deemed necessary.	F 325		

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	245616	A. BUILDING **02 - GREENBUSH MANOR** B. WING _____	**04/16/2015**

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K 000	INITIAL COMMENTS Anderson, James A. FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENTS ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey, LifeCare Greenbush Manor was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 18 New Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: HEALTH CARE FIRE INSPECTIONS STATE FIRE MARSHAL DIVISION 444 CEDAR STREET, SUITE 145	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		05/08/2015

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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K 000	Continued From page 1 ST. PAUL, MN 55101-5145, or By e-mail to: Marian.Whitney@state.mn.us or Angela.Kappenman@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. LifeCare Greenbush Manor was built in 2010, is a 1-story building without a basement and was determined to be Type V(111) construction, A clinic and an assisted living building are attached and separated with 2-hour fire barriers between the Manor and the clinic, and the Manor and the assisted living building. The facility is divided into 4 smoke compartments with 1-hour and 2-hour fire barriers. The facility is fully protected with an automatic sprinkler system installed in accordance with NFPA 13 The Standard for the Installation of Sprinkler Systems 1999 edition. The facility has a fire alarm system which includes corridor smoke detection throughout and in all common areas, installed in accordance with NFPA 72 "The National Fire	K 000		

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K 000	Continued From page 2 Alarm Code" 1999 edition. All sleeping rooms have smoke detection and hazardous areas have automatic fire detection in accordance with the Minnesota State Fire Code 2007 edition. The fire alarm system is monitored for automatic fire department notification. The facility has a capacity of 40 beds and had a census of 39 at the time of the survey. The facility was surveyed as one building. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 025 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers are constructed to provide at least a one-hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels in approved frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 18.3.7.3, 18.3.7.5, 18.1.6.3 This STANDARD is not met as evidenced by: Based on observations and staff interview, it was determined that the facility failed to maintain smoke barrier walls in accordance with NFPA	K 025	LifeCare Greenbush Manor had a passing score after a Fire Safety Evaluation System (FSES) survey on	4/16/15

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K 025	Continued From page 3 101-2000 edition, Sections 18.3.7, 18.3.7.1, 18.3.7.3, 8.3.2, and 8.3.6. This deficient practice could allow the products of combustion spread throughout the facility in the event of a fire which could affect all 40 residents, staff and visitors. Findings include: On facility tour between 9:30 PM to 2:30 PM on 04/16/2015, it was observed that the smoke barrier walls do not extend thought the attic space above the ceiling. This condition is not covered by the NFPA 101 (00) 8-3.2 exceptions and does not meet the requirement for a smoke barrier wall. These deficient practices were confirmed by the Maintenance Supervisor (BD).	K 025	4/16/15 conducted by the State Fire Marshal. Brett Dallager, Maintenance Supervisor, will be responsible for maintaining the ongoing compliance with the conditions necessary to maintain a passing FSES score.	

Sheehan, Pat (DPS)

From: Sheehan, Pat (DPS)
Sent: Friday, April 24, 2015 10:20 AM
To: rochi_lsc@cms.hhs.gov
Cc: james.a.anderson@state.mn.us; 'slisell@lifecaremc.com'; 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: Lifecare Greenbush Manor 2015 FSES for K25 - Previously Approved - No Changes

This is to inform you that I am accepting the FSES that was conducted at Lifecare Greeenbush Manor 4-16-15 as a result of the K25, smoke barrier deficiency.

I am recommending that CMS approve this FSES.

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

F5616008

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	BUILDING
LifeCare Greenbush Manor	02 - Greenbush Manor

ZONE(S) EVALUATED: Rosewood

PROVIDER/VENDOR NO.	DATE OF SURVEY
245616	04/16/2015

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	3.2	X	1.5	X	1.1	X	1.2	X	1.2	=	7.6

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

TABLE 3A. (NEW BUILDINGS)

	F		R
1.0 X	7.6	=	7.6

TABLE 3B. (EXISTING BUILDINGS)

	F		R
0.6 X		=	

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

SURVEYOR SIGNATURE James Anderson	TITLE Deputy State Fire Marshal	DATE 04/16/2015
FIRE AUTHORITY SIGNATURE	TITLE Fire Safety Supervisor	DATE 4-25-15

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.	1
	-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					-5
	-5(0)[c] ✓	0	3					
10. Emergency Movement Routes	<2 Routes	Multiple Routes						0
		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			4
	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	1		1	1
6. Zone Dimensions			0	0
7. Vertical Openings	0		0	0
8. Hazardous Areas	0	0		0
9. Smoke Control			-5	-5
10. Emergency Movement Routes			0	0
11. Manual Fire Alarm		2		2
12. Smoke Detection and Alarm		4	4	4
13. Automatic Sprinklers	10	10	10 ÷ 2 = 5	10
Total Value	S_1= 17	S_2= 16	S_3= 8	S_4= 18

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 17	−	S_a 11	=	C 6		✓	
Extinguishment Safety (S_2)	minus	Mandatory Extinguishment (S_b)	≥ 0	S_2 16	−	S_b 15	=	E 1		✓	
People Movement Safety (S_3)	minus	Mandatory People Movement (S_c)	≥ 0	S_3 8	−	S_c 8	=	P 0		✓	
General Safety (S_4)	minus	Occupancy Risk (R)	≥ 0	S_4 18	−	R 7.6	=	G 0.4		✓	

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

F5616008

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
LifeCare Greenbush Manor	02 - Greenbush Manor

ZONE(S) EVALUATED: Edgewood

PROVIDER/VENDOR NO.	DATE OF SURVEY
245616	04/16/2015

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	3.2	X	1.5	X	1.1	X	1.2	X	1.2	=	7.6

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

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

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

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

TABLE 3A. (NEW BUILDINGS)

	F		R
1.0 X	7.6	=	7.6

TABLE 3B. (EXISTING BUILDINGS)

	F		R
0.6 X		=	

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

SURVEYOR SIGNATURE James Anderson	TITLE Deputy State Fire Marshal	DATE 04/16/2015
FIRE AUTHORITY SIGNATURE P Shelton	TITLE Fire Safety Supervisor	DATE 4-25-15

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	<1/2 hour	≥1/2 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.				1
	-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					-5
	-5(0)[c] ✓	0	3					
10. Emergency Movement Routes	<2 Routes	Multiple Routes						0
		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			4
	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	1		1	1
6. Zone Dimensions			0	0
7. Vertical Openings	0		0	0
8. Hazardous Areas	0	0		0
9. Smoke Control			-5	-5
10. Emergency Movement Routes			0	0
11. Manual Fire Alarm		2		2
12. Smoke Detection and Alarm		4	4	4
13. Automatic Sprinklers	10	10	10 ÷ 2 = 5	10
Total Value	S_1= 17	S_2= 16	S_3= 8	S_4= 18

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 17	−	S_a 11	=	C 6		✓	
Extinguishment Safety (S_2)	minus	Mandatory Extinguishment (S_b)	≥ 0	S_2 16	−	S_b 15	=	E 1		✓	
People Movement Safety (S_3)	minus	Mandatory People Movement (S_c)	≥ 0	S_3 8	−	S_c 8	=	P 0		✓	
General Safety (S_4)	minus	Occupancy Risk (R)	≥ 0	S_4 18	−	R 7.6	=	G 0.4		✓	

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

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ZONE 3 OF 4 ZONES

FIRE/SMOKE ZONE* EVALUATION WORKSHEET FOR HEALTH CARE FACILITIES

2000 LIFE SAFETY CODE

FACILITY LifeCare Greenbush Manor	BUILDING 02 - Greenbush Manor
ZONE(S) EVALUATED Administrative / Community Room Wing	
PROVIDER/VENDOR NO. 245616	DATE OF SURVEY 04/16/2015

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	3.2	X	2.0	X	1.1	X	1.2	X	1.2	=	10.1

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

TABLE 3A. (NEW BUILDINGS)

	F		R
1.0 X	10.1	=	10.1

TABLE 3B. (EXISTING BUILDINGS)

	F		R
0.6 X		=	

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

SURVEYOR SIGNATURE James Anderson	TITLE Deputy State Fire Marshal	DATE 04/16/2015
FIRE AUTHORITY SIGNATURE	TITLE Fire Safety Supervisor	DATE 4-25-15

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			1
	-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.			1
	-10 ☐	0 ☐	1(0)[d] ✓		2(0)[d] ☐			
6. Zone Dimensions	Dead End			No Dead Ends >30 ft and Zone Length Is				-2
	>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					-5
	-5(0)[c] ✓	0 ☐	3 ☐					
10. Emergency Movement Routes	<2 Routes	Multiple Routes						0
		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			4
	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	1			1
5. Doors to Corridor	1		1	1
6. Zone Dimensions			-2	-2
7. Vertical Openings	0		0	0
8. Hazardous Areas	0	0		0
9. Smoke Control			-5	-5
10. Emergency Movement Routes			0	0
11. Manual Fire Alarm		2		2
12. Smoke Detection and Alarm		4	4	4
13. Automatic Sprinklers	10	10	10 ÷ 2 = 5	10
Total Value	S_1= 18	S_2= 16	S_3= 6	S_4= 17

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

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

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

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

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

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

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

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

TABLE 7. ZONE FIRE SAFETY EQUIVALENCY EVALUATION										Yes	No
Containment Safety (S_1)	minus	Mandatory Containment (S_a)	≥ 0	S_1 18	−	S_a 11	=	C 7		✓	
Extinguishment Safety (S_2)	minus	Mandatory Extinguishment (S_b)	≥ 0	S_2 16	−	S_b 12	=	E 4		✓	
People Movement Safety (S_3)	minus	Mandatory People Movement (S_c)	≥ 0	S_3 6	−	S_c 5	=	P 1		✓	
General Safety (S_4)	minus	Occupancy Risk (R)	≥ 0	S_4 17	−	R 10.1	=	G 6.9		✓	

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

F5616008

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 LifeCare Greenbush Manor	BUILDING 02 - Greenbush Manor
ZONE(S) EVALUATED Support Services Wing	
PROVIDER/VENDOR NO. 245616	DATE OF SURVEY 04/16/2015

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	3.2	X	1.2	X	1.1	X	1.2	X	1.2	=	6.1

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

TABLE 3A. (NEW BUILDINGS)

	F		R
1.0 X	6.1	=	6.1

TABLE 3B. (EXISTING BUILDINGS)

	F		R
0.6 X		=	

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

SURVEYOR SIGNATURE James Anderson	TITLE Deputy State Fire Marshal	DATE 04/16/2015
FIRE AUTHORITY SIGNATURE	TITLE Fire Safety Supervisor	DATE 4-15-15

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			1
	-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.			1
	-10 ☐	0 ☐	1(0)[d] ✓		2(0)[d] ☐			
6. Zone Dimensions	Dead End			No Dead Ends >30 ft and Zone Length Is				-2
	>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					-5
	-5(0)[c] ✓	0 ☐	3 ☐					
10. Emergency Movement Routes	<2 Routes	Multiple Routes						0
		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			4
	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	1			1
5. Doors to Corridor	1		1	1
6. Zone Dimensions			-2	-2
7. Vertical Openings	0		0	0
8. Hazardous Areas	0	0		0
9. Smoke Control			-5	-5
10. Emergency Movement Routes			0	0
11. Manual Fire Alarm		2		2
12. Smoke Detection and Alarm		4	4	4
13. Automatic Sprinklers	10	10	10 ÷ 2 = 5	10
Total Value	S_1= 18	S_2= 16	S_3= 6	S_4= 17

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

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

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

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

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

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

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

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

TABLE 7. ZONE FIRE SAFETY EQUIVALENCY EVALUATION									Yes	No
Containment Safety (S_1)	minus	Mandatory Containment (S_a)	≥ 0	S_1 18	−	S_a 11	=	C 7	✓	
Extinguishment Safety (S_2)	minus	Mandatory Extinguishment (S_b)	≥ 0	S_2 16	−	S_b 12	=	E 4	✓	
People Movement Safety (S_3)	minus	Mandatory People Movement (S_c)	≥ 0	S_3 6	−	S_c 5	=	P 1	✓	
General Safety (S_4)	minus	Occupancy Risk (R)	≥ 0	S_4 17	−	R 6.1	=	G 10.9	✓	

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.