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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: ZPEF

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00253

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245492**
2.STATE VENDOR OR MEDICAID NO.
(L2) **080343000**

3. NAME AND ADDRESS OF FACILITY
(L3) **RICHFIELD A VILLA CENTER**
(L4) **7727 PORTLAND AVENUE SOUTH**
(L5) **RICHFIELD, MN** (L6) **55423**

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) **12/01/2017**

6. DATE OF SURVEY **09/30/2021** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

12.Total Facility Beds **112** (L18)
13.Total Certified Beds **112** (L17)

10.THE FACILITY IS CERTIFIED AS:
A. In Compliance With Program Requirements Compliance Based On:
___1. Acceptable POC
X B. Not in Compliance with Program Requirements and/or Applied Waivers:

And/Or Approved Waivers Of The Following Requirements:
__ 2. Technical Personnel
__ 3. 24 Hour RN
__ 4. 7-Day RN (Rural SNF)
X 5. Life Safety Code
__ 6. Scope of Services Limit
__ 7. Medical Director
__ 8. Patient Room Size
__ 9. Beds/Room
* Code: **B5*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	112			
(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 :
Angela Western, HFE NE II 11/18/2021 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 12/05/2021 (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
01/01/1987
(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.
06301
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

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

Richfield A Villa Center CCN 245492

Life safety code deficiency cited at K521 was requested for an annual waiver. The waiver requested has been forwarded to the CMS Region V Office for their determination and approval. Approval of the waiver has been recommended.

Refer to the CMS 2567 (for health, emergency preparedness and life safety code) along with their plan of correction.

Electronically delivered
October 27, 2021

Administrator
Richfield A Villa Center
7727 Portland Avenue South
Richfield, MN 55423

RE: CCN: 245492
Cycle Start Date: September 30, 2021

Dear Administrator:

On September 30, 2021, a 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 constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

ELECTRONIC PLAN OF CORRECTION (ePoC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved.

To be acceptable, a provider's ePOC must include the following:

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.
- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

The state agency may, in lieu of an onsite 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:

- Denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417);
- Civil money penalty (42 CFR 488.430 through 488.444).
- Termination of your facility's Medicare and/or Medicaid agreement (488.456(b)).

DEPARTMENT CONTACT

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

Jamie Perell, Unit Supervisor
Metro B District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
85 East Seventh Place, Suite 220
P.O. Box 64900
Saint Paul, Minnesota 55164-0900
Email: jamie.perell@state.mn.us
Office: (651) 245-8094

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 the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a Post Certification Revisit (PCR), of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

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.

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 December 30, 2021 (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).

In addition, if substantial compliance with the regulations is not verified by March 30, 2022 (six months after the identification of noncompliance) your provider agreement will be terminated. 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.

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.

INFORMAL DISPUTE RESOLUTION (IDR) / INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

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: https://mdhprovidercontent.web.health.state.mn.us/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: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

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:

William Abderhalden, Fire Safety Supervisor
Deputy State Fire Marshal
Health Care/Corrections Supervisor – Interim
Minnesota Department of Public Safety
445 Minnesota Street, Suite 145
St. Paul, MN 55101-5145
Cell: (507) 361-6204
Email: william.abderhalden@state.mn.us
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

Electronically delivered
October 27, 2021

Administrator
Richfield A Villa Center
7727 Portland Avenue South
Richfield, MN 55423

Re: State Nursing Home Licensing Orders
Event ID: ZPEF11

Dear Administrator:

The above facility was surveyed on September 27, 2021 through September 30, 2021 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

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

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html. The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the

"Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute or rule after the statement, "This MN Requirement is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

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

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

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

Jamie Perell, Unit Supervisor
Metro B District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
85 East Seventh Place, Suite 220
P.O. Box 64900
Saint Paul, Minnesota 55164-0900
Email: jamie.perell@state.mn.us
Office: (651) 245-8094

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

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

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health

Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00253	A. BUILDING: _____ B. WING _____	C 09/30/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RICHFIELD A VILLA CENTER	7727 PORTLAND AVENUE SOUTH RICHFIELD, MN 55423

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 9/27/21 to 9/30/21, a licensing survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was found NOT in compliance with the MN State Licensure and the following correction orders are issued. Please indicate in your electronic plan of correction you have reviewed	2 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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2 000	Continued From page 1 these orders, and identify the date when they will be completed. The following complaint was found to be SUBSTANTIATED: H5492130C (MN00049587), however, no deficiencies were cited. The following complaint was found to be UNSUBSTANTIATED: H5492201C (MN00051228) H5492202C (MN00051210) H5492203C (MN00050733) H5492122C (MN00049989) H5492129C (MN00049582) H5492123C (MN0049489 and MN00049460) H5492124C (MN00048963) H5492204C (MN00077058) Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled " ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm The State licensing orders are	2 000		

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2 000	Continued From page 2 delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000		
2 265	MN Rule 4658.0085 Notification of Chg in Resident Health Status A nursing home must develop and implement policies to guide staff decisions to consult physicians, physician assistants, and nurse practitioners, and if known, notify the resident's legal representative or an interested family member of a resident's acute illness, serious accident, or death. At a minimum, the director of nursing services, and the medical director or an attending physician must be involved in the development of these policies. The policies must have criteria which address at least the appropriate notification times for: A. an accident involving the resident which results in injury and has the potential for requiring physician intervention;	2 265		11/23/21

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2 265	Continued From page 3 B. a significant change in the resident's physical, mental, or psychosocial status, for example, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications; C. a need to alter treatment significantly, for example, a need to discontinue an existing form of treatment due to adverse consequences, or to begin a new form of treatment; D. a decision to transfer or discharge the resident from the nursing home; or E. expected and unexpected resident deaths. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to notify the physician of a significant weight change for 1 of 1 resident (R3) who took a diuretic (water pill). Findings include: R3's Diagnoses Report dated 9/3/21, indicated R3 had a history of cellulitis (skin infection) to their right lower limb, lymphedema (build up of fluid in soft tissues), and obesity. R3's quarterly Minimum Data Set (MDS) dated 7/6/21, indicated R3 was cognitively intact and required extensive assistance of two staff for bed mobility, toilet use, and personal hygiene. R3's Order Summary Report dated 9/30/21, indicated an order for monthly weights on the 7th of each month starting on 2/19/21. The report	2 265	corrected	

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2 265	Continued From page 4 also included an order for furosemide (a water pill) 20 milligrams (mg) daily started 5/3/19. Further, R3's furosemide order was increased from 20 mg to 40 mg on 9/24/21. R3's care plan dated 8/11/17, included an intervention to monitor weight per protocol. R3's Weights and Vitals Summary dated 9/30/21, indicated R3 weighed 450 pounds (lbs.) on 7/7/21, and 490 lbs. on 8/13/21. Both weights were taken via a mechanical lift. R3 had a 8.2 percent weight gain in 37 days. During an interview on 9/30/21 at 9:48 a.m. registered nurse (RN)-B stated nursing assistants took weights and reported the results back to the nurse. The nurse then entered the results in the electronic medical record (EMR). RN-B stated if there was a significant weight change and alert appeared. RN-B stated the provider should had been notified of a three pound weight change in a day or a five pound weight change in one week for any resident who took furosemide as a resident may be in fluid overload. RN-B expected the nurse to review R3's weights, update the provider to notify them of the 40 pound weight gain, and document a progress note. RN-B confirmed she was unable to find a progress note which indicated R3's provider was updated regarding a 40-pound weight gain. Review of R3's medical record, on 9/30/21, at 10:15 a.m., lacked documentation of provider notification of the significant weight gain identified on 8/13/21. During an interview on 9/30/21, at 11:57 a.m. the director of nursing (DON) stated the dietary department notified nursing of any significant	2 265		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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2 265	Continued From page 5	2 265		

weight gain of more than three pounds in a day or five pounds in a week. The DON stated nursing notified the medical provider. The DON stated if a resident was prescribed furosemide, staff would notify the provider according to parameters identified in an order. The DON stated the nurse who weighed R3 (on 7/7/21) should had reweigh/reassessed R3 and notified the provider of the 40-pound weight gain.

During an interview on 9/30/21, at 12:57 p.m. the dietary manager stated she did not track resident weights.

During an interview on 9/30/21, at 12:59 p.m. the regional director of nutrition services stated when a residents weight changed significantly an alert triggered in the EMR. She stated weights were reviewed at clinical meetings which took place three days per week. If there was a nursing concern, nursing staff contacted the provider. She was not aware of R3's weight gain and would had asked staff to reweigh R3 had she known.

During an interview on 9/30/21, at 2:11 p.m. the nurse practitioner clinical manager stated she expected staff to reweigh R3 to make sure the weight was accurate and notify her if still significantly high. If R3's kidneys could tolerate it, she would had made medication adjustments to reduce edema (swelling). She further stated another nurse practitioner evaluated R3 on 9/24/21, and increased R3's furosemide.

Facility policy titled Notification of Changes Guideline dated 5/11/18, indicated the nurse will notify the physician of any condition which may require an alteration in treatment or to begin a new treatment, and document the notification in the resident's medical record.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 265	Continued From page 6 SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee, could work with the medical director to update policies and procedures for when to notify the physician of changes in the resident, and then could educate staff. The DON or designee could also perform audits of resident records to determine if the physician had been notified, as appropriate. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 265		
2 550	MN Rule 4658.0400 Subp. 4 Comprehensive Resident Assessment; Review Subp. 4. Review of assessments. A nursing home must examine each resident at least quarterly and must revise the resident's comprehensive assessment to ensure the continued accuracy of the assessment. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure the Minimum Data Set (MDS) was coded to reflect correct anticoagulant medication consumption for 4 of 5 residents (R78, R40, R20, R29) reviewed for MDS accuracy. Findings include: The Centers for Medicare and Medicaid (CMS) Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual, dated 10/2019, outlined an overview which included, "The	2 550	corrected	11/23/21

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	00253	A. BUILDING: _____ B. WING _____	C 09/30/2021

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2 550	Continued From page 7 purpose of this manual is to offer clear guidance about how to use the [RAI] correctly and effectively to help provide appropriate care ... The RAI helps nursing home staff in gathering definitive information on a resident's strengths and needs, which must be addressed in an individualized care plan." The manual then outlined each MDS section with corresponding instructions and directions. This included Section N0410, "Medications Received," which had a section labeled, "Coding Instructions," directing, "N0410E, Anticoagulant ... Record the number of days an anticoagulant medication was received by the resident ... Do not code antiplatelet medications such as aspirin/extended release, dipyridamole, or clopidogrel here." R78's most recent quarterly MDS, dated 9/8/21, identified R78 received seven (7) days of anticoagulant medication during the look-back period. R78's Order Summary Report, printed 9/30/21 and which included both active and past/discontinued medications, outlined R78 had an order in place for aspirin on a daily basis; however, it lacked any evidence of anticoagulant medication being provided to R78 during the same period. R40's most recent significant change MDS, dated 8/13/21, identified R40 received seven (7) days of anticoagulant medication during the look-back period. R40's Order Summary Report, printed 9/30/21 and which included both active and past/discontinued medications, outlined R40 had an order in place for aspirin on a daily basis; however, it lacked any evidence of anticoagulant medication being provided to R40 during the same period. R20's most recent quarterly MDS, dated 7/13/21,	2 550		

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2 550	Continued From page 8 identified R20 received seven (7) days of anticoagulant medication during the look-back period. R20's Order Summary Report, printed 9/30/21 and which included both active and past/discontinued medications, outlined R20 had an order in place for aspirin on a daily basis; however, it lacked any evidence of anticoagulant medication being provided to R20 during the same period. R29's most recent quarterly MDS, dated 8/4/21, identified R29 received seven (7) days of anticoagulant medication during the look-back period. R29's Order Summary Report, printed 9/30/21 and which included both active and past/discontinued medications, outlined R29 had an order in place for aspirin on a daily basis; however, it lacked any evidence of anticoagulant medication being provided to R29 during the same period. On 9/30/21, at 10:48 a.m. registered nurse (RN)-E was interviewed and verified she was the RN responsible to complete the MDS(s) on campus; including Section N which recorded residents' consumed medications. RN-E reviewed the completed MDS(s) for R78, R40, R20 and R29 and explained she coded the consumed aspirin as an anticoagulant as that is how she had been instructed. RN-E then reviewed the RAI manual, dated 10/2019, and verified it directed to not record aspirin as an anticoagulant. The MDS(s) were incorrect and RN-E voiced she would modify and resubmit them. Further, RN-E expressed it was important to ensure the MDS was coded correctly as staff "want an accurate portrait of the care provided to the patient." A facility policy on MDS completion was requested, however, was not received.	2 550		

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2 550	Continued From page 9 SUGGESTED METHOD OF CORRECTION: The director of nursing (DON), or designee, could educate the nursing staff on completion of the Minimum Data Set (MDS) in accordance with the Resident Assessment Instrument (RAI) manual. They could then audit to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	2 550		
2 570	MN Rule 4658.0405 Subp. 4 Comprehensive Plan of Care; Revision Subp. 4. Revision. A comprehensive plan of care must be reviewed and revised by an interdisciplinary team that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, with the participation of the resident, the resident's legal guardian or chosen representative at least quarterly and within seven days of the revision of the comprehensive resident assessment required by part 4658.0400, subpart 3, item B. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to provide an opportunity to participate in care planning for 1 of 1 resident (R62) reviewed for care conferences. Findings include: R62's significant change Minimum Data Set	2 570	corrected	11/23/21

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2 570	Continued From page 10 (MDS) dated 8/29/21, indicated R62 had moderately impaired cognition and it was very important to be involved in discussions about goals of care. R62 was admitted to the facility in January 2020. R62's care plan dated 5/10/21, indicated, "Assist/encourage/support to set realistic goals." During an interview on 9/27/21, at 3:46 p.m. R62 stated had not had a care conference since he admitted to the facility. R62 stated he would like to be involved in conversations regarding his goals of care. During an interview on 9/28/21, at 2:54 p.m. social worker (SW)-A stated other than the interdisciplinary team members, R62 would be the only person to attend a care conference on his behalf due to limited support. SW-A stated R62 would likely attend a care conference, and review goals, if he was notified one was scheduled. SW-A was unable to verbalize the date of R62's most recent care conference and was unable to provide documentation which showed a care conference was conducted for R62 since he was admitted to the facility in January 2020. SW-A stated care conferences were coordinated by the social worker and scheduled to correlate with the MDS cycle. SW-A stated care conferences should be held quarterly, and as needed, to review and update a resident's goals of care. SW-A stated a resident should always be invited to attend their care conference. Review of R62's medical record lacked indication R62 was invited to participate in care planning since January 2020. Facility policy titled Care Plan Standard Guideline,	2 570		

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2 570	Continued From page 11 effective 11/28/17, directed, "The care plans will be reviewed and revised at the care conference in collaboration with the resident and/or resident representative." SUGGESTED METHOD OF CORRECTION: The director of social services, or designee, could review and/or revise policies and procedures to ensure a resident/resident representative in involved in the review of the care plan. The director of social services, or designee, could educate staff related to the need include the resident and/or resident representative in the interdisciplinary review of the care plan. The director of social services, or designee, could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 570		
2 915	MN Rule 4658.0525 Subp. 6 A Rehab - ADLs Subp. 6. Activities of daily living. Based on the comprehensive resident assessment, a nursing home must ensure that: A. a resident is given the appropriate treatments and services to maintain or improve abilities in activities of daily living unless deterioration is a normal or characteristic part of the resident's condition. For purposes of this part, activities of daily living includes the resident's ability to: (1) bathe, dress, and groom; (2) transfer and ambulate; (3) use the toilet; (4) eat; and (5) use speech, language, or other functional communication systems; and	2 915		11/23/21

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2 915	Continued From page 12 This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure staff consistently implemented the use of a computer-aided communication device to help improve the communication ability of 1 of 1 resident (R29) who was non-verbal and expressed frustration with staff not using the machine. Further, the facility failed to provide assistance with oral hygiene 1 of 1 resident (R3) who required set up assistance. Findings include: COMMUNICATION: R29's quarterly Minimum Data Set (MDS), dated 8/4/21, identified R29 had a history of stroke with aphasia (language disorder that affects a person's ability to communicate), required, at least, extensive assistance with his activities of daily living (ADLs), and had both long-term and short-term memory impairment. On 9/27/21, at 2:10 p.m. R29 was observed laying in bed in his room with various medical equipment (i.e., tube feeding) present at the bedside. This included a black monitor which was attached to a pole which was suspended over R29. R29's family member (FM)-A was present and seated next to him. They were interviewed at this time and FM-A expressed R29's "biggest thing" was he wished staff included him more in conversation during care and allowed him time to	2 915	corrected	

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2 915	Continued From page 13	2 915		

respond to them using his computer-aided communication device (the black monitor). FM-A expressed the computer-device, which used R29's eye movement to type out sentences which the machine would then read aloud, was his only way to express his wants or needs beyond basic 'yes or no questions' and the staff did not consistently use it which was upsetting.

R29's care plan, last reviewed 8/13/21, identified R29 had a communication deficit due to a past stroke. The care plan directed staff to anticipate and meet R29's needs, discuss any concerns or feelings regarding communication difficulty, and provide a translator as needed. However, the care plan lacked any direction or instructions regarding the use of R29's computer-aided communication device.

R29's Visual/Bedside Kardex Report, dated 9/29/21, identified the information the nursing assistant (NA) staff used to help guide their cares to be provided. However, this provided report lacked any direction or guidance to use R29's computer-aided communication device with cares.

On 9/29/21, at 8:58 a.m. R29's morning care was observed with nursing assistant (NA)-B and NA-C present. At this time, posted on the wall immediately above R29's headboard was signage which read, "USE TALKING DEVICE DURING CARES," and listed various calibration instructions to use the machine. The note concluded, "THIS ALL [calibration instructions and set-up] TAKES 1-2 MINUTES! THIS IS HIS VOICE! DON'T SILENCE HIM." NA-C approached R29 while he laid in bed and voiced, "Were just going to reposition you." NA-C then paused for several seconds and added, "Is that

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2 915	Continued From page 14 OK?" R29 nodded his head up and down to acknowledge. NA-C then proceeded to remove R29's bed sheet which revealed R29 laying on his back but with several pillows placed under his arms and legs. NA-C proceeded to remove these pillows and voiced aloud they were "going to check his brief." NA-B and NA-C then proceeded to use R29's draw sheet and voiced they were going to give him "a nice little boost" in bed. NA-C then proceeded to ask R29 aloud, "[Do] you want to be on your side or back?" R29 did not verbally respond nor make any head nod(s) to indicate a response. NA-C then stated, "On your back is OK[?]," before replacing the pillows underneath R29's arms and legs. NA-C then asked aloud, "Do you need anything else[?]" which R29 nodded his head side-to-side (i.e., No). Immediately following, registered nurse (RN)-A presented from behind R29's privacy curtain and asked R29 aloud, "You want the machine?" R29 nodded his head up and down to indicate a 'yes' response. RN-A then instructed the NA(s) to place the device in front of him so it could be used. The machine was then retrieved from the opposite corner of the room and placed approximately four feet in front of R29 who then used the device to type out, "Can you take the weight off my butt with pillows[?]" NA-C responded, "Of course." NA-C was questioned on the use of the machine during cares for R29 and voiced she had "never seen him [R29] use that before." Immediately following this observation, NA-B and NA-C were interviewed. NA-C expressed R29's computer machine, which allowed him to type using his eyes and would verbalize the sentences so staff could understand him, was "the neatest thing ever" and she verified she had not used the device during R29's cares prior to today when instructed by RN-A. NA-C explained they typically just used "yes or no	2 915		

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questions" when communicating with R29 and expressed she had never been directed or told to use the device before while providing cares to him. NA-B stated he had also never used the machine during cares adding he had "heard about it [machine] but never used it." When questioned on the signage placed above R29's bed directing to use the machine, NA-C stated she had "never paid attention [to it]."

When interviewed on 9/29/21, at 9:55 a.m. NA-D stated she had worked at the nursing home for several months and worked with R29 several times in the past. NA-D stated R29 communicated with the staff with "shake his head yes or no" and added she was aware R29 had a computer device which allowed him to type and speak; however, they (staff) had not yet been shown how to use the device. As a result, NA-D stated she did not use it with cares and reiterated the management had "never showed us aides how to use it."

During interview on 9/29/21, at 10:49 a.m. RN-A verified R29 used the computer machine for communication which she explained helped to "enhance [his] communication with staff." RN-A stated the machine was "pretty easy to use" and just needed to be charged up and placed in front of him to facilitate it's use. RN-A stated she was unaware the NA(s) were not using the device and stated she "assumed they would ask" how to use the machine when they observed the posted signage above R29's bed which directed it's use. RN-A explained the machine's use was facilitated through speech therapy (SLP) and they were responsible to ensure staff were trained and using the device. This was important to do "in case he [R29] wants to express something."

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2 915	Continued From page 16 On 9/29/21, at 11:54 a.m. speech language pathologist (SLP)-A was interviewed. She explained a previous SLP had completed a majority of the training with R29 on the use of the device which she described as a "Tobi Dynavox" which was "eye gazed based" and allowed him to communicate beyond just simple yes-and-no questions. SLP-A stated just placing signage in R29's room with instructions on the device' use was not likely effective and clarified she had not been involved with providing any training or education to the direct care staff on how to use the machine. SLP-A voiced she was unable to provide any documented evidence the staff had been educated on the machines use and stated it was important to ensure education was done across multiple shifts. SLP-A expressed an "ideal" situation would be to develop a functional maintenance program (FMP) for the machine's use and implement it as, like the posted signage in R29's room outlines, "It's his voice." Further, SLP-A explained she was aware R29's FM-A had asked for additional staff training on the machine's use in the past; however, SLP-A expressed she was not aware if such training had been completed or not. On 9/29/21, at 12:12 p.m. the director of nursing (DON) and administrator were interviewed. They explained R29's computer device had been present at the nursing home for "a little while" and was meant to be used with cares to help foster better communication with him. However, the DON stated she did not think the staff had been directed on when exactly to use the device and expressed the previous SLP placed the instructions on R29's wall but these were likely "too much" for staff to read and follow. The DON stated additional training needed to be completed with staff to ensure the device was being used	2 915		

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routinely as it improved R29's communication ability and without it, R29 was "not able to talk." Further, the DON reviewed R29's care plan and verified it lacked any guidance, directions or explanation on the machine's use and verified it should have been added.

A facility' policy on the use of computer-aided communication devices was requested, however, was not received.

ORAL HYGIENE:

R3's Diagnosis Report dated 9/30/21, indicated R3 had diagnoses which included muscle weakness and obesity.

R3's quarterly Minimum Data Set (MDS) dated 7/6/21, indicated R3 was cognitively intact and required extensive assistance of two staff with bed mobility, dressing, toilet use, and personal hygiene.

R3's care plan dated 8/9/17, indicated an ADL focus which identified R3 had a self-care performance deficit related to impaired/limited mobility, atrophy (decreased muscle), and muscle weakness secondary to severe morbid obesity. R3's goal indicated she would be neat, clean, and well-groomed daily. R3 required set-up prompts of one caregiver to brush her teeth. Further, R3's care plan identified she had dental health problems related to poor oral hygiene with an intervention to provide mouth care.

During an interview on 9/27/21, at 2:35 p.m. R3 stated staff never gave her anything to brush her teeth with. Further, she had an electric toothbrush which was still in the box she had purchased during the summer and staff had not used it. R3

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2 915	Continued From page 18 stated staff never helped her brush her teeth and no one was around to assist. R3 stated she had her own teeth and wanted to keep them. R3 stated she cleaned her teeth with a cotton swab and toothpaste and rubbed it off with a tissue. There was no toothbrush observed for R3's use within the resident's room or bathroom. During an interview on 9/29/21, at 1:41 p.m. nursing assistant (NA)-E stated R3 had her toothbrush and toothpaste at bedside and could brush her own teeth. Further, R3 could use a silver-colored bottle of drinking water to brush her teeth and assumed R3 would spit in a little cup or a garbage under her over-bed table. During an interview on 9/30/21, at 9:33 a.m. R3 stated staff had not helped her brush her teeth. She stated her electric toothbrush was still in the wooden nightstand next to her bed in the bottom drawer. R3 stated she had a manual tooth brush a long time ago, but it fell on the floor and staff did not provide a new one. R3 stated she used a cotton swab and some toothpaste from her purse to brush her teeth. R3 stated staff also did not give her water to use for brushing. An electric toothbrush was observed in the bottom drawer of a wooden side table and was still in its packaging in a retail bag. Neither a toothbrush, nor a basin for rinsing or spitting was observed within reach of R3. During an interview on 9/30/21, at 9:48 a.m. registered nurse (RN)-B stated staff should had offered to assist R3 obtain required supplies including a toothbrush, toothpaste, a cup of water, and other cup/emesis basin to spit in. RN-B stated R3 was physically unable to get her own supplies and should not be expected to spit into her water bottle or garbage. RN-B stated she	2 915		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 915	Continued From page 19 thought everyone had a toothbrush and she would need to re-educate staff. During an interview on 9/30/21, at 11:57 a.m. the director of nursing stated she expected all nursing assistants to assist residents to brush their teeth both in the morning and at night. Further, R3 should have had a toothbrush and have access to it along with an emesis basin. The DON stated it was "terrible" R3 was using cotton swabs and toothpaste and stated she would make sure R3 had supplies close to her. The DON expected everyone should be able to brush their teeth to prevent decay and would educate staff. Facility policy titled Activities of Daily Living (ADLs), undated, indicated in accordance with the comprehensive assessment, together with respect for individual resident needs and choices the facility provides care and services for the following activities: Hygiene - Bathing, dressing, grooming, and oral care. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON), or designee, could educate staff on the use of resident personal communication device(s) and ensuring residents receive appropriate assistance to carry out activities of daily living; then audit to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	2 915		
21426	MN St. Statute 144A.04 Subd. 3 Tuberculosis Prevention And Control (a) A nursing home provider must establish and maintain a comprehensive tuberculosis	21426		11/23/21

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21426	Continued From page 20 infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in CDC's Morbidity and Mortality Weekly Report (MMWR). This program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, residents, and volunteers. The Department of Health shall provide technical assistance regarding implementation of the guidelines. (b) Written compliance with this subdivision must be maintained by the nursing home. This MN Requirement is not met as evidenced by: Based on interview and document review, the agency failed to ensure 6 of 6 residents (R60, R80, R62, R79, R73, R34) and 2 of 5 employee's (E1, E2) staff were screened for tuberculosis (TB). This had the potential to affect all residents who resided at the facility. Findings include: R60 admitted to the facility on 5/26/20. The medical record contained no indication R60 was screened for symptoms of tuberculosis (TB) upon admission to the facility. R80 admitted to the facility on 8/21/20. The medical record contained no indication R80 was screened for symptoms of tuberculosis (TB) upon	21426	corrected	

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21426	Continued From page 21 admission to the facility. R62 admitted to the facility on 1/29/20. The medical record contained no indication R62 was screened for symptoms of tuberculosis (TB) upon admission to the facility. R79 admitted to the facility on 7/26/18. The medical record contained no indication R79 was screened for symptoms of tuberculosis (TB) upon admission to the facility. R73 admitted to the facility on 9/3/21. The medical record contained no indication R73 was screened for symptoms of tuberculosis (TB) upon admission to the facility. R34 admitted to the facility on 5/29/20. The medical record contained no indication R34 was screened for symptoms of tuberculosis (TB) upon admission to the facility. E1 was hired on 9/9/19. The facility was unable to produce documentation showing this employee was screened for symptoms of TB before starting work at the facility. E2 was hired on 3/5/19. The facility was unable to produce documentation showing this employee was screened for symptoms of TB before starting work at the facility. During an interview on 9/30/21, at 2:33 p.m. the director of nursing (DON) stated all newly admitted residents needed to be screened for symptoms of TB immediately upon arrival to the facility and results should be documented in the resident's medical record. All staff members needed to be screened for symptoms of TB prior to starting work and results should be	21426		

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21426	Continued From page 22 documented in the employee's employment file. Facility policy Tuberculosis Exposure Control Plan (2017), included, "It is the policy of this facility to institute an active Tuberculosis (TB) Control Plan that includes identification of risk (to be included in the facility assessment information), early detection of latent TB infection, screening for infectious TB disease, follow-up where necessary, appropriate transfer isolation of infection TB, and treatment of persons with non-infectious TB." SUGGESTED METHOD OF CORRECTION: The director of nursing and/or designee could review and revise policies and procedures, train staff and monitor to assure TB screenings are completed for residents and employees. The director of nursing and/or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21426		
21525	MN Rule 4658.1305 A.B.C Pharmacist Service Consultation A nursing home must employ or obtain the services of a pharmacist currently licensed by the Board of Pharmacy who: A. provides consultation on all aspects of the provision of pharmacy services in the nursing home; B. establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and C. determines that drug records are accurately maintained and that an account of all	21525		11/23/21

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21525	Continued From page 23 controlled drugs is maintained. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure a liquid controlled substance was able to be reconciled to rapidly detect drug diversion for 1 of 3 medication carts reviewed for medication storage. Findings include: R9's Face Sheet dated 9/30/21, indicated R9 was diagnosed with convulsions (seizure). R9's provider orders dated 7/26/21, indicated R9 was prescribed Phenobarbital elixir (medication used to control seizures) 20 milligrams per five mililiters (mL); give 25 ml for seizures. During an observation of the first floor west side medication cart on 9/28/21, at 10:06 a.m. a bottle of Phenobarbital elixir was found secured in the medication cart with other controlled substances. The Phenobarbital elixir was prescribed to R9. The medication bottle had a dark brown color and the liquid medication was not able to be visualized/reconciled through the bottle. RN-C confirmed the amount of medication in the Phenobarbital bottle was unable to be verified, however, was signed off by facility staff. RN-C stated each dose given to R9 was 25 mL, hence, when documenting amount of medication remaining 25 mL was subtracted from the last amount identified in the bottle and recorded in the narcotic book. RN-A approached, and stated the Phenobarbital elixir needed to be in a clear bottle and would discuss the issue with the director of nursing (DON).	21525	corrected	

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21525	Continued From page 24 During an interview on 9/28/21, at 1:14 p.m. RN-D stated Phenobarbital should come in a clear bottle from the pharmacy. RN-D stated she would reach out to the pharmacy to send a clear and labeled bottle so the medication could be reconciled. During an interview on 9/29/21, at 12:50 p.m. RN-A stated a new bottle for R9's Phenobarbital was received during the evening on 9/28/21. RN-A stated the amount in the Phenobarbital bottle was 150 mL, however, the narcotic book indicated 92 mL remained. RN-A stated sometimes pharmacy overfilled bottles, but verified there should not had been that amount of excess medication. Upon reviewing the medication label on the bottle, the label read phyonten (a medication used to control seizures). RN-A stated it was not the correct label and unsure if the medication was phyonten or Phenobarbital. During an interview on 9/29/21, at 1:03 p.m. RN-D stated they spoke to the pharmacist and was not sure why an incorrect bottle was sent. RN-D stated when the clear bottle arrived, two nurses should had reconciled the medication and identified the wrong label. The DON stated the evening nurse needed to be notified to determine what happened. During an interview on 9/29/21, at 3:05 p.m. RN-C stated they poured the Phenobarbital elixir from the dark bottle into the clear one from the pharmacy the previous evening. RN-C stated they completed this without another nurse verifying as it was too busy. RN-C stated the medication was reconciled with the night nurse at the completion of her shift. RN-C verified the medication count	21525		

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21525	Continued From page 25 was off, but was going to talk to RN-A about it the next morning and was unsure what facility policy was. During an interview on 9/30/21, at 2:46 p.m. the DON stated the facility was unsure why there was a discrepancy with the Phenobarbital. The DON stated nurses should know controlled medications should not be in a dark bottle as there was no way to ensure the amount remaining. Further, two nurses were needed to reconcile medications and there should had been two nurses when changing the Phenobarbital from the dark bottle to the clear bottle. The DON stated their expectation was for nurses to verify the amount of medication in bottles and discrepancies should had been identified. A facility policy on controlled medication reconciliation was requested from the facility but was not received. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) and the Consulting Pharmacist could establish a system for accurate accounting of narcotic medication to prevent potential loss or diversion. The DON could randomly audit the system to record if this policy is implemented and adhered to correctly by licensed staff who are reconciling narcotic counts and reviewing for expired medications as indicated in the policy and report audits to the quality assurance committee. TIME PERIOD OF CORRECTION: Twenty-one (21) days.	21525		
21565	MN Rule 4658.1325 Subp. 4 Administration of Medications Self Admin	21565		11/23/21

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21565	Continued From page 26 Subp. 4. Self-administration. A resident may self-administer medications if the comprehensive resident assessment and comprehensive plan of care as required in parts 4658.0400 and 4658.0405 indicate this practice is safe and there is a written order from the attending physician. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure a resident was appropriate to self-administer medication prior medication administration for 1 of 1 resident (R37) who was observed alone when a nebulizer treatment was received. Findings include: R37's quarterly Minimum Data Set (MDS) dated 8/12/21, indicated R37 had severely impaired cognition and diagnoses which included dementia with behavioral disturbance, chronic obstructive pulmonary disease, and other signs and symptoms involving cognitive functions and awareness. A Physician Order dated 6/2/21, indicated R37 was prescribed Budesonide Suspension (reduces airway swelling) 0.5 milligrams per 2 mililiters (mg/mL). Inhale 0.5 mg/mL via nebulizer two times a day for COPD. During an observation on 9/27/21, at 4:23 p.m. R37 was seated in a recliner in his room by himself receiving a nebulizer treatment. R37 was leaning to his right side and was asleep. A nebulizer mask was partially off R37's mouth. Licensed practical nurse (LPN)-E entered R37's room and removed the nebulizer mask from	21565	corrected	

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21565	Continued From page 27 R37's face. LPN-E turned off the nebulizer machine. During an observation on 9/29/21, at 7:23 a.m. R37 was seated in a recliner in his room by himself and received a nebulizer treatment. The nebulizer mask was pulled to the left of R37's face and on his left cheek. LPN-A entered R37's room, removed the nebulizer mask from R37's face, and turned the nebulizer machine off. No vapors were observed coming from R37's nebulizer mask and no medication remained in the nebulizer when removed. During an interview on 9/29/21, at 9:06 a.m. LPN-C stated R37 required staff to stay with them during nebulizer treatment to ensure he kept it on and monitor breathing. LPN-C stated R37 needed to be monitored frequently because he often became short of breath. During an interview on 9/29/21, at 12:45 p.m. LPN-A stated she was supposed to stay in R10's room when he received a nebulizer treatment. She further stated, "I know I wasn't in there with him" because "I was too busy." During an interview on 9/30/21, at 12:57 p.m. LPN-E stated we are supposed to stay in the room with R10 during his nebulizer treatment. During an interview on 9/30/21, at 9:37 a.m. the director of nursing stated she would expect nursing staff to stay in R37's room while he received his nebulizer treatment. The DON confirmed R37 did not have a self-administration order. Review of R10's medical record lacked indication a self administration of medication assessment	21565		

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21565	Continued From page 28 was completed. The facility's medication administration policy dated April 2018, directed residents can self-administer medications only when specifically authorized by the attending physician and in accordance with procedures for self administration of medications. It further directed staff should remain with the resident during nebulizer treatments unless the resident has been assessed and authorized to self-administer. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON), or designee, could review applicable policies and procedures to ensure residents' are assessed to determine if self administering medications was appropriate. The DON, or designee, could provide staff education regarding self-administration of medications. The quality assurance committee could monitor for compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21565		
21810	MN St. Statute 144.651 Subd. 6 Patients & Residents of HC Fac.Bill of Rights Subd. 6. Appropriate health care. Patients and residents shall have the right to appropriate medical and personal care based on individual needs. Appropriate care for residents means care designed to enable residents to achieve their highest level of physical and mental functioning. This right is limited where the service is not reimbursable by public or private resources.	21810		11/23/21

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21810	Continued From page 29 This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to facilitate obtaining a wheelchair to enhance mobility for 1 of 1 resident (R3) reviewed for accommodation of needs. Findings include: R3's Diagnoses Report dated 9/30/21, indicated R3 had a history of cellulitis to their right lower limb, lymphedema (fluid accumulation in soft tissues), muscle weakness, and obesity. R3's quarterly Minimum Data Set (MDS) dated 7/6/21, indicated R3 was cognitively intact and required extensive assistance of two staff for bed mobility, dressing, and personal hygiene. The MDS lacked indication R3 transferred from bed or participated in locomotion (on unit, off unit) within the previous seven days. Further, The MDS indicated no mobility devices, such as a wheelchair, were used by R3. R3's care plan dated 8/9/17, identified R3 had limited physical mobility related to muscular atrophy (decreased muscle mass) and weakness. The care plan included an intervention to provide assistance with mobility, as needed. During an interview on 9/27/21, at 2:25 p.m. R3 stated she was unable to walk, had foot drop, and was bed bound. Further, she had a wheelchair in storage, but could not use it because it caused her leg to turn purple and red. R3 stated she asked about getting a new wheelchair last year. During an interview on 9/29/21, at 1:41 p.m. nursing assistant (NA)-E stated R3 never got out	21810	corrected	

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21810	Continued From page 30	21810		

of bed. NA-E stated R3 had an electric wheelchair when she was admitted to the facility, but R3 told her it did not fit her and R3 refused to sit in a manual wheelchair. NA-E stated there was a wheelchair across the street which might fit R3 and staff were planning to make adjustments, but never did.

During an interview on 9/30/21, at 9:33 a.m. R3 stated she had a power wheelchair, "supposedly" stored in the facility garage. R3 stated she inquired about a new chair and therapy tried to get one, but therapy would not take her case anymore. R3 stated the lack of a wheelchair stopped her from doing things she wanted to do. R3 stated she wanted to have a wheelchair to leave her room.

During an interview on 9/30/21, at 9:48 a.m. registered nurse (RN)-B stated she did not know why R3 did not have a wheelchair of any kind. She stated R3 suggested she needed a reclining wheelchair which would keep her feet elevated. Further, R3 should be allowed the option to get up, if she wished, even if she chose to stay in bed.

During an interview on 9/30/21, at 10:53 a.m. occupation therapist (OT)-A stated R3 had not been on their case load for some time and was unsure when R3 was last seen by OT. OT-A stated her understanding was R3 refused to get out of bed. Further, R3 had a personal wheelchair which was once stored at the end of the hall due to space limitations, but the wheelchair was removed and stored across the street in a storage facility where staff placed items which were not regularly used. Additionally, it was possible R3 may had exceeded the weight limit of the wheelchair and the facility would need to

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21810	Continued From page 31 involve the vendor to assess. OT-A stated she had not heard R3 might want to get up and OT had not received a referral for a wheelchair evaluation. OT-A stated R3 refused and did not think she had ever got up. OT-A stated she felt it was valid to have a wheelchair option at the facility for the resident. During an interview on 9/30/21, at 11:57 a.m. the director of nursing (DON) stated she spoke to R3 in the past and R3 never wanted to get up. Further, it was very reasonable for R3 to have a wheelchair and everyone should have the opportunity to be mobile, even if they chose to stay in bed. The DON stated R3 might one day want to get up and it would be nice to have an option. A facility policy regarding wheelchair accommodation was requested but not provided. SUGGESTED METHOD OF CORRECTION: The administrator, director of nursing (DON), and occupational therapist could review resident mobility requirements and preferences to ensure resident needs are met, and periodically review for continually changing needs. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21810		
21855	MN St. Statute 144.651 Subd. 15 Patients & Residents of HC Fac.Bill of Rights Subd. 15. Treatment privacy. Patients and residents shall have the right to respectfulness and privacy as it relates to their medical and personal care program. Case discussion, consultation, examination, and treatment are	21855		11/23/21

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21855	Continued From page 32 confidential and shall be conducted discreetly. Privacy shall be respected during toileting, bathing, and other activities of personal hygiene, except as needed for patient or resident safety or assistance. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to safeguard and maintain the privacy of personal care information for 1 of 1 resident (R9) observed to have personal toileting information posted in their room which was easily visible from the hallway to other residents and visitors. Findings include: R9's quarterly Minimum Data Set (MDS), dated 7/27/21, identified R9 was in a persistent vegetative state and required total assistance to complete his activities of daily living (ADLs). On 9/27/21, at 4:28 p.m. R9's room door was open to the hallway and R9 was observed laying in bed with his eyes closed. However, above the head of R9's bed was a white sign with black-colored, bold font which read, "CHECK AND CHANGE RESIDENT Q [EVERY] 2 HOURS." This signage, along with R9, were visible from the hallway to anyone passing by the room. During subsequent observations, on 9/28/21 at 1:34 p.m. and 9/29/21 at 7:10 a.m., R9 remained in bed in his room with the same signage posted above his bed. The signage and R9 continued to be easily visible to anyone who passed the room.	21855	corrected	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00253	A. BUILDING: _____ B. WING _____	C 09/30/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RICHFIELD A VILLA CENTER	7727 PORTLAND AVENUE SOUTH RICHFIELD, MN 55423

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21855	Continued From page 33 R9's sensory and communication care plan, last reviewed 2018, identified R9 had an alteration in these areas due to a past stroke. The care plan lacked evidence R9 was to have posted care instructions and/or signage displayed in his room, nor evidence the observed signage had been reviewed or discussed with R9's appointed guardian. On 9/29/21, at 10:27 a.m. R9's guardian (GD)-A was interviewed via telephone. GD-A explained he had been R9's appointed guardian for "a few years," however, had not been able to visit R9 in the nursing home recently due to the pandemic. GD-A was questioned on the signage posted above R9's bed and GD-A voiced he was unaware such signage had been posted as nobody had contacted him to discuss it or seek his permission. GD-A stated he recalled R9's doorway was "typically open" to allow staff to better supervise him and added the signage should be moved "so that it wouldn't be visible from the hallway." When interviewed on 9/29/21, at 10:39 a.m. nursing assistant (NA)-D explained R9 had respiratory impairments and, as a result, the staff leave his doorway open most of the time to allow better observation of him. NA-D stated R9 required total care which included checking and changing his incontinence brief every couple of hours. NA-D then observed the posted signage above R9's bed and stated it had been there for "a good six months" to her knowledge. NA-D stated the posted signage should not be placed in areas visible to others in the hallway and added, "You don't want people to know their personal information." On 9/29/21, at 12:16 p.m. the interim	21855		

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21855	Continued From page 34 administrator and director of nursing (DON) were interviewed, and they verified they had been made aware of the signage posted in R9's room which outlined toileting information and was easily visible from the hallway. The DON stated the signage was "not needed" and should not had been displayed in such a manner to help protect the resident's dignity. A provided Resident Rights policy, dated 11/2017, identified the facility would provide an environment for the residents which allowed them to exercise their rights on a daily basis. This included being treated with dignity and respect, and the right to privacy and confidentiality. SUGGESTED METHOD OF CORRECTION: The administrator, or designee, could ensure all posted resident care information is not visible to the general public; then educate staff on resident right's and personal privacy. They could then audit to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	21855		
21880	MN St. Statute 144.651 Subd. 20 Patients & Residents of HC Fac.Bill of Rights Subd. 20. Grievances. Patients and residents shall be encouraged and assisted, throughout their stay in a facility or their course of treatment, to understand and exercise their rights as patients, residents, and citizens. Patients and residents may voice grievances and recommend changes in policies and services to facility staff and others of their choice, free from restraint, interference, coercion, discrimination, or reprisal, including threat of discharge. Notice of the	21880		11/23/21

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21880	Continued From page 35 grievance procedure of the facility or program, as well as addresses and telephone numbers for the Office of Health Facility Complaints and the area nursing home ombudsman pursuant to the Older Americans Act, section 307(a)(12) shall be posted in a conspicuous place. Every acute care inpatient facility, every residential program as defined in section 253C.01, every nonacute care facility, and every facility employing more than two people that provides outpatient mental health services shall have a written internal grievance procedure that, at a minimum, sets forth the process to be followed; specifies time limits, including time limits for facility response; provides for the patient or resident to have the assistance of an advocate; requires a written response to written grievances; and provides for a timely decision by an impartial decision maker if the grievance is not otherwise resolved. Compliance by hospitals, residential programs as defined in section 253C.01 which are hospital-based primary treatment programs, and outpatient surgery centers with section 144.691 and compliance by health maintenance organizations with section 62D.11 is deemed to be compliance with the requirement for a written internal grievance procedure. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure a report of missing money was followed up on for 1 of 1 resident (R82) who reported missing property.	21880	corrected	

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21880	Continued From page 36 Findings include: R82's quarterly Minimum Data Set (MDS) dated 9/10/21, indicated R82 had intact cognition and no documented behaviors during the assessment period. During an interview on 9/27/21, at 12:23 p.m. R82 stated he reported his shorts were sent to laundry with $26.00 in the pocket on 9/6/21. R82 stated when the shorts returned from laundry the following day, he checked the pockets and no money was found. He talked to laundry staff who stated no money was turned in. R82 stated he spoke to the administrator who said she would, "Look into it, but I haven't heard anything else since." During an interview on 9/29/21, at 11:17 a.m. the director of laundry services stated she did not recall R82 asking about missing money. Further, laundry staff do not search pockets prior to washing personal items. When personal items were found, everything was given to the administrator. Additionally, "Money does come down," but did not recall any money being found in the month of September. During an interview on 9/29/21, at 11:28 a.m. the administrator confirmed, earlier this month (September), R82 reported he left money in the pocket of his shorts when sent to laundry. Further, laundry staff reported they had not found anything and R82 was reminded to empty his pockets prior to sending clothing to laundry. Additionally, "I told him I'd keep an eye out for it." The administrator stated she did not complete a facility grievance form regarding the missing money as, "I did one when he reported clothes missing" the month before. Further, "It didn't need	21880		

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21880	Continued From page 37 an investigation. I lose money in my washing machine all the time. It didn't seem like a full-fledged grievance." The facility Concerns Log printed 9/28/21, which reflected 7/28/21, through 9/28/21, lacked documentation of R82's voiced grievance concerning missing money or follow-up provided to R82. Facility policy Grievance Guideline, revised 4/23/18, included, "Upon receipt of a grievance or concern, the Grievance Official will review the grievance; determine immediately if the grievance meets a reportable complaint." "The Grievance Official will initiate the appropriate notification and investigation processes per individual circumstances and facility guidelines. The investigation will consist of at least the following: A review of the completed complaint report; An interview with the person or personas reporting the incident if applicable; Interviews with any witnesses to the incident or concern; A review of the resident medical record if indicated; A search of resident room (with resident permission); An interview with staff members having contact with the resident during the relevant periods or shifts of the alleged incident; Interviews with the resident's roommate, family members, and visitors; A root-cause analysis of all circumstances surround the incident. As necessary, the Grievance Official and facility leadership will take immediate action to prevent further potential violates of any resident right while the alleged violation is being investigated." SUGGESTED METHOD OF CORRECTION: The director of social services, or administrator, could educate all appropriate staff members on the process of reporting missing personal items.	21880		

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21880	Continued From page 38 The director of social services, or administrator, could develop monitoring systems to ensure ongoing compliance and follow up on missing items is being done. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	21880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245492	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**09/30/2021**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RICHFIELD A VILLA CENTER	**7727 PORTLAND AVENUE SOUTH** **RICHFIELD, MN 55423**

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K 000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety Code survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 09/30/2021. At the time of this survey, RICHFIELD A VILLA CENTER was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: IF PARTICIPATING IN THE E-POC PROCESS, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED.	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		11/03/2021

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 Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR By email to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A detailed description of the corrective action taken or planned to correct the deficiency. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. 4. Identify who is responsible for the corrective actions and monitoring of compliance. 5. The actual or proposed date for completion of the remedy. RICHFIELD A VILLA CENTER is a 3 story building with full basement. The building was constructed in 1964 and was determined to be Type II (222) construction. The facility is fully protected throughout by an automatic sprinkler system and has a fire alarm system with smoke detection in resident rooms, corridors and spaces open to the corridors that is monitored for automatic fire department	K 000		

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K 000	Continued From page 2 notification. The facility has a capacity of 112 beds and had a census of 88 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidence by:	K 000		
K 291 SS=C	Emergency Lighting CFR(s): NFPA 101 Emergency Lighting Emergency lighting of at least 1-1/2-hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to test emergency egress lighting devices in accordance with the NFPA 101 (2012 edition), Life Safety Code, sections 19.2.9.1 and 7.9.3.1.1. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 09/30/2021 between 9:30 AM to 2:30 PM, it was revealed during documentation review that the inspection records presented for review were a bulk testing report. Documentation did not identify each emergency light fixture, the individual 30 second monthly, and individual 90-minute annual testing. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 291	Each emergency light will be assigned specific number for individual testing. Individual lights are tested for 30 seconds once a month and for 90 minutes once a year. Forms will be audited monthly for 3 months for compliance and brought to QAPI by NHA/designee.	11/23/21
K 353	Sprinkler System - Maintenance and Testing	K 353		11/23/21

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K 353 SS=E	Continued From page 3 CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to inspect and maintain the sprinkler system in accordance with NFPA 101 (2012 edition), Life Safety Code, sections 9.7.5, 9.7.6, and NFPA 25 (2011 edition) Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, sections 5.2, 5.2.1.1.1, 5.2.1.1.2, 5.2.1.1.4, 5.2.1.2, 5.2.2.2, and NFPA 13 (2010 edition), Standard for the Installation of Sprinkler Systems, sections 8.5.6, 8.5.6.1. These deficient findings could have a patterned impact on the residents within the facility. Findings include:	K 353	The three identified sprinkler heads in the kitchen replaced 10/29/2021. Zip ties and data lines from sprinkler pipe were removed 10/21/2021 and new conduit ran for data lines. Maintenance Director will complete monthly audits which will include checking sprinkler heads and pipes to ensure they meet regulations. Audits will be verified by NHA and brought to QAPI.	

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K 353	Continued From page 4 1. On 09/30/2021 between 9:30 AM to 2:30 PM, it was revealed during the walk-through of the facility that in the Kitchen, the sprinkler heads near the food prep area, the main stove, and the dish-washing area, exhibited signs of oxidation. 2. On 09/30/2021 between 9:30 AM to 2:30 PM, it was revealed during the walk-through of the facility that the Staffing Central Supplies area, located in the basement, was found to have data cabling zip-tied to the sprinkler system piping. An interview with the Maintenance Director verified these deficient findings at the time of discovery.	K 353		
K 511 SS=E	Utilities - Gas and Electric CFR(s): NFPA 101 Utilities - Gas and Electric Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NFPA 70, National Electric Code. Existing installations can continue in service provided no hazard to life. 18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain security to an electrical panel in a resident accessible corridor in accordance with NFPA 99, (2012 edition), Health Care Facilities Code, section 6.3.2.2.1.3. This deficient finding could have a patterned impact on	K 511	New lock ordered. Old lock will be removed and new lock installed. Each electrical panel will be audited at least once a week for 4 weeks and then once a month for 3 months. Audits will be completed by maintenance director and	11/23/21

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K 511	Continued From page 5 the residents within the facility. Findings include: On 09/30/2021 between 9:30 AM to 2:30 PM, it was revealed during the walk-through of the facility that the electrical panel on the 1st floor in the main resident corridor was found unsecured. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 511	brought to QAPI by NHA/designee.	
K 521 SS=F	HVAC CFR(s): NFPA 101 HVAC Heating, ventilation, and air conditioning shall comply with 9.2 and shall be installed in accordance with the manufacturer's specifications. 18.5.2.1, 19.5.2.1, 9.2 This REQUIREMENT is not met as evidenced by: Based on observations and staff interview, it was revealed that the facility is using the corridors as an air plenum which is not in accordance with NFPA 101 (2012 edition), Life Safety Code, section 19.5.2 and NFPA 90A (2012 edition), Standard for the Installation of Air-Conditioning and Ventilating Systems, section 4.3.12.1.1. This deficient finding could have a widespread impact on the residents within the facility. Findings include:	K 521	Waiver filled out with updated quote from Kaster Construction.	11/23/21

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 521	Continued From page 6 On 09/30/2021 between 09:30 AM to 02:30 PM, observations revealed that the ventilation system for the corridors is utilizing the egress corridor as an exhaust plenum for the ducted make-up air. A hot water system heats the resident rooms, and the corridors are heated by forced air. The resident bathroom fans run continuously and exhaust to the exterior and have dampers located in them. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 521		
K 541 SS=F	Rubbish Chutes, Incinerators, and Laundry Chu CFR(s): NFPA 101 Rubbish Chutes, Incinerators, and Laundry Chutes 2012 EXISTING (1) Any existing linen and trash chute, including pneumatic rubbish and linen systems, that opens directly onto any corridor shall be sealed by fire resistive construction to prevent further use or shall be provided with a fire door assembly having a fire protection rating of 1-hour. All new chutes shall comply with 9.5. (2) Any rubbish chute or linen chute, including pneumatic rubbish and linen systems, shall be provided with automatic extinguishing protection in accordance with 9.7. (3) Any trash chute shall discharge into a trash collection room used for no other purpose and protected in accordance with 8.4. (Existing laundry chutes permitted to discharge into same room are protected by automatic sprinklers in accordance with 19.3.5.9 or 19.3.5.7.) (4) Existing fuel-fed incinerators shall be sealed	K 541		11/23/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245492	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**09/30/2021**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RICHFIELD A VILLA CENTER	**7727 PORTLAND AVENUE SOUTH** **RICHFIELD, MN 55423**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 541	Continued From page 7 by fire resistive construction to prevent further use. 19.5.4, 9.5, 8.4, NFPA 82 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain the laundry chute in accordance with the NFPA 101 (2012 edition), Life Safety Code, sections 19.5.4.3, 8.7, 8.7.1.3, 7.2.1.8. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 09/30/2021 between 9:30 AM to 2:30 PM, it was revealed during the walk-through of the facility that the 2nd floor Soiled Linen Room laundry chute door was found to be left open and missing self-closing hardware. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 541	New linen chutes ordered and will replace when received. Linen chutes will be weekly for 4 weeks by maintenance director to ensure they self-close appropriate. Audits will be brought to QAPI by NHA for continued quality assurance.	
K 923 SS=F	Gas Equipment - Cylinder and Container Storag CFR(s): NFPA 101 Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited- combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are	K 923		11/23/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245492	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**09/30/2021**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RICHFIELD A VILLA CENTER	**7727 PORTLAND AVENUE SOUTH** **RICHFIELD, MN 55423**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 923	Continued From page 8 separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain medical gas storage per NFPA 99 (2012 edition), Health Care Facilities Code, sections 11.3.2.3, 11.3.4, 11.6.2.3, 11.6.5 These deficient findings could have a widespread impact on the residents within the facility. Findings include: 1. On 09/30/2021 between 9:30 AM to 2:30 PM, it was revealed during the walk-through of the facility that the 3rd Floor - Med Gas Storage	K 923	Printed new signage for third floor oxygen room 9/30/2021. New locking door handles ordered on 11/1/2021 to be placed on 1st and 2nd floor oxygen rooms. Oxygen cylinders were secured in locked oxygen storage rooms 9/29/2021. Audits will be conducted 3 times a week by Maintenance Director or Designee for 4 weeks to ensure compliance. Audit results will be brought to QAPI by NHA.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245492	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**09/30/2021**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RICHFIELD A VILLA CENTER	**7727 PORTLAND AVENUE SOUTH** **RICHFIELD, MN 55423**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 923	Continued From page 9 Room was missing wall signage to identify the location for empty cylinders. 2. On 09/30/2021 between 9:30 AM to 2:30 PM, it was revealed during the walk-through of the facility that the 2nd Floor - Med Gas Storage Room was found to be unsecured and had unsecured oxygen cylinders inside the room. 3. On 09/30/2021 between 9:30 AM to 2:30 PM, it was revealed during the walk-through of the facility that the 1st Floor - Med Gas Storage Room was found to be unsecured, had unsecured oxygen cylinders, and had mixed storage of empty/full cylinders. An interview with the Maintenance Director verified these deficient findings at the time of discovery.	K 923		
K 930 SS=D	Gas Equipment - Liquid Oxygen Equipment CFR(s): NFPA 101 Gas Equipment - Liquid Oxygen Equipment The storage and use of liquid oxygen in base reservoir containers and portable containers comply with sections 11.7.2 through 11.7.4 (NFPA 99). 11.7 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to store liquid oxygen equipment per NFPA 99 (2012 edition), Health Care Facilities Code, section 11.7.4. This deficient finding could have an isolated impact on the residents within the facility. Findings include:	K 930	Empty oxygen tank was removed from room and put into storage 9/29/2021. Oxygen company informed of practice and resident rooms with oxygen will be audited by Maintenance Director or Designee for proper liquid oxygen storage and use. Audits will be conducted 3 times a week for 4 weeks and results will be	11/23/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245492	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**09/30/2021**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RICHFIELD A VILLA CENTER	**7727 PORTLAND AVENUE SOUTH** **RICHFIELD, MN 55423**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 930	Continued From page 10 On 09/30/2021 between 9:30 AM to 2:30 PM, it was revealed during the walk-through of the facility that on the 2nd Floor in resident RM 218 that two 31 liter liquid oxygen cylinders were in the room. One cylinder was confirmed to be in use; the second cylinder was being stored in the room. An interview with the Maintenance Director verified these deficient findings at the time of discovery.	K 930	brought to QAPI by NHA.	

FIRE SAFETY SURVEY REPORT - 2012 LIFE SAFETY CODE HEALTHCARE

1. (A) PROVIDER NUMBER	1. (B) MEDICAID I.D. NO.
K1 245492	K2

PART I — Life Safety Code, New and Existing
PART II — Health Care Facilities Code, New and Existing
PART III — Recommendation for Waiver
PART IV – Crucial Data Extract
OPTIONAL — Chapter 4 – NFPA 101A - Fire Safety Evaluation System for Health Care Occupancies – CMS-2786T

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

2. NAME OF FACILITY	2. (A) MULTIPLE CONSTRUCTION (BLDGS)	2. (B) ADDRESS OF FACILITY (STREET, CITY, STATE, ZIP CODE)	
RICHFIELD A VILLA CENTER	A. BUILDING 01 B. WING C. FLOOR K3	7727 PORTLAND AVE SOUTH RICHFIELD, MN 55423	A. (●) Fully Sprinklered (All required areas are sprinklered) B. ( ) Partially Sprinklered (Not all required areas are sprinklered) C. ( ) None (No sprinkler system) K0180

3. SURVEY FOR	4. DATE OF SURVEY	DATE OF PLAN APPROVAL	SURVEY UNDER
[✔] MEDICARE [✔] MEDICAID	09/30/2021 K4	K6	5. (●) 2012 EXISTING 6. ( ) 2012 NEW K7

5. SURVEY FOR CERTIFICATION OF

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

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

1. [✔] ENTIRE FACILITY 2. [ ] DISTINCT PART OF (SPECIFY) _____

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

6. BED COMPOSITION				
a. TOTAL NO. OF BEDS IN THE FACILITY 112	b. NUMBER OF HOSPITAL BEDS CERTIFIED FOR MEDICARE ____	c. NUMBER OF SKILLED BEDS CERTIFIED FOR MEDICARE 112	d. NUMBER OF SKILLED BEDS CERTIFIED FOR MEDICAID 112	e. NUMBER OF NF or ICF/IID BEDS CERTIFIED FOR MEDICAID ____

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

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

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

SURVEYOR *(Signature)*	TITLE	OFFICE	DATE
SURVEYOR ID 40003 K10	Deputy State Fire Marshal	Minnesota State Fire Marshal Division	10/08/2021
FIRE AUTHORITY OFFICIAL William Abderhalden 37009	TITLE Fire Safety Supervisor	OFFICE Minnesota State Fire Marshal Division	DATE 10/26/2021

CMS FORMS SHALL BE COMPLETED AND RETAINED AS PART OF THE SURVEY RECORD.

ID PREFIX		MET	NOT MET	N/A	REMARKS
	PART I – NFPA 101 LSC REQUIREMENTS (Items in italics relate to the FSES)				
	SECTION 1 – GENERAL REQUIREMENTS				
K100	**General Requirements – Other** List in the REMARKS section any LSC Section 18.1 and 19.1 General Requirements that are not addressed by the provided K-tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567.	◉	○	○	
K111	**Building Rehabilitation** ***Repair, Renovation, Modification, or Reconstruction*** Any building undergoing repair, renovation, modification, or reconstruction complies with both of the following: • Requirements of Chapter 18 and 19. • Requirements of the applicable Sections 43.3, 43.4, 43.5, and 43.6. 18.1.1.4.3, 19.1.1.4.3, 43.1.2.1 ***Change of Use or Change of Occupancy*** Any building undergoing change of use or change of occupancy classification complies with the requirements of Section 43.7, unless permitted by 18.1.1.4.2 or 19.1.1.4.2. 18.1.1.4.2 (4.6.7 and 4.6.11), 19.1.1.4.2 (4.6.7 and 4.6.11), 43.1.2.2 (43.7) ***Additions*** Any building undergoing an addition shall comply with the requirements of Section 43.8. If the building has a common wall with a nonconforming building, the common wall is a fire barrier having at least a two hour fire resistance rating constructed of materials as required for the addition. Communicating openings occur only in corridors and are protected by approved self-closing fire doors with at least a 1-1/2 hour fire resistance rating. Additions comply with the requirements of Section 43.8. 18.1.1.4.1 (4.6.7 and 4.6.11), 18.1.1.4.1.1 (8.3), 18.1.1.4.1.2, 18.1.1.4.1.3, 19.1.1.4.1 (4.6.7 and 4.6.11), 19.1.1.4.1.1 (8.3), 19.1.1.4.1.2, 19.1.1.4.1.3, 43.1.2.3(43.8)	○	○	◉	

ID PREFIX		MET	NOT MET	N/A	REMARKS
K112	**Sprinkler Requirements for Major Rehabilitation** If a nonsprinklered smoke compartment has undergone major rehabilitation the automatic sprinkler requirements of 18.3.5 have been applied to the smoke compartment. In cases where the building is not protected throughout by a sprinkler system, the requirements of 18.4.3.2, 18.4.3.3, and 18.4.3.8 are also met. Note: Major rehabilitation involves the modification of more than 50 percent, or more than 4500 ft² of the area of the smoke compartment. 18.1.1.4.3.3, 19.1.1.4.3.3	○	○	◉	
K131	**Multiple Occupancies – Sections of Health Care Facilities** Sections of health care facilities classified as other occupancies meet all of the following: • They are not intended to serve four or more inpatients for purposes of housing, treatment, or customary access. • They are separated from areas of health care occupancies by construction having a minimum two hour fire resistance rating in accordance with Chapter 8. • The entire building is protected throughout by an approved, supervised automatic sprinkler system in accordance with Section 9.7. Hospital outpatient surgical departments are required to be classified as an Ambulatory Health Care Occupancy regardless of the number of patients served. 18.1.3.3, 19.1.3.3, 42 CFR 482.41, 42 CFR 485.623	○	○	◉	
K132	**Multiple Occupancies – Contiguous Non-Health Care Occupancies** Non-health care occupancies that are located immediately next to a Health Care Occupancy, but are primarily intended to provide outpatient services are permitted to be classified as Business or Ambulatory Health Care Occupancies, provided the facilities are separated by construction having not less than two hour fire resistance-rated construction, and are not intended to provide services simultaneously for four or more inpatients. Outpatient surgical departments must be classified as Ambulatory Health Care Occupancy regardless of the number of patients served. 18.1.3.4.1, 19.1.3.4.1	○	○	◉	

<table>
<tr><th>ID PREFIX</th><th></th><th>MET</th><th>NOT MET</th><th>N/A</th><th>REMARKS</th></tr>
<tr><td>K133</td><td>Multiple Occupancies – Construction Type
Where separated occupancies are in accordance with 18/19.1.3.2 or 18/19.1.3.4, the most stringent construction type is provided throughout the building, unless a two hour separation is provided in accordance with 8.2.1.3, in which case the construction type is determined as follows:
• The construction type and supporting construction of the health care occupancy is based on the story in which it is located in the building in accordance with 18/19.1.6 and Tables 18/19.1.6.1.
• The construction type of the areas of the building enclosing the other occupancies shall be based on the applicable occupancy chapters.
18.1.3.5, 19.1.3.5, 8.2.1.3</td><td>◉</td><td>○</td><td>○</td><td></td></tr>
<tr><td>K161</td><td>Building Construction Type and Height
2012 EXISTING
Building construction type and stories meets Table 19.1.6.1, unless otherwise permitted by 19.1.6.2 through 19.1.6.7
19.1.6.4, 19.1.6.5
<table>
<tr><th></th><th></th><th>Construction Type</th><th></th></tr>
<tr><td>1</td><td>◉</td><td>I (442), I (332), II (222)</td><td>Any number of stories non-sprinklered or sprinklered</td></tr>
<tr><td>2</td><td>○</td><td>II (111)</td><td>One story non-sprinklered
Maximum 3 stories sprinklered</td></tr>
<tr><td>3</td><td>○</td><td>II (000)</td><td rowspan="4">Not allowed non-sprinklered
Maximum 2 stories sprinklered</td></tr>
<tr><td>4</td><td>○</td><td>III (211)</td></tr>
<tr><td>5</td><td>○</td><td>IV (2HH)</td></tr>
<tr><td>6</td><td>○</td><td>V (111)</td></tr>
<tr><td>7</td><td>○</td><td>III (200)</td><td rowspan="2">Not allowed non-sprinklered
Maximum 1 story sprinklered</td></tr>
<tr><td>8</td><td>○</td><td>V (000)</td></tr>
</table>
Sprinklered stories must be sprinklered throughout by an approved, supervised automatic system in accordance with section 9.7. (See 19.3.5)
Give a brief description, in REMARKS, of the construction, the number of stories, including basements, floors on which patients are located, location of smoke or fire barriers and dates of approval. Complete sketch or attach small floor plan of the building as appropriate.</td><td>◉</td><td>○</td><td>○</td><td>RICHFIELD A VILLA CENTER is a 3 story building with full basement. The building was constructed in 1964 and was determined to be Type II (222) construction.

The facility is fully protected throughout by an automatic sprinkler system and has a fire alarm system with smoke detection in resident rooms, corridors and spaces open to the corridors that is monitored for automatic fire department notification.</td></tr>
</table>

ID PREFIX		MET	NOT MET	N/A	REMARKS
K161	2012 NEW Building construction type and stories meets Table 18.1.6.1, unless otherwise permitted by 18.1.6.2 through 18.1.6.7 18.1.6.4, 18.1.6.5	○	○	◉	

		Construction Type	
1	○	I (442), I (332), II (222)	Not allowed non-sprinklered Any number of stories sprinklered
2	○	II (111)	Not allowed non-sprinklered Maximum 3 stories sprinklered
3	○	II (000)	Not allowed non-sprinklered Maximum 1 story sprinklered
4	○	III (211)	
5	○	IV (2HH)	
6	○	V (111)	
7	○	III (200)	Not allowed non-sprinklered
8	○	V (000)	

Sprinklered stories must be sprinklered throughout by an approved, supervised automatic system in accordance with section 9.7. (See 18.3.5)

Give a brief description, in REMARKS, of the construction, the number of stories, including basements, floors on which patients are located, location of smoke or fire barriers and dates of approval. Complete sketch or attach small floor plan of the building as appropriate.

K162	**Roofing Systems Involving Combustibles** 2012 EXISTING Buildings of Type I (442), Type I (332), Type II (222), or Type II (111) having roof systems employing combustible roofing supports, decking or roofing meet the following: 1. roof covering meets Class C requirements. 2. roof is separated from occupied building portions with a noncombustible floor assembly using not less than 2½ inches concrete or gypsum fill. 3. attic or other space is either unoccupied or protected throughout by an approved automatic sprinkler system. 19.1.6.2*, ASTM E108, ANSI/UL 790	◉	○	○	

ID PREFIX		MET	NOT MET	N/A	REMARKS
K162	2012 NEW Buildings of Type I (442), Type I (332), Type II (222), Type II (111) having roof systems employing combustible roofing supports, decking or roofing meet the following: 1. roof covering meets Class A requirements. 2. roof is separated from occupied building portions with 2 hour fire resistive noncombustible floor assembly using not less than 2½ inches concrete or gypsum fill. 3. the structural elements supporting the rated floor assembly meet the required fire resistance rating of the building. 18.1.6.2, ASTM E108, ANSI/UL 790	○	○	◉	
K163	**Interior Nonbearing Wall Construction** Interior nonbearing walls in Type I or II construction are constructed of noncombustible or limited-combustible materials. Interior nonbearing walls required to have a minimum 2 hour fire resistance rating are permitted to be fire-retardant-treated wood enclosed within noncombustible or limited-combustible materials, provided they are not used as shaft enclosures. 18.1.6.4, 18.1.6.5, 19.1.6.4, 19.1.6.5	◉	○	○	
	SECTION 2 – MEANS OF EGRESS REQUIREMENTS				
K200	**Means of Egress Requirements – Other** List in the REMARKS section any LSC Section 18.2 and 19.2 Means of Egress requirements that are not addressed by the provided K-tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. 18.2, 19.2	◉	○	○	
K211	**Means of Egress – General** Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1	◉	○	○	

ID PREFIX		MET	NOT MET	N/A	REMARKS
K221	**Patient Sleeping Room Doors** Locks on patient sleeping room doors are not permitted unless the key-locking device that restricts access from the corridor does not restrict egress from the patient room, or the locking arrangement is permitted for patient clinical, security or safety needs in accordance with 18.2.2.2.5 or 19.2.2.2.5. 18.2.2.2, 19.2.2.2, TIA 12-4	◉	○	○	
K222	**Egress Doors** Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: ☐ CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 ☐ SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4	◉	○	○	

ID PREFIX		MET	NOT MET	N/A	REMARKS
K222	☐ DELAYED-EGRESS LOCKING ARRANGEMENTS Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 ☐ ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted. 18.2.2.2.4, 19.2.2.2.4 ☐ ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4	◉	○	○	
K223	**Doors with Self-Closing Devices** Doors in an exit passageway, stairway enclosure, or horizontal exit, smoke barrier, or hazardous area enclosure are self-closing and kept in the closed position, unless held open by a release device complying with 7.2.1.8.2 that automatically closes all such doors throughout the smoke compartment or entire facility upon activation of: • Required manual fire alarm system; and • Local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system; and • Automatic sprinkler system, if installed; and • Loss of power. 18.2.2.2.7, 18.2.2.2.8, 19.2.2.2.7, 19.2.2.2.8	◉	○	○	

ID PREFIX		MET	NOT MET	N/A	REMARKS
K224	**Horizontal-Sliding Doors** Horizontal-sliding doors permitted by 7.2.1.14 that are not automatic-closing are limited to a single leaf and shall have a latch or other mechanism to ensure the door will not rebound. Horizontal-sliding doors serving an occupant load fewer than 10 shall be permitted, providing all of the following criteria are met: • Area served by the door has no high hazard contents. • Door is operable from either side without special knowledge or effort. • Force required to operate the door in the direction of travel is ≤ 30 lbf to set the door in motion and ≤ 15 lbf to close or open to the required width. • Assembly is appropriately fire rated, and where rated, is self-or automatic-closing by smoke detection per 7.2.1.8, and installed per NFPA 80. • Where required to latch, the door has a latch or other mechanism to ensure the door will not rebound. 18.2.2.2.10, 19.2.2.2.10	○	○	◉	
K225	**Stairways and Smokeproof Enclosures** Stairways and Smokeproof enclosures used as exits are in accordance with 7.2. 18.2.2.3, 18.2.2.4, 19.2.2.3, 19.2.2.4, 7.2	◉	○	○	
K226	**Horizontal Exits** Horizontal exits, if used, are in accordance with 7.2.4 and the provisions of 18.2.2.5.1 through 18.2.2.5.7, or 19.2.2.5.1 through 19.2.2.5.4. 18.2.2.5, 19.2.2.5	○	○	◉	
K227	**Ramps and Other Exits** Ramps, exit passageways, fire and slide escapes, alternating tread devices, and areas of refuge are in accordance with the provisions 7.2.5 through 7.2.12. 18.2.2.6 to 18.2.2.10 or 19.2.2.6 to 19.2.2.10	◉	○	○	
K231	**Means of Egress Capacity** The capacity of required means of egress is in accordance with 7.3. 18.2.3.1, 19.2.3.1	◉	○	○	

ID PREFIX		MET	NOT MET	N/A	REMARKS
K232	**Aisle, Corridor or Ramp Width** 2012 EXISTING The width of aisles or corridors (clear or unobstructed) serving as exit access shall be at least 4 feet and maintained to provide the convenient removal of nonambulatory patients on stretchers, except as modified by 19.2.3.4, exceptions 1-5. 19.2.3.4, 19.2.3.5	◉	○	○	
	2012 NEW The width of aisles or corridors (clear and unobstructed) serving as exit access in hospitals and nursing homes shall be at least 8 feet. In limited care facility and psychiatric hospitals, width of aisles or corridors shall be at least 6 feet, except as modified by the 18.2.3.4 or 18.2.3.5 exceptions. 18.2.3.4, 18.2.3.5	○	○	◉	
K233	**Clear Width of Exit and Exit Access Doors** 2012 EXISTING Exit access doors and exit doors are of the swinging type and are at least 32 inches in clear width. Exceptions are provided for existing 34-inch doors and for existing 28-inch doors where the fire plan does not require evacuation by bed, gurney, or wheelchair. 19.2.3.6, 19.2.3.7	◉	○	○	
	2012 NEW Exit access doors and exit doors are of the swinging type and are at least 41.5 inches in clear width. In psychiatric hospitals or limited care facilities, doors are at least 32 inches wide. Doors not subject to patient use, in exit stairway enclosures, or serving newborn nurseries shall be no less than 32 inches in clear width. If using a pair of doors, the doors shall be provided with a rabbet, bevel, or astragal at the meeting edge, at least one of the doors shall provide 32 inches in clear width, and the inactive leaf of the pair shall be secured with automatic flush bolts. 18.2.3.6, 18.2.3.7	○	○	◉	
K241	**Number of Exits – Story and Compartment** Not less than two exits, remote from each other, and accessible from every part of every story are provided for each story. Each smoke compartment shall likewise be provided with two distinct egress paths to exits that do not require the entry into the same adjacent smoke compartment. 18.2.4.1-18.2.4.4, 19.2.4.1-19.2.4.4	◉	○	○	

ID PREFIX		MET	NOT MET	N/A	REMARKS
K251	**Dead-End Corridors and Common Path of Travel** 2012 EXISTING Dead-end corridors shall not exceed 30 feet. Existing dead-end corridors greater than 30 feet shall be permitted to be continued to be used if it is impractical and unfeasible to alter them. 19.2.5.2	◉	○	○	
K251	2012 NEW Dead-end corridors shall not exceed 30 feet. Common path of travel shall not exceed 100 feet. 18.2.5.2, 18.2.5.3	○	○	◉	
K252	**Number of Exits – Corridors** Every corridor shall provide access to not less than two approved exits in accordance with Sections 7.4 and 7.5 without passing through any intervening rooms or spaces other than corridors or lobbies. 18.2.5.4, 19.2.5.4	◉	○	○	
K253	**Number of Exits – Patient Sleeping and Non-Sleeping Rooms** Patient sleeping rooms of more than 1,000 square feet or nonsleeping rooms of more than 2,500 square feet have at least two exit access doors remotely located from each other. 18.2.5.5.1, 18.2.5.5.2, 19.2.5.5.1, 19.2.5.5.2	◉	○	○	
K254	**Corridor Access** All habitable rooms not within suites have a door leading directly outside to grade or have a door leading to an exit access corridor. Patient sleeping rooms with less than eight patient beds may have one room intervening to reach an exit access corridor provided the intervening room is equipped with an approved automatic smoke detection system. 18.2.5.6.1 through 18.2.5.6.4, 19.2.5.6.1 through 19.2.5.6.4	◉	○	○	
K255	**Suite Separation, Hazardous Content, and Subdivision** All suites are separated from the remainder of the building (including from other suites) by construction meeting the separation provisions for corridor construction (18.3.6.2-18.3.6.5 or 19.3.6.2-19.3.6.5). Existing approved barriers shall be allowed to continue to be used provided they limit the transfer of smoke. Intervening rooms have no hazardous areas and hazardous areas within suites comply with 18/19.2.5.7.1.3. Subdivision of suites shall be by noncombustible or limited-combustible construction. 18.2.5.7.1.2 through 18.2.5.7.1.4, 19.2.5.7.1.2, 19.2.5.7.1.3, 19.2.5.7.1.4	◉	○	○	

ID PREFIX		MET	NOT MET	N/A	REMARKS
K256	**Sleeping Suites** Occupants shall have exit access to a corridor or direct access to a horizontal exit. Where ≥ 2 exits are required, one exit access door may be to a stairway, passageway or to the exterior. Suites shall be provided with constant staff supervision. Staff shall have direct visual supervision of patient sleeping rooms, from a constantly attended location or the room shall be provided with an automatic smoke detection system. Suites more than 1,000 ft² shall have 2 or more remote exits. One means of egress from the suite shall be to a corridor and one may be into an adjacent suite separated in accordance with corridor requirements. Suites shall not exceed the following size limitations: • 5,000 square feet if the suite is not fully smoke detected or fully sprinklered. • 7,500 square feet if the suite is either fully smoke detected or fully sprinklered. • 10,000 square feet if the suite is both fully smoke detected and fully sprinklered and the sleeping rooms have direct supervision from a constantly attended location. Travel distance between any point in a suite to exit access shall not exceed 100 feet and distance to an exit shall not exceed 150 feet (200 feet if building is fully sprinklered). 18.2.5.7.2, 19.2.5.7.2	○	○	◉	
K257	**Non-Sleeping Suites** Occupants shall have exit access to a corridor or direct access to a horizontal exit. Where ≥ 2 exits are required, one exit access door may be to a stairway, passageway or to the exterior. Suites more than 2,500 ft² shall have 2 or more remote exits. One means of egress from the suite shall be to a corridor and one may be into an adjacent suite separated in accordance with corridor requirements. Suites shall not exceed 10,000 ft². Travel distance between any point in a suite to exit access shall not exceed 100 feet and distance to an exit shall not exceed 150 feet (200 feet if building is fully sprinklered). 18.2.5.7.3, 19.2.5.7.3	◉	○	○	

ID PREFIX		MET	NOT MET	N/A	REMARKS
K261	**Travel Distance to Exits** Travel distance (excluding suites) to exits are measured in accordance with 7.6. • From any point in the room or suite to exit less than or equal to 150 feet (less than or equal to 200 feet if the building is fully sprinklered). • Point in a room to room door less than or equal to 50 feet. 18.2.6, 19.2.6	◉	○	○	
K271	**Discharge from Exits** Exit discharge is arranged in accordance with 7.7, provides a level walking surface meeting the provisions of 7.1.7 with respect to changes in elevation and shall be maintained free of obstructions. Additionally, the exit discharge shall be a hard packed all-weather travel surface. 18.2.7, 19.2.7	◉	○	○	
K281	**Illumination of Means of Egress** Illumination of means of egress, including exit discharge, is arranged in accordance with 7.8 and shall be either continuously in operation or capable of automatic operation without manual intervention. 18.2.8, 19.2.8	◉	○	○	
K291	**Emergency Lighting** Emergency lighting of at least 1-1/2 hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1	○	◉	○	On 09/30/2021 between 09:30 AM to 02:30 PM, it was revealed during documentation review that the documentation presented for review was a bulk testing report. Documentation did not identify each emergency light fixture, the individual 30 second monthly, and the 90 minute annual testing.
K292	**Life Support Means of Egress** 2012 NEW (INDICATE N/A FOR EXISTING) Buildings equipped with or requiring the use of life support systems (electro-mechanical or inhalation anesthetics) have illumination of means of egress, emergency lighting equipment, exit, and directional signs supplied by the life safety branch of the electrical system described in NFPA 99. (Indicate N/A if life support equipment is for emergency purposes only.) 18.2.9.2, 18.2.10.5	○	○	◉	

ID PREFIX		MET	NOT MET	N/A	REMARKS
K293	**Exit Signage** 2012 EXISTING Exit and directional signs are displayed in accordance with 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1 (Indicate N/A in one-story existing occupancies with less than 30 occupants where the line of exit travel is obvious.)	◉	○	○	
	2012 NEW Exit and directional signs are displayed in accordance with 7.10 with continuous illumination also served by the emergency lighting system. 18.2.10.1	○	○	◉	
	SECTION 3 – PROTECTION				
K300	**Protection – Other** List in the REMARKS section any LSC Section 18.3 and 19.3 Protection requirements that are not addressed by the provided K-tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567.	◉	○	○	
K311	**Vertical Openings – Enclosure** 2012 EXISTING Stairways, elevator shafts, light and ventilation shafts, chutes, and other vertical openings between floors are enclosed with construction having a fire resistance rating of at least 1-hour. An atrium may be used in accordance with 8.6. 19.3.1.1 through 19.3.1.6 *If all vertical openings are properly enclosed with construction providing at least a 2 hour fire resistance rating, also check this box.* ☐	◉	○	○	
	2012 NEW Stairways, elevator shafts, light and ventilation shafts, chutes, and other vertical openings between floors are enclosed with construction having a fire resistance rating of at least 2 hours connecting four or more stories. (1-hour for single story building and buildings up to three stories in height.) An atrium may be used in accordance with 8.6.7. 18.3.1 through 18.3.1.5	○	○	◉	

ID PREFIX		MET	NOT MET	N/A	REMARKS
K321	**Hazardous Areas – Enclosure** 2012 EXISTING Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with ¾ hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. *Describe the floor and zone locations of hazardous areas that are deficient in REMARKS.* 19.3.2.1, 19.3.5.9		◉	○	○	

Area	Automatic Sprinkler	Separation	N/A
a. Boiler and Fuel-Fired Heater Rooms	☑	☑	☐
b. Laundries (larger than 100 sq. ft.)	☑	☑	☐
c. Repair, Maintenance, and Paint Shops	☑	☑	☐
d. Soiled Linen Rooms (exceeding 64 gal.)	☑	☑	☐
e. Trash Collection Rooms (exceeding 64 gal.)	☑	☑	☐
f. Combustible Storage Rooms/Spaces (over 50 sq. ft.)	☑	☑	☐
g. Laboratories (if classified as Severe Hazard - see K322)	☐	☐	☑

ID PREFIX		MET	NOT MET	N/A	REMARKS
K321	2012 NEW Hazardous areas are protected in accordance with 18.3.2.1. The areas shall be enclosed with a 1-hour fire-rated barrier, with a ¾ hour fire-rated door without windows (in accordance with 8.7.1.1). Doors shall be self-closing or automatic-closing in accordance with 7.2.1.8. Hazardous areas are protected by a sprinkler system in accordance with 9.7, 18.3.2.1, and 8.4. *Describe the floor and zone locations of hazardous areas that are deficient in REMARKS.* 18.3.2.1, 7.2.1.8, 8.4, 8.7, 9.7	○	○	◉	

Area	Automatic Sprinkler	Separation	N/A
a. Boiler and Fuel-Fired Heater Rooms	☐	☐	☐
b. Laundries (larger than 100 sq. ft.)	☐	☐	☐
c. Repair, Maintenance, and Paint Shops	☐	☐	☐
d. Soiled Linen Rooms (exceeding 64 gal.)	☐	☐	☐
e. Trash Collection Rooms (exceeding 64 gal.)	☐	☐	☐
f. Combustible Storage Rooms/Spaces (over 50 and less than 100 sq. ft.)	☐	☐	☐
g. Combustible Storage Rooms/Spaces (over 100 sq. ft.)	☐	☐	☐
h. Laboratories (if classified as Severe Hazard - see K322)	☐	☐	☐

ID PREFIX		MET	NOT MET	N/A	REMARKS
K322	**Laboratories** Laboratories employing quantities of flammable, combustible, or hazardous materials that are considered a severe hazard are protected by 1-hour fire resistance-rated separation, automatic sprinkler system, and are in accordance with 8.7 and with NFPA 99. Laboratories not considered a severe hazard are protected as hazardous areas (see K321). Laboratories using chemicals are in accordance with NFPA 45, *Standard on Fire Protection for Laboratories Using Chemicals*. Gas appliances are of appropriate design and installed in accordance with NFPA 54. Shutoff valves are marked to identify material they control. Devices requiring medical grade oxygen from the piped distribution system meet the requirements under 11.4.2.2 (NFPA 99). 18.3.2.2, 19.3.2.2, 8.7, 8.7.4.1 (LSC) 9.3.1.2, 11.4.3.2, 15.4 (NFPA 99)	○	○	◉	

ID PREFIX		MET	NOT MET	N/A	REMARKS
K323	**Anesthetizing Locations** Areas designated for administration of general anesthesia (i.e., inhalation anesthetics) are in accordance with 8.7 and NFPA 99. Zone valves are: located immediately outside each life-support, critical care, and anesthetizing location of moderate sedation, deep sedation, or general anesthesia for medical gas or vacuum; readily accessible in an emergency; and arranged so shutting off any one anesthetizing location will not affect others. Area alarm panels are provided to monitor all medical gas, medical-surgical vacuum, and piped WAGD systems. Panels are at locations that provide for surveillance, indicate medical gas pressure decreases of 20 percent and vacuum decreases of 12 inch gauge HgV, and provide visual and audible indication. Alarm sensors are installed either on the source side of individual room zone valve box assemblies or on the patient/use side of each of the individual zone box valve assemblies. The EES critical branch supplies power for task illumination, fixed equipment, select receptacles, and select power circuits, and EES equipment system supplies power to ventilation system. Heating, cooling, and ventilation are in accordance with ASHRAE 170. Medical supply and equipment manufacturer's instructions for use are considered before reducing humidity levels to those allowed by ASHRAE, per S&C 13-58. 18.3.2.3, 19.3.2.3 (LSC) 5.1.4.8.7, 5.1.4.8.7.2, 5.1.9.3, 5.1.9.3.4, 6.4.2.2.4.2 (NFPA 99)	○	○	◉	

ID PREFIX		MET	NOT MET	N/A	REMARKS
K324	**Cooking Facilities** Cooking equipment is protected in accordance with NFPA 96, *Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations*, unless: • residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2. • cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or • cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2	◉	○	○	
K325	**Alcohol Based Hand Rub Dispenser (ABHR)** ABHRs are protected in accordance with 8.7.3.1, unless all conditions are met: • Corridor is at least 6 feet wide. • Maximum individual dispenser capacity is 0.32 gallons (0.53 gallons in suites) of fluid and 18 ounces of Level 1 aerosols. • Dispensers shall have a minimum of four foot horizontal spacing. • Not more than an aggregate of 10 gallons of fluid or 1135 ounces of aerosol are used in a single smoke compartment outside a storage cabinet, excluding one individual dispenser per room. • Storage in a single smoke compartment greater than 5 gallons complies with NFPA 30. • Dispensers are not installed within 1 inch of an ignition source. • Dispensers over carpeted floors are in sprinklered smoke compartments. • ABHR does not exceed 95 percent alcohol. • Operation of the dispenser shall comply with Section 18.3.2.6(11) or 19.3.2.6(11). • ABHR is protected against inappropriate access. 18.3.2.6, 19.3.2.6, 42 CFR Parts 403, 418, 460, 482, 483, and 485	◉	○	○	

ID PREFIX		MET	NOT MET	N/A	REMARKS
K331	**Interior Wall and Ceiling Finish** 2012 EXISTING Interior wall and ceiling finishes, including exposed interior surfaces of buildings such as fixed or movable walls, partitions, columns, and have a flame spread rating of Class A or Class B. The reduction in class of interior finish for a sprinkler system as prescribed in 10.2.8.1 is permitted. 10.2, 19.3.3.1, 19.3.3.2 *Indicate flame spread rating(s).* B	◉	○	○	
	2012 NEW Interior wall and ceiling finishes, including exposed interior surfaces of buildings such as fixed or movable walls, partitions and columns have a flame spread rating of Class A. The reduction in class of interior finish for a sprinkler system as prescribed in 10.2.8.1 is permitted. Individual rooms not exceeding four persons may have a Class A or B finish. Lower half of corridor walls, not exceeding 4 feet in height, may have a Class A or B flame spread rating. 10.2, 18.3.3.1, 18.3.3.2 *Indicate flame spread rating(s).* _____	○	○	◉	
K332	**Interior Floor Finish** 2012 NEW (Indicate N/A for 2012 EXISTING) Interior finishes shall comply with 10.2. Floor finishes in exit enclosures and exit access corridors and spaces not separated by walls that resist the passage of smoke shall be Class I or II. 18.3.3.3.1, 18.3.3.3.2, 18.3.3.3.3, 10.2, 10.2.7.1, 10.2.7.2	○	○	◉	
K341	**Fire Alarm System – Installation** A fire alarm system is installed with systems and components approved for the purpose in accordance with NFPA 70, *National Electric Code,* and NFPA 72, *National Fire Alarm Code* to provide effective warning of fire in any part of the building. In areas not continuously occupied, detection is installed at each fire alarm control unit. In new occupancy, detection is also installed at notification appliance circuit power extenders, and supervising station transmitting equipment. Fire alarm system wiring or other transmission paths are monitored for integrity. 18.3.4.1, 19.3.4.1, 9.6, 9.6.1.8	◉	○	○	

ID PREFIX		MET	NOT MET	N/A	REMARKS
K342	**Fire Alarm System – Initiation** Initiation of the fire alarm system is by manual means and by any required sprinkler system alarm, detection device, or detection system. Manual alarm boxes are provided in the path of egress near each required exit. Manual alarm boxes in patient sleeping areas shall not be required at exits if manual alarm boxes are located at all nurse's stations or other continuously attended staff location, provided alarm boxes are visible, continuously accessible, and 200' travel distance is not exceeded. 18.3.4.2.1, 18.3.4.2.2, 19.3.4.2.1, 19.3.4.2.2, 9.6.2.5	◉	○	○	
K343	**Fire Alarm – Notification** 2012 EXISTING Positive alarm sequence in accordance with 9.6.3.4 are permitted in buildings protected throughout by a sprinkler system. Occupant notification is provided automatically in accordance with 9.6.3 by audible and visual signals. In critical care areas, visual alarms are sufficient. The fire alarm system transmits the alarm automatically to notify emergency forces in the event of a fire. 19.3.4.3, 19.3.4.3.1, 19.3.4.3.2, 9.6.4, 9.7.1.1(1)	◉	○	○	
	2012 NEW Positive alarm sequence in accordance with 9.6.3.4 are permitted. Occupant notification is provided automatically in accordance with 9.6.3 by audible and visual signals. In critical care areas, visual alarms are sufficient. The fire alarm system transmits the alarm automatically to notify emergency forces in the event of a fire. Annunciation and annunciation zoning for fire alarm and sprinklers shall be provided by audible and visual indicators and zones shall not be larger than 22,500 square feet per zone. 18.3.4.3 through 18.3.4.3.3, 9.6.4	○	○	◉	
K344	**Fire Alarm – Control Functions** The fire alarm automatically activates required control functions and is provided with an alternative power supply in accordance with NFPA 72. 18.3.4.4, 19.3.4.4, 9.6.1, 9.6.5, NFPA 72	◉	○	○	

ID PREFIX		MET	NOT MET	N/A	REMARKS
K345	**Fire Alarm System – Testing and Maintenance** A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, *National Electric Code,* and NFPA 72, *National Fire Alarm and Signaling Code.* Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72	◉	○	○	
K346	**Fire Alarm – Out of Service** Where required fire alarm system is out of services for more than 4 hours in a 24 hour period, the authority having jurisdiction shall be notified, and the building shall be evacuated or an approved fire watch shall be provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service. 9.6.1.6	◉	○	○	
K347	**Smoke Detection** 2012 EXISTING Smoke detection systems are provided in spaces open to corridors as required by 19.3.6.1. 19.3.4.5.2	◉	○	○	
	2012 NEW Smoke detection systems are provided in spaces open to corridors as required by 18.3.6.1 In nursing homes, an automatic smoke detection system is installed in the corridors of all smoke compartments containing resident sleeping rooms, unless the resident sleeping rooms have: • smoke detection, or • automatic door closing devices with integral smoke detectors on the room side that provide occupant notification. Such detectors are electrically interconnected to the fire alarm system. 18.3.4.5.2, 18.3.4.5.3	○	○	◉	

ID PREFIX		MET	NOT MET	N/A	REMARKS
K351	**Sprinkler System – Installation** 2012 EXISTING Nursing homes, and hospitals where required by construction type, are protected throughout by an approved automatic sprinkler system in accordance with NFPA 13, *Standard for the Installation of Sprinkler Systems.* In Type I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where state or local regulations prohibit sprinklers. In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area of the closet does not exceed 6 ft² and sprinkler coverage covers the closet footprint as required by NFPA 13, *Standard for Installation of Sprinkler Systems.* 19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1)	◉	○	○	
	2012 NEW Buildings are to be protected throughout by an approved automatic sprinkler system in accordance with NFPA 13, *Standard for the Installation of Sprinkler Systems.* In Type I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where State and local regulations prohibit sprinklers. Listed quick-response or listed residential sprinklers are used throughout smoke compartments with patient sleeping rooms. In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area of the closet does not exceed 6 ft² and sprinkler coverage covers the closet footprint as required by NFPA 13, *Standard for Installation of Sprinkler Systems.* 18.3.5.1, 18.3.5.4, 18.3.5.5, 18.3.5.6, 9.7, 9.7.1.1(1), 18.3.5.10	○	○	◉	
K352	**Sprinkler System – Supervisory Signals** Automatic sprinkler system supervisory attachments are installed and monitored for integrity in accordance with NFPA 72, *National Fire Alarm and Signaling Code,* and provide a signal that sounds and is displayed at a continuously attended location or approved remote facility when sprinkler operation is impaired. 9.7.2.1, NFPA 72	◉	○	○	

ID PREFIX		MET	NOT MET	N/A	REMARKS
K353	**Sprinkler System – Maintenance and Testing** Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, *Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems.* Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked. 07/22/2021 b) Who provided system test. SUMMIT c) Water system supply source. CITY *Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system.* 9.7.5, 9.7.7, 9.7.8, and NFPA 25	○	◉	○	1. On 09/30/2021 between 09:30 AM to 02:30 PM, it was revealed during the walk-through of the facility that in the Kitchen, the sprinkler heads near the food prep area, the main stove, and the dish-washing area, exhibited signs of oxidation. 2. On 09/30/2021 between 09:30 AM to 02:30 PM, it was revealed during the walk-through of the facility that in the Staffing Central Supplies area, located in the basement, was found to have data cabling zip-tied to the sprinkler system piping.
K354	**Sprinkler System – Out of Service** Where the sprinkler system is impaired, the extent and duration of the impairment has been determined, areas or buildings involved are inspected and risks are determined, recommendations are submitted to management or designated representative, and the fire department and other authorities having jurisdiction have been notified. Where the sprinkler system is out of service for more than 10 hours in a 24 hour period, the building or portion of the building affected are evacuated or an approved fire watch is provided until the sprinkler system has been returned to service. 18.3.5.1, 19.3.5.1, 9.7.5, 15.5.2 (NFPA 25)	◉	○	○	
K355	**Portable Fire Extinguishers** Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, *Standard for Portable Fire Extinguishers.* 18.3.5.12, 19.3.5.12, NFPA 10	◉	○	○	
K361	**Corridors – Areas Open to Corridor** Spaces (other than patient sleeping rooms, treatment rooms and hazardous areas), waiting areas, nurse's stations, gift shops, and cooking facilities, open to the corridor are in accordance with the criteria under 18.3.6.1 and 19.3.6.1. 18.3.6.1, 19.3.6.1	◉	○	○	

ID PREFIX		MET	NOT MET	N/A	REMARKS
K362	**Corridors – Construction of Walls** 2012 EXISTING Corridors are separated from use areas by walls constructed with at least ½ hour fire resistance rating. In fully sprinklered smoke compartments, partitions are only required to resist the transfer of smoke. In nonsprinklered buildings, walls extend to the underside of the floor or roof deck above the ceiling. Corridor walls may terminate at the underside of ceilings where specifically permitted by Code. Fixed fire window assemblies in corridor walls are in accordance with Section 8.3, but in sprinklered compartments there are no restrictions in area or fire resistance of glass or frames. *If the walls have a fire resistance rating, give the rating* SMK *if the walls terminate at the underside of the ceiling, give brief description in REMARKS, describing the ceiling throughout the floor area.* 19.3.6.2, 19.3.6.2.7	◉	○	○	
	2012 NEW Corridor walls shall form a barrier to limit the transfer of smoke. Such walls shall be permitted to terminate at the ceiling where the ceiling is constructed to limit the transfer of smoke. No fire resistance rating is required for the corridor walls. 18.3.6.2	○	○	◉	

ID PREFIX		MET	NOT MET	N/A	REMARKS
K363	**Corridor – Doors** 2012 EXISTING Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1¾ inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5lbf is applied, whether or not power is applied. Clearance between bottom of door and floor covering is not exceeding 1 inch. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc.	◉	○	○	
	2012 NEW Doors protecting corridor openings shall be constructed to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have self-latching and positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5lbf is applied, whether or not power is applied. Clearance between bottom of door and floor covering is not exceeding 1 inch. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 18.3.6.3.6 are permitted. 18.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatic closing devices, etc.	○	○	◉	

ID PREFIX		MET	NOT MET	N/A	REMARKS
K364	**Corridor – Openings** Transfer grilles are not used in corridor walls or doors. Auxiliary spaces that do not contain flammable or combustible materials are permitted to have louvers or be undercut. In other than smoke compartments containing patient sleeping rooms, miscellaneous openings are permitted in vision panels or doors, provided the openings per room do not exceed 20 in² and are at or below half the distance from floor to ceiling. In sprinklered rooms, the openings per room do not exceed 80 in². Vision panels in corridor walls or doors shall be fixed window assemblies in approved frames. (In fully sprinklered smoke compartments, there are no restrictions in the area and fire resistance of glass and frames.) 18.3.6.5.1, 19.3.6.5.2, 8.3	◉	○	○	
K371	**Subdivision of Building Spaces – Smoke Compartments** 2012 EXISTING Smoke barriers shall be provided to form at least two smoke compartments on every sleeping floor with a 30 or more patient bed capacity. Size of compartments cannot exceed 22,500 square feet or a 200-foot travel distance from any point in the compartment to a door in the smoke barrier. 19.3.7.1, 19.3.7.2 *Detail in REMARKS zone dimensions including length of zones and dead-end corridors.*	◉	○	○	
	2012 NEW Smoke barriers shall be provided to form at least two smoke compartments on every floor used by inpatients for sleeping or treatment, and on every floor with an occupant load of 50 or more persons, regardless of use. Size of compartments cannot exceed 22,500 square feet or a 200-foot travel distance from any point in the compartment to a door in the smoke barrier. Smoke subdivision requirements do not apply to any of the stories or areas described in 18.3.7.2. 18.3.7.1, 18.3.7.2 *Detail in REMARKS zone dimensions including length of zones and dead-end corridors.*	○	○	◉	

ID PREFIX		MET	NOT MET	N/A	REMARKS
K372	**Subdivision of Building Spaces – Smoke Barrier Construction** 2012 EXISTING Smoke barriers shall be constructed to a ½ hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) *Describe any mechanical smoke control system in REMARKS.*	◉	○	○	
	2012 NEW Smoke barriers shall be constructed to provide at least a 1-hour fire resistance rating and constructed in accordance with 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations of fully ducted HVAC systems. 18.3.7.3, 18.3.7.4, 18.3.7.5, 8.3 *Describe any mechanical smoke control system in REMARKS.*	○	○	◉	
K373	**Subdivision of Building Spaces – Accumulation Space** Space shall be provided on each side of smoke barriers to adequately accommodate the total number of occupants in adjoining compartments. 18.3.7.5.1, 18.3.7.5.2, 19.3.7.5.1, 19.3.7.5.2	◉	○	○	
K374	**Subdivision of Building Spaces – Smoke Barrier Doors** 2012 EXISTING Doors in smoke barriers are 1¾-inch thick solid bonded wood-core doors or of construction that resists fire for 20 minutes. Nonrated protective plates of unlimited height are permitted. Doors are permitted to have fixed fire window assemblies per 8.5. Doors are self-closing or automatic-closing, do not require latching, and are not required to swing in the direction of egress travel. Door opening provides a minimum clear width of 32 in for swinging or horizontal doors. 19.3.7.6, 19.3.7.8, 19.3.7.9	◉	○	○	

ID PREFIX		MET	NOT MET	N/A	REMARKS
K374	2012 NEW Doors in smoke barriers have at least a 20-minute fire protection rating or are at least 1¾-inch thick solid bonded core wood. Required clear widths are provided per 18.3.7.6(4) and (5). Nonrated protective plates of unlimited height are permitted. Horizontal-sliding doors comply with 7.2.1.14. Swinging doors shall be arranged so that each door swings in an opposite direction. Doors shall be self-closing and rabbets, bevels, or astragals are required at the meeting edges. Positive latching is not required. 18.3.7.6, 18.3.7.7, 18.3.7.8	○	○	◉	
K379	**Smoke Barrier Door Glazing** 2012 EXISTING Openings in smoke barrier doors shall be fire-rated glazing or wired glass panels in steel frames. 19.3.7.6, 19.3.7.6.2, 8.5	◉	○	○	
	2012 NEW Windows in smoke barrier doors shall be installed in each cross corridor swinging or horizontal-sliding door protected by fire-rated glazing or by wired glass panels in approved frames. 18.3.7.9	○	○	◉	
K381	**Sleeping Room Outside Windows and Doors** Every patient sleeping room has an outside window or outside door. In new occupancies, sill height does not exceed 36 inches above the floor. Windows in atrium walls are considered outside windows. Newborn nurseries and rooms intended for occupancy less than 24 hours have no outside window or door requirements. Window sills in special nursing care areas (e.g., ICU, CCU, hemodialysis, neonatal) do not exceed 60 inches above the floor. 42 CFR 403, 418, 460, 482, 483, and 485	◉	○	○	
	SECTION 4 – SPECIAL PROVISIONS				
K400	**Special Provisions – Other** List in the REMARKS section any LSC Section 18.4 and 19.4 Special Provisions requirements that are not addressed by the provided K-tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567.	◉	○	○	

ID PREFIX		MET	NOT MET	N/A	REMARKS
K421	**High-Rise Buildings** 2012 EXISTING High-rise buildings are protected throughout by an approved, supervised automatic sprinkler system in accordance with Section 9.7 within 12 years of LSC final rule effective date. 19.4.2	○	○	◉	
	2012 NEW High-rise buildings comply with section 11.8. 18.4.2	○	○	◉	
	SECTION 5 – BUILDING SERVICES				
K500	**Building Services – Other** List in the REMARKS section any LSC Section 18.5 and 19.5 Building Services requirements that are not addressed by the provided K-tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567.	◉	○	○	
K511	**Utilities – Gas and Electric** Equipment using gas or related gas piping complies with NFPA 54, *National Fuel Gas Code*, electrical wiring and equipment complies with NFPA 70, *National Electric Code*. Existing installations can continue in service provided no hazard to life. 18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2	○	◉	○	On 09/30/2021 between 09:30 AM to 02:30 PM, it was revealed during the walk-through of the facility that the electrical panel on the 1st floor in the main resident corridor was found unsecured.
K521	**HVAC** Heating, ventilation, and air conditioning shall comply with 9.2 and shall be installed in accordance with the manufacturer's specifications. 18.5.2.1, 19.5.2.1, 9.2	○	◉	○	On 09/30/2021 between 09:30 AM to 02:30 PM, observations revealed the ventilation system for the corridors are utilizing the egress corridor as an exhaust plenum for the ducted make-up air. The resident rooms are heated by hot water system and the corridors are heated by forced air. The resident bathroom fans run continuously and exhaust to the exterior and have dampers located in them.
K522	**HVAC – Any Heating Device** Any heating device, other than a central heating plant, is designed and installed so combustible materials cannot be ignited by device, and has a safety feature to stop fuel and shut down equipment if there is excessive temperature or ignition failure. If fuel fired, the device also: • is chimney or vent connected. • takes air for combustion from outside. • provides for a combustion system separate from occupied area atmosphere. 18.5.2.2, 19.5.2.2	◉	○	○	

ID PREFIX		MET	NOT MET	N/A	REMARKS
K523	**HVAC – Suspended Unit Heaters** Suspended unit heaters are permitted provided the following are met: • Not located in means of egress or in patient rooms. • Located high enough to be out of reach of people in the area. • Has a safety feature to stop fuel and shut down equipment if there is excessive temperature or ignition failure. 18.5.2.3(1), 19.5.2.3(1)	○	○	◉	
K524	**HVAC – Direct-Vent Gas Fireplaces** Direct-vent gas fireplaces, as defined in NFPA 54, inside of all smoke compartments containing patient sleeping areas comply with the requirements of 18.5.2.3(2), 19.5.2.3(2). 18.5.2.3(2), 19.5.2.3(2), NFPA 54	○	○	◉	
K525	**HVAC – Solid Fuel-Burning Fireplaces** Solid fuel-burning fireplaces are permitted in other than patient sleeping areas provided: • Areas are separated by 1-hour fire resistance construction. • Fireplace complies with 9.2.2. • Fireplace enclosure resists breakage up to 650°F and has heat-tempered glass. • Room has supervised CO detection per 9.8. 18.5.2.3(3) and 19.5.2.3(3)	○	○	◉	
K531	**Elevators** 2012 EXISTING Elevators comply with the provision of 9.4. Elevators are inspected and tested as specified in ASME A17.1, *Safety Code for Elevators and Escalators.* Firefighter's Service is operated monthly with a written record. Existing elevators conform to ASME/ANSI A17.3, *Safety Code for Existing Elevators and Escalators.* All existing elevators, having a travel distance of 25 feet or more above or below the level that best serves the needs of emergency personnel for firefighting purposes, conform with Firefighter's Service Requirements of ASME/ANSI A17.3. (Includes firefighter's service Phase I key recall and smoke detector automatic recall, firefighter's service Phase II emergency in-car key operation, machine room smoke detectors, and elevator lobby smoke detectors.) 19.5.3, 9.4.2, 9.4.3	◉	○	○	

ID PREFIX		MET	NOT MET	N/A	REMARKS
K531	2012 NEW Elevators comply with the provision of 9.4. Elevators are inspected and tested as specified in ASME A17.1, *Safety Code for Elevators and Escalators.* Firefighter's Service is operated monthly with a written record. New elevators conform to ASME/ANSI A17.1, *Safety Code for Elevators and Escalators,* including Firefighter's Service Requirements. (Includes firefighter's Phase I key recall and smoke detector automatic recall, firefighter's service Phase II emergency in-car key operation, machine room smoke detectors, and elevator lobby smoke detectors.) 18.5.3, 9.4.2, 9.4.3	○	○	◉	
K532	**Escalators, Dumbwaiters, and Moving Walks** 2012 EXISTING Escalators, dumbwaiters, and moving walks comply with the provisions of 9.4. All existing escalators, dumbwaiters, and moving walks conform to the requirements of ASME/ANSI A17.3, *Safety Code for Existing Elevators and Escalators.* (Includes escalator emergency stop buttons and automatic skirt obstruction stop. For power dumbwaiters, includes hoistway door locking to keep doors closed except for floor where car is being loaded or unloaded.) 19.5.3, 9.4.2.2	○	○	◉	
	2012 NEW Escalators, dumbwaiters, and moving walks comply with the provisions of 9.4. 18.5.3, 9.4.2.2	○	○	◉	

ID PREFIX		MET	NOT MET	N/A	REMARKS
K541	**Rubbish Chutes, Incinerators, and Laundry Chutes** 2012 EXISTING (1) Any existing linen and trash chute, including pneumatic rubbish and linen systems, that opens directly onto any corridor shall be sealed by fire resistive construction to prevent further use or shall be provided with a fire door assembly having a fire protection rating of 1-hour. All new chutes shall comply with 9.5. (2) Any rubbish chute or linen chute, including pneumatic rubbish and linen systems, shall be provided with automatic extinguishing protection in accordance with 9.7. (3) Any trash chute shall discharge into a trash collection room used for no other purpose and protected in accordance with 8.4. (Existing laundry chutes permitted to discharge into same room are protected by automatic sprinklers in accordance with 19.3.5.9 or 19.3.5.7.) (4) Existing fuel-fed incinerators shall be sealed by fire resistive construction to prevent further use. 19.5.4, 9.5, 8.4, NFPA 82	○	◉	○	On 09/30/2021 between 09:30 AM to 02:30 PM, it was revealed during the walk-through of the facility that the 2nd floor - Soiled Linen Room, laundry chute door was found to be left open and missing self-closing hardware.
	2012 NEW Rubbish chutes, incinerators, and laundry chutes shall comply with the provisions of Section 9.5, unless otherwise specified in 18.5.4.2. • The fire resistance rating of chute charging room shall not be required to exceed 1-hour. • Any rubbish chute or linen chute shall be provided with automatic extinguishing protection in accordance with Section 9.7. • Chutes shall discharge into a trash collection room used for no other purpose and shall be protected in accordance with 8.7. 18.5.4.2, 8.7, 9.5, 9.7, NFPA 82	○	○	◉	
	SECTION 6 – RESERVED				
	SECTION 7 – OPERATING FEATURES				
K700	**Operating Features – Other** List in the REMARKS section any LSC Section 18.7 and 19.7 Operating Features requirements that are not addressed by the provided K-tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included in Form CMS-2567.	◉	○	○	

ID PREFIX		MET	NOT MET	N/A	REMARKS
K711	**Evacuation and Relocation Plan** There is a written plan for the protection of all patients and for their evacuation in the event of an emergency. Employees are periodically instructed and kept informed with their duties under the plan, and a copy of the plan is readily available with telephone operator or with security. The plan addresses the basic response required of staff per 18/19.7.2.1.2 and provides for all of the fire safety plan components per 18/19.7.2.2. 18.7.1.1 through 18.7.1.3, 18.7.2.1.2, 18.7.2.2, 18.7.2.3, 19.7.1.1 through 19.7.1.3, 19.7.2.1.2, 19.7.2.2, 19.7.2.3	◉	○	○	
K712	**Fire Drills** Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 18.7.1.4 through 18.7.1.7, 19.7.1.4 through 19.7.1.7	◉	○	○	

ID PREFIX		MET	NOT MET	N/A	REMARKS
K741	**Smoking Regulations** Smoking regulations shall be adopted and shall include not less than the following provisions: (1) Smoking shall be prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area shall be posted with signs that read NO SMOKING or shall be posted with the international symbol for no smoking. (2) In health care occupancies where smoking is prohibited and signs are prominently placed at all major entrances, secondary signs with language that prohibits smoking shall not be required. (3) Smoking by patients classified as not responsible shall be prohibited. (4) The requirement of 18.7.4(3) shall not apply where the patient is under direct supervision. (5) Ashtrays of noncombustible material and safe design shall be provided in all areas where smoking is permitted. (6) Metal containers with self-closing cover devices into which ashtrays can be emptied shall be readily available to all areas where smoking is permitted. 18.7.4, 19.7.4	◉	○	○	
K751	**Draperies, Curtains, and Loosely Hanging Fabrics** Draperies, curtains including cubicle curtains and loosely hanging fabric or films shall be in accordance with 10.3.1. Excluding curtains and draperies: at showers and baths; on windows in patient sleeping room located in sprinklered compartments; and in non-patient sleeping rooms in sprinklered compartments where individual drapery or curtain panels do not exceed 48 square feet or total area does not exceed 20 percent of the wall. 18.7.5.1, 18.3.5.11, 19.7.5.1, 19.3.5.11, 10.3.1	◉	○	○	

ID PREFIX		MET	NOT MET	N/A	REMARKS
K752	**Upholstered Furniture and Mattresses** Newly introduced upholstered furniture meets Class I or char length, and heat release criteria in accordance with 10.3.2.1 and 10.3.3, unless the building is fully sprinklered. Newly introduced mattresses shall meet char length and heat release criteria in accordance with 10.3.2.2 and 10.3.4, unless the building is fully sprinklered. Upholstered furniture and mattresses belonging to nursing home residents do not have to meet these requirements as all nursing homes are required to be fully sprinklered. Newly introduced upholstered furniture and mattresses means purchased on or after the LSC final rule effective date. 18.7.5.2, 18.7.5.4, 19.7.5.2, 19.7.5.4	◉	○	○	
K753	**Combustible Decorations** Combustible decorations shall be prohibited unless one of the following is met: • Flame retardant or treated with approved fire-retardant coating that is listed and labeled for product. • Decorations meet NFPA 701. • Decorations exhibit heat release less than 100 kilowatts in accordance with NFPA 289. • Decorations, such as photographs, paintings and other art are attached to the walls, ceilings and non-fire-rated doors in accordance with 18.7.5.6(4) or 19.7.5.6(4). • The decorations in existing occupancies are in such limited quantities that a hazard of fire development or spread is not present. 18.7.5.6, 19.7.5.6	◉	○	○	
K761	**Maintenance, Inspection & Testing - Doors** Fire doors assemblies are inspected and tested annually in accordance with NFPA 80 *Standard for Fire Doors and Other Opening Protectives*. Fire doors that are not located in required fire barriers, including corridor doors to patient rooms and smoke barrier doors, are routinely inspected as part of the facility maintenance program. Individuals performing the door inspection and testing have an understanding of the operating components of the doors. Written records of inspection and testing are maintained and are available for review. 18.7.6, 19.7.6, 8.3.3.1 (LSC), 5.2, 5.2.3 (NFPA 80)	◉	○	○	

ID PREFIX		MET	NOT MET	N/A	REMARKS
K754	**Soiled Linen and Trash Containers** Soiled linen or trash collection receptacles shall not exceed 32 gallons in capacity. The average density of container capacity in a room or space shall not exceed 0.5 gallons/square feet. A total container capacity of 32 gallons shall not be exceeded within any 64 square feet area. Mobile soiled linen or trash collection receptacles with capacities greater than 32 gallons shall be located in a room protected as a hazardous area when not attended. Containers used solely for recycling are permitted to be excluded from the above requirements where each container is ≤ 96 gal. unless attended, and containers for combustibles are labeled and listed as meeting FM Approval Standard 6921 or equivalent. 18.7.5.7, 19.7.5.7	◉	○	○	
K771	**Engineer Smoke Control Systems** 2012 EXISTING When installed, engineered smoke control systems are tested in accordance with established engineering principles. Test documentation is maintained on the premises. 19.7.7	○	○	◉	
	2012 NEW When installed, engineered smoke control systems are tested in accordance with NFPA 92, *Standard for Smoke Control Systems*. Test documentation is maintained on the premises. 18.7.7	○	○	◉	
K781	**Portable Space Heaters** Portable space heating devices shall be prohibited in all health care occupancies. Unless used in nonsleeping staff and employee areas where the heating elements do not exceed 212 degrees Fahrenheit (100 degrees Celsius). 18.7.8, 19.7.8	○	○	◉	
K791	**Construction, Repair, and Improvement Operations** Construction, repair, and improvement operations shall comply with 4.6.10. Any means of egress in any area undergoing construction, repair, or improvements shall be inspected daily to ensure its ability to be used instantly in case of emergency and compliance with NFPA 241. 18.7.9, 19.7.9, 4.6.10, 7.1.10.1	○	○	◉	

ID PREFIX		MET	NOT MET	N/A	REMARKS
	PART II – HEALTH CARE FACILITIES CODE REQUIREMENTS				
K900	**Health Care Facilities Code - Other** List in the REMARKS section any NFPA 99 requirements (excluding Chapter 7, 8, 12, and 13) that are not addressed by the provided K-Tags, but are deficient. This information, along with the applicable Health Care Facilities Code or NFPA standard citation, should be included on Form CMS-2567.	◉	○	○	
K901	**Fundamentals – Building System Categories** Building systems are designed to meet Category 1 through 4 requirements as detailed in NFPA 99. Categories are determined by a formal and documented risk assessment procedure performed by qualified personnel. Chapter 4 (NFPA 99)	◉	○	○	
K902	**Gas and Vacuum Piped Systems – Other** List in the REMARKS section any NFPA 99 Chapter 5 Gas and Vacuum Systems requirements that are not addressed by the provided K-Tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. Chapter 5 (NFPA 99)	○	○	◉	
K903	**Gas and Vacuum Piped Systems – Categories** Medical gas, medical air, surgical vacuum, WAGD, and air supply systems are designated: ☐ Category 1. Systems in which failure is likely to cause major injury or death. ☐ Category 2. Systems in which failure is likely to cause minor injury. ☐ Category 3. Systems in which failure is not likely to cause injury, but can cause discomfort. Deep sedation and general anesthesia are not to be administered using a Category 3 medical gas system. 5.1.1.1, 5.2.1, 5.3.1.1, 5.3.1.5 (NFPA 99)	○	○	◉	
K904	**Gas and Vacuum Piped Systems – Warning Systems** All master, area, and local alarm systems used for medical gas and vacuum systems comply with appropriate Category warning system requirements, as applicable. 5.1.9, 5.2.9, 5.3.6.2.2 (NFPA 99)	○	○	◉	

ID PREFIX		MET	NOT MET	N/A	REMARKS
K905	**Gas and Vacuum Piped Systems – Central Supply System Identification and Labeling** Containers, cylinders and tanks are designed, fabricated, tested, and marked in accordance with 5.1.3.1.1 through 5.1.3.1.7. Locations containing only oxygen or medical air have doors labeled with "Medical Gases, NO Smoking or Open Flame". Locations containing other gases have doors labeled "Positive Pressure Gases, NO Smoking or Open Flame, Room May Have Insufficient Oxygen, Open Door and Allow Room to Ventilate Before Opening." 5.1.3.1, 5.2.3.1, 5.3.10 (NFPA 99)	○	○	◉	
K906	**Gas and Vacuum Piped Systems – Central Supply System Operations** Adaptors or conversion fittings are prohibited. Cylinders are handled in accordance with 11.6.2. Only cylinders, reusable shipping containers, and their accessories are stored in rooms containing central supply systems or cylinders. No flammable materials are stored with cylinders. Cryogenic liquid storage units intended to supply the facility are not used to transfill. Cylinders are kept away from sources of heat. Valve protection caps are secured in place, if supplied, unless cylinder is in use. Cylinders are not stored in tightly closed spaces. Cylinders in use and storage are prevented from exceeding 130°F, and nitrous oxide and carbon dioxide cylinders are prevented from reaching temperatures lower than manufacture recommendations or 20°F. Full or empty cylinders, when not connected, are stored in locations complying with 5.1.3.3.2 through 5.1.3.3.3, and are not stored in enclosures containing motor-driven machinery, unless for instrument air reserve headers. 5.1.3.2, 5.1.3.3.17, 5.1.3.3.1.8, 5.1.3.3.4, 5.2.3.2, 5.2.3.3, 5.3.6.20.4, 5.6.20.5, 5.3.6.20.7, 5.3.6.20.8, 5.3.6.20.9 (NFPA 99)	○	○	◉	
K907	**Gas and Vacuum Piped Systems – Maintenance Program** Medical gas, vacuum, WAGD, or support gas systems have documented maintenance programs. The program includes an inventory of all source systems, control valves, alarms, manufactured assemblies, and outlets. Inspection and maintenance schedules are established through risk assessment considering manufacturer recommendations. Inspection procedures and testing methods are established through risk assessment. Persons maintaining systems are qualified as demonstrated by training and certification or credentialing to the requirements of AASE 6030 or 6040. 5.1.14.2.1, 5.1.14.2.2, 5.1.15, 5.2.14, 5.3.13.4.2 (NFPA 99)	○	○	◉	

ID PREFIX		MET	NOT MET	N/A	REMARKS
K908	**Gas and Vacuum Piped Systems – Inspection and Testing Operations** The gas and vacuum systems are inspected and tested as part of a maintenance program and include the required elements. Records of the inspections and testing are maintained as required. 5.1.14.2.3, B.5.2, 5.2.13, 5.3.13, 5.3.13.4 (NFPA 99)	○	○	◉	
K909	**Gas and Vacuum Piped Systems – Information and Warning Signs** Piping is labeled by stencil or adhesive markers identifying the gas or vacuum system, including the name of system or chemical symbol, color code (Table 5.1.11), and operating pressure if other than standard. Labels are at intervals not more than 20 feet, are in every room, at both sides of wall penetrations, and on every story traversed by riser. Piping is not painted. Shutoff valves are identified with the name or chemical symbol of the gas or vacuum system, room or area served, and caution to not use the valve except in emergency. 5.1.14.3, 5.1.11.1, 5.1.11.2, 5.2.11, 5.3.13.3, 5.3.11 (NFPA 99)	○	○	◉	
K910	**Gas and Vacuum Piped Systems – Modifications** Whenever modifications are made that breach the pipeline, any necessary installer and verification test specified in 5.1.2 is conducted on the downstream portion of the medical gas piping system. Permanent records of all tests required by system verification tests are maintained. 5.1.14.4.1, 5.1.14.4.6, 5.2.13, 5.3.13.4.3 (NFPA 99)	○	○	◉	
K911	**Electrical Systems – Other** List in the REMARKS section any NFPA 99 Chapter 6 Electrical Systems requirements that are not addressed by the provided K-Tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. Chapter 6 (NFPA 99)	◉	○	○	
K912	**Electrical Systems – Receptacles** Power receptacles have at least one, separate, highly dependable grounding pole capable of maintaining low-contact resistance with its mating plug. In pediatric locations, receptacles in patient rooms, bathrooms, play rooms, and activity rooms, other than nurseries, are listed tamper-resistant or employ a listed cover. If used in patient care room, ground-fault circuit interrupters (GFCI) are listed. 6.3.2.2.6.2 (F), 6.3.2.2.4.2 (NFPA 99)	◉	○	○	

ID PREFIX		MET	NOT MET	N/A	REMARKS
K913	**Electrical Systems – Wet Procedure Locations** Operating rooms are considered wet procedure locations, unless otherwise determined by a risk assessment conducted by the facility governing body. Operating rooms defined as wet locations are protected by either isolated power or ground-fault circuit interrupters. A written record of the risk assessment is maintained and available for inspection. 6.3.2.2.8.4, 6.3.2.2.8.7, 6.4.4.2	○	○	◉	
K914	**Electrical Systems – Maintenance and Testing** Hospital-grade receptacles at patient bed locations and where deep sedation or general anesthesia is administered, are tested after initial installation, replacement or servicing. Additional testing is performed at intervals defined by documented performance data. Receptacles not listed as hospital-grade at these locations are tested at intervals not exceeding 12 months. Line isolation monitors (LIM), if installed, are tested at intervals of ≤ 1 month by actuating the LIM test switch per 6.3.2.6.3.6, which activates both visual and audible alarm. For LIM circuits with automated self-testing, this manual test is performed at intervals ≤ 12 months. LIM circuits are tested per 6.3.3.3.2 after any repair or renovation to the electric distribution system. Records are maintained of required tests and associated repairs or modifications, containing date, room or area tested, and results. 6.3.4 (NFPA 99)	◉	○	○	
K915	**Electrical Systems – Essential Electric System Categories** ○ Critical care rooms (Category 1) in which electrical system failure is likely to cause major injury or death of patients, including all rooms where electric life support equipment is required, are served by a Type 1 EES. ◉ General care rooms (Category 2) in which electrical system failure is likely to cause minor injury to patients (Category 2) are served by a Type 1 or Type 2 EES. ○ Basic care rooms (Category 3) in which electrical system failure is not likely to cause injury to patients and rooms other than patient care rooms are not required to be served by an EES. Type 3 EES life safety branch has an alternate source of power that will be effective for 1 1/2 hours. 3.3.138, 6.3.2.2.10, 6.6.2.2.2, 6.6.3.1.1 (NFPA 99), TIA 12-3	◉	○	○	

ID PREFIX		MET	NOT MET	N/A	REMARKS
K916	**Electrical Systems – Essential Electric System Alarm Annunciator** A remote annunciator that is storage battery powered is provided to operate outside of the generating room in a location readily observed by operating personnel. The annunciator is hard-wired to indicate alarm conditions of the emergency power source. A centralized computer system (e.g., building information system) is not to be substituted for the alarm annunciator. 6.4.1.1.17, 6.4.1.1.17.5 (NFPA 99)	◉	○	○	
K917	**Electrical Systems – Essential Electric System Receptacles** Electrical receptacles or cover plates supplied from the life safety and critical branches have a distinctive color or marking. 6.4.2.2.6, 6.5.2.2.4.2, 6.6.2.2.3.2 (NFPA 99)	◉	○	○	
K918	**Electrical Systems – Essential Electric System Maintenance and Testing** The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70)	◉	○	○	

ID PREFIX		MET	NOT MET	N/A	REMARKS
K919	**Electrical Equipment – Other** List in the REMARKS section any NFPA 99 Chapter 10, *Electrical Equipment*, requirements that are not addressed by the provided K-Tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. Chapter 10 (NFPA 99)	◉	○	○	
K920	**Electrical Equipment – Power Cords and Extension Cords** Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5	◉	○	○	

ID PREFIX		MET	NOT MET	N/A	REMARKS
K921	**Electrical Equipment – Testing and Maintenance Requirements** The physical integrity, resistance, leakage current, and touch current tests for fixed and portable patient-care related electrical equipment (PCREE) is performed as required in 10.3. Testing intervals are established with policies and protocols. All PCREE used in patient care rooms is tested in accordance with 10.3.5.4 or 10.3.6 before being put into service and after any repair or modification. Any system consisting of several electrical appliances demonstrates compliance with NFPA 99 as a complete system. Service manuals, instructions, and procedures provided by the manufacturer include information as required by 10.5.3.1.1 and are considered in the development of a program for electrical equipment maintenance. Electrical equipment instructions and maintenance manuals are readily available, and safety labels and condensed operating instructions on the appliance are legible. A record of electrical equipment tests, repairs, and modifications is maintained for a period of time to demonstrate compliance in accordance with the facility's policy. Personnel responsible for the testing, maintenance and use of electrical appliances receive continuing training. 10.3, 10.5.2.1, 10.5.2.1.2, 10.5.2.5, 10.5.3, 10.5.6, 10.5.8	◉	○	○	
K922	**Gas Equipment – Other** List in the REMARKS section any NFPA 99 Chapter 11 Gas Equipment requirements that are not addressed by the provided K-Tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. Chapter 11 (NFPA 99)	◉	○	○	

ID PREFIX		MET	NOT MET	N/A	REMARKS
K923	**Gas Equipment – Cylinder and Container Storage** **≥ 3,000 cubic feet** Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. **> 300 but <3,000 cubic feet** Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited- combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating. **≤ 300 cubic feet** In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of ≤ 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING". Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99)	○	◉	○	1. On 09/30/2021 between 09:30 AM to 02:30 PM, it was revealed during the walk-through of the facility that the 3rd Floor - Med Gas Storage Room was missing wall signage to identify the location for empty cylinders. 2. On 09/30/2021 between 09:30 AM to 02:30 PM, it was revealed during the walk-through of the facility that the 2nd Floor - Med Gas Storage Room was found to be unsecured and had unsecured oxygen cylinders inside the room. 3. On 09/30/2021 between 09:30 AM to 02:30 PM, it was revealed during the walk-through of the facility that the 1st Floor - Med Gas Storage Room was found to be unsecured, had unsecured oxygen cylinders, and had mixed storage of empty / full cylinders.
K924	**Gas Equipment – Testing and Maintenance Requirements** Anesthesia apparatus are tested at the final path to patient after any adjustment, modification or repair. Before the apparatus is returned to service, each connection is checked to verify proper gas and an oxygen analyzer is used to verify oxygen concentration. Defective equipment is immediately removed from service. Areas designated for servicing of oxygen equipment are clean and free of oil, grease, or other flammables. Manufacturer service manuals are used to maintain equipment and a scheduled maintenance program is followed. 11.4.1.3, 11.5.1.3, 11.6.2.5, 11.6.2.6 (NFPA 99)	○	○	◉	

ID PREFIX		MET	NOT MET	N/A	REMARKS
K925	**Gas Equipment – Respiratory Therapy Sources of Ignition** Smoking materials are removed from patients receiving respiratory therapy. When a nasal cannula is delivering oxygen outside of a patient's room, no sources of ignition are within in the site of intentional expulsion (1-foot). When other oxygen deliver equipment is used or oxygen is delivered inside a patient's room, no sources of ignition are within the area are of administration (15-feet). Solid fuel-burning appliances is not in the area of administration. Nonmedical appliances with hot surfaces or sparking mechanisms are not within oxygen-delivery equipment or site of intentional expulsion. 11.5.1.1, TIA 12-6 (NFPA 99)	◉	○	○	
K926	**Gas Equipment – Qualifications and Training of Personnel** Personnel concerned with the application, maintenance and handling of medical gases and cylinders are trained on the risk. Facilities provide continuing education, including safety guidelines and usage requirements. Equipment is serviced only by personnel trained in the maintenance and operation of equipment. 11.5.2.1 (NFPA 99)	◉	○	○	
K927	**Gas Equipment – Transfilling Cylinders** Transfilling of oxygen from one cylinder to another is in accordance with CGA P-2.5, *Transfilling of High Pressure Gaseous Oxygen Used for Respiration*. Transfilling of any gas from one cylinder to another is prohibited in patient care rooms. Transfilling to liquid oxygen containers or to portable containers over 50 psi comply with conditions under 11.5.2.3.1 (NFPA 99). Transfilling to liquid oxygen containers or to portable containers under 50 psi comply with conditions under 11.5.2.3.2 (NFPA 99). 11.5.2.2 (NFPA 99)	◉	○	○	

ID PREFIX		MET	NOT MET	N/A	REMARKS
K928	**Gas Equipment – Labeling Equipment and Cylinders** Equipment listed for use in oxygen-enriched atmospheres are so labeled. Oxygen metering equipment and pressure reducing regulators are labeled "OXYGEN-USE NO OIL". Flowmeters, pressure reducing regulators, and oxygen-dispensing apparatus are clearly and permanently labeled designating the gases for which they are intended. Oxygen-metering equipment, pressure reducing regulators, humidifiers, and nebulizers are labeled with name of manufacturer or supplier. Cylinders and containers are labeled in accordance with CGA C-7. Color coding is not utilized as the primary method of determining cylinder or container contents. All labeling is durable and withstands cleaning or disinfecting. 11.5.3.1 (NFPA 99)	◉	○	○	
K929	**Gas Equipment – Precautions for Handling Oxygen Cylinders and Manifolds** Handling of oxygen cylinders and manifolds is based on CGA G-4, Oxygen. Oxygen cylinders, containers, and associated equipment are protected from contact with oil and grease, from contamination, protected from damage, and handled with care in accordance with precautions provided under 11.6.2.1 through 11.6.2.4 (NFPA 99). 11.6.2 (NFPA 99)	◉	○	○	
K930	**Gas Equipment – Liquid Oxygen Equipment** The storage and use of liquid oxygen in base reservoir containers and portable containers comply with sections 11.7.2 through 11.7.4 (NFPA 99). 11.7 (NFPA 99)	○	◉	○	On 09/30/2021 between 09:30 AM to 02:30 PM, it was revealed during the walk-through of the facility that on the 2nd Floor in resident RM 218 that two 31 liter liquid oxygen cylinders were in the room. One cylinder was confirmed to be in use, the second cylinder was being stored in the room.
K931	**Hyperbaric Facilities** All occupancies containing hyperbaric facilities comply with construction, equipment, administration, and maintenance requirements of NFPA 99. Chapter 14 (NFPA 99)	○	○	◉	
K932	**Features of Fire Protection – Other** List in the REMARKS section any NFPA 99 Chapter 15 Features of Fire Protection requirements that are not addressed by the provided K-Tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. Chapter 15 (NFPA 99)	◉	○	○	

ID PREFIX		MET	NOT MET	N/A	REMARKS
K933	**Features of Fire Protection – Fire Loss Prevention in Operating Rooms** Periodic evaluations are made of hazards that could be encountered during surgical procedures, and fire prevention procedures are established. When flammable germicides or antiseptics are employed during surgeries utilizing electrosurgery, cautery or lasers: • packaging is non-flammable. • applicators are in unit doses. • Preoperative "time-out" is conducted prior the initiation of any surgical procedure to verify: o application site is dry prior to draping and use of surgical equipment. o pooling of solution has not occurred or has been corrected. o solution-soaked materials have been removed from the OR prior to draping and use of surgical devices. o policies and procedures are established outlining safety precautions related to the use of flammable germicide or antiseptic use. Procedures are established for operating room emergencies including alarm activation, evacuation, equipment shutdown, and control operations. Emergency procedures include the control of chemical spills, and extinguishment of drapery, clothing and equipment fires. Training is provided to new OR personnel (including surgeons), continuing education is provided, incidents are reviewed monthly, and procedures are reviewed annually. 15.13 (NFPA 99)	○	○	◉	

PART III – RECOMMENDATION FOR WAIVER OF SPECIFIC LIFE SAFETY CODE PROVISIONS

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

PROVISION NUMBER(S)	JUSTIFICATION
K400	

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

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

Provider Number	Facility Name	Survey Date
K1		*K4

K6 DATE OF PLAN APPROVAL

K3 MULTIPLE CONSTRUCTION ☐

TOTAL NUMBER OF BUILDINGS _____

NUMBER OF THIS BUILDING _____

A. BUILDING
B. WING
C. FLOOR
D. APARTMENT UNIT

LSC FORM INDICATOR

HEALTH CARE FORM		
12	2786R	2012 EXISTING
13	2786R	2012 NEW

AHCO FORM		
14	2786U	2012 EXISTING
15	2786U	2012 NEW

ICF/IID FORM		
16	2786V, W, X	2012 EXISTING
17	2786V, W, X	2012 NEW

*K7 ☐ SELECT NUMBER OF FORM USED FROM ABOVE

COMPLETE IF ICF/IID IS SURVEYED UNDER CHAPTER 33, EXISTING

SMALL (16 BEDS OR LESS)

K8 ☐
1. PROMPT
2. SLOW
3. IMPRACTICAL

LARGE

K8 ☐
4. PROMPT
5. SLOW
6. IMPRACTICAL

APARTMENT HOUSE

K8 ☐
7. PROMPT
8. SLOW
9. IMPRACTICAL

(Check if K321 or K351 are marked as not applicable in the 2786 M, R, T, U, V, W, X, and Y.)

K321: ☐ K351: ☐

COMPLETE IF ICF/IID IS SURVEYED UNDER CHAPTER 33, EXISTING

ENTER E – SCORE

K5: ☐ e.g. 2.5

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

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

FACILITY DOES NOT MEET LSC

B. ☐

K0180

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

*MANDATORY

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

PROVIDER NUMBER	FACILITY NAME	SURVEY DATE
K1 245492	**RICHFIELD A VILLA CENTER**	*K4 **09/30/2021**

K6 DATE OF PLAN APPROVAL

K3 : MULTIPLE CONSTRUCTION

TOTAL NUMBER OF BUILDINGS 1

NUMBER OF THIS BUILDING 01

[A]

A BUILDING
B WING
C FLOOR
D APARTMENT UNIT

LSC FORM INDICATOR

Health Care Form		
12	2786 R	2012 EXISTING
13	2786 R	2012 NEW

ASC Form		
14	2786 U	2012 EXISTING
15	2786 U	2012 NEW

ICF/MR Form		
16	2786 V, W, X	2012 EXISTING
17	2786 V, W, X	2012 NEW

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

(Check if K321 or K351 are marked as not applicable in the 2786 M, R, T, U, V, W, X, Y and Z.)

K321: [3] K351: [3]

COMPLETE IF ICF/MR IS SURVEYED UNDER CHAPTER 21

SMALL (16 BEDS OR LESS)

K8: [ ]

1 PROMPT
2 SLOW
3 IMPRACTICAL

LARGE

K8: [ ]

4 PROMPT
5 SLOW
6 IMPRACTICAL

APARTMENT HOUSE

K8: [ ]

7 PROMPT
8 SLOW
9 IMPRACTICAL

ENTER E-SCORE HERE

K5: [ ] e.g 2.5

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

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

FACILITY DOES NOT MEET LSC:

B. [ ]

K180:

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

*MANDATORY